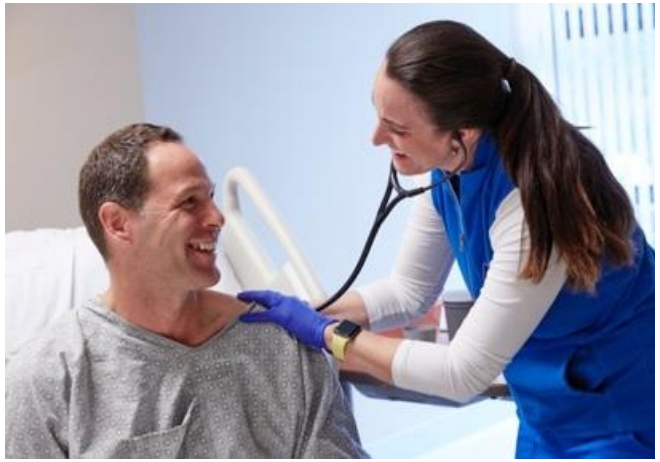




Physician Education in Clinical Documentation Integrity

Accurately Documenting and Supporting Diagnoses in the Delivery of Inpatient Healthcare

CME

Q3 2025

Objectives

- Understand the impact of documentation on various patient, physician, and hospital metrics
- 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 WHY?

- Your documentation reflects the patient in the bed, the necessity of clinical diagnostics, the need for continued length of stay (LOS) and the quality of care provided.

- The final coded record, which is the outcome of your documentation, is shared and available to CMS, data mining agencies and insurers. The information is also used by the hospital to evaluate quality, financial performance and healthcare initiatives for the organization.

LIVER DISEASE

Liver Disease

More than 100 million people in the U.S. are affected by liver disease, and chronic liver disease and cirrhosis rank among the leading causes of death. To ensure accurate coding, quality tracking, and reimbursement, it's critical to document liver conditions to the highest level of specificity.

- Hepatic Failure
- Hepatitis
- Cirrhosis

Liver Failure

DEFINITIONS

Acute hepatic failure refers to the development of severe acute liver injury (identified by liver test abnormalities) with encephalopathy and prolonged prothrombin time (INR of ≥1.5) in patients without cirrhosis or pre-existing liver disease.

“Shock liver,” also known as ischemic hepatitis, describes acute liver failure due to severe hypotension/shock.

Chronic hepatic failure is most common and usually due to cirrhosis.

Acute on chronic hepatic failure is decompensation of pre-existing chronic hepatic failure.

Hepatic encephalopathy describes a spectrum of neurologic impairment in patients with liver failure. It can be acute (overt), chronic, or acute on chronic.

What to Document

Hepatic Failure	Hepatitis	Cirrhosis
Alcoholic Hepatic Failure: ◆ Specify with or without coma ◆ Include pattern of alcohol use (e.g., abuse dependence)	**Alcoholic Hepatitis:** ◆ Specify with or without ascites ◆ Include alcohol use pattern if applicable	**Alcoholic Cirrhosis:** ◆ Document with or without ascites ◆ Include alcohol use pattern
Non-Alcoholic Hepatic Failure: ◆ Document acuity (acute/subacute or chronic) ◆ Specify with or without coma	**Viral Hepatitis:** ◆ Document type (A, B [± delta], C, E) ◆ Specify acute or chronic ◆ Indicate with or without hepatic coma	**Non-Alcoholic Cirrhosis:** ◆ Specify underlying type if known (e.g., NASH, autoimmune)

Documentation Key Points

✅ Specify type and acuity of liver disease

✅ Document presence or absence of:

- Hepatic coma
- Ascites

✅ Use linking terms (e.g., “due to,” “caused by”) to connect alcohol to liver disease

✅ Identify associated clinical conditions, such as:

- Hepatic encephalopathy
- Portal hypertension
- Coagulopathy
- Spontaneous bacterial peritonitis (SBP)
- Hepatorenal syndrome
- Malnutrition
- Substance abuse or dependence

📌 ***Avoid vague phrases like “ETOH liver disease” or “cirrhosis of unclear etiology.” Be specific.***

Sample Documentation

- ✓ **Alcoholic hepatitis with ascites**, patient is alcohol dependent
- ✓ **Acute hepatic failure with coma** due to intentional acetaminophen overdose
- ✓ **Hepatic encephalopathy** due to alcoholic cirrhosis with **ascites and portal hypertension**

Hepatorenal Syndrome

Hepatorenal Syndrome (HRS) is a life-threatening complication of advanced liver disease. It is defined by an abrupt decline in kidney function due to portal hypertension-induced vasodilatation, mostly seen in patients with **decompensated cirrhosis and ascites.**

Hepatorenal syndrome is a diagnosis of exclusion — it cannot be confirmed if the patient's AKI is due to other causes such as dehydration, sepsis, infections, NSAIDs, or intrinsic renal disease.

Diagnostic Criteria (must meet all):

- Cirrhosis and ascites
- Acute Kidney Injury (AKI) per KDIGO:
  - ↑ Serum creatinine ≥0.3 mg/dL in 48 hours, or
  - ↑ SCr ≥1.5x baseline within 7 days
- No alternate cause of AKI

Documentation Best Practices

✅ Link AKI to hepatorenal syndrome, when supported by clinical evidence

✅ Specify the associated liver condition — include cirrhosis, ascites, and portal hypertension

✅ Document related clinical factors as applicable:

- Alcohol dependence
- Spontaneous bacterial peritonitis
- Bleeding esophageal varices
- Hypocoagulopathy

✅ Avoid the abbreviation "HRS" — spell out "Hepatorenal Syndrome" in documentation

✅ Use linking terms (e.g., “due to,” “secondary to”) to clearly establish cause-and-effect

Sample Documentation

- ✓ "Patient presents with AKI due to hepatorenal syndrome with end-stage liver failure due to alcoholic liver cirrhosis with ascites and portal hypertension."

- ✓ "Bleeding esophageal varices due to chronic alcoholic liver cirrhosis with ascites and portal hypertension, AKI due to hepatorenal syndrome."

Tenet Health

CEREBRAL EDEMA AND BRAIN COMPRESSION

Cerebral Edema and Compression

DEFINITIONS

Cerebral edema (also called "vasogenic") is swelling/edema within brain tissue.

Cerebral compression is pressure on the brain due to external (e.g. subdural) or internal (e.g., cerebral hemorrhage, tumor, CVA, hydrocephalus) mass effect.

Cerebral herniation represents displacement of brain tissue through/across a fixed intracranial structure (e.g., falx, tentorium, foramen magnum).

Cerebral Edema and Brain Compression

"Midline shift" has ***no*** ICD-10 code to support the severity of illness and risk of mortality of patients.

Consider **Brain Compression and/or Cerebral Herniation** when a midline shift is present. Also, document any Cerebral Edema independently to help support the Severity of Illness (SOI) and Risk of Mortality (ROM) of your patient. **Cerebral edema** is its own diagnosis (and is a major co-morbid condition).

Brain Compression

- Cannot be coded from the radiologist's report. Document in the clinical notes.
- Midline shift is a non-specific term, commonly used by radiologists. It has no ICD-10 code.
- **Midline shift with brain compression or Brain compression noted by effacement of cisterns, sulci, ventricles is more specific.**

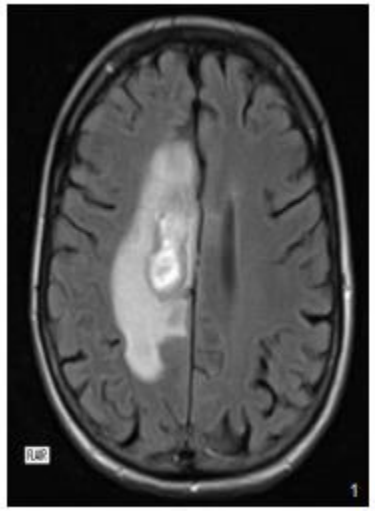
Cerebral Edema

- Cannot be coded from the radiologist's report. Document in the clinical notes.
- When present, it should be documented in the progress note(s) and reiterated in the discharge summary. Document the treatment e.g. steroids or other interventions used to independently manage it.

Cerebral Edema and Brain compression

Documentation Requirements:

- Clarify if traumatic or non-traumatic
- Clarify if associated with loss of consciousness
  - If so, the time of LOC in minutes
  - If consciousness not regained, identify cause such as death due to brain injury or other cause
- Clarify encounter type
  - Initial, subsequent, or sequelae
- Coma scale can also be captured



Documentation should clearly identify the underlying etiology of cerebral edema as well as all related complications which could include organ system failure, brain displacement, brain herniation, coma, and brain death.

Clinical significance of the cerebral edema should be documented to appropriately reflect the severity of the condition.

RECOMMENDED TERMINOLOGY

- Cerebral (brain) edema
- Vasogenic edema
- Cerebral (brain) compression
- Cerebral (brain) herniation
- Distinguish traumatic from atraumatic causes

TERMS TO AVOID

Avoid using only non-diagnostic descriptive terms

- Mass effect
- Midline shift
- Space occupying lesion
- Effacement

Cerebral Edema and Compression –Documentation examples

- MRI showing vasogenic edema from tumor, clinically significant. Will treat with Decadron and repeat imaging.
- CT revealed mass effect and compression of ventricle. Treating with hypertonic saline. Will monitor ICP readings, with intervention at >22 mmHg.
- Repeat imaging shows increased cerebral edema correlating with new mental status changes. Will discuss with neurology. Elevated HOB to 30 degrees.
- Patient with cerebral edema from Streptococcus pneumoniae meningitis, treated with steroids.
- Patient with posterior fossa lesions causing cerebral edema and brainstem compression; consult neurosurgery for possible decompressive craniectomy.

Cerebral edema/compression 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.

Cerebral edema with brain compression

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.

- Cerebral edema
- Cerebral edema with brain compression
- Other explanation of clinical findings (please specify)
- Unable to determine

Clinical information

- Reason for Clarification: Please clarify the CT and MRI findings
- Signs and Symptoms
  - Diagnostic Imaging: "Surrounding vasogenic edema is seen." ; ". Left middle cranial fossa intracranial hemorrhage with a volume of 10.6 mL. Surrounding mass effect." CT Head or Brain W/O Contrast by Dr. [redacted] at [redacted]

    "Blooming artifact from left temporal hematoma. Surrounding vasogenic edema. This appears similar to prior CT exams." MRI Brain WO/W Contrast by Dr. [redacted] at [redacted]
- Risk Factors
  - Other: "The patient has a large left-sided intraparenchymal hemorrhage. He will be given 1 g of Keppra loading dose .. Keppra 500 mg IV every 12" Admission H&P by Dr. [redacted] at [redacted]
- Treatment
  - Frequent neuro checks: "We will continue to follow him closely with every hour neurochecks admit him to the surgical ICU" Admission H&P by Dr. [redacted] at [redacted]

Pre-Query DRG , SOI/ROM , GMLOS

Medicare DRG and MDC Information

084	TRAUMATIC STUPOR AND COMA >1 HOUR WITHOUT CC/MCC CMS wt 0.9056 A/LOS 2.6 G/LOS 2.1
001	DISEASES AND DISORDERS OF THE NERVOUS SYSTEM

APR (all versions) DRG and MDC Information

055	Head trauma with coma > 1 hour or hemorrhage APR wt 0.9267 Low Trim 1 High Trim 13 ALOS 3.51 GLOS 2.82 Status: LOS Inlier
001	DISEASES AND DISORDERS OF THE NERVOUS SYSTEM
2	Moderate Severity of Illness
2	Moderate Risk of Mortality

Admit Diagnosis

	Code	Description
1.	R4182	Altered mental status, unspecified

Diagnosis Code Detail

	Code	Description	Affect	SOI	ROM	Elix
1.	S065X9A	Principal Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, initial encounter	✓	P	P	
2.	K7210	Chronic hepatic failure without coma		2	2	✓

Post-Query DRG , SOI/ROM , GMLOS

Medicare DRG and MDC Information

082	TRAUMATIC STUPOR AND COMA >1 HOUR WITH MCC CMS wt 2.2639 A/LOS 6.4 G/LOS 4.2
001	DISEASES AND DISORDERS OF THE NERVOUS SYSTEM

APR (all versions) DRG and MDC Information

055	Head trauma with coma > 1 hour or hemorrhage APR wt 0.9267 Low Trim 1 High Trim 13 ALOS 3.51 GLOS 2.82 Status: LOS Inlier
001	DISEASES AND DISORDERS OF THE NERVOUS SYSTEM
2	Moderate Severity of Illness
3	Major Risk of Mortality

Admit Diagnosis

	Code	Description
1.	R4182	Altered mental status, unspecified

Diagnosis Code Detail

	Code	Description	Affect	MCC	SOI	ROM	Elix
1.	S065X9A	Principal Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, initial encounter	✓		P	P	
2.	S06A0XA	Traumatic brain compression without herniation, initial encounter	✓	✓	1	3	
3.	K7210	Chronic hepatic failure without coma			2	2	✓
4.	K7460	Unspecified cirrhosis of liver			1	2	
5.	S062X9A	Diffuse traumatic brain injury with loss of consciousness of unspecified duration, initial encounter			X	X	
6.	S061X9A	Traumatic cerebral edema with loss of consciousness of unspecified duration, initial encounter			X	X	

PANCREATITIS

Pancreatitis

DEFINITION

Acute: acute onset inflammation of the pancreas usually non-infectious. Includes acute exacerbation of chronic pancreatitis.

Chronic: persistent or recurrent pancreatitis for 3 months or more characterized primarily by chronic abdominal pain with or without elevated enzymes.

Acute findings may include : fever, leukocytosis, vomiting, ileus, hypocalcemia, dehydration and/or AKI.

Chronic findings may include : chronic pain (often-opioid dependent), pancreatic insufficiency, secondary diabetes, pancreatic cyst or cancer

Pancreatitis – General Documentation Practices

Document the following

- **Acuity**:
  - Acute pancreatitis, recurrent acute pancreatitis, chronic pancreatitis, acute on chronic pancreatitis

- **Subtypes:**
  - Interstitial acute pancreatitis, necrotizing acute pancreatitis, large duct chronic pancreatitis, small duct chronic pancreatitis

- **Severity:**
  - Mild acute pancreatitis, moderate acute pancreatitis, severe acute pancreatitis

- **Pancreatitis related complications:**
  - Acute peripancreatic fluid collection, acute necrotic collection, pseudocyst, walled-off necrosis, infected fluid collection, pseudoaneurysms, venous thrombosis, organ failure (respiratory, cardiovascular, renal, sepsis), ileus, ascites and abdominal compartment syndrome, hyperglycemia, malnutrition, and abnormal weight loss

- **Etiology:**
  - Gallstones, alcoholic, smoking related, idiopathic, hypertriglyceridemia, drug-induced, hypercalcemia, autoimmune, genetic, traumatic, endoscopy related, obstructive, viral, others

Pancreatitis – Documentation Examples

- Acute severe gallstone necrotizing pancreatitis, due to choledocholithiasis. Complicated by pancreatic acute necrotic fluid collection and respiratory failure.
- Acute mild alcoholic interstitial pancreatitis.
- Recurrent moderate necrotizing hypertriglyceridemia-related acute pancreatitis. Complicated by splenic vein thrombosis and ileus.
- Acute on large duct chronic alcoholic pancreatitis.
- Chronic abdominal pain secondary to large-duct calcific chronic pancreatitis.
- Pancreatic endocrine dysfunction with type 3C diabetes secondary to large duct calcific alcoholic chronic pancreatitis.
- Exocrine pancreatic insufficiency secondary to idiopathic small duct non-calcific chronic pancreatitis.

RECOMMENDED TERMINOLOGY

Acute pancreatitis
Chronic pancreatitis
Acute exacerbation of chronic pancreatitis
Acute on chronic pancreatitis

KEY TAKEAWAYS

- **Liver Disease: Specify acute/subacute/chronic hepatic failure + cause**
- **Hepatic Encephalopathy: document coma if present**
- **Cerebral Edema/Brain Compression: Cannot code from radiology report. Must diagnose!**
- **Pancreatitis: Document acuity of pancreatitis (acute, chronic, acute on chronic)**

APPENDIX

What is CDI?

Clinical Documentation Integrity (CDI). A CDI program is designed to concurrently improve the integrity (i.e., completeness, accuracy and clarity) of the clinical documentation in the inpatient setting. The goals of the CDI program are to:

- Accurately reflect the severity of illness of the patient population
- Ensure accurate payment (i.e., all services provided are captured and patient acuity/complexity is accurately recorded)
- Reduce compliance exposure
- Reduce coding turnaround time and decrease post-discharge questions to physicians
- Prevent audit contractor denials and DRG changes

The Impact of Clinical Documentation

- *Documentation Explosion*

Documentation Impact

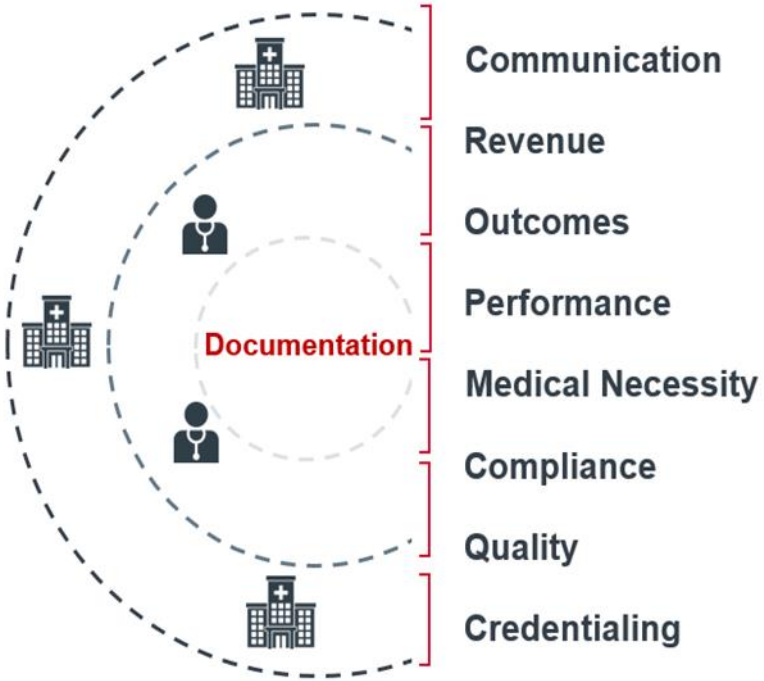
- Payers, Patients, State and Federal Governments
- Professional fees, VBP, MIPS
- Medical necessity, Level of Care, Hospital DRG's

Publiclly Reported Quality Data

- CMS Star ratings, Leapfrog Group, Specialty Societies

Population Health and Chronic Disease Managemer

- Claims data used to identify population groups



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.**

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

Key Documentation - Present On Admission

Critical to document Present On Admission

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

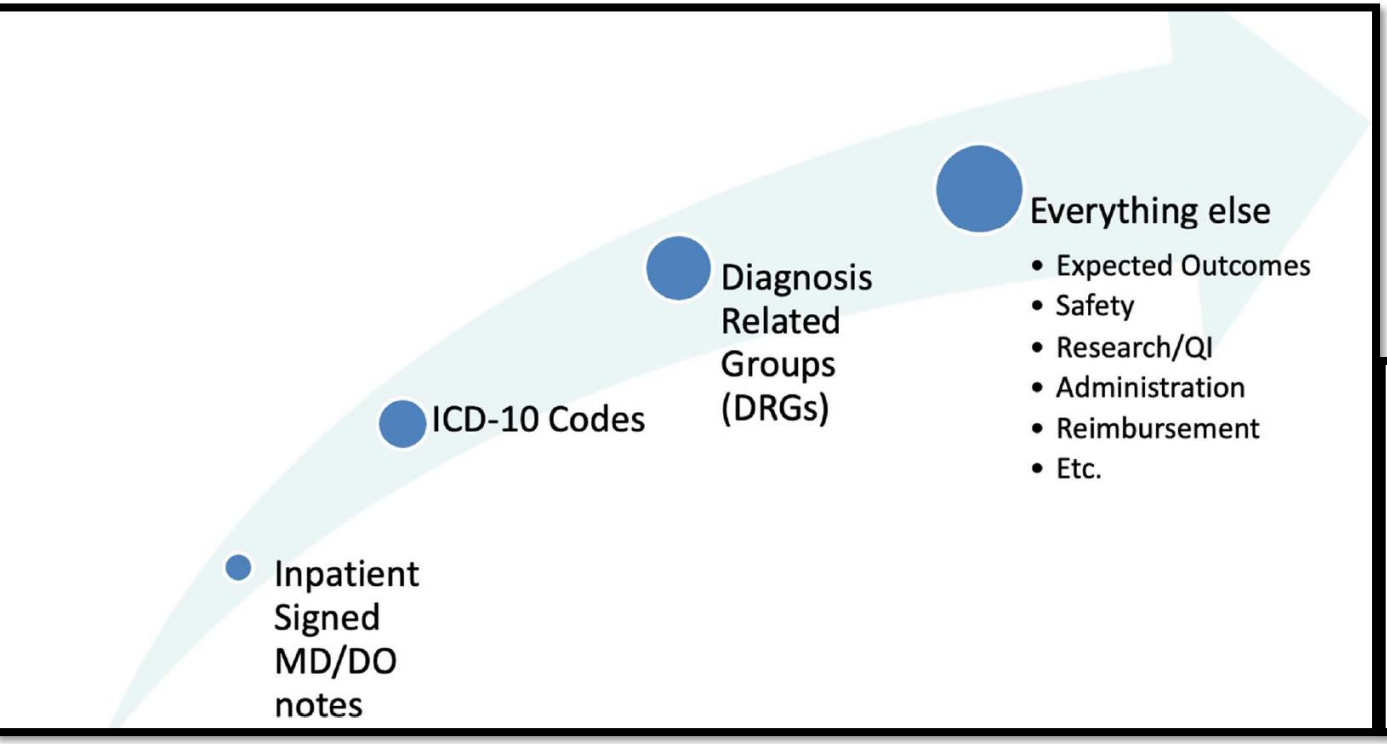
- All known details
- Type of encounter (initial, subsequent, sequelae) for injuries and poisonings
- Link a complication of medical care to its suspected cause
- Document suspected organism, if known or based on risk factors

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



Case Mix Index (CMI)

CMI is the average of all DRG relative weights in a given timeframe. It is commonly used as a measure of a Hospital's or Physician's patient population severity of illness.

CMI can also be used by government and other payers for hospital or physician comparison for any number of reasons, such as:

- Profiling
- Pay-for-Performance
- Value-Based Purchasing

What are DRGs?

DRGs: Groups of clinically related diagnoses with similar resource consumption

Two Common Types:

- MS-DRG (Medicare Severity-Diagnostic Related Group)
- APR-DRG (All Patient Refined-Diagnostic Related Group)

Only 1 DRG is assigned per inpatient discharge

CMS releases the updated DRG table on October 1st each year.

Concepts- Defining Diagnoses

Principal Diagnosis

The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care

- *Example: Patient admitted with acute on chronic systolic CHF and pneumonia. Patient given IV Lasix and IV antibiotics. Either may be sequenced as principal diagnosis.*
- Best practice: Meet core measures for both diagnoses.

Secondary Diagnoses

All other conditions, either present on admission or that develop subsequently, may qualify as secondary diagnoses if they are monitored, evaluated, or treated during the encounter.

- *Example: Patient admitted with a diagnosis of probable aspiration pneumonia, treated with IV antibiotics. Patient was noted to have a BMI of 45 which indicates morbid obesity and dietary counselling was ordered.*

Concepts- Secondary Conditions Further Defined

Comorbid Conditions (CC)

Complication or comorbidity that has been identified as having impact on severity of illness and/or risk of mortality

Major Comorbid Conditions (MCC)

Major complication or comorbid condition that has been identified as having **significant** impact on the severity of illness and/or risk of mortality

CMS decides what codes are considered CC/MCCs. These codes are reviewed annually and changes to code designations are announced in **the "Final Rule," which becomes effective** October 1st annually.

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

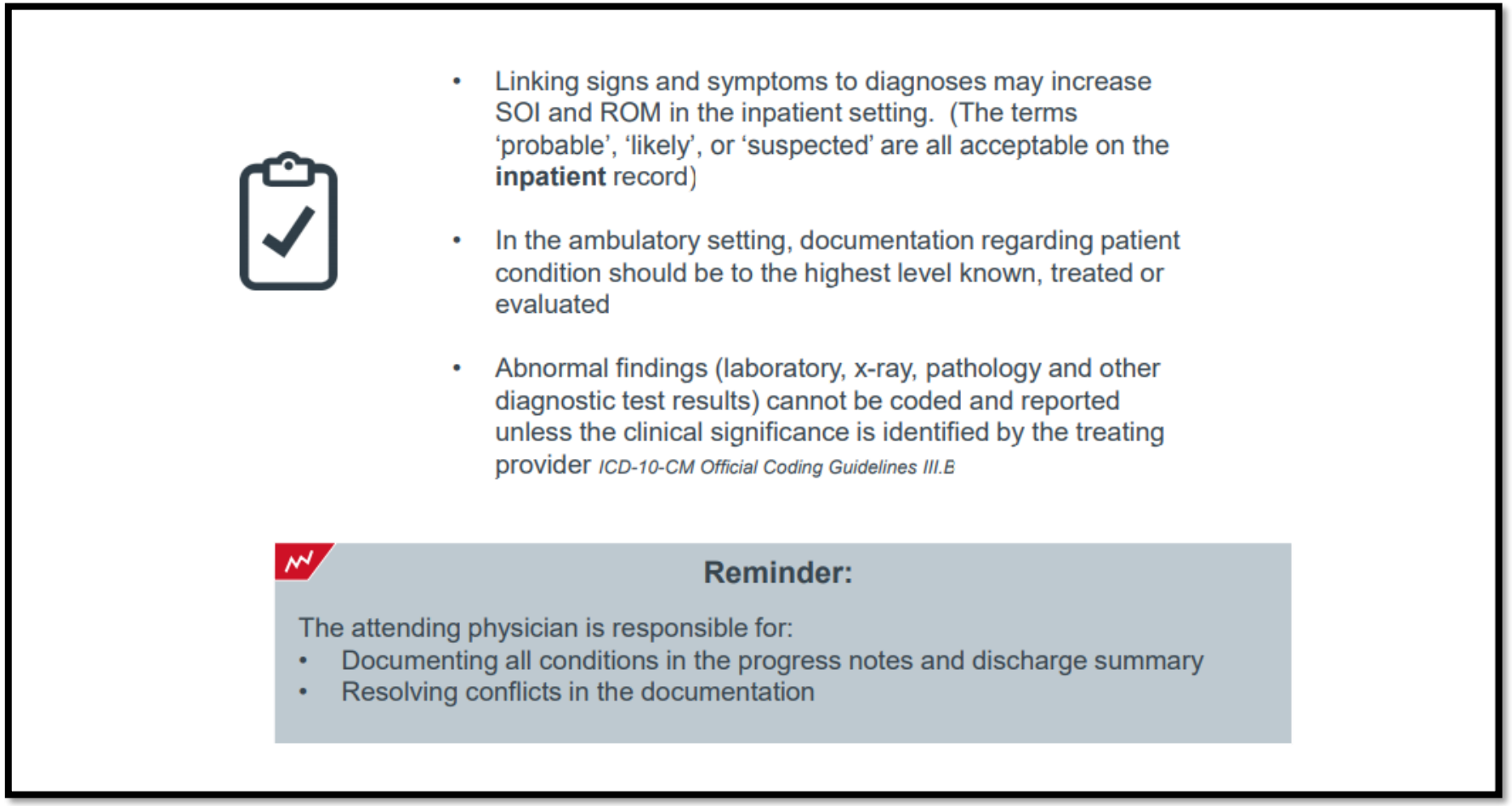
Clinical Case Assessment -Impact of SOI & ROM

	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

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

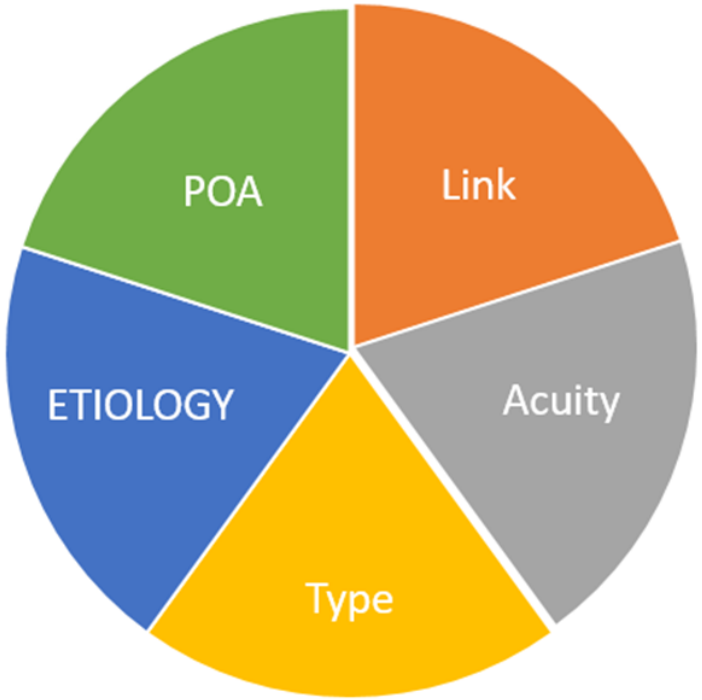
If a provisional or differential diagnosis is determined not to be present, not clinically supported, or ruled out by the time of discharge, it should not be documented as an uncertain diagnosis using the above terms.

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/

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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