Documentation Tips – Pulmonology/Critical Care

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 on chronic respiratory failure due to presumed aspiration pneumonia"*)

Secondary Diagnoses (CCs/MCCs):

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

Pearls for Pulmonologist 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)
  - Right heart failure = heart failure to a coder … consider "Acute cor pulmonale" (an MCC) if indicated
- **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*

- 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
  - COPD, describe as acute exacerbation
  - If intubated, document time spent on ventilator
  - Document reason for weaning difficulties
  - Respiratory distress = *low severity*
  - Pulmonary insufficiency (except post-op) = *low severity*
- **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*
- **Pleural Effusions**
  - *Exudative is* non-specific to a coder – state *malignant, bacterial*, etc.
  - *Empyema* codes same as complex pna
- **Pulmonary Embolism**
  - Document *acute cor pulmonale* (MCC) if present
- **Acute Coronary Syndrome** (ACS)
  - Documentation of ACS = unstable angina to coders
  - Document AMI (STEMI vs. NSTEMI) if indicated
  - "8 week window" for AMI – document when MI occurred and whether this is first episode of care
- **Symbols**
  - ↓ Na^+ ≠ hyponatremia (to a coder)
- **Cardiac Arrest vs. Respiratory Arrest**
  - Be specific – "Cardiopulmonary Arrest" will code to cardiac arrest and lower RW DRG