Documentation Tips – Internal Medicine

- 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 if specific type, "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