



Documentation Tips – Hospitalists

- Describe your “**Clinical Impression**” (e.g. thought process) even if not certain, using words like *probable, likely, suspect*, etc.
- **Heart Failure** (“CHF” no longer adds to severity)
 - *Chronic* systolic, diastolic (or combined) failure is a CC
 - *Acute* systolic, diastolic (or combined) failure is an MCC
- **Sepsis** = SIRS due to infection – an MCC
 - Dx doesn’t require + blood cultures (i.e., bacteremia)
 - Urosepsis = UTI (*not* sepsis due to UTI) to a coder
- **UTI** - clarification is necessary
 - Document if due to indwelling catheter *and* if POA
 - Document if presumed due to yeast/candida
- **Acute Renal Failure/Acute Kidney Injury (AKI)** – a CC
 - ↑ in Cr by 0.3-0.5 above normal baseline = *Stage 1 AKI*
 - Acute on chronic (CC), ESRD also MCC (“insufficiency” no CC)
 - ARnF(AKI) with ATN (acute tubular necrosis) remains an MCC
- **Chronic Kidney Disease (CKD)** – *must* identify stage
 - Stage 4 (GFR<30) and stage 5 (GFR<15) are CCs
 - Chronic Renal Insufficiency (CRI) = *low severity* – no CC
- **Acute Respiratory Failure** – an MCC
 - Clinical diagnosis and no need for ETT/mechanical ventilation
 - Not respiratory *distress* or *insufficiency*
 - If intubated, document time spent on ventilator
 - Document reason for weaning difficulties
- **Encephalopathy** – an MCC
 - “Delirium” is a CC, “altered MS” is a *symptom*
- **Chest pain** – need “probable” cause (GERD, chest wall, etc.)
- **Pneumonia** – *Simple vs. Complex (higher severity)*
 - VAP, HCAP, HAP, NH-acquired, nosocomial, etc. = *simple Pna*
 - *Probable* gram neg, MRSA, aspiration, etc. = *complex Pna*
- **Pleural Effusions** – *Exudative/transudative* non-specific to a coder, state *malignant, presumed bacterial*, etc.



- **Decubitus Ulcers** – Stage 3 and 4 are MCCs
 - Document as “POA,” even if lesser stage
- **Acute Coronary Syndrome (ACS)** = codes to *unstable angina* if not specified; document AMI (STEMI vs. NSTEMI) if indicated
- **Acute MI** - “8 week window” for AMI – document when MI (presumably) occurred and whether this is first episode of care
- **Cardiac Arrest vs. Respiratory Arrest** - be specific, as “*Cardiopulmonary Arrest*” will code to *cardiac arrest*
- **Severe Malnutrition** = MCC; malnutrition (or cachexia) = CC
- **Acute blood loss anemia (CC)** – “↓ crit” not sufficient
 - Don’t need transfusion or active bleeding for dx
- **Symbols** -- ↓ Na⁺ ≠ hyponatremia (to a coder)
- **Pancreatitis** - document SIRS and any acute organ dysfunction
- **Acute Gastroenteritis (AGE)**
 - Capture comorbidities, often *acute renal failure*
 - Identify underlying cause (e.g. organism) even if *presumed*
 - *Presumed* infectious colitis/GE/diarrhea is a CC
- **Meningitis** - *presumed bacterial* if treating, even w/o + Cx’s
- **FUO** - Consider *fever presumed 2° bacterial infection* if on Abx
- **Dementia, advanced** - “Functional Quadriplegia” is an MCC
- **Stroke/CVA** – w/hemiparesis/hemiplegia (new or old) – a CC
 - w/cerebral edema – an MCC
- **Hypertensive Encephalopathy** - *Accelerated* or *Malignant* HTN are CCs (“urgency,” “crisis,” or “emergency” are non-specific)
- **Syncope** – describe “probable” underlying etiology (“*Syncope due to presumed carotid sinus hypersensitivity*”)
- **Pulmonary Embolism** - document *acute cor pulmonale* (an MCC) if present
- **Pathologic (or Osteoporotic) Fx** – instead of *compression fx*
- **Aplastic Anemia, Bone Marrow failure, or Pancytopenia 2° Chemo** - all MCCs. Anemia 2° Chemo – *not* a CC or MCC