Compliant Documentation Guidelines
Physician documentation forms the basis of clinical coding. The Compliant Documentation Improvement Program is focused on bridging the gap between clinical and coding language which is directly linked to Quality of Care, health care costs and public reporting of data that reflects:

- Complexity of Care
- Severity of Illness
- Resources consumed
- Risk of mortality

Inadequate clinical documentation has consequences with far-reaching impact:

- Inaccurate or non-specific clinical documentation
  - Inaccurate code assignment
  - Inaccurate representation of patient severity of illness
  - Inaccurate reflection of rates of mortality / morbidity
  - Complication data

**Using This Guide**

High frequency conditions occurring at MoBap are provided as examples of the level of specificity necessary for ICD10 coding. Applying the spirit of these examples to other diagnoses with which you deal will result in fewer queries.
Physician Queries: Why Are They Necessary?

When a documented diagnosis results in an unspecified code, a query is needed only when a more specific code impacts the DRG assignment, quality outcomes, CMS pay for performance initiatives or helps to justify medical necessity/severity/degree of comorbidities. Documentation of greater specificity is not necessary simply because a more specific code exists.

Basic Documentation

Reason for Admission

- Document the cause of presenting symptoms.
- If the cause is not definitive, indicate “suspected,” “probable,” “possible,” or “likely” etiology.
- Once the cause is known, document the specific condition.
- Clarify after testing, all conditions that have been ruled in and/or ruled out.
- Document each condition with the corresponding treatment, intervention or monitoring.

Definitions

Principal Diagnosis: That condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

*Secondary Diagnosis(es): Comorbidities/Complications - all conditions that coexist at the time of the admission, develop subsequently, which affect treatment and/or length of stay. These conditions reflect the overall severity of the patient’s health and require:
- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of stay
- Increased Monitoring/Nursing Care
- Physician indication if they were POA (present on admission)

Present on Admission (POA): POA is defined as present at the time the order for inpatient admission occurs, as well as conditions that develop during an outpatient encounter. ED, Observation encounter, or OP surgery are considered POA. Condition(s) that develop as a result of (or during OP treatment) and then transition to an IP level of care will be identified as POA.

Examples:
- Catheter associated UTI
- Ulcers: identify type, location and stage
- DVTs if identified after study (2nd day of stay)

Complications: There must be a cause and effect relationship between the care provided and the condition. Document clearly that a complication has or has not occurred and that the condition is either inherent to or unrelated to the procedure.
**Use of the term “Congestive Heart Failure” without additional specificity will generate a query. Document congestive heart failure in terms of Acuity Status, Type and Severity Impact:**

**Documentation Guidelines**

1. **Acuity Status**
   - Acute
   - Chronic
   - Post-Procedural

2. **Type**
   - Systolic
   - Diastolic
   - Combined Systolic and Diastolic

3. **Severity Impact**
   - Chronic stable
   - Asymptomatic

**Documentation Examples**

- Acute systolic congestive heart failure
- Acute diastolic congestive heart failure
- Acute combined systolic/diastolic congestive heart failure
- Acute on chronic systolic/diastolic congestive heart failure

**Severity Impact**

- Documenting to this level will accurately reflect the level of acuity in your patient(s).
- Chronic stable, asymptomatic heart failure is considered to have significant “severity” to qualify for a “CC” (comorbid condition) status but only when documented as Systolic or Diastolic.
1. Specify Acuity and the MI as STEMI or NSTEMI:

**Acuity**
- Acute
  - Initial: acute with a stated duration of 4 wks (28 days) or less from onset
  - Subsequent – subsequent MI occurring within 4 weeks (28 days) of previous acute MI

**Pathology:**

- **STEMI**
  - Left main coronary artery
  - Left anterior descending coronary artery
  - Anterior wall / anteroapical / anterolateral / anteroseptal
  - Right coronary artery
  - Artery inferior wall
  - Apical-lateral/inferolateral transmural
  - Basal-lateral transmural
  - High lateral transmural
  - Posterior / posterobasal/ posteriolateral/ posteroseptal/ Septal transmural

- **NSTEMI**
  - Acute subendo MI
  - Non-Q wave MI
  - Nontransmural MI

2. Document Current Complications of the Initial Acute MI:

- Atrial septal defect
- Ventricular septal defect
- Hemopericardium
- Rupture of cardiac wall
- Rupture chordae tendineae
- Rupture papillary muscle
- Thrombosis of atrium, auricular appendage, ventricle

3. MI by History:

- **s/p administration of tPA** in a different facility within 24 hrs prior to admission to MBMC
- OLD MI -- Document age
- Post-MI Syndrome

**Tobacco Exposure:**
- Current use/dependence
- Hx of tobacco use
- Exposure to tobacco use
- Occupational exposure

**Documentation Guidelines**

**Exclusions:** Old Myocardial Infarction and Post Myocardial Infarction Syndrome.
Documentation of Gastric Ulcer requires documentation of acuity, associations with other conditions and patient use of alcohol or other substances:

1. **Specify Acuity As:**
   - Acute
   - Chronic

2. **Cite Other Condition Associations:**
   - Document gastric ulcer with:
     - Hemorrhage
     - Perforation
     - Both hemorrhage and perforation
     - Without hemorrhage or perforation
   - Further document alcohol abuse/dependence when applicable

**Documentation Example**

Acute gastric ulcer with hemorrhage and perforation. History of alcohol abuse x 20 years
### Documentation Guidelines

A query will be generated if acuity and laterality are not documented.

#### Severity Level
- Acute
- Chronic

#### Location and Laterality
- **Vena Cava**
  - Superior
  - Inferior
- **Thoracic Vein (brachiocephalic)**
- **Upper/Lower Extremity (include laterality)**
  - Right / Left
  - Bilateral
  - Distal/Proximal

#### Specific Vein:
- **Femoral**
- **Iliac**
- **Popliteal**
- **Tibial**
- **Axillary**
- **Subclavian**
- **Internal jugular**
- **Superficial**

### Documentation Examples

- **Acute embolism and thrombosis of right femoral vein, right lower extremity**

- **Chronic embolism and thrombosis of left popliteal vein, left lower extremity**

- **Acute embolism and thrombosis of superficial veins of right upper extremity**
Risk Factors

Inability to reposition self, debilitated, dehydration, malnutrition, bed or chair confined, sensory deficits, fecal/urinary incontinence, inability to feed self.

Documentation Guidelines

Provide specific documentation on the stage of the ulcer (Classification), laterality, location and whether or not Present on Admission (POA).

Specify The Stage (Per Classification):

Stage I: Non-blanching erythema of skin (redness that does not turn pale when pressed and released with a fingertip) with intact skin (no dermal ulceration).

Stage II: Partial thickness ulceration and loss of epidermis with abrasion, blister, or shallow ulcer.

Stage III: Full-thickness ulceration into subcutaneous fat; may extend up to (but not through) deep fascia.

Stage IV: Deep ulceration to muscle, tendons, joint, and/or bone (often with osteomyelitis); extensive tissue necrosis/destruction.

Unstageable: A scab or scar forming on the surface may obscure the true extent of the ulcer, which is considered “unstageable.” Generally require debridement for correct staging and treatment.

Document:

Laterality
Location
Present on Admission (POA)

Documentation Examples

Pressure ulcer left buttock, stage 3, present on admission
Pressure ulcer right heel, stage 2, present on admission
Pressure ulcer left elbow, stage 1
Specific Pulmonary (Artery) Hypertension

Primary (idiopathic) pulmonary hypertension
Secondary pulmonary hypertension

Further Specify with:
Cor pulmonale – Acute or Chronic
Right heart ventricular failure/strain - Acute

Documentation Examples
Acute Pulmonary Artery Hypertension - Primary pulmonary artery with acute right ventricular strain
Documentation guidelines require specificity in the description of the type of Anemia and the underlying cause. Anemia alone may generate a query. Document Anemia in terms of:

1. **Acuity Level:**
   - Acute
   - Chronic
   - Post-Procedural

2. **Possible Cause/Examples:**
   - Due to or secondary to:
     - Blood loss (acute or chronic)
     - Chronic Kidney Disease
     - Specific Cardiac Condition
     - Specific Drugs

3. **Examples of Specific Type:**
   - Hemolytic
   - Acute
   - Acquired
   - Iron Deficiency

**Documentation Examples**

Anemia due to blood loss (further specify as acute or chronic)

Anemia due to drug (type) + (further specify as acute/chronic and include specific drug)

Chronic Hemolytic Anemia, acquired with hemoglobinuria
**Documentation Guidelines**

*Document specific site(s) of primary and secondary malignancy, behavior(s) as well as any other conditions:*

1. **State the specific site of the Primary malignancy:**
   
   **EXAMPLE:**
   Malignant neoplasm of lower outer quadrant, right breast

2. **Specify the site of any secondary malignancies (metastatic sites):**
   
   **EXAMPLE:**
   Secondary malignant neoplasm of lymph nodes, axilla and right upper limb

3. **When applicable, document the behavior of specific site(s) as:**
   
   Ca in situ
   Uncertain behavior
   Unspecified behavior

4. **Document any other conditions and sequelae during the acute episode in order to reflect severity:**
   
   **EXAMPLES:**
   Hemoptysis
   Acute esophagitis
   Cachexia/wasting
   Acute tracheitis
   Nausea/vomiting
   Diarrhea

5. **Document past history/treatment:**
   
   **EXAMPLES:**
   Personal history of malignant neoplasm right breast
   Acquired absence of breast, nipple
   Personal history of irradiation
   Presence of breast implant
**Documentation of Neoplasms requires the following level of specificity:**

1. **General Documentation:**
   - Laterality – right/left
   - Specific location within the organ
   - Description of the neoplasm as:
     - Primary malignant
     - Secondary malignant
     - Ca in situ
     - Benign
     - Uncertain behavior
     - Unspecified behavior

2. **Specific Location:**
   - Azygos lobe
   - Casina
   - Hilum
   - Linqula
   - Lower lobe
   - Main bronchus
   - Middle lobe
   - Upper lobe
   - Pleural
   - Overlapping lesion

3. **Conditions that impact overall morbidity and reflect severity of illness:**
   - Document all secondary conditions that reflect the patient’s overall health history.

   **Document:**
   - Primary Malignancy
   - Secondary Malignancy
   - History of malignancy
   - Co-morbid conditions
   - Sequela

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**Documentation Examples**

Primary malignant neoplasm, left upper lobe

Primary malignant neoplasm sigmoid colon with metastasis to left lower lobe, lung
**Symptoms**

Two or more of the following symptoms must be present:
- Fever above 101.3°F (38.5°C) or below 95°F (35°C)
- Heart rate higher than 90 beats/minute
- Respiratory rate higher than 20 breaths/minute
- Probable or confirmed infection

**Severe Sepsis**

The diagnosis of Sepsis will be upgraded to severe sepsis when at least one of the following signs and symptoms are present (indicators of organ failure):
- Significantly decreased urine output
- Abrupt change in mental status
- Decrease in platelet count
- Difficulty breathing
- Abnormal heart pumping function
- Abdominal pain

**Septic Shock**

Must have signs and symptoms of severe sepsis +
- Extremely low blood pressure – that does not adequately respond to simple fluid replacement

**Documentation Guidelines**

Severe Sepsis (SIRS) = Sepsis + Organ Dysfunction. Documentation should clarify if the organ dysfunction is due to another medical condition or specifically r/t Sepsis. If it is not clearly documented, a Query will be generated.

Severe Sepsis with acute organ dysfunction

Further Specify Condition or clinical indicators:
- Acute kidney failure
- Acute respiratory failure
- DIC
- Septic shock (Severe Sepsis + Hypotension)
- Hepatic failure
- Ileus
- Myopathy
- Polyneuropathy

Sepsis/Septicemia = SIRS due to infection

**Document underlying/localized infection type:**
- Pneumonia
- Cellulitis
- UTI

Sepsis due to device, implant or graft:

**Document Sepsis and Provide Further Specificity RE:**
- Specific device
- Implant
- Graft

See the next page for additional examples
**Documentation Guidelines (Continued)**

**Sepsis due to organism**

Specify the Organism

- E Coli
- Staphylococcal Aureus
- Streptococcal
- MRSA

**Sepsis following a procedure; Infection following a procedure**

Document As:

- Post-procedural infection
- Intra-abdominal abscess
- Wound abscess following procedure
- Post-procedural septic shock

**Documentation Examples**

- Severe Sepsis with acute respiratory failure
- Severe Sepsis with multi-organ failure: respiratory, kidney failure
- Sepsis due to gram-negative organism
- Sepsis due to E.coli
- Gangrenous Sepsis
- Post-procedural Sepsis
- Post-procedural Septic shock: Post procedural gram negative septic shock
- Sepsis due to dialysis catheter
- Sepsis due to arterial graft
- Sepsis due to joint prosthesis
Two Major Causes Of AKI In Hospitalized Patients:

1. “Pre-re nal” AKI
2. ATN* -- Acute Tubular Necrosis, associated with:
   • Hypotension
   • Sepsis
   • Surgery
   • Obstetrical Complications

* Renal function in ATN usually takes more than 72 hours for renal function to return to baseline.

Avoid documenting as “Acute Renal Insufficiency” – this is vague, non-specific, does not reflect the severity of AKI and will generate a query.*

Criteria defining AKI were established March 2012 by the National Kidney Foundation Conference (KDIGO 1).

KDIGO Clinical Criteria define AKI as any one of the following:

1. Increase creatinine greater than/equal to 0.3 mg/dl from baseline within 48 hrs

2. Increase in creatinine level to greater than/equal to 1.5x baseline, which is known or presumed to have occurred within the prior 7 days

3. Urine output <0.5ml/kg/hr for 6 hours

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

Chronic Kidney Disease:
Chronic renal insufficiency, chronic renal failure, or chronic renal disease are equivalent to CKD CKD conditions must be staged:

<table>
<thead>
<tr>
<th>CKD Stage</th>
<th>GFR</th>
<th>Serum Creatinine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>&gt;90</td>
<td>&lt;0.9</td>
</tr>
<tr>
<td>Stage 2</td>
<td>60-89</td>
<td>1.0 - 1.3</td>
</tr>
<tr>
<td>Stage 3</td>
<td>30-59</td>
<td>1.4 - 2.4</td>
</tr>
<tr>
<td>Stage 4 (CC*)</td>
<td>15-29</td>
<td>2.5 - 4.5</td>
</tr>
<tr>
<td>Stage 5 (CC)</td>
<td>&lt;15</td>
<td>&gt;4.5</td>
</tr>
<tr>
<td>ESRD (MCC**)</td>
<td>N/A</td>
<td>Dialysis Dependent</td>
</tr>
</tbody>
</table>

* CC = Complication / Comorbidity
** MCC = Major Complication / Comorbidity
Under ICD 10, Diabetes Mellitus classifications have been revised according to the types shown. Include underlying condition(s), stage, and additional inclusions by stating:

The type, the underlying condition, and additional conditions.

<table>
<thead>
<tr>
<th>Documentation Example 1</th>
<th>Documentation Example 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type 1 Diabetes</strong></td>
<td><strong>Type 2 Diabetes</strong></td>
</tr>
<tr>
<td>DM Type</td>
<td>DM Type</td>
</tr>
<tr>
<td><strong>Underlying Condition</strong></td>
<td><strong>Underlying Condition</strong></td>
</tr>
<tr>
<td>(Due To ________________)</td>
<td>(Due To ________________)</td>
</tr>
<tr>
<td><strong>Additional Conditions</strong></td>
<td><strong>Additional Conditions</strong></td>
</tr>
<tr>
<td>(With _________________) (and ____)</td>
<td>(With _________________) (and ____)</td>
</tr>
<tr>
<td>due to acute pancreatitis</td>
<td>due to acute pancreatitis</td>
</tr>
<tr>
<td>with ketoacidosis without coma</td>
<td>with mild/moderate, severe nonproliferative diabetic retinopathy</td>
</tr>
</tbody>
</table>

**Type 1 Includes:**
- Brittle diabetes
- Diabetes due to autoimmune process
- Diabetes due to immune mediated pancreatic islet beta-cell destruction
- Idiopathic diabetes
- Juvenile onset diabetes
- Ketosis-prone diabetes

**Type 2 Includes:**
- Brittle diabetes
- Diabetes due to autoimmune process
- Diabetes due to immune mediated pancreatic islet beta-cell destruction
- Idiopathic diabetes
- Juvenile onset diabetes
- Ketosis-prone diabetes

**Drug or Chemical Documentation Examples:**
- (Drug/chemical) induced Diabetes Mellitus with hyperosmolality with/without coma
- (Drug/chemical) induced Diabetes Mellitus with diabetic kidney disease

**Document the Drug or Chemical first, then the conditions r/t Diabetes Mellitus**

Examples of other underlying conditions...
- Cushings Disease
- Malignant Neoplasm
- Cystic Fibrosis

Examples of other conditions...
- Diabetic nephropathy
- Diabetic peripheral angiopathy with gangrene

Document the stage of the kidney disease

Examples of other underlying conditions...
- Cushings Disease
- Malignant Neoplasm
- Cystic Fibrosis

Examples of other conditions...
- Diabetic nephropathy
- Diabetic chronic kidney disease
- Diabetic polyneuropathy
- Diabetic peripheral angiopathy with/without gangrene
- Diabetic gastroparesis
**Nephrotic Syndrome/Nephrosis**

**Documentation Guidelines**

Severity, acute or chronic specifics and underlying conditions are necessary for Nephrotic Syndrome/Nephrosis. These guidelines are examples only.

1. **Severity Level**
   - Acute
   - Chronic

2. **Document Nephrotic Syndrome (Acute/Chronic) with:**
   - Proliferative glomerulonephritis
   - Membranous glomerulonephritis
   - Membranoproliferative glomerulonephritis
   - Minimal change glomerulonephritis

3. **Specify Underlying Conditions:**
   - r/t Nephrotic Syndrome:
     - Diabetes Mellitus
     - Amyloidosis
     - Polyarteritis
     - Systemic lupus erythematosus
     - Malaria
   - If Lesion, Further Document As
     - Endothelial
     - Lobular
     - Mixed membranous and proliferative
     - Hypocomplementemic persistent

**Documentation Examples**

- Acute nephrotic syndrome with proliferative glomerulonephritis
- Acute nephrotic syndrome with lesion of endothelial
- Acute nephrotic syndrome with lesion of focal glomerulonephritis
## Documentation Guidelines

**Indication:** Persistence of a focal neurologic deficit > 24 hours from onset (CVA not TIA) Duration is counted from onset, not presentation.

### Document in terms of:

<table>
<thead>
<tr>
<th>Laterality</th>
<th>Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-traumatic / Traumatic</td>
<td></td>
</tr>
<tr>
<td>Intracerebral Hemorrhage</td>
<td></td>
</tr>
<tr>
<td>Intracranial Hemorrhage</td>
<td></td>
</tr>
<tr>
<td>Cerebral Infarction due to: embolism, thrombosis, occlusion, stenosis</td>
<td></td>
</tr>
<tr>
<td>Iatrogenic</td>
<td></td>
</tr>
<tr>
<td>Post procedural</td>
<td></td>
</tr>
</tbody>
</table>

### Specify:

<table>
<thead>
<tr>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acuity</td>
</tr>
<tr>
<td>Laterality</td>
</tr>
<tr>
<td>Neurologic deficits</td>
</tr>
<tr>
<td>Administration of tPA</td>
</tr>
</tbody>
</table>

### Documentation Examples

- Nontraumatic intracerebral hemorrhage in brain stem with (include specific neurologic deficits)
- Cerebral infarction due to thrombosis of right vertebral artery (include specific neurologic deficits)
- Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side
**Documentation Guidelines**

**Indication:** Acute generalized alteration in all aspects of brain function (communication, memory, speech, orientation, behavior) due to a systemic underlying cause that is usually reversible when the underlying cause is corrected. Documentation reflecting acute encephalopathy is critical for accurate diagnostic and severity of illness classification.

1. **Dementia vs. Encephalopathy Assessment:**
   
   A query may be necessary when documentation of a patient with a pre-existing dementia presents with altered mental status.

   **A dementia patient has encephalopathy when:**
   
   There is a genuine acute or subacute mental status alteration from baseline

   Associated with metabolic or toxic factors that improves or returns to baseline status when the causative factors are corrected

2. **Specify Acuity As:**
   
   - Acute
   - Chronic

3. **Specify Acute Encephalopathy Type and Associated Causation Factors:**
   
   **Metabolic:** Due to fever, dehydration, electrolyte imbalance, acidosis, hypoxia, infection, organ failure

   **Toxic:** Effects of drugs, toxins, poisons, and medications. Often used when describing encephalopathy caused by fever, sepsis or other toxic conditions.

   **Toxic-Metabolic:** Combination of both metabolic and toxic factors

   **Septic:** Clinical term that expresses brain dysfunction as a manifestation of severe sepsis (metabolic). Specify septic type as:

   - Hepatic
   - Hypoxic / Anoxic
   - Dialysis-associated
Documentation Guidelines

Cite whether adult or pediatric, the specific type and underlying condition.

1. State Specific Type:
   - Obstructive
   - Primary central
   - Idiopathic sleep related non-obstructive alveolar hypoventilation
   - Mixed

2. Specify Underlying Condition:
   - Obesity
   - Macroglossia
     - Acquired
     - Congenital

Documentation Examples

Adult Sleep Apnea - Idiopathic Sleep Related Non-Obstructive Hypoventilation

Pediatric Sleep Apnea - Obstructive
For asthma, be specific as to the acuity level, specific type and further as indicated:

1. Specify Acuity
   - Mild
   - Moderate
   - Severe

2. If Acute, Further Specify As:
   - Mild
   - Moderate
   - Severe

And further specify as:
- Intermittent
- Persistent

3. Qualify Type of Asthma:
   - Allergic asthma
   - Allergic bronchitis
   - Atopic asthma
   - Extrinsic allergic asthma
   - Hay fever with asthma
   - Nonallergic asthma

Provide Specific Exposure Information
(e.g. occupational, hx of tobacco use, etc.)

Documentation Examples
- Mild persistent asthma with acute exacerbation
- Moderate persistent asthma with status asthmaticus
- Severe persistent asthma (uncomplicated)
- Severe persistent asthma with acute exacerbation
A query will be generated if the level of specificity indicated below is not provided:

1. **State Acuity Level**
   - Acute
   - Subacute
   - Chronic

2. **Specify As:**
   - Allergic
   - Asthmatic
   - Mucopurulent
   - Emphysematous
   - Non-obstructive
   - Purulent

3. **Specify With:**
   - Tracheitis – Acute or Subacute
   - Tracheitis – Chronic
   - Bronchospasm

4. **Specify Due To:**
   - Virus – (ex. Echovirus, Rhinovirus, Parainfluenza, Respiratory Syncytial)
   - Fumes/vapor
   - Haemophilus influenza
   - Mycoplasma Pneumoniae
   - Streptococcus

**If Obstructive:**

**Specify Obstruction:**
- Diffuse
- Fibrinous
- Hypostatic
- Infective
- Membraneous

**Documentation Examples**

- Acute and subacute bronchitis with bronchospasm
- Acute bronchitis due to Hemophilus influenza
- Acute bronchitis with chronic obstructive asthma
- Acute bronchitis with COPD
- Acute and subacute septic bronchitis
COPD (Chronic Obstructive Pulmonary Disease)

**Documentation Guidelines**

*COPD includes the following examples of specific conditions. Documentation of each condition is required to adequately reflect severity and specificity.*

1. **Specific Conditions:**
   - Asthma with COPD
   - Chronic asthmatic obstructive bronchitis
   - Chronic bronchitis with emphysema
   - Chronic emphysemous bronchitis
   - Chronic obstructive asthma
   - Chronic obstructive bronchitis
   - Chronic obstructive tracheobronchitis

2. **Specify With:**
   - COPD with acute lower respiratory infection
   - COPD with acute bronchitis
   - COPD with Hypoxia
   - COPD with Hypercapnia

3. **Specific COPD Example Conditions:**
   - COPD with acute bronchitis
   - COPD with acute lower respiratory infection
   - Asthma with chronic obstructive pulmonary disease
   - Chronic asthmatic obstructive bronchitis
   - Chronic bronchitis with emphysema
   - Chronic obstructive asthma
   - Chronic obstructive tracheobronchitis

**Documentation Examples**

- Chronic obstructive pulmonary disease with acute lower respiratory infection (document the specific organism when identified)
- Chronic obstructive pulmonary disease with acute exacerbation
- Chronic obstructive pulmonary disease with acute exacerbation
Documentation Guidelines

Interstitial Lung Disease specificity is indicated below:

1. Identify Acuity:
   - Acute (i.e. acute interstitial pneumonitis)
   - Chronic
   - Pulmonary fibrosis
   - Capillary

2. Further Specify
   - Interstitial
   - Idiopathic
   - Lymphangioleiomyomatosis
   - Adult pulmonary Langerhans cell histiocytosis
   - Surfactant mutations – lung
   - Postinflammatory
   - Interstitial Pneumonia
   - Idiopathic interstitial pneumonia
   - Organizing pneumonia due to collagen vascular disease
   - Endogenous lipoid pneumonia
   - Drugs
   - Inhaled exposures

Documentation Examples

- Acute interstitial pneumonitis
- Respiratory bronchiolitis interstitial lung disease
- Interstitial pneumonia
- Idiopathic interstitial pneumonia
- Idiopathic pulmonary fibrosis
- Alveolar proteinosis
General Documentation:

1. Acute vs. Chronic
2. Double
3. Migratory
4. Purulent
5. Septic
6. Unresolved

Further Specify As:

1. Community Acquired
2. Hospital Acquired
3. Ventilator Associated (VAP)
4. Lobar (disseminated, double, interstitial)
5. Aspiration (Further specify cause due to food, blood, mucus, vomitus, etc)
6. Viral
7. Interstitial
8. Broncho
9. Bacterial

Identify Causation

1. Organism
2. Gram-negative
3. Bacterial

Specify the organism (examples)

1. E. coli
2. Klebsiella pneumonia
3. Candidiasis
4. Parainfluenza
5. Pneumonococcus
6. Pseudomonas
7. Enterobacter
8. Proteus
9. Staphylococcus
10. Fungal

Documentation Examples

Acute double purulent pneumonia - bacterial pneumonococcus acquired through aspiration of food received in nursing home. Left side is more acute than right side.
Documentation Guidelines

1. **Specific Type:**
   - Artery
   - Vein

2. **Further Specify As:**
   - Acute
   - Infarction
   - Thromboembolism
   - Thrombosis
   - Chronic
   - Healed/old
   - Saddle
   - Septic
   - In pregnancy, childbirth, puerperium

3. **Provide Additional Specificity:**
   - Specify With or Without:
     - Acute cor pulmonale

**Documentation Examples**

- Acute pulmonary (artery/vein) infarction
- Acute pulmonary (artery/vein) thromboembolism
- Acute pulmonary (artery/vein) thrombosis
- Pulmonary embolism with acute cor pulmonale
- Pulmonary embolism without cor pulmonale
- Septic pulmonary embolism (document underlying infection)
- Septic pulmonary embolism with acute cor pulmonale
- Saddle pulmonary embolism
- Saddle pulmonary embolism with acute cor pulmonale
**Documentation Guidelines**

1. **Specify Acuity**
   - Acute
   - Acute and Chronic
   - Chronic

2. **Further Specify:**
   - Hypercapnia
   - Hypoxia

3. **Indicate if**
   - POA
   - Post-Surgical

**Documentation Examples**

Acute and Chronic Respiratory Failure with Hypercapnia or Hypoxia

Chronic Respiratory Failure with Hypercapnia

Intervention: Intubation/ventilation tracheostomy or Bipap - high flow 40% or more supplemental O₂

**Addendum/Qualifiers**

**Hypoxemic:** Partial pressure of oxygen (pO₂) level less than (<) 60 millimeter(s) of mercury (mmHg) (oxygen saturation (SpO₂) <91% on room air, or pO₂ / fraction of inspired oxygen (FIO₂) (P/F) ratio <300, or 10 mmHg decrease in baseline pO₂ (if known)

**Hypercapneic:** Acute Hypercapnic Respiratory Failure -- The hallmark of acute hypercapnic respiratory failure is elevated pCO₂ due to retention/accumulation of carbon dioxide gas resulting in an acidic pH less than 7.35.

There are many causes but COPD is the most common. Physicians may document as “respiratory acidosis” which is the same as acute hypercapneic respiratory failure. Unfortunately, “respiratory acidosis” does not code to acute hypercapneic respiratory failure. A clarification to the physician from a documentation specialist or coder would be needed.

**Post-Surgical:**

See the following page

*Note: if pH is normal with elevated pCO₂, the patient has chronic respiratory failure and should be specified as such.*
Post-Surgical:

Respiratory Failure following Surgery or Trauma

(Patient remains intubated post procedure with planned extubation within a defined timeframe)

A patient who requires a short period of ventilator support during surgical recovery does not have acute respiratory failure and should not be coded as such. The same is true for any duration of mechanical ventilation that is usual or expected following the type of surgery performed, unless there is a true underlying acute pulmonary dysfunction.

However, if the post surgical patient subsequently develops a respiratory dysfunction/condition that would require an extention of ventilator support – Provide detailed documentation of the change in condition and condition that requires prolonged support.

Documentation Required:

Document the oversight and monitoring of these respiratory scenarios as post surgical ventilator support with expected extubation.

Examples of Post-Procedural Complications:

- Acute pulmonary insufficiency following thoracic surgery
- Post-procedural respiratory failure (further specify any underlying comorbid respiratory conditions)
- Chronic pulmonary insufficiency following surgery

Additional Points

*Physicians should not use “pulmonary insufficiency” in the post-op setting unless the patient actually has acute severe pulmonary dysfunction.

Arterial Blood Gas (ABG)

- pH(normal = 7.35-7.45) – degree of acidity; lower pH is more acid (acidosis)
- pC02 (normal = 35-45) – partial pressure proportion or amount) of carbon dioxide gas
- pO2 (normal = 80-100) – partial pressure of oxygen

FI02 (fraction or percent of inspired oxygen) is reported as a decimal that indicates the amount of oxygen the patient is breathing (e.g., FI02 – 0.40 – 40%)

P/F ratio: tool that identifies acute hypoxemic respiratory failure while a patient is receiving supplemental oxygen.

P/F ratio equals the arterial pO2(P) from the ABG divided by the FI02 (F) – the fraction(%) of inspired oxygen that the pt. is receiving expressed as a decimal (40% O2 = FI02 of 0.40).

P/F ratio less than 300 indicates acute respiratory failure.

P/F ratio <300 is equivalent to a pO2 <60 mm Hg on room air
P/F ratio <250 is equivalent to a pO2 <50 mm Hg on room air
P/F ratio <200 is equivalent to a pO2 <40 mm Hg on room air
Post-Surgical:

**P/F ratio:** The Infectious Disease Society of America and American Thoracic Society recognize a P/F ratio less than 250 as one of the 10 criteria for “severe” community acquired pneumonia that may require admission to the ICU.

The International Sepsis Definition criteria (2001) and the Surviving Sepsis – Severe Sepsis Guidelines (2008-2012) use a P/F ratio <300 as an indicator of acute organ (respiratory) failure.

The P/F ratio should not be used to diagnosis acute-on-chronic respiratory failure as many chronic failure patients already have a P/F ratio of < 300.