UCONN HEALTH

# PHYSICIAN DOCUMENTATION TIPS FOR INPATIENTS

## What should you document?

- Document the reason(s) for the inpatient admission & the complex medical judgement factors to be considered, include the severity of the signs & symptoms. Whenever possible, provide substantiation for seve of illness & risk of mortality.
- Document all conditions still present even if controlled if they are still being monitored, evaluated, treated or causing increased nursing care, length of stay or use of additional other resources. These diagnoses should be listed as current medical conditions.
- For all medications, treatments, & diagnostic studies document the corresponding diagnoses indicating the clinical significance of the diagnosis.
- Clarify all conditions that are present on admission.
- Clearly document all procedures whether done in the O.R. or at the bedside.

## Coding Tips – Did you know?

**Coders cannot make assumptions…**

- When a patient presents with a history of recent large-volume blood loss & resultant "anemia," the coder cannot code the type of anemia as "due to blood loss without physician documentation that supports the cause/effect relationship of these two events.

**Codes can be assigned for uncertain diagnoses…**

- Document ALL conditions including probable, rule out, possible, presumed, suspected, still to be ruled out, likely or questionable based on your independent professional judgement & the clinical evidence & treatment provided. These conditions will be coded as if they exist. **Clearly document if a condition was ruled out or was still considered probable at the time of discharge.**

**Diagnoses cannot be assigned for abnormal test results…**

- Abnormal findings (laboratory, x-ray, pathologic, & other diagnostic results) are not coded/reported unless the provider CORRELATES THE FINDING TO A DIAGNOSIS AND DOCUMENTS IT AS SUCH. Codes may not be assigned based on abnormal lab results or diagnostic report findings alone.

# You Found that Where? Who Wrote it?

**Medical record documentation for inpatient coding is obtained from:**

- Discharge summary
- History & Physical
- ED record
- Provider progress notes
- Consultant's notes
- Physician's orders
- Operative reports
- CCDA
- Problem lists (if appropriately updated)

**The following systems <u>are</u> <u>not</u> used when coding inpatient medical records:**

- LCR
- Patient Keeper
- NextGen

***PLEASE NOTE:*** *When diagnostic information is contained in other parts of the medical record (dietician note, wound care, laboratory, pathology or radiology results or other ancillary reports) a physician directly participating in the care of the patient will be required to confirm and document the existence of the diagnosis before it can be coded.*

*Code assignment for diagnoses documented by a provider other than the attending (consultant, anesthesiologist , resident, APRN, PA) is allowable as long as it is does not conflict with other documentation in the record. It is helpful for the attending to document that he/she concurs with the diagnosis as rendered by other treating providers.*

**DEFINITIONS**

**Principal Diagnosis –** The condition established *after study* to be *chiefly* responsible for occasioning the admission of the patient to the hospital for care.

**Secondary Diagnosis/Additional Diagnoses –** All conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.

**Comorbidity** – A pre-existing condition present at the time of admission which may cause an increase in length of stay.

**Complication –** A condition that arises during the hospital stay that may prolong the length of stay.

**POA** – Present on admission

**HAC** – Hospital acquired condition

**ROM** – Risk of mortality

**SOI** – Severity of illness

**Questions?** Please feel free to contact the Clinical Documentation team on your unit or the coding department at X3875 or X3464