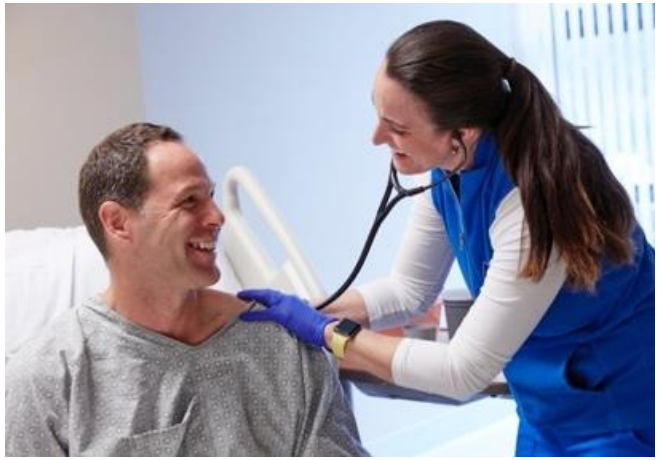




Tenet Health

Physician Education in Clinical Documentation Integrity

Accurately Documenting and Supporting Diagnoses in the Delivery of Inpatient Healthcare

CME

Q1 2025

Objectives

- Understand the impact of documentation on various patient, physician, and hospital metrics
- Understanding Discharge Planning
- Understand the basic concepts that occur when translating clinical language to coding language
- Be able to effectively and efficiently document clinical conditions for accurate SOI/ROM
- Understand how to use the Tenet tools available to assist with documentation
- Reduction in physician documentation clarification query volume

Goals for Participation

- Ensure clinical treatment matches the medical record documentation
- Utilize Tenet tools to assist with clinical documentation
- Reduce queries

The Impact of Clinical Documentation

- *Documentation Explosion*

Documentation Impact

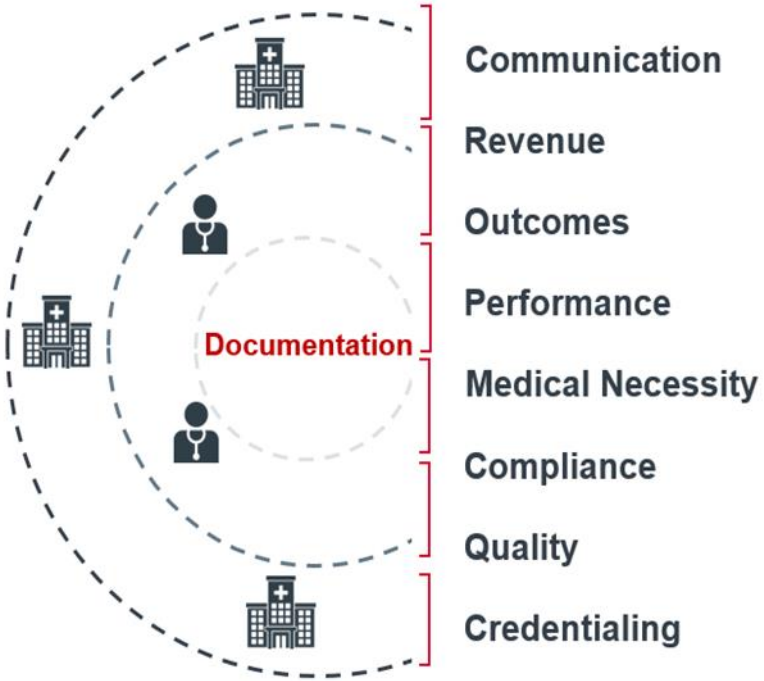
- Payers, Patients, State and Federal Governments
- Professional fees, VBP, MIPS
- Medical necessity, Level of Care, Hospital DRG's

Publiclly Reported Quality Data

- CMS Star ratings, Leapfrog Group, Specialty Societies

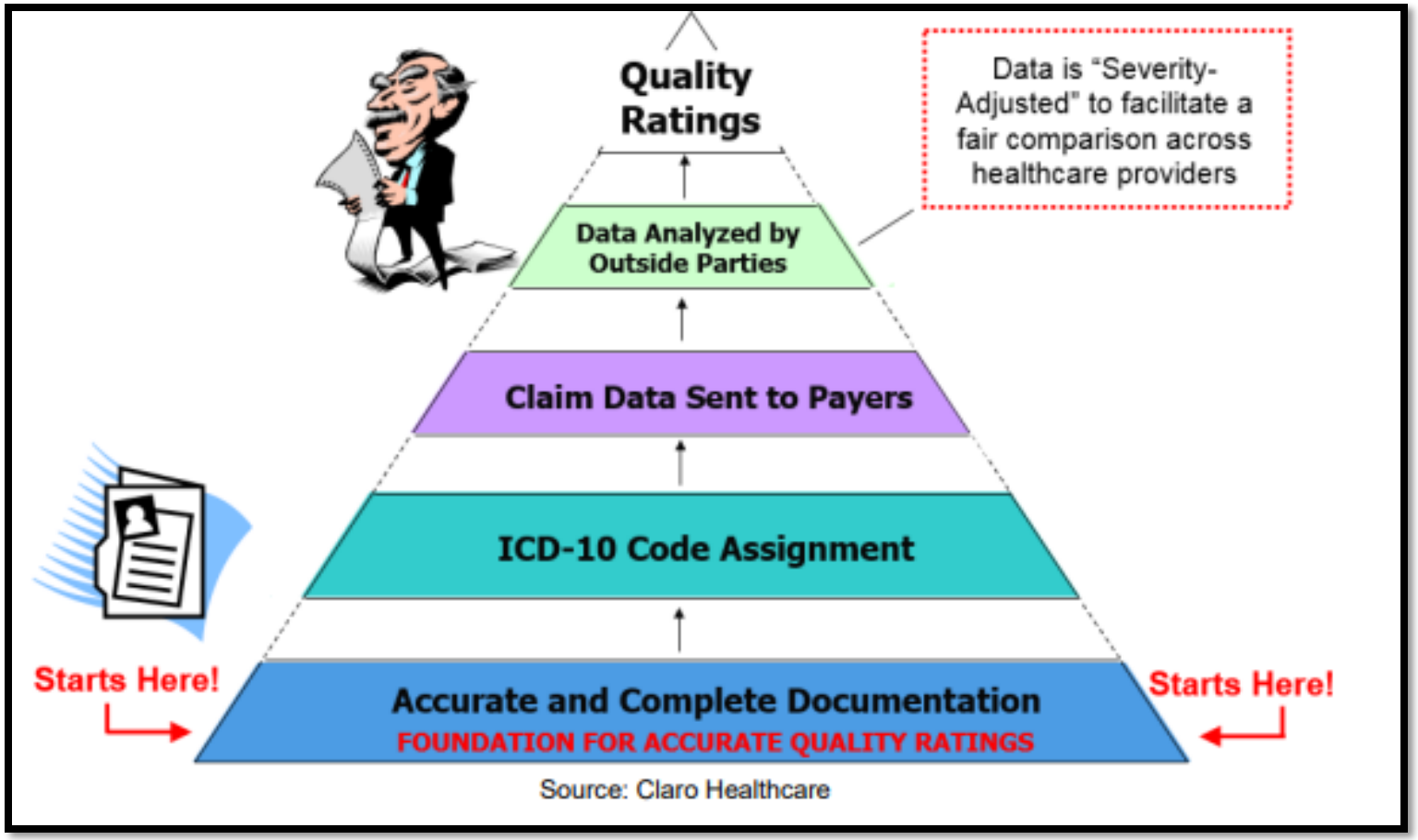
Population Health and Chronic Disease Managemer

- Claims data used to identify population groups



Documentation Impact

Lack of complete and accurate documentation can have a negative impact on the expected length of stay, expected mortality and quality ratings for both the hospital and the provider in the increasingly changing healthcare landscape.

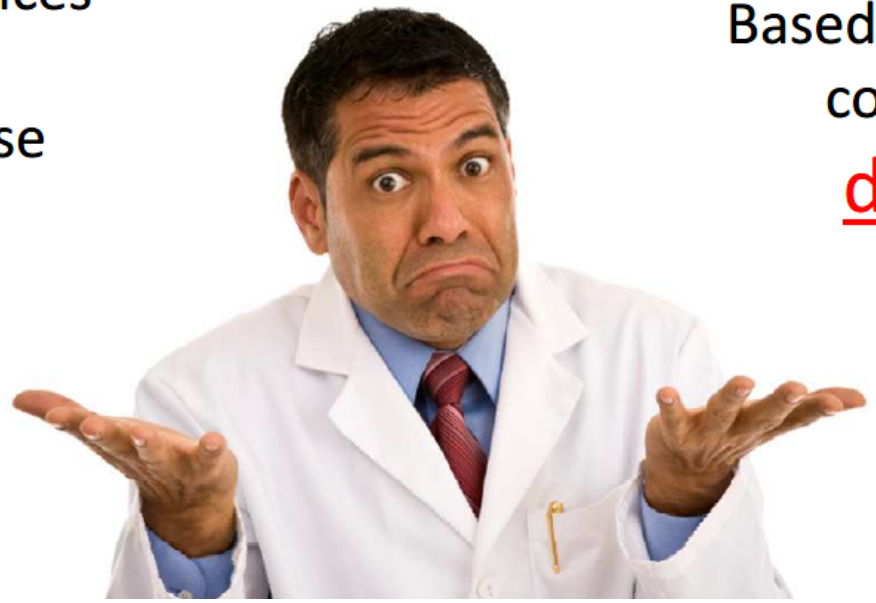


The Challenge of Documentation

CLINICAL DOCUMENTATION

Based on historical practices and training, physicians/providers use

clinical terms



CODING REQUIREMENTS

Based on rules and regulations, coding requires specific

diagnostic terms

Coders

submit PDX, MSDRG, CC, MCC

CDS

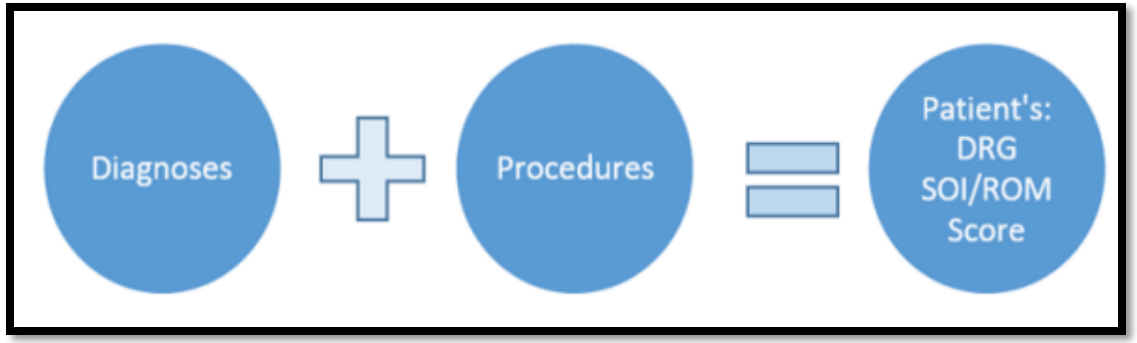
Review clinical documentation in real-time

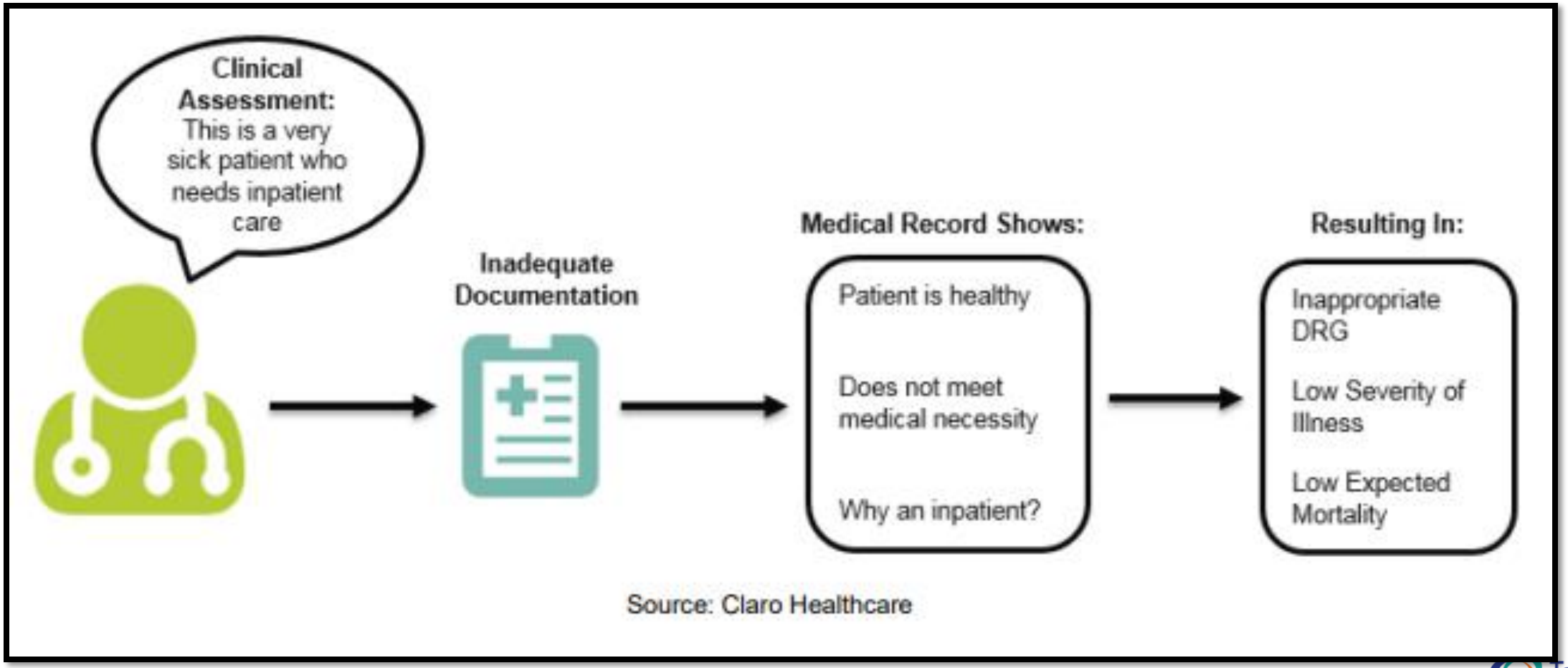
MD notes

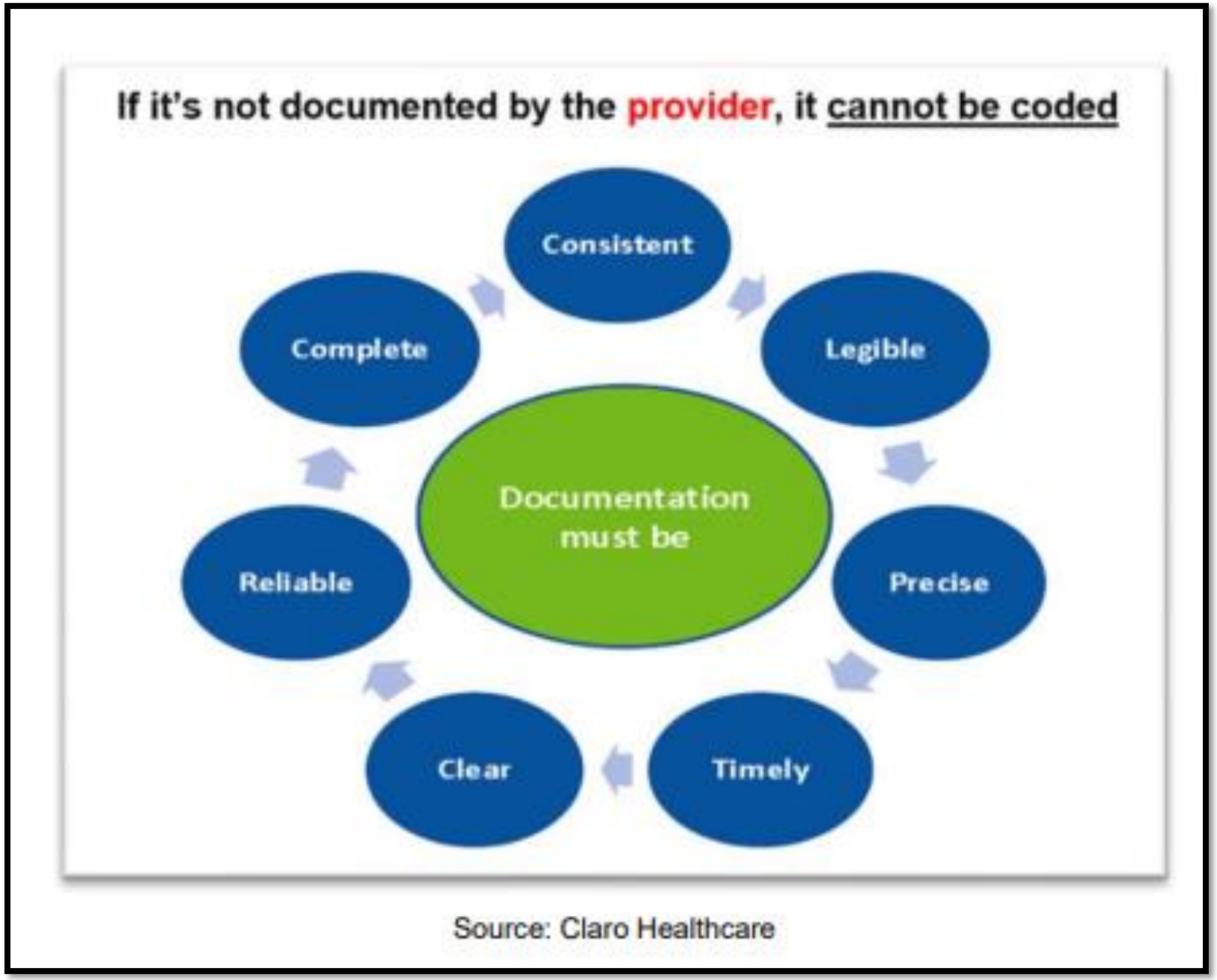
- Direct patient care
- Communication

Documentation Gaps

- A gap commonly exists between clinical documentation and coding requirements. When the documentation does not reflect accurate Severity of Illness and Risk of Mortality, it appears as if healthy patients are having poor outcomes.
- ICD-10 codes are used to calculate Severity of Illness (SOI) and Risk of Mortality (ROM) scores, which determine the ratio of observed to expected deaths. To calculate a correct expected risk of mortality, we need to accurately capture all diagnoses and all procedures.
- Clinical language does NOT equal coding language. Clinical language and coding rules often do not line up, which may be a source of confusion among providers. The medical complexity and/or severity of illness of a patient may not be appropriately reflected on a medical claim if the provider does not utilize appropriate, codable terms.


Diagnoses
Procedures
Patient's:
DRG
SOI/ROM
Score


Clinical Assessment: This is a very sick patient who needs inpatient care
Inadequate Documentation
Medical Record Shows:
Patient is healthy
Does not meet medical necessity
Why an inpatient?
Resulting In:
Inappropriate DRG
Low Severity of Illness
Low Expected Mortality
Source: Claro Healthcare



Source: Claro Healthcare

Case Mix Index

	CMI	Average LOS	Total # Of Case Mortalities 2017
Dr. Smith	1.7	5 days	6
Dr. Jones	2.6	5 days	6

Lower CMI with *same* length of stay?

Lower CMI and *same* mortality rate?

- Which physician looks “inefficient”?
- Which physician appears to give a higher quality of care?
- Which physician has to explain why their “less sick” patients are dying at the same rate?

Risk Adjustment

What is Risk Adjustment?

Risk adjustment is a statistical method used to accurately and fairly predict healthcare outcomes.

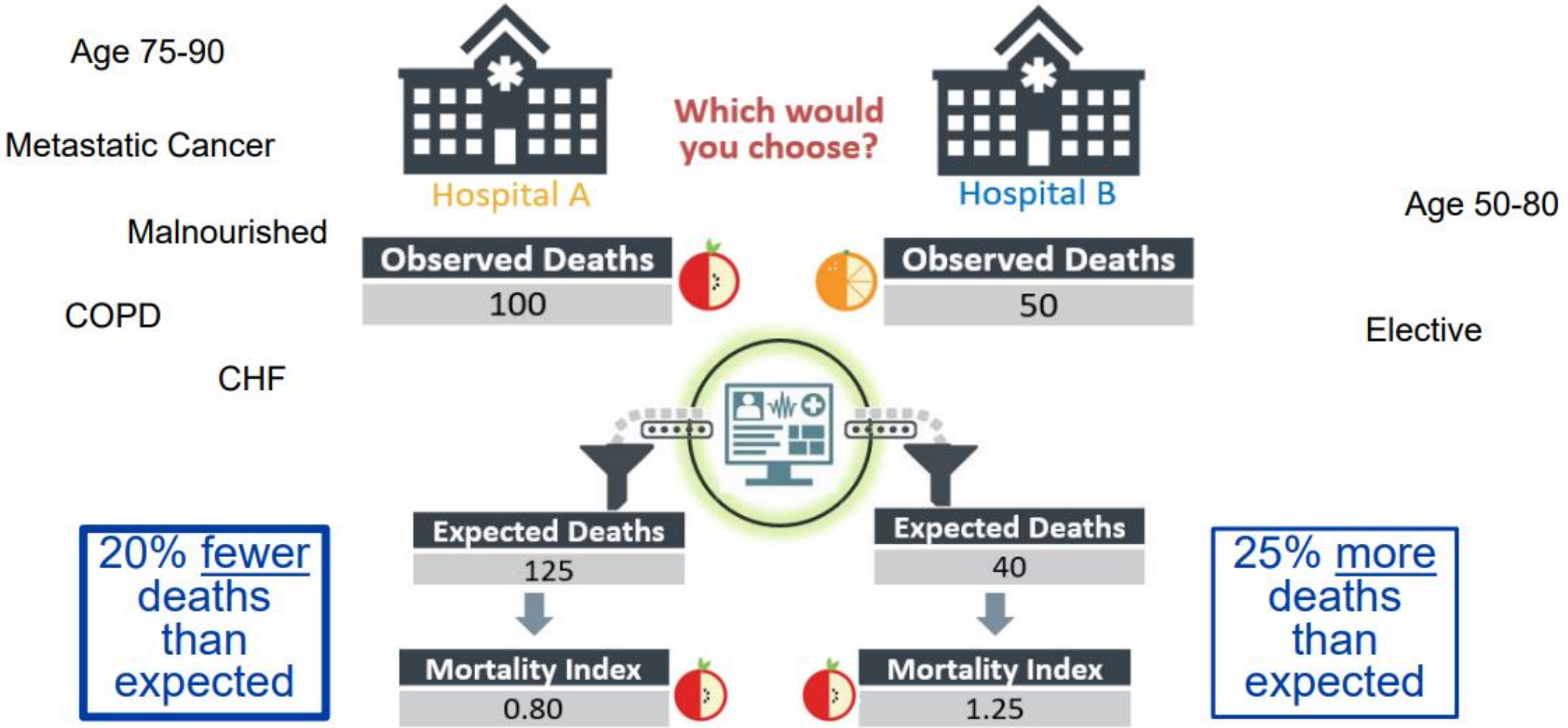
How does Risk Adjustment Work?

Risk Adjustment models take into account underlying health status, as well as other risk factors to 'score' individual patients, providers, and healthcare organizations.

Why Risk Adjust?

Aims to answer the question: "How would performance of various units compare if they had the same mix of patients?"

Why Risk Adjust



Length of Stay (LOS)

Observed vs. expected LOS: Why does it matter?

Observed LOS

The actual number of days the patient is in the hospital.

vs.

Expected LOS

The average number of days patients within a given DRG stay in the hospital.

Best Practice Documentation Supports Accurate Assignment of Expected LOS

	Written Documentation	Assigned DRG	Observed LOS	Expected LOS
Insufficient Documentation	*68 y/o elective admission for planned colectomy due to CA colon, develops SOB post op.*	***331 – Major Small & Large Bowel Procedures w/o cc/mcc***	10.0	4.0
Best Practice Documentation	*68yo elective admission for planned colectomy due to CA colon, develops **acute respiratory failure** due to exacerbation of systolic heart failure following surgery*	***329 – Major Small & Large Bowel Procedures w/mcc***	10.0	11.3

Expected Mortality

Observed to Expected (O/E) Mortality

- The ratio of observed deaths to expected deaths
- Used to assess whether the hospital had more deaths than expected (ratio > 1.0), the same number of deaths as expected (ratio = 1.0), or fewer deaths than expected (ratio < 1.0).
- **O/E ratio** is calculated by dividing the observed mortality by the expected mortality.

$$\frac{\text{The number of actual or 'observed' patient deaths in the hospital}}{\text{The } \textbf{expected} \text{ average of hospitalized patient deaths with a particular illness or condition that are beyond the control of the medical center, such as age, gender and other medical problems}}$$

Quality of documentation has an impact on the "expected" – poor documentation results in lower expected numbers and high O/E ratio , which inaccurately reflects how sick our patients are.

Documentation Impact on Quality Measures

Severity of illness(SOI) and Risk of Mortality (ROM)

- Documentation should reflect the acuity of the patient…
- If a patient dies because he or she was severely ill, but the documentation translates into codes that do not reflect the severity, the adjusted SOI and ROM poorly reflect the care provided
- Publically reported quality metrics are “risk-adjusted” to account for the acuity of illness and care provided
- Categories are determined based on numerous factors including principal and secondary diagnoses, comorbidities, demographics, patient history, treatment and/or procedures provided, etc.
- Mortalities with lower SOI/ROM are subject to peer review

Four Severity of Illness Subclasses	Four Risk of Mortality Subclasses
1. Minor	1. Minor
2. Moderate	2. Moderate
3. Major	3. Major
4. Extreme	4. Extreme

Examples of progression of SOI/ROM

SEVERITY OF ILLNESS (SOI)		SECONDARY DIAGNOSIS OF DIABETES MELLITUS
1	Minor	Uncomplicated Diabetes
2	Moderate	Diabetes with Nephropathy
3	Major	Diabetes with ketoacidosis without coma
4	Severe	Diabetes with Hyperosmolar Coma

SEVERITY OF ILLNESS (SOI)		SECONDARY DIAGNOSIS OF RENAL FAILURE
1	Minor	Acute or Chronic Renal Insufficiency; CKD Stages 1-5
2	Moderate	End Stage Renal Disease(ESRD) ; Acute Renal Failure, unspecified
3	Major	None
4	Severe	Acute Tubular Necrosis (ATN)

RISK OF MORTALITY (ROM)		SECONDARY DIAGNOSIS OF RESPIRATORY FAILURE
1	Minor	Acute Respiratory Distress/Insufficiency
2	Moderate	Chronic Respiratory Failure
3	Major	None
4	Severe	Acute Respiratory Failure; Acute Respiratory Distress Syndrome

RISK OF MORTALITY (ROM)		SECONDARY DIAGNOSIS OF CARDIAC DYSRHYTHMIAS
1	Minor	Premature Beats
2	Moderate	Sick Sinus Syndrome
3	Major	Ventricular Tachycardia
4	Severe	Ventricular Fibrillation

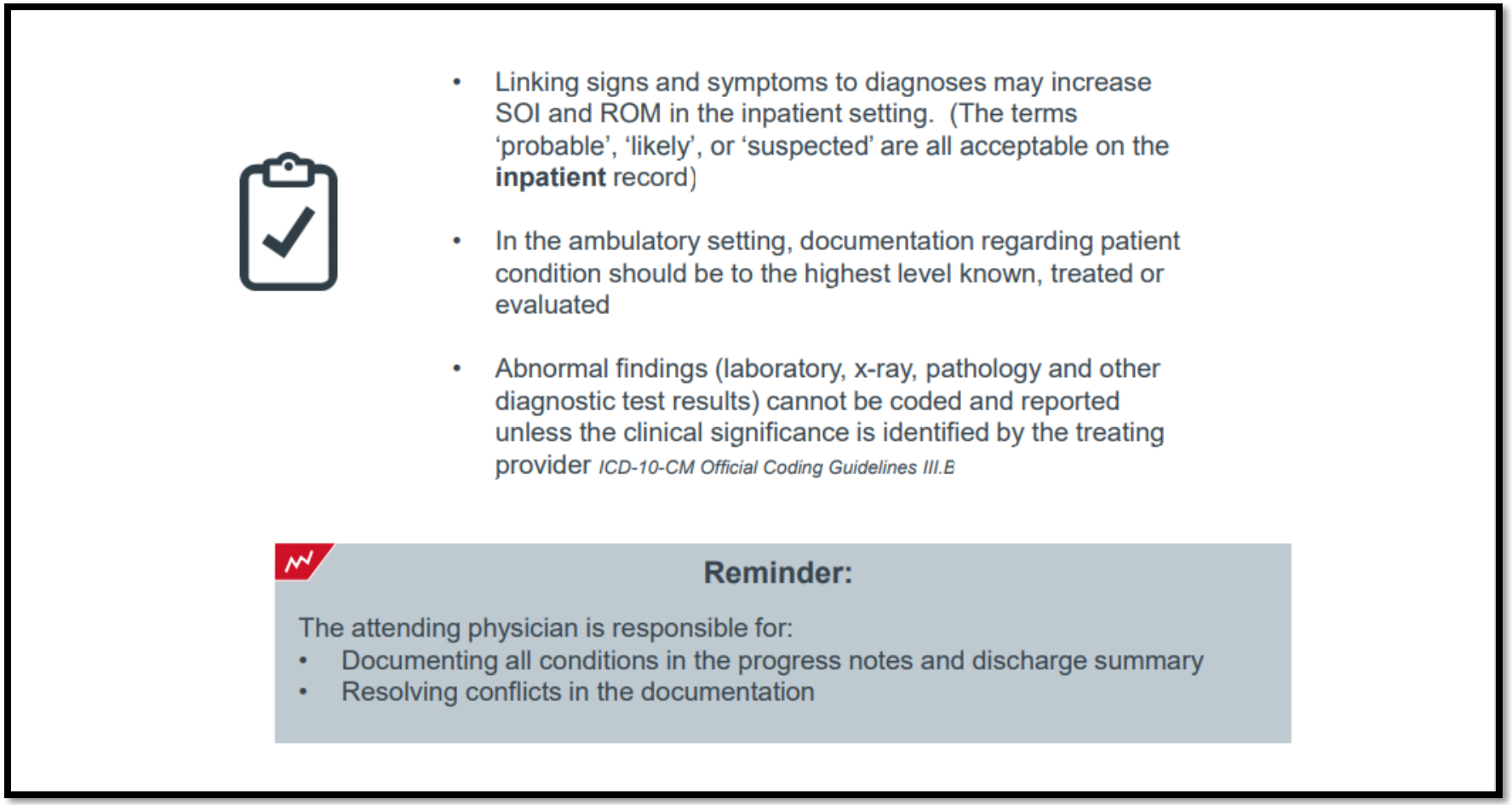
Clinical Case Assessment -Impact of SOI & ROM

	Physician 1	Physician 2	Physician 3
Principal Problem **Associated Comorbidities:**	**Hypotension** Acute renal insufficiency Hypoxia Low Hgb / GIB	**Shock** Acute renal failure/AKI Respiratory distress Acute blood loss anemia	**Hemorrhagic Shock** Acute renal failure/AKI due to ATN Acute hypoxemic respiratory failure Acute blood loss anemia
Severity of Illness	Low	Moderate	Major
Risk of Mortality	Low	Moderate	Major
Expected Mortality	0.2%	0.7%	12.7%

Physician 3's documentation reflects a higher SOI/ROM of the patient , which leads to an accurate O/E representation of the patient we cared for.

Remember: Signs, Symptoms & Test Results Must Be Linked to Related Diagnoses

While important pieces of the medical record, signs, symptoms and test results are not sufficient for coders to assign a diagnosis.



- Linking signs and symptoms to diagnoses may increase SOI and ROM in the inpatient setting. (The terms 'probable', 'likely', or 'suspected' are all acceptable on the **inpatient** record)
- In the ambulatory setting, documentation regarding patient condition should be to the highest level known, treated or evaluated
- Abnormal findings (laboratory, x-ray, pathology and other diagnostic test results) cannot be coded and reported unless the clinical significance is identified by the treating provider *ICD-10-CM Official Coding Guidelines III.E*

Reminder:

The attending physician is responsible for:
- Documenting all conditions in the progress notes and discharge summary
- Resolving conflicts in the documentation

Key Documentation - Present On Admission

Critical to document Present On Admission

If a condition is Present on Admission (POA), document

- All known details
- Type of encounter (initial, subsequent, sequelae) for injuries and poisonings
- Link a complication of medical care to its suspected cause
- Document suspected organism, if known or based on risk factors

Present on Admission (POA) status is a significant driver of quality reporting and risk stratification. Some conditions (e.g. UTI or pressure ulcer) when not identified as POA, are considered a Hospital-Acquired Conditions (HACs) and negatively impact quality scores

Note: Make sure infection due to a device is clearly documented as POA if appropriate

Documentation Examples

- UTI due to indwelling Foley, POA
- MRSA infection due to central venous catheter, POA
- Stage 3 Pressure Ulcer to Buttock, POA

Discharge Planning Documentation

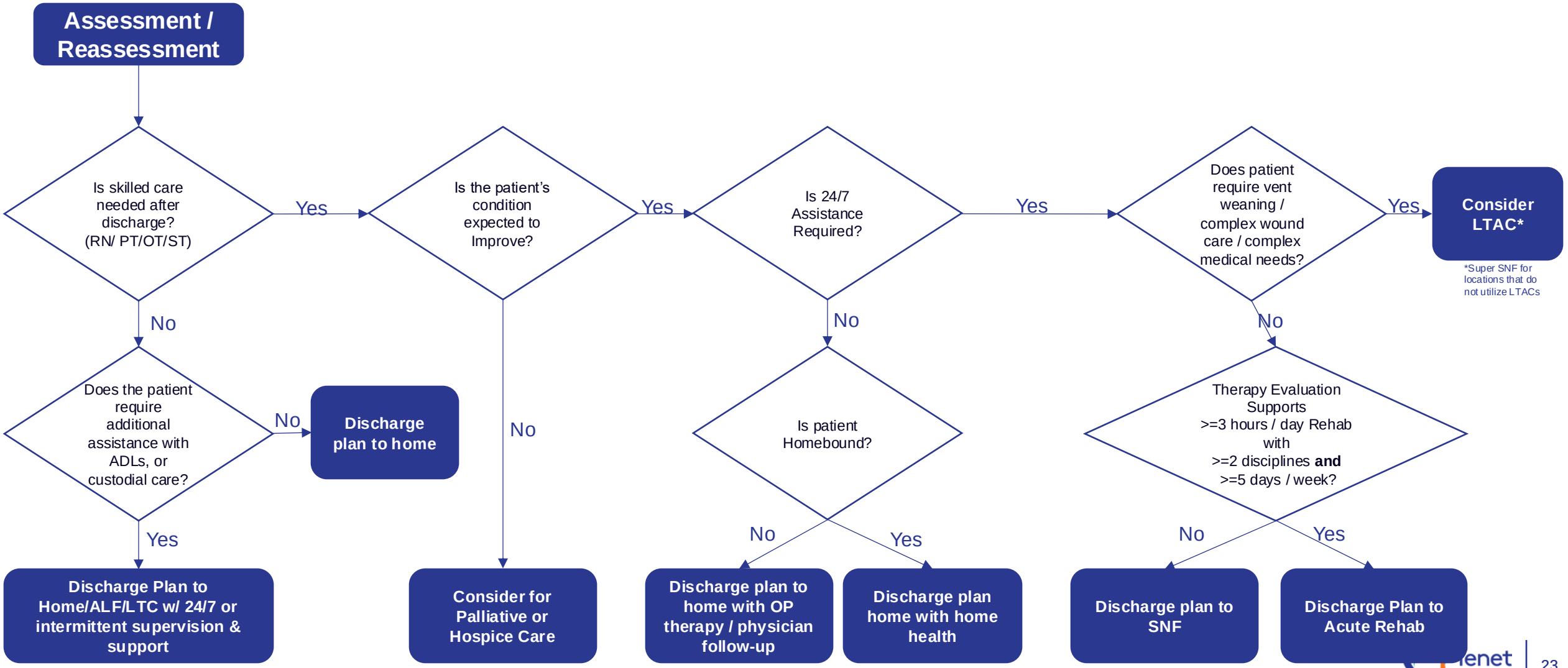
2025 Q1 Education

Guide for Discharge Planning

Criteria	Home	Home Health	Skilled Nursing Facility (SNF)	Long Term or Custodial SNF	Inpatient/Acute Rehab (IRF/ARU)	Long Term Acute Care (LTAC)
% of Discharges	65 – 70%	10 – 15%	10%	2%	2%	</= 1%
Scope of Services	Outpatient care including PCP, dialysis, OP wound care, community services	Outpatient care for home bound* patient including intermittent skilled care for therapy services or home IV	Requires 24 hour skilled care and participates in therapy services with at least one (Medicare) or two (Non-Medicare) disciplines for a minimum 5 hours a week that would be difficult or too complex to obtain at home.	Requires 24 hour care giver support and/or assistance with ADLs and does not tolerate or participate in therapy services, does not required skilled care	Requires 24 hour skilled care with multi-disciplinary rehabilitation services and participates in at least three hours of therapy services a day for 5 days a week	Requires acute level of care for medically complex care from specialized staff and intensive nursing care
Conditions Treated	OP IV, PT/OT/ST, wound care Meals on Wheels Shelter services	IV medications PT/OT/ST services Wound care, Medication management, Transition to hospice care	Short term (7 – 21 days) care for patients following hospitalization commonly for joint fracture or replacement, pneumonia, or heart failure	Long term (100+ days) care for patients who need nursing home caregiver support and nursing home residence for dementia and/or other long term conditions	Short term (7 – 15 days) care for patients following hospitalization commonly for stroke, brain injury, spinal injury or trauma	Respiratory system diagnoses requiring vent support for patients hospitalized more than 21 days in ICU and/or management of complex wounds or severe sepsis
Insurance Considerations		Prior authorization not required if provider is in network	Prior authorization required. Medicare benefit 100 days per calendar year	Not a covered benefit Patient responsible for cost	Physician Peer to Peer usually required for payer authorization	Physician Peer to Peer usually required for payer authorization

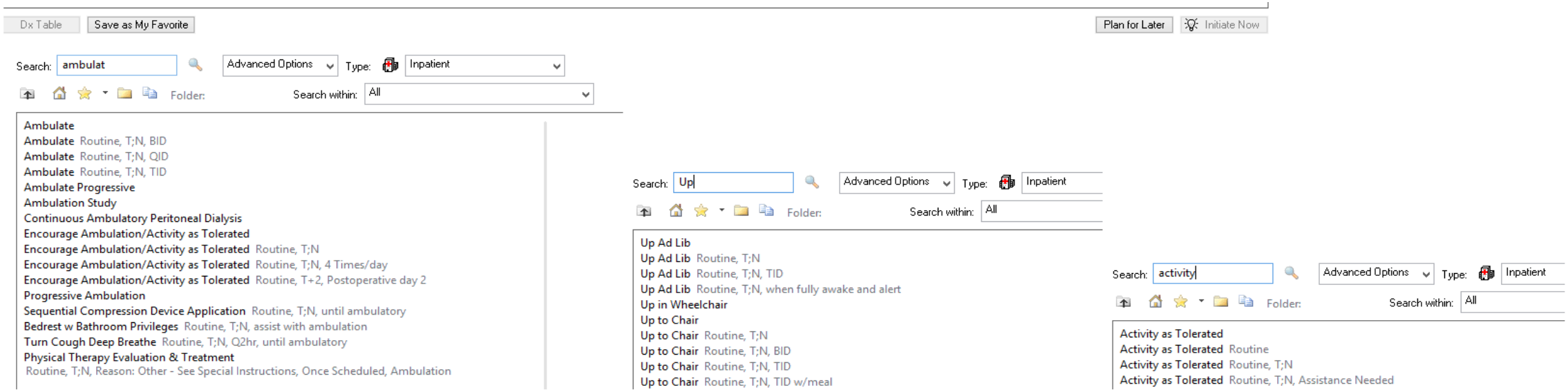
*Medicare uses the following criteria to define homebound: To leave your home, you need help, including the help of another person, crutches, a walker, a wheelchair, or special transportation. Your need for help must stem from an illness or injury.

Discharge Decision Tree



Discharge Planning Tips

- Collaborate with Case Management for discharge planning, as they have insight into patient benefits and in-network facilities.
- Assess the need for PT/OT evaluation on admission instead of adding PT/OT orders to general Power Plans.
- Consider baseline evaluation and bedside assessment before ordering PT/OT.
- Promote early ambulation orders - Examples below:



Discharge Planning Documentation Tips

Insurance companies and post-acute services look for the specific criteria below in Physician Documentation:

SNF: SNF Care Coverage

- Must be able to tolerate 1 hour of therapy per day, 5 days per week.
- If patient is walking 150 feet with minimal assistance there's likely no "skilled' therapy need- patient will need to qualify via another skilled needs including IV ABX, advanced wound care, etc
- *Recommended Documentation: "Patient requires at least 1 hr of therapy (PT/OT) per day at a minimum of 5 days per week."*

IRF: IRF/ARU Guidelines

- Must be able to tolerate a minimum of 3 hours of therapy per day 5 days per week.
- Requires 2 therapy needs at minimum- 1 of these must be either physical or occupational therapy.
- Not appropriate for patients requiring 1:1 sitter, TPN, or advanced respiratory care.
- *Recommended Documentation: "Patient requires at least 3 hrs of therapy (PT/OT/ST) per day at a minimum of 5 days per week. Patient requires daily physician monitoring."*

LTAC: Acute, LTAC, IRF, SNF LTAC Criteria

- Appropriate for patients who are vent dependent (weaning trials are unsuccessful)- requires vent support for at least 7 days.
- Telemetry monitoring is only available in LTAC level of care.
- *Recommended Documentation: Need for continuous cardiac monitoring for more than 25 days, Number of weaning trials and indications of failure to transition off the vent.*

Home Health: CMS Home Health Services

- Must be home bound – Patient cannot leave their home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury.

Key Points:

- Documentation should not be ***"PT/OT Recommends SNF."***
- Documentation should include your assessment as the treating provider, specifying the appropriate discharge plan for the patient and the reasons for this decision.

** References hyperlinked*

Tenet Health

COMMONLY QUERIED DIAGNOSES AND CASE EXAMPLES

Cardiovascular

Sepsis

Specify:

- If sepsis was present on admission
- Suspected or confirmed causative organism
- Source and location of infection and link to the underlying localized infection if known (e.g., sepsis due to cellulitis of the right lower extremity, sepsis due to acute cystitis, sepsis due to pneumonia)
- If sepsis was due to a device (e.g., catheter associated sepsis, central line associated sepsis, vent associated sepsis, other)
- Suspected or confirmed post-procedural or post-operative sepsis

Diagnosis of sepsis should be documented consistently on active hospital problem list, progress notes, and on the discharge summary (even if resolved).

If signs of SIRS and/or sepsis are found to be due to another condition, document sepsis ruled out and clearly link the symptoms (e.g., SIRS due to pancreatitis or sepsis due to UTI).

Sepsis with organ dysfunction

Clearly document the link between the organ dysfunction and sepsis:

- If you initiate the sepsis protocol, remember to document interventions
- If unable to follow protocol, document reason for deviation, e.g., "patient unable to tolerate fluid bolus due to ___"
- If alert initiated and sepsis later ruled out, clearly document other reason for clinical indicator such as "hypotension due to diarrhea and volume depletion" or "acute kidney failure due to dehydration"
- Document if sepsis was present on admission
- If you ruled out sepsis make this clear in your note
- If organ failure is not due to sepsis document this clearly in your notes

Urosepsis

There is NO CODE in ICD-10 for Urosepsis. Documenting the term “urosepsis” is ambiguous and nonspecific for coding purposes.

Recommended terminologies

- UTI only
- Sepsis secondary to UTI (if patient meets clinical criteria for sepsis)

Severity of illness (SOI)

No SOI	Low SOI	High SOI
Urosepsis	UTI	Sepsis secondary to UTI

This tip will help reflect severity of illness (SOI) and have your patient appear as sick on paper as they are in the bed.

Infections Due to Devices

- ICD-10-CM codes are assigned for infection and inflammatory reaction due to internal prosthetic devices, implants, and grafts
- This requires documentation from the provider of a direct causal relationship between the device, implant, or graft, and the infection

"In the setting of"≠ "Due to" or "Secondary to" in coding translation.

There are multiple MS-DRG options for these cases:		Relative Weights	GMLOS
MS-DRG 690	UTI not linked to the Foley catheter	0.7946	3.0 Days
MS-DRG 699	UTI due to Foley catheter and will allow a CC	1.0466	3.5 Days
MS-DRG 698	Sepsis due to catheter associated UTI and will allow an MCC	1.5881	4.9 Days

TERMS TO AVOID

- Infectious SIRS
- SIRS due to infection
- Urosepsis - must be clarified as meaning either sepsis or UTI without sepsis
- Bacteremia - means nothing more than “positive blood culture” and is not equivalent to or a criterion for sepsis. Unless the patient just has bacteremia without evidence of sepsis.
- Sepsis syndrome - considered an ambiguous term that requires further clarification as Sepsis

Query examples

Sepsis — Archived

Based on the clinical indicators listed below and your professional judgement, can a diagnosis be established? Please complete by selecting one of the options below.

SIRS with sepsis (with infectious source, please specify source) Pt had sepsis secondary to urinary tract infection

Based on the clinical indicators listed below and your professional judgement, can a diagnosis be established? Please complete by selecting one of the options below.

- SIRS with sepsis (with infectious source, please specify source)
- SIRS without sepsis (non-infectious source) (if so, please specify source)
- Local infection only (if so, please specify the site of the local infection)
- Other explanation of clinical findings (please specify)
- Unable to determine

Clinical information

- Reason for Clarification: Please clarify the infectious process in this patient (if any)
- Signs and Symptoms
  - Vital signs: Temperature (Core) : 36.4 degC (L) ; 35.9 degC (L) ; 36.3 degC (L) ; 36.2 degC (L) - 2/17/2022 Respiratory rate ; 28 breaths/m ; 27 breaths/m ; 30 breaths/m; 40 breaths/m
  - Labs: Bands % 6 (H) - 2/17/2022 09:41
    WBC 25.27 (H) - 2/17/2022 09:07
- Risk Factors
  - UTI: "Initial work-up in the ED was consistent with diabetic ketoacidosis with significant lactic acidosis 9.5 bicarbonate 12 with noted leukocytosis UA consistent with UTI" Admission H&P EMR [redacted] at 2/20/2022
  - Other: "presents with decreased oxygen saturation at 80s, altered mentation x1 day. "; "She was placed on nonrebreather with oxygen saturation going up to 93%. "; " Arterial blood gas shows a pH of 7.35, bicarb 11, PCO2 21 and oxygen saturation 99. Patient oxygen level on the monitor is 80 however the waveform is poor and I believe the ABG more. " ED Note by [redacted] at 2/17/2022
- Treatment
  - Other: " Ordered ceftriaxone, IVF and insulin drip. " ED Note-Physician by [redacted] at 2/17/2022 "Central line was not placed due to her POLST stating comfort measures only." ED Note-Physician by [redacted] at 2/17/2022

Mortality case with 1 day LOS. Pre query DRG, SOI, ROM

Medicare DRG and MDC Information

637	DIABETES WITH MCC CMS wt 1.3766 A/LOS 5.0 G/LOS 3.8 Length of stay, discharge to a post-acute care provider, and home health service condition codes can significantly impact reimbursement for this DRG.
010	ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES AND DISORDERS

APR (all versions) DRG and MDC Information

420	Diabetes APR wt 0.7921 Low Trim 1 High Trim 14 ALOS 4.13 GLOS 3.46 Status: LOS Inlier
010	ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES AND DISORDERS
3	Major Severity of Illness
2	Moderate Risk of Mortality

Post query DRG ,SOI/ROM

Medicare DRG and MDC Information

871	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC CMS wt 1.8722 A/LOS 6.2 G/LOS 4.8 Length of stay, discharge to a post-acute care provider, and home health service condition codes can significantly impact reimbursement for this DRG.
018	INFECTIOUS AND PARASITIC DISEASES, SYSTEMIC OR UNSPECIFIED SITES

APR (all versions) DRG and MDC Information

720	Septicemia and disseminated infections APR wt 2.0860 Low Trim 1 High Trim 30 ALOS 8.24 GLOS 6.25 Status: LOS Inlier
018	INFECTIOUS AND PARASITIC DISEASES, SYSTEMIC OR UNSPECIFIED SITES
4	Extreme Severity of Illness
4	Extreme Risk of Mortality

Sepsis*

Archiv

Based on your professional medical judgement and review of the clinical indicators listed below, can an associated diagnosis be documented? Please complete by selecting all that apply from the options below.

Streptococcus anginosus Sepsis; Severe sepsis

Based on your professional medical judgement and review of the clinical indicators listed below, can an associated diagnosis be documented? Please complete by selecting all that apply from the options below.

- Streptococcus anginosus Sepsis
- Severe sepsis
- Sepsis with septic shock
- Other explanation of clinical findings (please specify)
- Unable to determine

- Reason for Clarification: Please clarify any associated condition, if known. Thank you.
- Signs and Symptoms
  - Vital signs: -
    11/27/21 12:48 BP 99/54, MAP 69, HR 111, RR 20
    11/27/21 14:30 HR 102, RR 24
    11//27/21 15:41 SpO2 87%, room air
    11/27/21 15:42 on O2 via NC @ 2lpm

    11/27/21 17:30 BP 88/60
    11/27/21 18:30 BP 89/63
  - Labs: -
    WBC - 50 I- 11/27/2021 14:58
    WBC - 37.7 I- 11/28/2021 13:58
    WBC - 32.5 I- 11/29/2021 15:23

    Bands % - 30 H- 11/27/2021 20:54

    Lactic Acid - 4.08 H- 11/27/2021 14:18
    Lactic Acid - 1.9 - 11/27/2021 19:00
    Lactic Acid - 3.3 I- 11/28/2021 15:39
    Lactic Acid - 2.3 I- 11/28/2021 23:07

    Bilirubin (total) - 1.6 H- 11/27/2021 14:59
    Bilirubin (total) - 2 H- 11/28/2021 14

    Creatinine - 2.3 H- 11/27/2021 14:17
  - Other: 1. "Leukocytosis" ; "Lactic acidosis" ; "'Patient tachycardic, borderline hypotensive on arrival." Per Dr. [redacted] ED note, 11/2721

    2. Bld cx 11/27/21 "In 1 of 1 blood culture bottles drawn. Streptococcus anginosus" Per cerner microbiology, 11/30/21
- Risk Factors
  - Other: 1. "Patient was recently diagnosed with likely cholecystitis on 11/14 and subsequently left against medical advice." Per NP [redacted] PN, 11/29/21

    2. "Acute-chronic perforated cholecystitis" Per NP [redacted]PN, 11/29/21
- Treatment
  - Normal Saline: 1 L bolus 11/29/21 14:16, 11/27/21 14:16 ; 1,220ml NaCl 0.9% bolus 11/27/21 16:13, per cerner MAR
  - Lactated Ringers: 1 L bolus, 11/28/21 15:57, 11/27/21 23:03, per cerner MAR
  - Other: 1. Piperacillin -Tazobanctam 3.375g IVPB q8H, per cerner MAR
    2. Albumin 25g IVPB 11/28/21 17:43

Pre query DRG,SOI/ROM,LOS

Medicare DRG and MDC Information

418	LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITH CC CMS wt 1.6890 A/LOS 4.2 G/LOS 3.5
007	DISEASES AND DISORDERS OF THE HEPATOBILIARY SYSTEM AND PANCREAS

APR (all versions) DRG and MDC Information

263	Cholecystectomy APR wt 1.6090 Low Trim 1 High Trim 18 ALOS 5.70 GLOS 4.87 Status: LOS Inlier
007	DISEASES AND DISORDERS OF THE HEPATOBILIARY SYSTEM AND PANCREAS
3	Major Severity of Illness
3	Major Risk of Mortality

Admit Diagnosis

	Code	Description
1.	R109	Unspecified abdominal pain

Diagnosis Code Detail

	Code	Description	Affect	CC	SOI	ROM	PSI
1.	K8066	Principal Calculus of gallbladder and bile duct with acute and chronic cholecystitis without obstruction	✓		P	P	
2.	K82A2	Perforation of gallbladder in cholecystitis	✓	✓	3	2	
3.	E872	Acidosis		✓	2	2	

Post query DRG,SOI/ROM,LOS

Medicare DRG and MDC Information

854	INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH CC CMS wt 2.1222 A/LOS 6.6 G/LOS 5.3 Length of stay, discharge to a post-acute care provider, and home health service condition codes can significantly impact reimbursement for this DRG.
018	INFECTIOUS AND PARASITIC DISEASES, SYSTEMIC OR UNSPECIFIED SITES

APR (all versions) DRG and MDC Information

710	Infectious and parasitic diseases including HIV with O.R. procedure APR wt 2.4475 Low Trim 2 High Trim 32 ALOS 10.07 GLOS 8.64 Status: LOS Inlier
018	INFECTIOUS AND PARASITIC DISEASES, SYSTEMIC OR UNSPECIFIED SITES
3	Major Severity of Illness
4	Extreme Risk of Mortality

Admit Diagnosis

	Code	Description
1.	R109	Unspecified abdominal pain

Diagnosis Code Detail

	Code	Description	Affect	CC	SOI	ROM	PSI
1.	A408	Principal Other streptococcal sepsis	✓		P	P	
2.	K8066	Calculus of gallbladder and bile duct with acute and chronic cholecystitis without obstruction	✓	✓	3	1	
3.	E872	Acidosis		✓	2	3	
4.	N179	Acute kidney failure, unspecified		✓	2	3	
5.	K82A2	Perforation of gallbladder in cholecystitis		✓	3	2	
6.	J90	Pleural effusion, not elsewhere classified		✓	2	2	X
7.	R6520	Severe sepsis without septic shock			4	4	

Sepsis - 3

DIAGNOSTIC CRITERIA: SOFA SCORE

Sepsis-3 SOFA Scale
Acute change due to infection: Score ≥ 2 points

OBJECTIVE MEASUREMENT	POINTS				
	0	1	2	3	4
Respiratory PAO2/FIO2	≥ 400	< 400	< 300	< 200 with resp support	< 100 with resp support
Coagulation Platelet count	≥ 150,000	< 150,000	< 100,000	< 50,000	< 20,000
Hepatic Bilirubin (mg/dL)	< 1.2	1.2-1.9	2.0-5.9	6.0-11.9	> 12.0
Cardiovascular MAP (mmHg) or vasopressor	MAP ≥ 70	MAP < 70	DPA ≤ 5	DPA 5.1-15	DPA >15
Neurologic Glasgow Coma Scale Score	15	13-14	10-12	6-9	< 6
Renal Creatinine (mg/dL) or urine output	< 1.2 -	1.2-1.9 -	2.0-3.4 -	3.5-4.9 < 500 ml/d	> 5.0 < 200 ml/d

JAMA published new criteria regarding the diagnosis of sepsis to follow SOFA (Sequential Organ Failure Assessment) criteria rather than SIRS criteria to avoid over-diagnosis of sepsis. CMS' response indicated that Sepsis 1 criteria will still be followed. It is recommended that documentation include the medical decision making supporting the diagnosis of sepsis. Additionally, link the source of the infection as well as any associated organisms and organ failure or organ dysfunction for the most accurate depiction of the patient's status.

Recommendation:

Link sepsis to the infection and any acute organ dysfunction, to protect record from third-party denials using terms such as "sepsis due to UTI with AKI" or "sepsis due to pneumonia with Acute Respiratory failure."

Sepsis - 3

DEFINITION

Sepsis - 3: Life-threatening organ dysfunction caused by a *dysregulated host response to confirmed or suspected infection*. Defined by a 2-point or more increase from baseline in the total Sequential [Sepsis-Related] Organ Failure Assessment (SOFA) score.

Septic shock: Persisting hypotension requiring vasopressors for at least 1 hour to maintain MAP > 65 mmHg AND having a serum lactate level >2 mmol/L despite adequate volume resuscitation.

Note: The 2001 Sepsis-2 definition and SIRS criteria has been superseded by the 2016 Sepsis-3 definition and SOFA criteria. In addition, the 2005 Pediatric sepsis definition based on SIRS criteria has been superseded by the 2024 Pediatric sepsis definition and Phoenix criteria. SIRS criteria alone are no longer the authoritative diagnostic criteria for sepsis for adults or pediatrics.

Sepsis - 3

RECOMMENDED TERMINOLOGY

- Sepsis with acute organ dysfunction [specify the organ dysfunction]
- Sepsis-related [specify the organ dysfunction]
- Organ dysfunction [e.g., AKI, hypoxemia, hyperbilirubinemia] due to sepsis
- Severe sepsis
- Septic shock

TERMS TO AVOID

- Urosepsis - must be clarified as meaning either sepsis or UTI without sepsis
- Bacteremia - means nothing more than “positive blood culture” and is not equivalent to or a criterion for sepsis.
- Sepsis syndrome - considered an ambiguous term that requires further clarification as Sepsis

Heart Failure

DEFINITIONS

Heart failure: inadequate cardiac output resulting from functional or structural abnormalities of the heart

Systolic heart failure or heart failure with reduced ejection fraction (HfrEF): EF <40%

- "Heart failure with mid-range ejection fraction" (HFmrEF): EF = 41-49% (may be considered systolic)

Diastolic heart failure or heart failure with preserved ejection fraction (HFrEF): EF >50%

Combined systolic/diastolic heart failure : EF <50% + "diastolic dysfunction " on imaging (e.g., echocardiogram)

Heart Failure - Documentation

DIAGNOSTIC CRITERIA

- Clinical diagnosis of heart failure based on Framingham criteria.
- Imaging and lab testing for confirmation, evaluation of cause and classification
  - Systolic
    - EF <40% = HFrEF
    - EF 41-49% = HFmrEF
  - Diastolic: EF > 50% = HFpEF
- Evidence suggesting acute decompensation/exacerbation may be any of the following:
  - Exacerbation of symptoms
  - IV diuretic
  - Pulmonary edema/congestion; increasing (or new) pleural effusion
  - Supplemental oxygen
  - BNP > 500, or NT-proBNP based on age (if no renal impairment): > 450 (age < 50), > 900 (age 50-75), > 1,800 (age > 75)

Heart Failure Specificity for Severity of Illness

Link all indicators of an illness to get the highest severity of illness to support tests, procedures or therapies

Components to Best Practice Documentation

- Specify Acuity: Acute, Chronic or Acute on Chronic Heart Failure
- Specify Type: Systolic, Diastolic, or Combined Systolic and Diastolic
- Clarify the relationship of the hypertension to the heart disease or heart failure
  Linking together may impact the severity of illness and risk of mortality of the patient
- Identify, if known, the underlying etiology of the failure
  Is it an exacerbation of stable heart failure, due to fluid overload, or due to missed dialysis
- Echocardiogram Findings
  If available, document findings of systolic, diastolic or combined heart failure from the echo in your progress notes and discharge summary

Heart Failure Combination Code Examples:

- Hypertensive heart disease with Acute on Chronic Diastolic CHF

Heart Failure - Documentation

RECOMMENDED TERMINOLOGY

- Systolic heart failure or HFrEF
- Diastolic heart failure or HFrEF
- Combined systolic/diastolic heart failure
- HFmrEF
- HFrecEF or HFimpEF
- Distinguish between acute decompensation/exacerbation and stable chronic.

TERMS TO AVOID

- Heart failure without functional description of systolic (HFrEF) or diastolic (HFpEF)
- Omission of acute decompensation/exacerbation when supported by findings
- HFmrEF without mention of “systolic” (improper code assignment)

Clarification Impact

63-year-old admitted with STEMI. PMH: MR s/p MV replacement, congestive heart failure, hypertension, asthma, HLD, OSA. Discharged home. LOS 3 days.

Documentation:

ED: **Chest x-ray demonstrated mild changes of CHF but no acute process.**

Initial Labs: WBC 6.0, Hgb 2.3, Hct 35.2, BUN 12, creatinine 0.61, troponin 0.07-0.19-3.31, **BNP 163**

CXR: **Pattern suggesting mild pulmonary venous hypertension changes of congestive heart failure.**

Echo: **Overall ejection fraction 60% to 65%.** The E/A ratio was reduced at 0.81 with a deceleration time of 280 msec and E/e' ratio of 9.7. **This would be most consistent with relaxation abnormality of the left ventricle.**

Discharge Summary (Cardiology): ST-elevation myocardial infarction. Hypertension, poorly controlled**. Fluid overload with shortness of breath. Diuresed after cardiac catheterization and took off a significant amount of fluid.** Needs cardiac rehabilitation for better conditioning. **Heart disease/Congestive Heart Failure.**

Recommendation:

1. Clarify the type and acuity of the heart failure.

	Actual	Educational
Principal Diagnosis	ST Elevation Myocardial Infarction	ST Elevation Myocardial Infarction
Secondary Diagnoses	Hypoxemia Fluid Overload, Unspecified Hypertension Hyperlipidemia Sleep Apnea, Unspecified	**Chronic Diastolic Heart Failure** Hypoxemia Fluid Overload, Unspecified Hypertension Hyperlipidemia Sleep Apnea, Unspecified
MS-DRG	282 – Acute Myocardial Infarction, Discharged Alive without CC/MCC	**281 – Acute Myocardial Infarction, Discharged Alive with CC**
Relative Weight	0.7181	**0.913**
GMLOS	1.8 Days	**2.4 Days**
SOI/ROM	2 (Moderate) / 1 (Minor)	2 (Moderate) / **2 (Moderate)**

Encephalopathy

The hallmark of encephalopathy is an altered mental state. Other signs and symptoms are progressive loss of memory and cognitive ability, inability to concentrate, subtle personality changes, lethargy, and progressive loss of consciousness.

When documenting encephalopathy, ***link to terms*** describing the reason, cause or special conditions leading to the brain disorder.

It is important to document with greater specificity the ***underlying etiology*** (The clinical response to insult or injury to the brain and whether it is transient, permanent, or both).

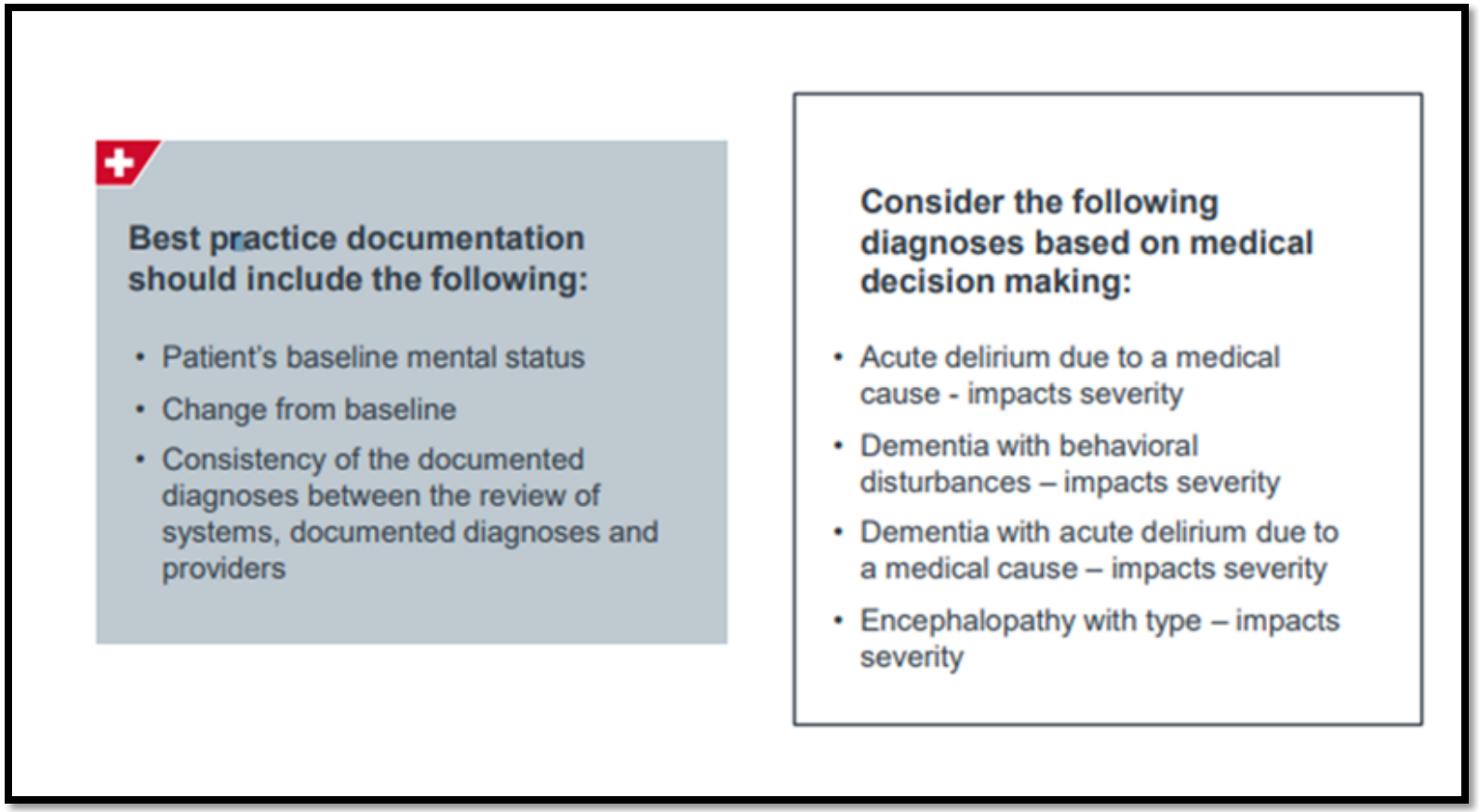
Be specific when documenting ***Transient types***:

- Toxic encephalopathy due to [medication or toxic substance]
- Metabolic encephalopathy
- Septic encephalopathy
- Delirium due to [toxic / metabolic] encephalopathy
- Hypertensive encephalopathy
- Dementia complicated by acute metabolic or toxic encephalopathy

Hepatic Encephalopathy*- specify acuity (Acute, subacute or chronic)** document link between the liver condition and psychomotor symptoms. Document ***"with coma" and link if applicable to the patient.

Be specific when documenting ***Permanent types:*** Anoxic, Alcoholic

Altered Mental Status/Encephalopathy



TERMS TO AVOID

- Altered mental status - represents a non-specific, non-diagnostic symptom
- Alert, awake and oriented – frequently used incorrectly when the patient is actually encephalopathic.
- Delirium only – classified as a non-specific symptom; delirium due encephalopathy (specify type) is preferred and recommended by DSM-5
- Drug-induced delirium only – does not reflect the severity impact of "toxic encephalopathy"
- Hypoxic encephalopathy (coded as anoxic brain injury) when due to acute hypoxemia – use metabolic instead
- Unspecified encephalopathy – without the specifying the type

Mental status query example

Based on your professional medical judgement and review of the clinical indicators listed below, can an associated diagnosis be documented? Please complete by selecting one of the options below.

Metabolic encephalopathy

Based on your professional medical judgement and review of the clinical indicators listed below, can an associated diagnosis be documented? Please complete by selecting one of the options below.

- Metabolic encephalopathy
- Toxic encephalopathy
- Delirium (please specify type)
- Encephalopathy due to narcotic overdose
- Other explanation of clinical findings (please specify)
- Unable to determine

Clinical information

- Reason for Clarification: Please clarify the altered mental status documented
- Signs and Symptoms
  - Mental status: "Altered mentation secondary to narcotic overdose, resolved with Narcan." Progress Note by Dr. [redacted] at 2/2/2022
  - Other: "Received call yesterday evening bedside RN reported patient increased somnolent, arousable and respiratory distress." ;"Patient was given 1 dose of Narcan and was alert and oriented afterwards." Progress Note by Dr. [redacted] at 2/2/2022
- Risk Factors
  - Electrolyte status: "Hyponatremia 2/2 SIADH" Progress Note by Dr. [redacted] at 2/2/2022
  - Other: "hypotension earlier (SBP 60s) responded to IVF d/w Dr [redacted] as pt not as responsive as yesterday" Progress Note by Dr. [redacted] at 2/1/2022
- Treatment
  - Other: "Discontinue oxycodone extended release" Progress Note by Dr. [redacted] at 2/2/2022
    "Sodium improving. Continue fluid restriction." Progress Note by Dr. [redacted] at 2/2/2022

Medicare DRG and MDC Information

644 ENDOCRINE DISORDERS WITH CC
CMS wt 1.0198 A/LOS 4.2 G/LOS 3.5
Length of stay, discharge to a post-acute care provider, and home health service condition codes can significantly impact reimbursement for this DRG.
010 ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES AND DISORDERS

APR (all versions) DRG and MDC Information

426 Non-hypovolemic sodium disorders
APR wt 0.5776 Low Trim 1 High Trim 11 ALOS 3.50 GLOS 2.96
Status: LOS Inlier
010 ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES AND DISORDERS
2 Moderate Severity of Illness
3 Major Risk of Mortality

Admit Diagnosis

	Code	Description
1.	E222	Syndrome of inappropriate secretion of antidiuretic hormone

Diagnosis Code Detail

	Code	Description	Affect	CC	SOI	ROM	Elix
1.	E222	Principal Syndrome of inappropriate secretion of antidiuretic hormone	✓		P	P	
2.	E872	Acidosis	✓	✓	2	2	
3.	I130	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease		✓	2	2	✓
4.	B0229	Other postherpetic nervous system involvement		✓	2	1	
5.	I5022	Chronic systolic (congestive) heart failure		✓	1	2	✓
6.	L0390	Cellulitis, unspecified		✓	1	1	
7.	E876	Hypokalemia			1	1	

Pre-Query GMLOS SOI/ROM

Medicare DRG and MDC Information

643 ENDOCRINE DISORDERS WITH MCC
CMS wt 1.6677 A/LOS 6.3 G/LOS 5.0
Length of stay, discharge to a post-acute care provider, and home health service condition codes can significantly impact reimbursement for this DRG.
010 ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES AND DISORDERS

APR (all versions) DRG and MDC Information

426 Non-hypovolemic sodium disorders
APR wt 0.8699 Low Trim 1 High Trim 17 ALOS 5.20 GLOS 4.34
Status: LOS Inlier
010 ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES AND DISORDERS
3 Major Severity of Illness
3 Major Risk of Mortality

Admit Diagnosis

	Code	Description
1.	E222	Syndrome of inappropriate secretion of antidiuretic hormone

Diagnosis Code Detail

	Code	Description	Affect	MCC	CC	SOI	ROM	Elix
1.	E222	Principal Syndrome of inappropriate secretion of antidiuretic hormone	✓			P	P	
2.	G9341	Metabolic encephalopathy	✓	✓		3	3	
3.	E872	Acidosis			✓	2	2	
4.	I130	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease			✓	2	2	✓
5.	B0229	Other postherpetic nervous system involvement			✓	2	1	
6.	I5022	Chronic systolic (congestive) heart failure			✓	1	2	✓

Post-Query GMLOS SOI/ROM

Coma

GCS Score						
Criteria Type & Points	**1**	**2**	**3**	**4**	**5**	**6**
Eyes Open	Never[1]	To pain[1]	To sound	Spontaneous	N/A	N/A
Best Verbal Response	None[1]	Incomprehensible words[1]	Inappropriate words	Confused conversation	Oriented; converses normally	N/A
Best Motor Response	None[1]	Extension to painful stimuli[1]	Abnormal flexion to painful stimuli	Flexion withdrawal from painful stimuli[1]	Localizes painful stimuli	Obeys commands

Scale

- Minor, GCS > 13
- Moderate, GCS 9-12
- Severe, GCS <9

Documentation Tips:

- Report each of the subcategory scores rather than just the total score
- Some coma diagnoses codes are categorized as MCCs
- Used in conjunction with: traumatic brain injury, acute cerebrovascular disease, and other sequelae of cerebrovascular disease

RECOMMENDED TERMINOLOGY

- Coma
- Include “coma” when describing persistent vegetative state

TERMS TO AVOID

- Altered level of consciousness (if GCS < 8) without mention of coma
- Persistent vegetative state without mention of coma

Abnormal Renal Function

Why am I receiving a Renal Query?

- Abnormal renal labs with no documented renal condition like AKI or CKD
- Conflicting documentation such as acute kidney *failure* vs renal *insufficiency*
- Documentation of CKD *with no improvement from baseline* (could this be a natural progression of CKD, or is this AKI on CKD ? What is the stage of CKD?
- AKI without any improvement in renal function (could this be CKD or ATN?)
- CKD documented with no stage

Acute Renal Failure = Acute Kidney Injury (AKI) (same medical code)

Acute Renal ***DISEASE*** is ***not*** the same as Acute Renal ***FAILURE***

- Specify Acute Renal Failure do not use the word “Disease”
- Acute Renal *Disease* is a symptom code

Renal Insufficiency

Avoid using renal *insufficiency* and renal *failure* interchangeably

Using the term insufficiency may result in a query if clinical indicators support further specification.

Avoid using pre-renal azotemia as it may result in a query if clinical indicators support further specification.

Abnormal Renal Function **contd.**

DIAGNOSTIC CRITERIA

The current consensus-based criteria for acute kidney injury (AKI) is the National Kidney Foundation (NKF) KDIGO conference definition. This criteria applies to both adult and pediatric patients.

KDIGO defines AKI (applicable to both adult or pediatric patients) as any of the following:

- Increase in creatinine level to ≥ 1.5x baseline (historical or measured), which is known or presumed to have occurred within the prior 7 days; or
- Increase creatinine ≥ 0.3 mg/dl from baseline within 48 hours; or
- Urine output < 0.5 ml/kg/hr for 6 hours

When baseline creatinine is unknown, KDIGO advises: "The lowest SCr [Creatinine level] obtained during a hospitalization is usually equal to or greater than the baseline. This SCr should be used to diagnose (and stage) AKI."

AKI/ATN

Acute Tubular Necrosis is a frequently overlooked cause of acute kidney failure

Causes of ATN:

- Contrast nephropathy (following CT scan, cardiac catheterization)
- Medications (Antibiotics, Antifungals, Immunosuppressive agents, etc.)
- Prolonged ischemia, hypotention and/or shock
- Sepsis
- Rhabdomyolysis
- Hypovolemia

Consider Documenting Acute Tubular Necrosis when:

- Your patient's Acute Kidney Failure lasts for > 3 days after fluid resuscitation
- Your patient's urinalysis demonstrates significant proteinuria, muddy brown casts, or epithelial cell casts
- Your patient's Fractional Excretion of Sodium is > 2 %

Documentation Examples:

- "Acute renal failure secondary to probable ATN"

No severity of illness	Moderate severity of illness	Maximal severity of illness
Azotemia, Dehydration	Acute Kidney Failure	Acute Kidney Failure due to ATN

Chronic Kidney Disease

Identify the stage	**Stage 1** = GFR >90 with kidney damage measure(s) **Stage 2** = GFR 60 – 90 with kidney damage measure(s) **Stage 3a** = GFR 45 –59 **Stage 3b** = GFR 30 – 44 **Stage 4** = GFR 15 – 29 **Stage 5** = GFR <15
Is CKD related to Hypertension or Diabetes?	If so, document with the linkage (“due to”, “secondary to” or “with”)
Transplant Status Matters	**Document if**: ▪ The patient has had a transplant ▪ If the patient is a candidate for a transplant

Renal failure

RECOMMENDED TERMINOLOGY

- Acute kidney injury (AKI)
- Acute renal failure
- Acute tubular necrosis (where applicable)
- CKD with stage

TERMS TO AVOID

- Renal insufficiency and Renal failure interchangeably
- “Insufficiency” may result in a query if clinical indicators support further specification.
- Pre-renal Azotemia may result in a query if clinical indicators support further specification.
- AKI when creatinine increased > 72 hours without mention of ATN
- "Contrast-induced" or "drug induced" without mention of ATN
- Toxic nephropathy without mention of ATN
- CKD without a stage

Case Scenario

What was coded based on physician documentation	What was coded post CDI query
Pdx: Hypotension Secondary Dx: UTI Bacteremia DM Disorder Kidney and ureter HTN Ventilator Intubation SOI 1 and ROM 3	Pdx: Sepsis Secondary dx: Septic Shock ARF/ATN Acute Resp. Failure Coma UTI Severe Sepsis T2DM Ventilator Intubation SOI 4 and ROM 4

90 yo F w/hx of T2DM, HTN, CAD. Found at home unresponsive by caregiver. Upon arrival at hospital: BP 75/49, RR8, HR 105, T103, o2sat 87% on non-rebreather, CXR negative, Labs show WBC 42, BUN 62, Creatinine 3.4, Urinalysis turbid urine,4+LE's,>50WBC,4+bacteria
Treatment: 3L IVF's, Levophed drip, Vancomycin IV, Intubated and on ventilator
Doctor Documented:
UTI on vanco, cultures pending. Respiratory Distress on vent. T2DM monitor bs, insulin started. Bacteremia; Hypotensive prob due to UTI;
Elevated Bun/Creat.prob AKI vs renal insufficiency, baseline creatinine is 1.0; Unresponsive- pupils 4mm, unreactive, no response to pain noted. Check neuro status every hour.

Pressure Ulcers

DEFINITION

Localized damage to the skin and/or underlying soft tissue due to intense or prolonged pressure often associated with immobility and/or absent sensation. Moisture and nutritional deficiency (or obesity) also contribute.

Common locations for pressure ulcers include sacrum/coccyx, heel, buttocks (gluteal), low back, elbow. Most foot/ankle ulcers other than heel are not pressure ulcers.

Documentation Concepts	
Laterality	• Right or Left
Sites	• Ankle • Elbow • Back (Upper, Lower or Sacral region) • Buttock • Hip • Heel • Head
Severity	• Identify Stage: I – IV • (Stage III and IV are MCCs if POA)
New or Healing?	• Gangrenous or not
Other Type of Ulcer	• Diabetic • Non-pressure, chronic-include depth • Traumatic wound

!

- Document if pressure ulcer is present on admission (POA)
- If the pressure ulcer was POA, but not documented, it may result in a Hospital Acquired Condition (HAC)

Pressure Ulcer/Injury Stages

Stage 1 - Non-blanching erythema of intact skin: may appear differently in darkly pigmented skin.

Stage 2 - Partial thickness (epidermal) skin loss exposing the vascular dermis (like a superficial abrasion). The wound bed is viable, pink or red, moist; may also present as an intact or ruptured serum-filled blister. Subcutaneous adipose tissue (fat) and deeper tissues are not exposed.

Stage 3 - Full thickness skin loss : Full-thickness loss of skin, in which subcutaneous adipose tissue is exposed and visible in the ulcer; granulation is often present. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.

Stage 4 - Full-thickness skin and tissue loss : Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer.

Deep tissue pressure injury (DTPI) - Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister consistent with stage 3 or 4.

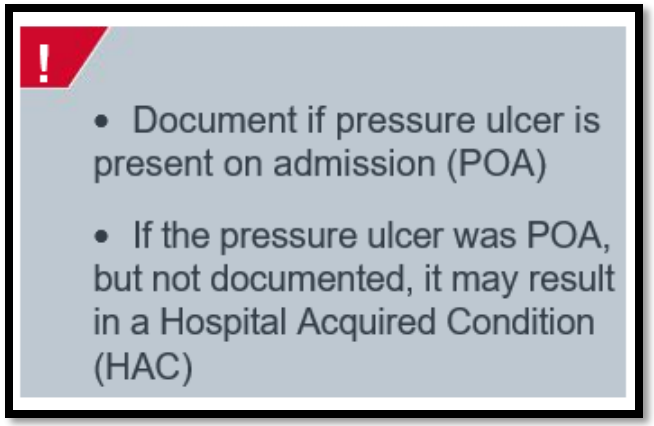
Unstageable - Obscured full-thickness and tissue loss: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or 4 pressure injury will be revealed.

Unspecified. No documentation regarding stage. All pressure ulcers should be staged or classified as noted above.

Pressure Ulcers

RECOMMENDED TERMINOLOGY

- Pressure ulcer and location, and if present on admission
- Stage: non-physician (e.g., nurse may document stage)



TERMS TO AVOID

- Undocumented location, stage, or POA status

Uncertain Diagnosis

DEFINITION

An uncertain diagnosis is one that is likely or suspected on clinical grounds but cannot be absolutely confirmed with certainty.

Diagnosis of many conditions is dependent on clinical circumstances and professional judgment without a confirmatory test.
Diagnoses and conditions that are uncertain and not ruled out at the time of discharged are coded as if existed or established (for hospital inpatients only).

DIAGNOSTIC CRITERIA

State that the diagnosis remains likely or suspected in the **discharge summary** or **final progress note**. This will avoid ambiguity and confirm that it was not ruled out.

Uncertain Diagnosis

TERMINOLOGY FOR UNCERTAIN DIAGNOSES

- Probable / Possible
- Suspected / Likely
- Questionable
- Consistent with
- Compatible with
- Comparable with
- Suggestive of
- Indicative of
- Appears to be

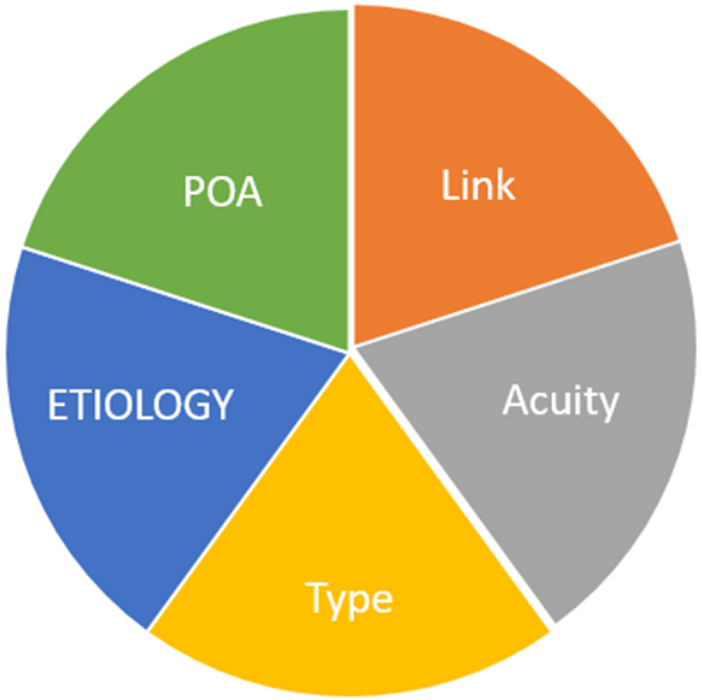
If a provisional or differential diagnosis is determined not to be present, not clinically supported, or ruled out by the time of discharge, it should not be documented as an uncertain diagnosis using the above terms.

Physician Documentation Queries

How to get them off your PLATE

- Use the PLATE pneumonic when documenting any principal or secondary diagnosis

- P – Present on admission
- L – Linking conditions
- A – Acuity
- T – Type
- E – Etiology



Discharge Summary

Did you know? **The Discharge Summary is the most important document in the medical record.**

The Discharge Summary is the first document hospital coders review when they start coding any given hospitalization. The Discharge Summary is considered the final diagnostic statement for the entire hospitalization.

- Please include a complete list of every diagnosis or medical issue that impacted your patient's care during their hospitalization.

The Discharge Summary is also the first document Recovery Auditors review in their efforts to deny any given hospitalization and remove important diagnoses.

- There should be no conflicting documentation between what is contained in the Discharge Summary and what has previously been documented in the rest of the medical record.

Please complete the Discharge Summary on the day your patient leaves the hospital.

- Note: Important medical information about your patients and additional significant diagnoses are lost to future providers as all memory naturally diminishes with time.

Studies have demonstrated a trend toward a decreased risk of readmission when the discharge summary arrives before the outpatient follow-up visit takes place. The study, by van Walraven and colleagues (J Gen Intern Med. 2002; 17:186-192), found a 0.74 relative risk of decreased rehospitalization for these patients.

Reference - https://brundagegroup.com/tips/

KEY TAKEAWAYS

- **Sepsis 3 -** Life-threatening organ dysfunction caused by a *dysregulated host response to confirmed or suspected infection*. Defined by a 2-point or more increase from baseline in the total Sequential [Sepsis-Related] Organ Failure Assessment (SOFA) score. Clearly document "Sepsis with acute organ dysfunction [specify the organ dysfunction]" and the present on admission status (POA – yes or POA – no)

- **Encephalopathy & Delirium** – Specify AMS or confusion (non-specific symptoms)

- **Pressure/Skin Ulcers** – Recommend terminology: Pressure ulcer, location, stage, and POA status

- **CHF – Three components – 1. Acuity, 2. Systolic (HFrEF)/Diastolic (HFpEF), 3. Underlying Etiology**

- **AKI –** To represent severity when patient meets KDIGO Criteria document "Acute Kidney Injury (AKI)" or "Acute Renal Failure". (Note: "Renal Insufficiency" and "Pre-Renal Azotemia" do not represent severity.

- **ATN –** Consider when creatine is increased >72 hrs consider ATN due to underlying cause (contrast induced, hypotension, medications, chemicals and toxins, myoglobinuria: tumor necrosis syndrome, or Pre-ren AKI – prolonged)

- **Uncertain Diagnoses -** State that the diagnosis remains likely or suspected in the **discharge summary** or **final progress note**. This will avoid ambiguity and confirm that it was not ruled out.

- **Discharge Summaries-** Need to be done in a timely manner and should include all diagnoses treated on the admission , including resolved diagnosis (es) .

Physician Documentation Best Practices

Tell the Story

- Diagnoses which are monitored, evaluated, and/or treated should be documented
- Reflect the physician's critical decision making regarding each diagnosis
- "Tell the story" of the hospital stay

Specificity and Acuity

- Documented to the highest degree of specificity and acuity
- Capture with terms such as "acute," "chronic," "acute on chronic," "compensated," "decompensated," or "exacerbated"

Uncertain Diagnoses

- Captured with terms such as "suspected," "likely," or "probable"
- Confirm or rule out within the progress notes
- Use these terms for those conditions that remain uncertain at the time of discharge

Linking Conditions

- Link all symptoms and clinical indicators to underlying diagnoses
- All abnormal lab/diagnostic results of clinical significance need an associated diagnosis, as no diagnosis can be assumed

Discharge Summary

- Summarize the hospital course
- Identify all diagnoses that impacted the encounter
- Complete within 24-48 hours of discharge

Tenet Tools

artifact health

Physicians can choose to utilize the mobile app to receive and answer queries.

iodine

Iodine is a clinical documentation AI platform which assists in identifying documentation opportunities.

Cerner

Dragon Medical Advisor (DMA) – Identifies diagnoses and provides advice for specificity.

Tenet Health Physician Advisors

Tenet Physician Advisors are available to assist in education and are partners for CDI initiatives.


Tenet
Health