The do’s and don’ts of documenting Congestive Heart Failure:

**DO...**
- Specify acute, chronic, or acute on chronic congestive heart failure.
- Specify systolic, diastolic, or combined systolic/diastolic. Examples include acute systolic CHF or acute on chronic diastolic CHF.
- Use EF <40-45% as indicator of systolic failure.
- Use most recent TTE to guide your assessment. Make your best guess as to type.

**DON’T...**
- Use the terms “CHF exacerbation” or “decompensated CHF.” They code to unspecified CHF, which carries no weight. Your patient will appear healthier than they truly are after the chart is coded and this will negatively impact metrics on LOS and ROM.

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Dr. Alice Greene
ARF and AKI are synonymous terms. The definition was revised in 2011 by the KDIGO (Kidney Disease: Improving Global Outcomes) to either one of the following:

- Any rise in Cr of ≥ 1.5 times baseline (baseline is lowest recorded Cr in preceding 3 months)
- Or any rise in serum Cr of ≥ 1.0 mg/dl above patient’s baseline

If your patient has baseline Cr of .8, it must rise to 1.2 or above to qualify as ARF/AKI.

DON’T...
Use “azotemia” or “acute renal insufficiency” as they have little coding weight.
Acute Tubular Necrosis (ATN)

- Acute Tubular Necrosis (ATN) is a major comorbidity (MCC) while ARF/AKI is only a minor comorbidity.
- ATN carries significantly more coding weight so it is imperative to be specific.
- Consider ATN when AKI develops in the setting of hypotension or nephrotoxins (i.e. contrast induced, aminoglycosides, amphoB).

<table>
<thead>
<tr>
<th></th>
<th>ATN</th>
<th>Prerenal AKI</th>
</tr>
</thead>
<tbody>
<tr>
<td>UA</td>
<td>muddy brown granular or epithelial cell casts</td>
<td>normal or hyaline casts</td>
</tr>
<tr>
<td>FENa</td>
<td>&gt;2%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>BUN/Cr</td>
<td>normal</td>
<td>&gt;20/1</td>
</tr>
<tr>
<td>RESPONSE TO FLUIDS</td>
<td>poor</td>
<td>good</td>
</tr>
</tbody>
</table>

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Dr. Alice Greene
Chronic Kidney Disease

- It is imperative that all cases of CKD are staged.
- The staging allows for a more accurate reflection of the severity of illness (SOI) of your patient. Higher stages equal higher SOI.
- Avoid bland statements of "CKD" (with no stage) as they minimize how sick your patient is.
- This task is simple as GFR is now calculated on Cerner. Unfortunately, the coders can’t extrapolate from lab values so the stage must be documented by the MD.
- The stages of CKD are as follows:

<table>
<thead>
<tr>
<th>Stage</th>
<th>GFR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>≥ 90</td>
</tr>
<tr>
<td>2</td>
<td>60-89</td>
</tr>
<tr>
<td>3</td>
<td>30-59</td>
</tr>
<tr>
<td>4</td>
<td>15-29</td>
</tr>
<tr>
<td>5</td>
<td>&lt;15</td>
</tr>
<tr>
<td>ESRD</td>
<td>On dialysis</td>
</tr>
</tbody>
</table>

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Dr. Alice Greene
Metabolic Acidosis

- In Acute Renal Failure (ARF/AKI) always be sure to document the associated development of “metabolic acidosis.”
- It is an important comorbid condition which further supports the severity of illness (SOI) of your patient.
- In CKD, we are accustomed to documenting “renal tubular acidosis.” However, the coding rules do not recognize RTA as a form of metabolic acidosis, and we lose credit for this comorbidity.
- Document “metabolic acidosis secondary to RTA” to get the credit you deserve for diagnosing, monitoring, or treating this complex condition.

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Dr. Alice Greene
Electrolyte Abnormalities

- Electrolyte abnormalities can impact considerably on the severity of illness (SOI) assigned to your patient.
- They may be coded if there is evidence of treatment, monitoring, or diagnostic work-up. Any one suffices.
- Simply document the specific abnormality and plan of care (i.e. “following serial electrolytes” or “kayexalate given”).
- Be sure to document any of the following electrolyte abnormalities that you feel are clinically significant to your patient:

  - Hyperkalemia or hypokalemia
  - Hyperphosphatemia or hypophosphatemia
  - Hypernatremia or hyponatremia
  - Hypercalcemia or hypocalcemia
  - Hypermagnesemia or hypomagnesemia
Don’t use the terms “azotemia,” “uremia”, or “acute renal insufficiency” when the more appropriate ARF/AKI can be used.

These terms are assigned low severity codes given to signs and symptoms.

Always remember that codes assigned to diagnoses carry much more weight than codes assigned to signs or symptoms.

Don’t use up/down arrows or descriptive terms like low or high: “Low HCO₃” will not be coded, consider metabolic acidosis. “Elevated Cr” will not be coded, consider ARF/AKI. “High K+” will not be coded, consider hyperkalemia.
Sepsis secondary to UTI

This may be something you’ve heard many times before, but it’s worth repeating. The difference between getting it right and wrong has profound impact on the severity of illness (SOI) assigned to your patient.

- Always use the terms “Sepsis secondary to UTI” or “Sepsis due to UTI.”
- Never ever use the term “Urosepsis.” In the coding world, this term equates only to a simple UTI and the chart will be coded as if your patient had nothing more than cystitis.
UTI Secondary to Device

When a UTI is present on admission and related to a device, it is imperative that you clearly link them in your Admission H&P. Examples include:

- UTI secondary to indwelling Foley
- UTI secondary to catheterization
- UTI secondary to nephrostomy tube
- UTI secondary to supra-pubic catheter
- UTI secondary to ureteral stent

If the diagnosis was suspected on admission but not confirmed until days later, simply state that it was present on admission (POA). The statement of POA can be made at any time during the hospital stay so long as there was clinical evidence on admission to support this.

This increases the severity of illness (SOI) assigned to your patient and avoids the pitfall of being blamed for an iatrogenic complication.

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Dr. Alice Greene
Nephrolithiasis

- In the setting of nephrolithiasis, it is important to document “ureteral stone” or “ureterolithiasis” if there is evidence to support this increased specificity.

- Ureteral stones carry significant coding weight as a comorbidity.
In the setting of nephrolithiasis, it is important that you document the presence of hydronephrosis if seen on imagining studies.

Remember, coders are not allowed to infer from abnormal radiographic findings and depend on your determination of this diagnosis.

Hydronephrosis is an important comorbidity that carries additional severity of illness.
Renal and perinephric abscess are complications of UTI that usually occur in the setting of ascending infection with obstructed pyelonephritis.

If you are not certain, but have significant concern for abscess, simply use the terms “probable” or “possible” and describe your further evaluation and treatment.

CT findings of such abscesses must be reiterated by the physician as coders can’t code off of abnormal studies.

Such abscesses are a major comorbidity (MCC) and have enormous impact on severity of illness (SOI).

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Dr. Alice Greene
There are no codes for HAP, HCAP, and nosocomial pneumonia.
They code only to simple pneumonia, which carries a low SOI.
In order to capture the higher morbidity and mortality associated with these, specify the most likely pathogen guiding your antimicrobial selection.
Examples include:

- Probable gram neg. pneumonia
- Probable MRSA pneumonia
- Probable MRSA/gram neg. pneumonia
Aspiration pneumonia carries a high severity of illness (SOI) and risk of mortality (ROM).

- It codes to a complex pneumonia, rather than a simple one.
- If you are empirically treating pneumonia in a susceptible patient prone to aspiration, document “aspiration pneumonia” or “probable aspiration pneumonia.”
- In the absence of definitive culture results, let your antibiotic selection guide your description of pneumonia type.
Pleural Effusions may be coded as a comorbidity (CC) in the setting of pneumonia, if being treated, monitored, or requiring further diagnostic work-up.

Remember, the diagnosis of pleural effusion must be stated by the physician as coders can’t code from abnormal radiology reports.

Copying and pasting a radiology report into the note does **not** suffice.

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Dr. Alice Greene
More on Pleural Effusions

- If a diagnosis of CHF exists, the coder must automatically link the pleural effusion to the CHF.
- This negates the pleural effusion as a separate comorbidity.
- If you believe the effusion is NOT due to CHF, simply state “pleural effusion not due to CHF.”
- This ensures that you get credit for an additional comorbidity.
Be sure to specify the diagnosis of a malignant pleural effusion.
It carries significant weight as a comorbid condition.
If the diagnosis is suspected in a patient with advanced cancer, but not confirmed secondary to a decision to forgo aggressive interventions, simple state “probable malignant pleural effusion.”

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Dr. Alice Greene
Empyema

- Formation of empyema is characterized by bacterial organisms seen on Gram stain and/or the aspiration of pus on thoracentesis.
- A positive culture is not required for diagnosis since bacteria may not be cultured (anaerobic organisms are difficult to culture, sampling often done after antibiotics started, or sterile inflammatory fluid may be aspirated adjacent to infection).
- It carries significant weight as a major comorbidity (MCC) and increases expected LOS and ROM.
It is important to clearly define the acuity of an asthma attack.

By simply stating “asthma” as a bland diagnosis, the coder can not discern if it is an active problem or a chronic problem that is well controlled.

If you are treating an asthmatic patient for an active attack, it’s best to state “acute exacerbation of asthma.”

This language ensures that this important comorbidity is accurately coded.
Status asthmaticus is defined as a state of severe intractable asthma refractory to usual therapy.

It is a life threatening asthma attack that carries a high mortality risk.

Unfortunately, when coded, this diagnosis loses its gravity and falls into the same bucket as “acute exacerbation of asthma.”

So, be sure to consider documenting “acute respiratory failure” in any patient in status asthmaticus. This ensures that an accurate severity of illness (SOI) is assigned to this very sick patient.
It is important to clearly delineate the acuity of a COPD exacerbation.

By simply stating “COPD” as a bland diagnosis, the coder cannot discern if it is an active problem or a chronic problem that is well controlled.

If you are treating a patient with COPD with deterioration of symptoms from baseline, it’s best to state “acute exacerbation of COPD.”

This language ensures that this important comorbidity is accurately coded.
In acute respiratory acidosis the \( \text{PaCO}_2 \) is elevated with an accompanying acidemia (pH <7.35).

In chronic respiratory acidosis the \( \text{PaCO}_2 \) is elevated, but pH remains normal secondary to renal compensation which elevates serum bicarbonate (\( \text{HCO}_3^- \) >30 mm Hg).

In the setting of an acute exacerbation of COPD, always document an accompanying acute or chronic respiratory acidosis.

Both code the same to “respiratory acidosis,” which is an important comorbidity that enhances the severity of illness attributed to your patient.
COPD and Chronic Respiratory Failure

- COPD patients whose lung function is severely compromised and whose baseline ABG’s reflect chronic hypoxia may develop cor pulmonale (right heart failure).
- The long-term administration of oxygen has been shown to increase survival for these very ill patients.
- Document dependence on home oxygen as “chronic respiratory failure” to capture this important comorbidity (which carries a high severity of illness).
- Writing only “patient is on home O2” is NOT sufficient as it is not a diagnosis and thus it won’t be coded!

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Dr. Alice Greene
During acute exacerbations of COPD, the ensuing respiratory acidosis may have profound effects on mental status.

This includes increasing confusion, lethargy and ultimately coma.

The terms “CO2 narcosis” or “CO2 intoxication” should NOT be used as stand alone terms. They will code to mere symptoms, not diagnoses.

Better choices include:
- Hypercapnic encephalopathy
- Encephalopathy secondary to respiratory acidosis
- Encephalopathy secondary to CO2 narcosis or retention

This ensures that credit is given for this major comorbidity.

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Dr. Alice Greene
Emphysema may be associated with bullae or blebs (which are synonymous terms). They are defined as an airspace in the lung which measures ≥ 1 cm in diameter.

Because they are often sub-pleural, they may rupture and cause pneumothorax. Additionally, fluid may accumulate within a bulla and it can become secondarily infected.

Be sure to document either bulla or bleb as they count as an important comorbidity.

Remember to name them as coders can’t code from an abnormal CXR or Chest CT, even if you copy and paste it into your note.

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Dr. Alice Greene
Cor pulmonale is right ventricular dysfunction that results from pulmonary HTN due to diseases of the lung, with COPD being the most common cause.

It is estimated that 20-30% of patients with COPD have cor pulmonale.

Consider the diagnosis of “acute cor pulmonale” in your patients with advanced COPD and evidence of acute right ventricular heart failure.

Findings include increased JVP, peripheral edema, ascites, and an enlarged liver.

Acute cor pulmonale is a major comorbidity (MCC) that has enormous impact on severity of illness.