Points to Consider:
- Clarify if fever is suspected to be bacterial, viral or other (e.g., leukemia) in origin.
- Document all active chronic comorbid conditions which may be affecting the patient's current condition (e.g., COPD, heart failure, diabetes, seizure disorder), which are being evaluated, monitored or treated.
- Document any arrhythmias (atrial fibrillation, PSVT, ventricular tachycardia, ventricular fibrillation) which required treatment, evaluation or monitoring.
- “SIRS due to an infection.” Clarify if patient has sepsis (systemic infection) or a localized infection.
- Positive blood cultures are not required to document diagnosis of sepsis or suspected sepsis.
- List each organ failure individually when patient has “multi-organ failure.”
- Clarify whether gastroenteritis is infectious (bacterial or viral) or non-infectious.
- Document associated dehydration or hypotension with gastroenteritis.

Medical Record Completion Requirements
- H&P: Must be completed within 24 hours following admission, but prior to surgery. Needs to include the chief reason for admission and all pertinent diagnoses and conditions that are present on admission. Include all signs and symptoms the patient is experiencing.
- Operative report: Must be completed within 24 hours of procedure and include a full description of procedure and any intra-operative or postoperative complications, if known.
- Discharge summary: Needs to include the final principal diagnosis, all secondary diagnoses which were clinically significant for the current hospitalization including all conditions that were resolved and each procedure performed. Also include indication if plan for readmission.

Definitions Important for Complete Documentation
- Principal diagnosis is that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
- CC: Comorbidity/Complication
- Comorbidity: A pre-existing condition present at the time of admission which may cause an increase in the length of stay
- Complication: a condition that arises during the hospital stay that may prolong the length of stay
- MCC: Major Comorbidity/Complication
- POA: Present on Admission
- HAC: Hospital Acquired Condition
- ROM: Risk of Mortality
- SOI: Severity of Illness

Common Severity/Mortality Drivers
- Acute renal failure (indicate underlying cause)
- Atrial fibrillation/flutter (document etiology if known/suspected)
- Coma
- COPD (document if with exacerbation or decompensated)
- Electrolyte imbalances (hypo/hypotremia, hypo/hyperkalemia, hypo/hypermagnesemia, hypo/hypercalcemia)
- Encephalopathy (specify type, acuity and cause)
- Gastrointestinal hemorrhage (document acuity and link to site of bleed)
- Heart failure (specify acuity and type)
- Hypotension (specify cause)
- Ileus
- Malnutrition (specify severity)
- Pressure ulcer (include anatomic location, laterality and stage)
- Respiratory failure (specify acuity)
- UTI (specify site of infection such as bladder, kidney, or urethra)
- Ventricular fibrillation

Basic Physician Documentation Requirements
- Document the reason(s) for the inpatient admission and the complex medical judgment factors to be considered including the severity of the signs and symptoms and the medical predictability of something adverse happening to the patient whenever possible to provide appropriate substantiation for severity of illness and risk of mortality.
- For all medications, treatments, and diagnostic studies, document the corresponding medical diagnoses indicating the clinical significance of the diagnosis. A code may not be assigned based on abnormal laboratory results or diagnostic report findings alone.
- Document all conditions including probable, suspected, or questionable based on your independent professional judgment and the clinical evidence and treatment provided. Clearly document if a condition was ruled out or was still considered probable at the time of discharge. Documentation should include the medical decision making process and supportive clinical information.
- Document all conditions still present, thorough possibly compensated or controlled, if they are currently being monitored, evaluated, treated, or causing increased nursing care or length of stay. These diagnoses should be listed as current medical conditions.
- Remove diagnoses from the problem list that are not clinically significant or have been ruled out.
1. **Cardiac enzymes elevated, elevated troponin, EKG positive**
   - Acute myocardial infarction (specify type such as STEMI or NSTEMI; specific artery involved such as LAD, left circumflex; exact date of any recent AMI)

2. **Acute coronary syndrome (ACS)**
   - Document intended diagnosis such as intermediate/insufficientisficiency syndrome, unstable angina, coronary slow flow syndrome, myocardial infarction

3. **Chest pain will treat with IV nitro and evaluate by cath**
   - Chest pain, evaluates by cath

4. **Acute coronary syndrome (ACS)**
   - Troponin, EKG positive
   - Cardiac enzymes elevated, elevated

5. **Cough + sputum culture, productive**
   - LUL infiltrate + sputum culture, productive
   - Hypercapnia, if present

6. **Respiratory distress, cyanosis, O2SOB, Pao2 64, pH 7.32, pCO2 40, K↓, Na↑**
   - Respiratory distress, cyanosis, O2SOB, Pao2 64, pH 7.32, pCO2 40, K↓, Na↑
   - Respiratory failure (specify type such as acute, chronic, acute on chronic; document hypoxia, if present)

7. **Unresponsive to painful stimuli, obtunded, GCS=8**
   - Unresponsive to painful stimuli, obtunded, GCS=8
   - Un responsive to painful stimuli, obtunded, GCS=8

8. **GI hemorrhage**
   - GI hemorrhage (specify acuity, underlying cause and site, if known or suspected, such as GI bleed due to acute gastric ulcer, diverticulitis with hemorrhage)

9. **Anemia**
   - Anemia (specify type, if known or suspected, such as acute or chronic blood loss anemia, anemia of chronic disease, hemolytic anemia, iron deficiency anemia, pancytopenia anemia)

10. **Abdominal distended, tender**
    - Abdominal distended, tender

11. **Ascites, ileus, fecal impaction, peritonitis**
    - Ascites, ileus, fecal impaction, peritonitis

12. **Pancreatitis**
    - Pancreatitis (specify acuity such as acute or chronic; specify etiology such as idiopathic acute pancreatitis or alcohol induced acute pancreatitis)

13. **Emaciated, ↓ albumin, weight loss, BMI 16.5, nonhealing wounds, nutritional consult, ordered**
    - Malnutrition (specify type such as protein calorie, protein energy; and severity such as mild, moderate or severe first or second or third degree)

14. **Dry mucous membranes, poor skin turgor, will rehydrate patient**
    - Dehydration

15. **Urinary retention (specify underlying cause if known or suspected)**
    - Urinary retention (specify underlying cause if known or suspected)