Points to Consider

- Clarify maturity level such as:
  - Extreme immaturity (usually implies birth weight less than 1000 grams or less than 28 completed weeks of gestation)
  - Prematurity (usually implies birth weight 1000-2499 grams or 28 completed weeks to less than 37 completed weeks of gestation)
  - Full-term (usually implies birth weight over 2500 grams or 37 completed weeks to 40 completed weeks of gestation)
  - Post-term (usually implies gestation age over 40 completed weeks to 42 completed weeks)
- Documentation of “RDS” only defaults to RDS type I. A physician’s intent of documenting RDS may not necessarily be translated correctly in coding. Clearly document the condition as:
  - Type I RDS (also referred to as hyaline membrane disease, idiopathic respiratory distress syndrome [IRDS], pulmonary hypoperfusion syndrome)
  - Type II RDS (also referred to as transient tachypnea of newborn [TTN] and wet lung syndrome)
- Positive blood cultures are not required to document diagnosis of sepsis or suspected sepsis. The diagnosis is determined by the physician’s clinical judgment.
- Clarify if fever is suspected to be bacterial, viral or other (e.g., leukemia) in origin.
- Note all congenital conditions of infant.
- Clarify if infant’s mother with drug or tobacco dependence and whether or not infant has effects from this (e.g., drug dependent mother with drug dependent infant in withdrawal).

Medical Record Completion Requirements

- H&P: Must be completed within 24 hours following admission, but prior to surgery. Needs to include the chief reason for admission and all pertinent diagnoses and conditions that are present upon admission. Include all signs and symptoms the patient is experiencing.
- Operative report: Must be completed within 24 hours of procedure and include a full description of procedure and any intraoperative or postoperative complications, if known.
- Discharge summary: Needs to include the final principal diagnosis, all secondary diagnoses which were clinically significant for the current hospitalization including all conditions that were resolved and each procedure performed. Also include indication if plan for readmission.

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

- Apnea of newborn
- Atrial septal defect
- Congenital aortic stenosis
- Cyanosis of newborn
- Hyperbilirubinemia due to ABO incompatibility
- Hypoglycemia
- Hypoperfusion
- Hypoxemia of newborn
- Jaundice in preterm infant
- Meconium staining
- Neonatal bradycardia
- Neonatal dehydration
- Patent ductus arteriosus (PDA)
- Patent foramen ovale (PFO)
- Respiratory distress in newborn
- Respiratory distress syndrome
- Transitory tachypnea of newborn
- Ventricular septal defect

<table>
<thead>
<tr>
<th>Clinical Terms (Needs clarification)</th>
<th>Diagnostic Statement (Accurate code may be assigned)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestational age between 28-36 completed weeks of gestation</td>
<td>Prematurity</td>
</tr>
<tr>
<td>Gestational age less than 28 completed weeks of gestation</td>
<td>Extreme immaturity</td>
</tr>
<tr>
<td>Poor feeding, decreased urine output, fussiness, failure to gain weight</td>
<td>Failure to thrive, malnutrition</td>
</tr>
<tr>
<td>Baby turned blue and began choking after feeding, ALTE not further specified</td>
<td>Apparent life-threatening event (ALTE) with obstructive apnea due to GERD</td>
</tr>
<tr>
<td>Throat pain, gagging during feedings, large amounts of spit up following feedings</td>
<td>Gastroesophageal reflux disease (GERD), esophageal reflux</td>
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<tr>
<td>Fever</td>
<td>Specify probable source (e.g., &quot;probable bacterial infection&quot; or &quot;suspected viral infection&quot;)</td>
</tr>
<tr>
<td>Intraventricular hemorrhage (IVH)</td>
<td>Specify grade 1, grade 2, grade 3, grade 4</td>
</tr>
<tr>
<td>Retinopathy of prematurity</td>
<td>Specify stage 0, stage 1, stage 2, stage 3, stage 4, stage 5; specify eye involved: left, right, bilateral</td>
</tr>
<tr>
<td>Cool extremities, fluid bolus given</td>
<td>Hypoperfusion of neonate</td>
</tr>
<tr>
<td>Syndrome such as DiGeorge’s</td>
<td>List all manifestations associated with syndrome that patient has and note if current or resolved/repaired</td>
</tr>
</tbody>
</table>

### Clinical Terms (Needs clarification) | Diagnostic Statement (Accurate code may be assigned)

| Low O₂ sat, pH 7.21 | Document specific condition if known or suspected such as acidosis of newborn, late metabolic acidosis, respiratory acidosis, hypoxic ischemic encephalopathy (HIE) (specify mild, moderate, severe) |
| R/O sepsis | Document if the sepsis is confirmed, ruled out, or treated and resolved. Document organism and source if known and link to sepsis |
| Respiratory distress or RDS Type I RDS or Type II RDS (transitory tachypnea of newborn; TTN) | |
| Meconium | Document specific condition such as meconium aspiration (list any associated respiratory symptoms such as pneumonia), meconium passage, meconium staining |
| Increased bilirubin in premature infant | Hyperbilirubinemia of prematurity |
| Low blood sugar | Neonatal hypoglycemia |
| Dry mucus membranes, poor skin turgor, will rehydrate patient | Dehydration in newborn and specify cause if known or suspected |
| Mother with diabetes, large for gestational age (LGA) | Infant of diabetic mother |