



Internal / Family Medicine

Best Practice Documentation

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Vague Diagnoses to Avoid

The following terms are vague and do not support a definitive diagnosis demonstrating the severity of illness or risk of mortality of your patient.

Avoid these terms when following best practice documentation.

- Bacteremia – only document this term when it meets the true definition
 - Asymptomatic Positive Blood Cultures.
 - Does the clinical evidence demonstrate that you should be documenting:
 - Sepsis due to a localized infection (UTI, PNA, Cellulitis)
 - Positive Blood Cultures, contaminant
 - Positive Blood Cultures, source being worked up
 - Treating patient with XXXX IV antibiotics

- Urosepsis – do not document this term
 - Implies clinically evident severe infection of the urinary tract.
 - Does the clinical evidence demonstrate:
 - Sepsis Due to a UTI
 - UTI
 - Cystitis
 - Pyelonephritis
 - Other more specific localized infection



Sepsis

Best Practice Documentation

- Identified causal organism (when known)
- Underlying cause
 - Localized infection (i. e. pneumonia, cellulitis, UTI)
 - Device/Implant/Graft (i. e. PICC, central line, indwelling urinary catheter)
- Organ Failure
 - Link any associated organ failure with the key words “due to” when underlying cause is Sepsis
 - When organ failure is unrelated to Sepsis specify the underlying cause
- Septic Shock
 - Specify if patient is in Septic Shock
 - If Hypotensive and not in shock clarify in your documentation
- Document present on admission status of the sepsis
 - Present on admission
 - Evolving on admission
 - Developed subsequent to admission



Sepsis

Supporting Medical Necessity , Severity of Illness, and Risk of Mortality in your Septic Patient

- Specify the clinical criteria you are using to support the diagnosis of sepsis.
- Once “r/o sepsis” has been documented or documented once in the record specify if sepsis was:
 - Ruled in
 - Ruled out
 - Resolved
- Sepsis Syndrome and SIRS do not translate to a diagnosis of Sepsis. Follow the best practice tips provided. Follow the best practice documentation.



Sepsis Documentation Example

Insufficient Documentation

- Urosepsis with +UC for E. Coli

- Sepsis Syndrome with PNA

Best Practice Documentation

- **Sepsis due to E.coli UTI with 2 SIRS criteria T max 39.1, WBC >18.000**

- **Sepsis with 2 SIRS criteria, T max 39.1, HR 122 due to aspiration pneumonia**



HIV / AIDS

Best Practice Documentation

- Clearly delineate if the patient has:
 - AIDS
 - AIDS with an AIDS related illness
 - HIV Status – Asymptomatic (no history of any AIDS defining illness)
- Current Condition is:
 - Related to AIDS
 - Unrelated to AIDS
- Underlying manifestations and specify connection to the AIDS, such as:
 - Dementia
 - Pneumonia (specify type)
 - Opportunistic infections (specify)
 - Any other AIDS related illness identified in workup



HIV/AIDS Documentation Example

Insufficient Documentation

47 year old male with history of pneumonia and HIV positive presents as a trauma code s/p MVA .

Best Practice Documentation

47 year old male with history of **Pneumocystis Carinii and AIDS.** Presents as a trauma code s/p MVA.



Key Documentation Concepts for Infectious Diseases

- Document causal organism when known.
- Specify acute, acute recurrent, chronic when appropriate.
- Establish cause-and-effect relationships when applicable.
(e.g., UTI due to indwelling Foley catheter, line sepsis)
- Document whether a working diagnosis of sepsis, UTI, etc. is ruled in, ruled out or when / if it has resolved.
- If cultures and/or diagnostic tests are negative but patient is being treated clinically for a condition (e.g., UTI, pneumonia) document supporting clinical indicators.
- Document Present on Admission (POA) status, especially if diagnosis isn't confirmed until day two or three of admission.



Anemia

Best practice documentation for Anemia is to use the key elements outlined below and use the linking statement “due to” when documenting the cause of the anemia.

- Type
 - Nutritional (Iron, B12, or Folate Deficiency)
 - Hemolytic
 - Aplastic
 - Due to blood loss
 - Due to Procedure
 - Unrelated to Procedure

- Acuity:
 - Acute
 - Chronic
 - Acute on chronic

- Document a “due to” underlying condition causing the anemia
- Link any associated medication or drug use



Anemia Documentation Example

Insufficient Documentation

Patient presented with weakness, fatigue and rectal bleeding. HGB 6.2. Will transfuse and consult GI.

Best Practice Documentation

Patient presented with weakness, fatigue and rectal bleeding. **Acute blood loss anemia** secondary to GIB HGB 6.2. **GI Bleed is most likely due to patients chronic peptic ulcer.** Will transfuse and consult GI.



Sickle Cell Disease and Trait

- Identify as
 - Disease (anemia)
 - Trait
- Type
 - Hb-SS
 - Hb-C
 - Hb-SD
 - Hb-SE
 - Sickle-cell thalassemia
 - Sickle-cell beta thalassemia
 - Thalassemia Hb-S disease
- Crisis
 - With crisis
 - Acute chest syndrome
 - Splenic sequestration
 - Unspecified manifestation
 - Without crisis



Key Documentation Concepts for Blood/Hematologic Disorders

- Specify acute, chronic when appropriate.
- Specify underlying cause or associated disease, if known.
- Transfusions require associated diagnosis to be documented.



Diabetes Mellitus

To accurately capture the severity of illness and risk of mortality of your Diabetic patient, you must document all of the key elements associated with the condition including:

- Type
 - Type 1
 - Type 2
 - Drug/chemical induced
 - Due to underlying condition
 - Due to genetic defects of beta-cell function
 - Due to genetic defects of insulin action
 - Post-pancreatectomy
 - Postprocedural
- Control
 - Inadequate control
 - Out of control
 - Poorly Controlled
 - Hypoglycemia
 - Hyperglycemia
 - Insulin use



Diabetes Mellitus & Complications/Manifestations

Diabetic manifestations must be linked to the diagnosis to establish a cause and effect relationship.

Manifestations and Complications:

- Diabetic retinopathy
 - Diabetic Osteomyelitis
 - Diabetic PVD
 - With Diabetic Ulcer
 - Diabetic peripheral neuropathy
 - With Diabetic Ulcer
 - Diabetic nephropathy
 - Diabetic gastroparesis
 - Diabetic ulcer and/or gangrene
 - Diabetic Hyperosmolarity
 - Hyperglycemia/hypoglycemia
 - Diabetic Ketoacidosis
- } ➤ with coma
} ➤ without coma



Diabetes Mellitus Documentation Example

Insufficient Documentation

- Pt admitted with diabetes mellitus. Blood sugar 425. Ulcer noted on LLE.

- Diabetes uncontrolled

Best Practice Documentation

- Pt admitted with **DM 2 with hyperglycemia** with blood sugar on admission 425. Insulin dependent. **Diabetic foot ulcer due to Diabetic PVD** noted on left malleolus. Pt also has diabetic neuropathy and retinopathy.
- Type 1 diabetes **with hyperglycemia**



Diseases of the Thyroid

Non-toxic Goiter	Hypothyroidism	Hyperthyroidism (Thyrotoxicosis)
<ul style="list-style-type: none">○ Diffuse<ul style="list-style-type: none">□ Simple○ Single thyroid nodule<ul style="list-style-type: none">□ Colloid□ Uninodular○ Multinodular<ul style="list-style-type: none">□ Cystic	<ul style="list-style-type: none">○ Congenital with diffuse goiter○ Congenital w/o goiter○ Other	<ul style="list-style-type: none">○ With diffuse goiter<ul style="list-style-type: none">□ Exophthalmic□ Graves' Disease○ With single thyroid nodule○ With multinodular goiter○ From ectopic thyroid tissue○ Factitia <p><u>Specify:</u></p> <ul style="list-style-type: none">○ With or without thyrotoxic storm or crisis



BMI

When a patient has a clinically significant BMI, a supporting diagnosis reflecting the patient's overall clinical picture is required for best practice documentation.

≥ 40 BMI

- Associated Condition
 - Morbid obesity
 - Due to excess calories
 - With alveolar hypoventilation
 - Pickwickian syndrome
 - Obesity
 - Overweight

<19 BMI

- Associated Condition
 - Underweight
 - Cachexia
 - Malnourished
 - Mild (first degree)
 - Moderate (second degree)
 - Severe (third degree)



BMI Documentation Example

Insufficient Documentation

Patient has a BMI of 46.3.
The physical exam in the
H&P states abdomen: obese

Best Practice Documentation

Morbid obesity with BMI of
46.



Malnutrition

- Specify severity:
 - Mild (first degree)
 - Moderate (second degree)
 - Severe (third degree)
- Document any associated diagnoses/conditions (i.e. underweight, cachexia)



Malnutrition

- CCHS uses the **ASPEN** criteria to support the diagnosis of malnutrition. Refer to the Dietitian's progress note in the record.

- Guidelines advocate for provider use of a standardized set of diagnostic characteristics to identify and document adult malnutrition. The guidance says malnutrition should be diagnosed when at least two or more of the following six characteristics are identified:
 - ❑ Insufficient energy intake
 - ❑ Weight loss
 - ❑ Loss of muscle mass
 - ❑ Loss of subcutaneous fat
 - ❑ Localized or generalized fluid accumulation that may sometimes mask weight loss
 - ❑ Diminished functional status as measured by hand grip strength

- Providers must assess these six characteristics in the context of an acute illness or injury, a chronic illness, or social or environmental circumstances to determine whether malnutrition is present and whether it is severe or non severe (moderate). ACDIS 09/13/2013
http://malnutrition.andjnl.org/Content/articles/1-consensus_Statement.pdf



Malnutrition Documentation Example

Insufficient Documentation

Frail, poor appetite, recent weight loss.

Best Practice Documentation

Severe protein-calorie malnutrition , decreased PO intake and weight loss in this patient with cachexia. BMI 16.



Key Documentation Concepts for Endocrine

Document:

- Hyper or hypoglycemia if applicable
- “Link” associated diabetic manifestations
- Acuity and type of malnutrition with supporting clinical indicators and treatment
- Identify underlying conditions if present
- Diagnosis associated with abnormal BMI
- Electrolyte imbalances



Major Depressive Disorder

The diagnosis of Depression without identifying the 3 key elements below is equivalent to 'Major Depressive Order, Single Episode' in ICD-10 CM.

- Type
 - Single episode
 - Recurrent

- Severity
 - Mild
 - Moderate
 - Severe without psychotic features
 - Severe with psychotic features

- If in Remission, include:
 - In partial remission
 - In full remission



Substance Use, Abuse, Dependence

- Specify pattern of consumption and be consistent in your documentation:
 - Use
 - Abuse
 - Dependence

- When documenting the pattern of consumption be mindful:
 - If the patient uses and abuses the same substance this will be captured as abuse.
 - If the patient abuses and is dependent on the same substance this will be captured as dependence.
 - If the patient uses, abuses, and is dependent on the same substance, this will be captured as dependence
 - If the patient uses and is dependent on the same substance this will be captured as dependence

- Document the association of the psychoactive substance with the patient's mental or behavioral disorder (e.g. Cocaine dependence with mood disorder, Sleep disorder due to amphetamine abuse)



Drug and Alcohol Withdrawal

- By definition a patient who is going through withdrawal is dependent on the substance they are abusing.
- Conflicting documentation by the provider of Use, Abuse, and Dependence interchangeably in the setting of withdrawal will require additional clarification to determine the severity of illness related to your patient.
- When documenting Withdrawal it must always be linked with Dependence.
 - Alcohol Dependence being treated for withdrawal



Dementia

- Identify the type of dementia
 - Vascular dementia
 - Includes:
 - Arteriosclerotic
 - Multi-infarct
 - Dementia due to a specific disease, such as:
 - Alzheimer's Disease
 - Early Onset
 - Late Onset
 - Parkinson's Disease
 - Alcohol Dependence
 - AID's
- Document any associated Behavioral disturbance
 - Aggressive
 - Combative
 - Violent



Delirium vs. Encephalopathy

Delirium and Encephalopathy are often used interchangeably amongst providers. However the code set makes a clear delineation between the two. Best practice documentation requires providers to be as precise as clinically possible when using these diagnoses.

- **Delirium** - Classified as **physiological, chemical** or **psychological** depending on underlying cause
 - ❑ Known physiological condition (Acute confusional state, Sundowning, With dementia)
 - ❑ Chemical (secondary to drug or alcohol use, dependence or withdrawal)
 - ❑ Psychological (secondary to Psychosis, sleep deprivation), Hysterical
 - ❑ Hallucinations - specify if present

- **Encephalopathy**
 - ❑ Metabolic
 - ❑ Alcoholic
 - ❑ Hypoxic
 - ❑ Toxic
 - ❑ Hypertensive
 - ❑ Other – in disease classified elsewhere (specify underlying disease; needs to be linked to etiology)



Delirium / Encephalopathy Documentation Example

Insufficient Documentation

- Acute confusional state

- Change in mental status/confusion

Best Practice Documentation

- Acute delirium secondary to heroin abuse causing visual and auditory hallucinations.

- Toxic metabolic encephalopathy secondary to acute renal failure and ARDS.



Seizures

Seizures not diagnosed as a disorder or recurrent should specify the condition as being:

- Febrile (simple or complex)
- New Onset
- Single seizure or convulsion
- Post traumatic or hysterical
- Autonomic
- If the seizures are “sequela” of another condition (stroke, traumatic, etc.)



Epilepsy and Recurrent Seizures

○ Type

- ❑ Localization-related idiopathic or symptomatic
- ❑ Simple partial or complex partial seizures
- ❑ Generalized idiopathic

○ Intractable or Not Intractable

- ❑ Pharmacoresistant
- ❑ Pharmacologically resistant
- ❑ Treatment resistant
- ❑ Refractory (medically)
- ❑ Poorly controlled



○ Status

- ❑ With status epilepticus
- ❑ Without status epilepticus

○ Identify any special epileptic syndromes:

- ❑ Seizures related to alcohol, drugs, sleep deprivation, etc.



Epilepsy and Seizure Documentation Example

Insufficient Documentation

- Patient with history of epilepsy admitted with convulsions.
- Adolescent presents to ED with seizure like activity.
- Patient admitted with recurrent seizures.
- Febrile seizures noted.

Best Practice Documentation

- Patient with history of uncontrolled idiopathic epilepsy, admitted with status epilepticus secondary to medical noncompliance.
- Adolescent noted with myoclonic seizure secondary to probable hormonal changes and resistance to treatment.
- Recurrent seizures due to previous non-traumatic cerebral hemorrhage.
- Febrile seizures due to acute serous otitis media.



TIA

- Aborted Stroke = CVA
 - ❑ If CVA was ruled out document specific etiology of presenting signs and symptoms.
 - ❑ If your final clinical impression = TIA follow the best documentation practice below.

- Document the underlying etiology of the TIA when known:
 - ❑ Vertebro-basilar artery syndrome
 - ❑ Carotid artery syndrome
 - ❑ Pre cerebral artery syndrome
 - ❑ Amaurosis fugax
 - ❑ Transient global amnesia
 - ❑ TIA unspecified



TIA

Documentation Example

Insufficient Documentation

- TIA

Best Practice Documentation

- TIA due to carotid stenosis of the left internal carotid artery.

or

- TIA of unknown origin



Cerebral Infarction

CVA, Cerebral Infarction, Ischemic Stroke

To satisfy best practice requirements etiology, site and laterality should be documented.

- Etiology
 - Embolism
 - Thrombosis
 - Unspecified occlusion or stenosis

- Site
 - Precerebral artery (basilar, carotid, vertebral, other)
 - Cerebral (anterior, middle, posterior)
 - Cerebellar
 - Other cerebral artery

- Laterality
 - Right
 - Left



CVA

Documentation Example

Insufficient Documentation

- Acute embolic CVA.
- Lacunar infarct
- Mass effect (if symptomatic)

Best Practice Documentation

- 65 yo **left handed** male presenting with acute **embolic** ischemic infarct of the **right MCA** secondary to non-compliance with anticoagulation.
- 65 yo **right handed** male presenting with **left sided hemiparesis** due to and acute lunar infarct of the **right MCA** due to **vascular hyalinosis, associated with hyperlipidemia.**
- **Symptomatic cerebral edema or symptomatic intracerebral hemorrhage, whichever is applicable.**



Non-traumatic Hemorrhage

Ruptured Cerebral Aneurysm; Subdural Hematoma, non-traumatic

- Identify site:
 - Anterior or posterior communicating artery
 - Basilar artery
 - Carotid siphon and bifurcation
 - Middle cerebral artery
 - Vertebral artery
 - Other or unspecified intracranial artery
 - Other specified site:
 - Meningeal hemorrhage
 - Rupture of arteriovenous malformation

- Identify laterality, if applicable



Complications of Cerebral Infarction/Hemorrhage

Document related symptoms/ residual effect:

- Aphasia
- Brainstem herniation
- Cerebral edema (state if asymptomatic vs symptomatic)
- Coma/ comatose
- Dysphagia
- Dysphasia
- Encephalopathy
- Hemiparesis (specify laterality)
- Hemiplegia (specify laterality)
- Increased intracranial pressure
- Left sided neglect
- Seizures
- Vasogenic edema
- Vasospasm



Complications of Cerebral Infarction/Hemorrhage, (continued)

Further Specify:

- With/without tPA
 - Aborted or not

- Hemorrhagic conversion
 - Specify whether asymptomatic or symptomatic

- Evolution of previous stroke if known



CVA

Documentation Example

Insufficient Documentation

- Hemorrhagic stroke.

Best Practice Documentation

- 45 year old **right handed** female presenting with **acute left thalamic hemorrhagic stroke secondary to hypertension.**



Key Documentation Concepts for Cerebrovascular Diseases

Document:

- Specific location of infarct or culprit vessels.
- With or without infarction
- Affected side – right, left, bilateral
- Dominant side – right, left
- Specific complications
- Link residual or late effects with the infarction or hemorrhage
- Specify if stroke is new or an extension of prior stroke
- Any hemorrhagic conversion
- tPA administration (and time started). If stroke was aborted, document it!



Acute Myocardial Infarction

ST elevation (STEMI)

- Require site and specific artery:
 - Anterior Wall
 - Left main coronary artery
 - Left anterior descending artery
 - Other coronary artery of anterior wall
 - Inferior Wall
 - Right coronary artery
 - Other coronary artery of inferior wall
 - Other
 - Left circumflex coronary artery
 - Other Specified

Non-ST elevation MI (NSTEMI)

- No specific site requirements

Type II MI

- Requires the Specificity of STEMI or NSTEMI
- Best Practice Documentation when patient did not have an AMI:
 - “Acute subendocardial ischemia without AMI”

Time Element of Infarction is Required

All STEMI and NSTEMI's require documentation of timing of the infarction in relation to the visit:

- Document date of any recent acute MIs within 28 days of admission
- Document whether or not the current MI has occurred within 28 days of a previous MI
- If the patient has a history of an MI (older than 28 days)



Acute Coronary Syndrome (ACS) and Angina

ACS is an umbrella term for situations where the blood supplied to the heart muscle is suddenly blocked, it lacks clinical specificity.

ACS in terms of ICD-10 translates to Acute Ischemic Heart Disease.

Best Practice Documentation – do not use the term ACS describe the actual clinical condition you are treating, examples include:

- NSTEMI, initial episode of care
- Angina
 - with Coronary Atherosclerosis (unstable or with documented spasm)
 - Unstable
 - Angiospastic
 - Following MI (specify type of MI and onset)



Congestive Heart Failure

- Acuity
 - Acute
 - Chronic
 - Acute on chronic

- Type
 - Systolic
 - Diastolic
 - Combined systolic and Diastolic
 - Rheumatic

- Due to or associated with
 - Cardiac or other surgery
 - Hypertension
 - Valvular disease
 - Rheumatic heart disease
 - Endocarditis (valvitis)
 - Pericarditis
 - Myocarditis



Cardiomyopathy

Cardiomyopathy can have a host of underlying causes.

Best practice documentation is to specify the cause of the Cardiomyopathy:

- Ischemic
- Primary
- Dilated
- Obstructive hypertrophic
- Nonobstructive hypertrophic
- Endomyocardial
- Takotsubo (clarify with or without MI)
- Restrictive or Constrictive
- Alcoholic
- Due to drug or other external agent
- Associate with other disease – specify disease (such as amyloidosis, etc.)



Cardiac Arrest

- Cause
 - ❑ Underlying cardiac condition (specify)
 - ❑ Due to other acute or chronic underlying condition (specify)
 - ❑ Cardiac arrest of unknown etiology

- When related to an operative episode
 - ❑ Postprocedural cardiac arrest following cardiac surgery
 - ❑ Postprocedural cardiac arrest following other surgery
 - ❑ Intraoperative cardiac arrest during cardiac surgery
 - ❑ Intraoperative cardiac arrest during other surgery



Cardiovascular Documentation Example

Insufficient Documentation

- History of CM/CHF.

Best Practice Documentation

- Patient with history of **nonischemic cardiomyopathy** and **chronic diastolic CHF**.



Take the Extra Step!

For further specificity of individual systems, please refer to the specialty module dedicated to that system.

Document:

- ALL chronic conditions – present and stable but managed.
- Significance of abnormal tests (e.g., UTI, electrolytes, echo)
- Clarify whether diagnoses are ruled in or ruled out
- Establish cause-and-effect relationships (e.g., PICC line infection)
- Laterality, if applicable
- Explain the “why” and “because” to support medical necessity
- Any tobacco use, abuse, dependence, history of smoke exposure (e.g., second hand, occupational, etc.)



Internal / Family Medicine

This concludes the Internal/Family Medicine
Module 1

Continue with Internal/Family Medicine
Module 2 for other body system documentation