



CDI Quality Documentation Tips **Adults**

HEART FAILURE

Documentation Requirements:

- 1) **Acuity**: Acute, exacerbation/acute on chronic, or chronic
- 2) **Type**: With reduced EF, with preserved EF or with diastolic dysfunction
- 3) **If right sided HF**: Document any associated conditions (i.e., pulmonary hypertension, acute or chronic cor pulmonale, etc.)

CLINICAL INDICATORS OF ACUTE OR ACUTE ON CHRONIC HEART FAILURE:

- Elevated weight > 4.5kg in 5 days requiring CHF treatment
- Pulmonary edema, rales/crackles, tachypnea, orthopnea, extremity swelling
- Hyponatremia
- Persistent cough with white/pink blood-tinged phlegm
- Increasing/new pleural effusion on CXR, supplemental oxygen
- IV diuretic (usually Lasix or Bumex)
- In general, a BNP > 500 or proBNP > 3000 (in absence of renal dysfunction) is an indicator of acute or acute on chronic HF

ACUTE RENAL FAILURE/ACUTE KIDNEY INJURY

Documentation Requirements: “**Renal Insufficiency**” and “**Acute Kidney Disease**” are not reported as acute kidney injury or acute renal failure

CLINICAL INDICATORS OF ACUTE RENAL FAILURE/ACUTE KIDNEY INJURY:

- Serum creatinine increased 0.3 mg/dl in 48 hours OR
- Increased 1.5 x base creatinine in 7 days OR
- Urine output < 0.5 ml/kg/hour for 6 hours
- Diagnosis of **ACUTE KIDNEY INJURY** depends on the normal baseline for the individual patient, not the reference range for the test
- **Presence of AKI without improvement in creatinine ≥ 72 hours? Consider a diagnosis of AKI with ACUTE TUBULAR NECROSIS**

ALTERED MENTAL STATUS

Altered Mental Status (AMS) is a **symptom**– what is the cause?

Documentation Requirements – Encephalopathy:

- 1.) Presence of encephalopathy
- 2.) **Specificity/Etiology** of Encephalopathy:
 - Metabolic
 - Toxic
 - Septic
 - Hypertensive
 - Due to diabetes
 - Due to drugs
 - Hypoxic/anoxic
 - Is the encephalopathy acute or chronic?

CLINICAL INDICATORS OF ALTERED MENTAL STATUS

- Any diffuse disease of the brain that alters brain function
- Progressive memory loss, progressive loss of consciousness, lethargy, or loss of cognitive ability
- Reduced Glasgow Coma Scale
- Patient can be described as having delirium, acute confusion, or altered level of consciousness
- EEG demonstrates global dysfunction
- Mental status returns to baseline with correction of the underlying cause

MALNUTRITION

Documentation Requirements:

- 1) Presence of malnutrition
 - 2) Severity (mild, moderate, severe)
 - 3) With or without cachexia
- Specify **treatment and/or monitoring** associated with malnutrition diagnosis (i.e. dietary consult, dietary supplements, medications to stimulate appetite)
 - Relate Malnutrition diagnosis as a link to PREVIOUS GASTROINTESTINAL SURGERY, or other acute illness or trauma, etc., when appropriate

CLINICAL INDICATORS OF MALNUTRITION

- Insufficient energy intake
- Weight loss
- Loss of muscle mass
- Loss of subcutaneous fat
- Localized or generalized fluid accumulation that can mask weight loss (as an alternative to #2)
- Diminished functional status as measured by hand grip strength device

PNEUMONIA

Documentation Requirements:

- 1) Presence of pneumonia (clinical diagnosis)
- 2) Specificity of pneumonia based on treatment (Pneumonia due to aspiration, COVID-19, gram-negative bacteria, MRSA, etc.)

- **Documentation of type can be specified based on clinical suspicion and treatment**
- Sputum Culture is NOT required for diagnosis of Pneumonia
- **CAP, HAP, and HCAP** indicate where the Pneumonia was acquired and not a specific type (these will code to a pneumonia unspecified)
- Documentation of a “complex pneumonia” will not suffice
- Specify Type (i.e. bacterial [specify organism], viral, aspiration [specify substance], fungal, ventilator-associated, etc.)
- Specify associated conditions (i.e. sepsis, HIV disease, influenza, etc.)
- Antibiotics typically used to cover “Complex” Pneumonias: Amikin/Amikacin, Ancef/Cefazolin, Avelox/Moxifloxacin, Cefoxitin (Aspiration), Ceftaroline, Ceftin/Cefuroxime, Clindamycin (Aspiration), Gentamycin, Merrem/Meropenem, Unasyn/Ampicillin-Sulbactam, Vancocin/Vancomycin, Zyvox (Linezolid)

RESPIRATORY FAILURE

Documentation Requirements:

- Acuity (Acute, Acute on Chronic, Chronic)
- Type (Hypoxic, hypercapnic/hypercarbic)
- Oxygen dependence/Home oxygen
- Present on admission status
- Specify if applicable, tobacco use, abuse, dependence or exposure
- Mechanical Ventilation/Intubation is NOT required for a diagnosis

CLINICAL INDICATORS OF RESPIRATORY FAILURE

Acute

- Symptoms include: dyspnea, tachypnea (RR > 20, or < 10), nasal flaring, cyanosis, speaking in short sentences, possible use of accessory muscles, or reduced respiratory drive

Hypoxemic

- $pO_2 < 60$ mmHg ($SpO_2 < 91\%$) on room air*, or P/F ratio (pO_2/FiO_2) < 300*, or 10 mmHg decrease in baseline pO_2 (if known)
- *Do not use for patient with chronic respiratory failure on continuous home O₂*

Hypercapnic

- $pCO_2 > 50$ mmHg with pH < 7.35, or 10 mmHg increase in baseline pCO_2 (if known)
-

Acute on Chronic

- Home oxygen levels increase. Also see above for changes in baseline pO_2 and pCO_2

Chronic

- Typically on home O₂ for chronic hypoxemia. May be described as “oxygen and/or steroid dependent”; develops slowly, may demonstrate renal compensation and increased bicarb on ABGs (if Chronic Hypercarbic Respiratory Failure); Common for patients to also have issues with pulmonary mechanics (i.e. neuromuscular disease), pulmonary function (i.e. COPD) or abnormal central respiratory drive (i.e. spinal cord injury, Obesity-Hypoventilation Syndrome, etc.)

SEPSIS

- Do NOT document **“UROSEPSIS”** – document Sepsis secondary to UTI instead
- Bacteremia is NOT synonymous with Sepsis
- Specify Causative Organism if known
- Specify Related Local Infection (i.e. Pneumonia, Cellulitis, UTI, etc.)
- Specify Present on Admission (POA) vs. Hospital Acquired
- Specify Due to or Related to, if Sepsis is due to a Device, Implant, Graft, Infusion, or Abortion
- Specify Acute Organ Dysfunction that is due to Sepsis (i.e. Encephalopathy, ARDS, Acute Respiratory Failure, etc.)

CLINICAL INDICATORS OF SEPSIS

- Sepsis-3: Sepsis defined as acute organ dysfunction due to infection(confirmed or suspected)
- Acute Organ Dysfunction is determined by a 2-point change from baseline of the Sequential (Sepsis-related) OrganFailure Assessment (SOFA) using the six defined organ systems **(see next page)**

CLINICAL INDICATORS OF SEPSIS

Organ System, Measurement	0	1	2	3	4
Respiratory PaO ₂ /FiO ₂ , mmHg	Normal	< 400	< 300	< 200 (with respiratory support)	< 100 (with respiratory support)
Coagulation Platelets x10 ³ /mm ³	Normal	< 150	< 100	< 50	< 20
Hepatic Bilirubin, mg/dL (μmol/l)	Normal	1.2 – 1.9 (20 – 32)	2.0 – 5.9 (33 – 101)	6.0 – 11.9 (102 – 204)	>12.0 (> 204)
Cardiovascular MAP or use of vasopressor	Normal	MAP < 70 mmHg	Dopamine < 5 or dobutamine (any dose)	Dopamine > 5 or epinephrine < 0.1or norepinephrine < 0.1	Dopamine > 15 or epinephrine < 0.1or norepinephrine < 0.1
Central Nervous System Glasgow Coma Score	Normal	13 – 14	10 – 12	6 – 9	< 6



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