Points to Consider:

- “SIRS due to an infection.” Clarify if patient has sepsis (systemic infection) or a localized infection.
- Positive blood cultures are not required to document diagnosis of sepsis or suspected sepsis.
- List each organ failure individually when patient has “multi-organ failure.”
- Respiratory insufficiency and respiratory distress are symptomatic of underlying conditions. Be clear on the intended diagnosis such as respiratory failure. If respiratory failure is appropriate, document the acuity such as acute, chronic or acute on chronic; and presence of hypoxia and hypercapnia.
- Weaning from a mechanical ventilator: Document the appropriate corresponding diagnosis (e.g., chronic respiratory failure) and if the patient is dependent on the ventilator.
- Document any resistance to antimicrobial drugs.
- Provide causes (probable/suspected) of the presenting symptoms (e.g., chest pain, syncope, abdominal pain, back pain, headache) while awaiting confirmative workup and response to treatment.
- Clarify if fever is suspected to be bacterial, viral or other (e.g., leukemia) in origin.
- Document all active chronic comorbid conditions which may be affecting the patient’s current condition (e.g., COPD, heart failure, diabetes, seizure disorder), which are being evaluated, monitored, treated, or monitored.
- Document any arrhythmias (atrial fibrillation, PSVT, ventricular tachycardia, ventricular fibrillation) which required treatment, evaluation, or monitoring.
- Document any conditions that occur intraoperatively or postoperatively. Additionally, document a cause-and-effect relationship (or lack thereof) between the procedure and the condition and that the condition is a complication or an expected outcome.

Definitions Important for Complete Documentation

- Principal diagnosis is that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
- CC: Comorbidity/Complication
- Comorbidity: A pre-existing condition present at the time of admission which may cause an increase in the length of stay
- Complication: a condition that arises during the hospital stay that may prolong the length of stay
- MCC: Major Comorbidity/Complication
- POA: Present on Admission
- HAC: Hospital Acquired Condition
- ROM: Risk of Mortality
- SOI: Severity of Illness

Common Severity/Mortality Drivers

- Acute renal failure (indicate underlying cause)
- Atrial fibrillation/flutter (document etiology if known/suspected)
- Coma
- Deep venous thrombosis (specify chronicity, site and laterality)
- Electrolyte imbalances (hypo/hypokalemia, hypo/hyperkalemia, hypo/hypermagnesemia, hypo/hypercalcemia)
- Encephalopathy (specify type, acuity and cause)
- End stage renal disease (specify underlying cause)
- Gastrointestinal hemorrhage (document acuity and link to site of bleed)
- Heart failure (specify acuity and type)
- Hypotension (specify cause)
- Malnutrition (specify severity)
- Pressure ulcer (include anatomic location, laterality and stage)
- Pulmonary embolism
- Respiratory failure (specify acuity)
- UTI (specify site of infection such as bladder, kidney, or urethra)
- Ventricular fibrillation

Basic Physician Documentation Requirements

- Document the reason(s) for the inpatient admission and the complex medical judgment factors to be considered including the severity of the signs and symptoms and the medical predictability of something adverse happening to the patient whenever possible to provide appropriate substantiation for severity of illness and risk of mortality.
- For all medications, treatments, and diagnostic studies, document the corresponding medical diagnoses indicating the clinical significance of the diagnosis. A code may not be assigned based on abnormal laboratory results or diagnostic report findings alone.
- Document all conditions including probable, suspected, or questionable based on your independent professional judgment and the clinical evidence and treatment provided. Clearly document if a condition was ruled out or was still considered probable at the time of discharge. Documentation should include the medical decision making process and supportive clinical information.
- Document all conditions still present, though possibly compensated or controlled, if they are currently being monitored, evaluated, treated, or causing increased nursing care or length of stay. These diagnoses should be listed as current medical conditions.
- Remove diagnoses from the problem list that are not clinically significant or have been ruled out.

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