Internal/Family Medicine

Best Practice Documentation

Module 2 of 2

Click on the desired Diagnoses link or press Enter to view all information.

Diagnoses:

- Pneumonia
- Respiratory Failure
- Asthma
- Diverticulosis, Colitis
- GI Bleed, Ulcers
- Skin ulcers
- Non-pressure ulcers
- Pathologic fractures
- Gout
- Chronic Kidney Disease
- Acute Kidney Injury
- Pyelonephritis
- Drug toxicity
- Post op conditions

Contact the following for any documentation questions or concerns:

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Pneumonia

Best practice documentation for PNA requires documentation of the type of PNA and the causal organism. A provider can use clinical judgement and document the likely organism in the absence of a positive lab finding.

- Identify the type and likely causal organism
  - Aspiration
  - Bacterial (specify organism)
  - Fungal
  - Hypostatic
  - Interstitial
  - Viral
  - Lobar
- Document any associated illness
  - AIDS
  - Influenza
  - TB
  - Respiratory failure
  - Sepsis

Respiratory Failure

- Acuity
  - Acute
  - Chronic
  - Acute on chronic
- Type
  - With hypercapnia
  - With hypoxia
- Document clinical supporting factors for diagnosis
  - ABG's
  - Providing 40% or more supplemental O2
  - Inability to complete full sentences due to shortness of breath
  - Use of accessory muscles
  - Cyanosis
  - Tachypnea (RR>20)

Asthma

- Type:
  - Mild intermittent
  - Mild persistent
    - Acute Exacerbation
    - Status Asthmaticus
  - Moderate persistent
    - Acute Exacerbation
    - Status Asthmaticus
  - Severe persistent
    - Acute Exacerbation
    - Status Asthmaticus
  - Exercise Induced
- Link when asthma is due to a causative agent
  - Detergent
  - Wood
  - Miner's
  - Chemical (specify)

Respiratory Documentation Example

Insufficient Documentation

- Patient on chronic O2 3L at home presents with shortness of breath, increased work of breathing, Patient placed on BiPAP after obtaining ABGs. Admitted for COPD exacerbation.
- Patient with a history of asthma presents with shortness of breath. Treated with nebs and IV steroids.

Best Practice Documentation

- Patient on chronic O2 3L at home presents with shortness of breath, increased work of breathing, **use of accessory muscles, RR30.** Patient placed on BiPAP. after obtaining ABGs. Admitted for **acute on chronic respiratory failure** due to COPD exacerbation.
- Patient with history of **severe persistent** asthma presents with shortness of breath due to **asthma exacerbation.** Treated with nebs and IV steroids

Key Documentation Concepts for Respiratory Diseases

- Document causal organism when known.
- Specify acute, acute recurrent, chronic when appropriate.
- Link COPD with asthma and/or bronchitis when applicable.
- If cultures and/or diagnostic tests are negative but patient is being treated clinically for a condition (pneumonia, respiratory failure) document supporting clinical indicators.
- Document any tobacco use or exposure pertinent to the patient.

GI Bleed/Ulcers/Gastritis/Duodenitis

Best practice documentation is to indicate the cause of the GI bleed to the highest degree of specificity. A provider can, after clinical evaluation document the "likely" or "probable" source of the underlying GI bleed.

- Site – to the highest degree of anatomical specific
- Acuity
  - Acute
  - Chronic
- Specify with or without:
  - Hemorrhage
  - Perforation
  - Obstruction
- Document any associated disease:
  - H. pylori
  - Medication-related
  - Alcohol abuse or dependence

Ulcer
Documentation Example

Insufficient Documentation

- 45 year old female patient presents with abdominal pain and hematemesis. Diagnosed with a gastric ulcer without any complications.

Best Practice Documentation

- 45 year old female patient presents with abdominal pain and hematemesis. Diagnosed with an **acute gastric ulcer** with **no signs of hemorrhage or perforation per EGD, most likely due to patient's chronic NSAID use. Mallory – Weiss tear noted, probable cause of hematemesis.**

Diverticulosis/Diverticulitis/Colitis

- Site
  - Small intestine
  - Large intestine
  - Both small and large intestine
- Associated bleeding
  - With bleeding
  - Without bleeding
- Additional Diverticulosis Complications
  - Abscess
  - Perforation
  - Abscess
- Colitis Underlying Causes to be documented
  - Infectious
  - Ulcerative
  - Inflammatory
  - Ischemic
  - Radiation
  - Drug (specify)

GI
Documentation Examples

Insufficient Documentation

- Patient admitted with c/o abdominal pain. History of diverticulosis. CT scan reveals diverticulitis.
- 33 year old male patient admitted with gastritis. Hgb dropped from 12.1 to 8.3. Patient consumes a six pack of beer a night.

Best Practice Documentation

- Patient admitted with 3 day history of increasing lower left abdominal pain. **CT scan shows acute diverticulitis of the small bowel, uncomplicated**.
- 33 year old male patient admitted with **alcoholic gastritis with bleeding**. Hgb dropped from 12.1 to 8.3. Patient with **current history of alcohol abuse. Acute blood loss anemia**, transfuse one unit red blood cells.

Key Documentation Concepts for Digestive System Documentation

- Specify severity or status of the disease, (e.g., acute or chronic, recurrent)
- Specify exact site (e.g., large and/or small intestine, anal, rectal, anorectal, ischiorectal, intersphincteric)
- Clearly identify any complications that are often associated with a specific condition (e.g., bleeding, obstruction, abscess, etc.)
- Document the etiology of diseases (e.g., alcohol induced, gallstone, drug-induced, idiopathic, or other associated cause).

Skin Ulcers
(excluding Pressure Ulcers)

Best practice documentation requirements for skin ulcers requires a provider to capture all of the key elements in their documentation.

- Underlying Etiology
  - Diabetic
  - PAD/PVD
  - Venous stasis
- Associated Manifestations
  - Cellulitis
  - Gangrene
  - Osteomyelitis (acute, chronic)
- Depth
  - Limited to skin breakdown
  - With fat layer exposed
  - With muscle necrosis
  - With bone necrosis
- Site / Location/Laterality
- Present on Admission Status

Pressure Ulcer

- Site/Location/Laterality
- Stage I-IV, Unstageable
- Associated Manifestations
  - Cellulitis
  - Gangrene
  - Osteomyelitis (acute/chronic)
- Present on Admission Status

Ulcer
Documentation Example

Insufficient Documentation

- 53 year old man with history of DM2. Admission BS 373. Presents with chronic draining foot wound.

Best Practice Documentation

- 53 year old man with history of DM2. **Hyperglycemia**, BS 373 on admission. Presents with **chronic diabetic foot ulcer, right big toe with fat layer exposed.**

Pathologic Fractures

- Location:
  - Bone (distal, proximal, shaft, etc.)
  - Laterality
- Etiology:
  - Osteoporosis
    - Disuse
    - Drug-induced
    - Postmenopausal
    - Idiopathic
    - Postsurgical malabsorption
    - Other (specify)
  - Neoplastic disease
- Document encounter type:
  - Initial encounter
  - Subsequent encounter
    - Routine healing
    - Delayed healing
    - Nonunion
  - Sequela

Pathological Fracture Documentation Example

Insufficient Documentation

- 85 year old female with hx of osteoporosis presented with R hip pain. No recent falls. Xray shows fracture of right hip.

Best Practice Documentation

- 85 year old female with hx of osteoporosis presented with R hip pain. No recent falls. Xray shows fracture of right hip. **Will treat for pathologic right hip fx due to osteoporosis.**

Gout

- Type/Cause
  - Drug-induced
  - Idiopathic
  - Lead-induced
  - Primary
  - Secondary
  - Syphilitic
  - With renal impairment (specify the specific renal disease/disorder, including acuity and/or state)
- Joint involved and laterality
- Acuity
  - Acute
  - Chronic—With or Without Tophus
  - Gout attack
  - Gout flare

Chronic Kidney Disease

Best practice documentation for patients who have chronic kidney disease is to avoid terms such as renal insufficiency.

To accurately capture your patients severity of illness and risk of mortality you need to capture the data points outlined below.

- Stage
  - Identify stage I through V, End Stage Renal Disease (ESRD)
  - Dialysis status

- Underlying cause (when known)
  - Hypertension
  - Diabetes
  - Medication Induced

Acute Kidney Injury/Failure

- Due to
  - Acute tubular necrosis (ATN)
  - Acute cortical necrosis
  - Acute medullary necrosis
  - Drug or Chemical (specify, i.e. contrast)
  - Acute Condition (i.e. dehydration)
  - Traumatic Injury
  - Unknown etiology
- Provide your supporting clinical rational to support your diagnosis.
- If condition is "ruled out" include that in your updated documentation throughout the patient's stay or discharge summary.

CHRISTIANA CARE HEALTH SYSTEM

Renal Documentation Example

Insufficient Documentation

- 88 yr old female presented with UTI. Hx of DM,HTN, arthritis, kidney disease. Admission lab shows GFR = 18 .
- Pt admitted with elevated Bun/Cr and severely dehydrated.

Best Practice Documentation

- 88 yr old female presented with UTI. Hx of DM,HTN, arthritis, **CKD stage 4.** Admission lab shows GFR = 18 .
- Patient admitted in **Acute Renal Failure due to** dehydration.

Pyelonephritis

- Acuity (acute or chronic)
- Chronic - further specify:
  - Nonobstructive
  - Nonobstructive reflux associated
  - Obstructive (specify underlying obstruction)
- Associated diseases
  - Leukemia
  - Lymphoma
  - Sepsis
- Infectious organism, if known

Key Documentation Concepts for Renal Documentation

- Specify severity or status of the disease.(e.g. acute or chronic)
- Specify site, etiology and any secondary diseases associated with the diagnosis.
- Specify acquired vs congenital.
- Identify associated infectious agents.

Drug Toxicity

- Indicate Drug(s) or Chemical(s) causing toxicity

- Further Specify
  - Poisoning (improper use of mediation, overdose, wrong substance, etc)
    - Intent:
      - Accidental
      - Assault
      - Intentional self harm
      - Undetermined
  - Adverse effect (drug is taken as prescribed and properly administered)
    - Acute condition (hives, vomiting, diarrhea, ARF, etc)
  - Underdosing
    - Using a prescribed medication less frequently than prescribed, in small doses, or not using the medication as instructed should be documented as "underdosing" by the provider.
    - If the reduction in the prescribed dose of the medication results in a relapse or an exacerbation of the medical condition for which the drug is prescribed, the medical condition must also be documented.

Poisoning, Adverse Effect Documentation Examples

Insufficient Documentation

- Elevated INR; coagulopathy
- Patient admitted with acute systolic CHF, complaining of dry hacking cough. Lisinopril stopped.
- Patient admitted in respiratory failure due to drug overdose.

Best Practice Documentation

- **Coumadin coagulopathy**
- Patient admitted with acute systolic CHF, complaining of dry hacking cough. **Lisinopril was determined to be the cause of the cough. Lisinopril stopped due to cough.**
- Patient admitted with **acute hypoxic respiratory failure due to intentional drug overdose. Empty bottles of Xanax and Percocet found on patient's bedside table at home.**

Admission for Postop Complications

- Hematoma/seroma
  - Specify the site of the hematoma
  - Provide linking statement
    - Hematoma due to (specified) surgery dated 08/01/2015
    - Hematoma unrelated to (specified) surgery, and is due to (specified cause)
- DVT/Pulmonary Embolism
  - Specify laterality
  - Specify vein affected
  - Provide linking statement
    - DVT/PE due to (specified) surgery dated 08/01/2015
    - DVT/PE unrelated to (specified) surgery, and is due to (specified cause)
- Infection
  - Specify superficial or wound infection
  - Specify any other infection (i.e. sepsis, abscess, etc.)
  - Provide linking statement
    - Specified Infection due to (specified) surgery dated 08/01/2015
    - Specified Infection unrelated to (specified) surgery, and is due to (specified cause)

Take the Extra Step

For further specificity of individual systems, please refer to 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.)

This concludes the

Internal/Family Medicine

Module Two