**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/hypernatremia, 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





# EMERGENCY MEDICINE

## DOCUMENTATION IMPACTING MS-DRG & APR-DRG ASSIGNMENT AND SEVERITY/MORTALITY PROFILES

*Dear Doctor, Please note that the Clinical Terms and Diagnostic Statements referenced are examples only, and in no way intended to lead the physician to any particular diagnosis. Your independent clinical judgment and documentation is the ultimate source of reference in the medical record.*

*A patient's Severity of Illness (SOI) and Risk of Mortality (ROM) is determined by the diagnostic terminology expressed in the medical record. Documentation must be accurate, complete and specific.*

**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, though 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.

3M

| *Clinical Terms (Needs clarification)* | *Diagnostic Statement (Accurate code may be assigned)* |
|---|---|
| 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) |
| Acute coronary syndrome (ACS) | Document intended diagnosis such as **intermediate/insufficiency syndrome, unstable angina, coronary slow flow syndrome, myocardial infarction** |
| Chest pain will treat with IV nitro and evaluate by cath | Specify cardiac cause such as **CAD (known or suspected), stable angina, unstable angina, AMI, aortic stenosis, hypertension, CHF** |
| Chest pain, noncardiac, treated with NSAID and H2-blockers | Specify diagnosis being treated even if considered probable or suspected such as **chest wall pain, GERD, costochondritis** |
| 1. Rales & rhonchi lung bases, lungs sound wet, RR = 30, Ejection fraction 24%, JVD<br>2. History of CHF, will continue furosemide, ACE inhibitors | **Heart failure** (specify type such as systolic, diastolic, combined systolic and diastolic; specify acuity such as acute, chronic, acute on chronic) |
| ↓BP, hemodynamically unstable, IV fluid bolus started, dopamine ordered | **Shock, hypotension** (specify type and etiology such as chronic, drug-induced, iatrogenic, idiopathic, intra-dialytic, orthostatic, intraoperative or postoperative) |
| 1. SOB, $pO_2$ 55, $pCO_2$ 64, pH 7.32, $O_2$ sat 88%, $O_2$ at 100% on BiPAP, on home $O_2$<br>2. Respiratory distress, cyanosis, ↑HR, labored respirations, RR 36 | **Respiratory failure** (specify acuity, if known or suspected: acute, chronic or acute on chronic; document hypoxia, hypercapnia, if present) |
| 1. LUL infiltrate<br>2. + sputum culture, productive cough | **Pneumonia** (specify type and organism, if known or suspected, such as Klebsiella pneumonia – must link responsible pathogen to the pneumonia; document cause such as aspiration pneumonia) |

| *Clinical Terms (Needs clarification)* | *Diagnostic Statement (Accurate code may be assigned)* |
|---|---|
| Pleuritic chest pain, SOB, $O_2$ sat 65% | **Pulmonary embolism** (specify type, if known or suspected, such as saddle, septic; specify acuity such as acute or chronic, specify source such as DVT; healed/old; document presence of cor pulmonale if applicable) |
| Asthma | Document severity and type (mild intermittent, mild persistent, moderate persistent, severe persistent), document status (uncomplicated, with acute exacerbation, or with status asthmaticus) |
| CT scan/MRI of brain indicative of infarction | **CVA/stroke/cerebral infarction** (specify if due to embolism, thrombosis, occlusion, stenosis – document the clinical significance from the diagnostic findings to the current condition; document artery involved such as carotid, middle cerebral, vertebral; document laterality such as left or right; document any associated cerebral edema) |
| Unresponsive to painful stimuli, obtunded, GCS=8 | **Coma/Comatose** (document specific cause, if known or suspected) |
| Urosepsis | Be clear on intended diagnosis such as **UTI, sepsis or severe sepsis.** Document any organ dysfunction and presence of shock. (Urosepsis is not a codeable diagnosis in ICD-10-CM) |
| SIRS | Identify the source of SIRS such as sepsis, severe sepsis, SIRS due to a noninfectious process (pancreatitis, neoplasm). List both the systemic infection, if present, and localized infection, if known or suspected. Document any organ dysfunction. |
| UTI, fever, BP 70/40, AMS, anuria, + blood culture, ↑BUN/Cr ordered IV antibiotics, IV fluid | **Severe sepsis** (defined as sepsis with acute organ dysfunction), **acute renal failure** (document specificity if known or suspected such as ATN) |

| *Clinical Terms (Needs clarification)* | *Diagnostic Statement (Accurate code may be assigned)* |
|---|---|
| BUN 80, Cr 2.5, scant urine output | **Acute renal failure** (document etiology, if known or suspected such as acute tubular, cortical or medullary necrosis; postprocedural; post-traumatic or drug-induced) chronic kidney disease (specify stage, if known or suspected) |
| ↑Na, K↓ | **Hypernatremia, hypokalemia**; specify actual diagnosis |
| Right calf swollen, reddened and tender | **Phlebitis, thrombophlebitis, deep venous thrombosis** (document site, acuity and laterality – e.g., acute venous thrombosis of right greater saphenous) |
| Coffee ground emesis, stools black, + occult blood | **GI hemorrhage** (specify acuity, underlying cause and site, if known or suspected, such as GI bleed due to acute gastric ulcer, diverticulitis with hemorrhage) |
| Hgb 6.8, Hct 25.5, 2 units PRBCs ordered | **Anemia** (specify type, if known or suspected, such as acute or chronic blood loss anemia, anemia of chronic disease, hemolytic anemia, iron deficiency anemia, pernicious anemia) |
| Abdomen distended, tender | **Ascites, ileus, fecal impaction, peritonitis** |
| Abdominal pain, increased lipase and amylase | **Pancreatitis** (specify acuity such as acute or chronic; specify etiology such as idiopathic acute pancreatitis or alcohol induced acute pancreatitis) |
| Emaciated, ↓ albumin, weight loss, BMI 16.5, nonhealing wounds, nutritional consult, ordered supplements | **Malnutrition** (specify type such as protein calorie, protein energy; and severity such as mild, moderate or severe or first, second or third degree) |
| Dry mucus membranes, poor skin turgor, will rehydrate patient | **Dehydration** |
| Unable to void, straight cath with 600 ml | **Urinary retention** (specify underlying cause if known or suspected) |