Clinical Terms (Needs clarification) | Diagnostic Statement (Accurate code may be assigned)
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Traumatic fracture | Document open vs. closed, displaced vs. nondisplaced; specify bone, specific site on bone and laterality, document orientation of fractures such as transverse, oblique, spiral
Comminuted fracture | Specify if traumatic vs. nontraumatic; document site; indicate chronicity; if non-traumatic indicate underlying cause.
Vertebral fracture | Document presence of spinal cord injury; document specific vertebrae involved (e.g., third cervical vertebra, fourth thoracic vertebrae); document displaced vs. nondisplaced;
Pathological fracture | Specify location and laterality; specify whether etiology is osteoporosis, neoplastic or some other cause
Spondylosis | Document by type such as anterior spinal artery compression syndrome, vertebral artery compression syndrome; specify if with myelopathy or radiculopathy; document site as occipito-atlanto-axial, cervical, thoracic, lumbar or sacral
Rheumatoid arthritis | Document type such as RA with or without rheumatoid factor, rheumatoid bursitis, rheumatoid nodule, juvenile arthritis; specify site and laterality
Osteoarthritis | Document type such as primary generalized, primary, post-traumatic, other secondary; document site and laterality
Intervertebral disc disorders | Document site (cervical, thoracic, lumbar, sacral); document any associated myelopathy, radiculopathy, sciatica
Osteomyelitis | Document acute (acute, chronic, subacute); document type (hematogenous, multilocul, with draining sinus); specify location and laterality; indicate causative organism if known
Gout | Document acuity (acute, chronic); document type (idiopathic, lead induced, drug induced, due to renal impairment, other secondary);
Right calf swollen, reddened and tender | Phlebitis, thrombophilebitis, deep venous thrombosis (document site, acuity and laterality — e.g., acute venous thrombosis of right greater saphenous)
Wound red and indurated, IV antibiotics given | Cellulitis (document location, laterality, and organism; document any open wound, ulcer or traumatic wound associated with the cellulitis
Diabetes, blood sugar >360, will start insulin drip | Specify type (type 1, type 2, drug or chemical induced, other underlying condition), document any associated complications (diabetic autonomic neuropathy, diabetic foot ulcer, PVD due to diabetes — must document a cause and effect link), document insulin control status as controlled, out of control, with hyperglycemia
Hgb 6.8, Hct 27.5, will transfuse | Anemia (specify type, if known or suspected; such as acute or chronic blood loss anemia, anemia of chronic disease, hemolytic anemia, iron deficiency anemia, pernicious anemia)
Unable to void, straight cath with 600 ml | Urinary retention (specify underlying cause if known or suspected)
Dry mucus membranes, poor skin turgor, ↓ urinary output, ↓ BUN, will rehydrate patient | Dehydration
Continue home medications such as furosemide, HCTZ, ACE inhibitor | Document specific diagnosis such as chronic systolic/diastolic heart failure, CAD, atrial fibrillation, angina, HTN

Dear Doctor,

Please note that the Clinical Terms and Diagnostic Statements referenced are examples only, and in no way intended to lead the physician to any particular diagnosis. Your independent clinical judgment and documentation is the ultimate source of reference in the medical record.

A patient's Severity of Illness (SOI) and Risk of Mortality (ROM) is determined by the diagnostic terminology expressed in the medical record. Documentation must be accurate, complete and specific.

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.
Points to Consider:

- Specify the Gustilo classification for open fracture of the forearm, femur and lower leg:
  - Type I: clean wound less than 1 cm with minimal soft tissue injury. Bone fracture is simple with minimal comminution.
  - Type II: moderately contaminated wound greater than 1 cm with moderate soft tissue injury. Fracture contains moderate comminution.
  - Type III: extensive skin damage involving muscle or neurovascular. Type III is further subdivided as follows:
    - Type III A: extensive laceration of soft tissues with bone fragments from severe comminution or segmental fractures
    - Type III B: extensive lesion of soft tissues with periosteal stripping and contamination which usually requires a flap to cover the exposed bone
    - Type III C: exposed fracture with major vascular injury requiring repair for limb salvage
- Specify the Salter-Harris classification for physeal fractures:
  - Type I – transverse fracture through the hypertrophic zone of the physis.
  - Type II – fracture through the physis and metaphysis, but does not involve the epiphysis. This is the most common type and may cause minimal shortening, but rarely results in functional limitations.
  - Type III – fracture though the hypertrophic layer of the physis extending to split the epiphysis thereby damaging the reproductive layer of the physis.
  - Type IV – fracture through epiphysis, physis and metaphysis.
  - Type V – fracture involving only the physis which results in a compressive deformity of the growth plate.

- For sacral fractures, document:
  - Zone I, II or III (or vertical) fractures, which are also classified as nondisplaced, minimally displaced or severely displaced.
  - Additional classification as to Type 1, 2, 3, or 4 fractures which are indicative of transverse flexion, transverse extension or transverse segmental comminution.
  - 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.
  - Provide causes (probable/suspected) of presenting symptoms (e.g., back pain, leg pain, extremity weakness, gait disturbance) while awaiting confirmative workup and response to treatment.

Common Severity/Mortality Drivers

- Acute blood loss anemia
- Acute renal failure (indicate underlying cause)
- Arrhythmia (atrial fibrillation, atrial flutter, ventricular flutter, ventricular tachycardia)
- Cellulitis
- CVA/stroke
- Electrolyte imbalances (hypo/hypermagnesemia, hypo/hyperkalemia, hypo/hypercalcemia)
- Encephalopathy (specify type, acuity and cause)
- Fat embolism
- Fractures, traumatic and pathological
- Heart failure (specify acuity and type)
- Hypotension (specify cause)
- Malnutrition
- Osteomyelitis
- Pressure ulcer (include anatomic location, laterality and stage)
- Respiratory failure (specify acuity)
- Rhabdomyolysis
- UTI (specify site of infection such as bladder, kidney, or urethra)

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 on 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 intra-operative 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