Documentation Tips – Internal Medicine / Hospitalists

Principal Diagnoses (PDx):

- PDx is the condition(s) after careful study, present on admission (POA), requiring admission and treatment. Need to confirm even after resolved (i.e., *"Acute Respiratory Failure POA, resolved")*
- Explain underlying etiology where possible (i.e., *"Acute respiratory failure due to presumed gram negative pneumonia and longstanding chronic respiratory failure"*)

Secondary Diagnoses (CCs/MCCs):

- Include *all* diagnoses which are treated and/or monitored
- Identify as "present on admission" if appropriate
- Utilize subspecialty/surgical consults when needed to improve specificity of all diagnoses
- Consider documenting a diagnosis any time you do something to a patient *("CVC placement due to septic shock")*

Pearls for Hospitalist Documentation:

- Describe "Clinical Impression" (e.g. thought process)
  - Diagnoses are commonly not "certain"
  - Use words like *probable, likely, suspect*, etc.
- **Heart Failure** ("CHF" no longer adds to severity)
  - *Chronic* systolic, diastolic (or combined) failure adds severity as a comorbidity (CC)
  - *Acute* systolic, diastolic (or combined) failure adds severity as a *major* comorbidity (MCC)
- **Sepsis** = SIRS + infection (as the cause) – an MCC
  - Positive blood cultures not necessary
  - *Not* synonymous with "bacteremia"
  - "Urosepsis" = UTI (to a hospital coder)

- **Acute Renal Failure/Acute Kidney Injury** (AKI) – a CC
  - AKIN criteria - ↑ in Cr by 0.3-0.5 above normal baseline = *St 1 AKI*
  - Acute Renal *Insufficiency*, pre-renal azotemia, dehydration, etc = *low severity*

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- Acute Renal Failure with ATN (acute tubular necrosis) remains an MCC
- **Chronic Kidney Disease** (CKD) – *must* identify stage
  - Stage 4 (GFR<30) and stage 5 (GFR<15) = CC
  - Chronic Renal Insufficiency (CRI) = *low severity*
- **Acute Respiratory Failure** – an MCC
  - Clinical diagnosis, no need for ETT/mechanical ventilation
  - Respiratory distress = *little* credit
  - Pulmonary insufficiency (except post-op) = *low severity*
- **Encephalopathy** – an MCC
  - "Delirium" is not a CC unless specified as a certain type. Altered MS is a *symptom*
- **Chest pain** – need cause, even if "probable"
  - GERD, chest wall pain, angina, psychogenic angina, etc.
- **Pneumonia** – *Simple* vs. *Complex*
  - VAP, HCAP, HAP, NH-acquired, nosocomial, etc. = *simple Pna*
  - *Suspect* gram neg, MRSA, aspiration, etc. = *complex Pna*
- **Decubitus Ulcers** – Stage 3,4 are MCCs
  - Document as "POA," even if lesser stage on admission
- **Acute Coronary Syndrome** (ACS)
  - Documentation of ACS = unstable angina to coders
  - Document AMI (STEMI vs. NSTEMI) if indicated
- ***Severe* Malnutrition** (MCC)
  - Malnutrition or cachexia = CC
- **Acute blood loss anemia** (CC) – assoc w/GI diagnoses or post op
  - Don't need transfusion or active bleeding for dx
- **Symbols**
  - $\downarrow Na^{+} \neq$ hyponatremia (to a coder)

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