Clinical Terms (Needs clarification)	Diagnostic Statement (Accurate code may be assigned)
Patient with metastasis	Document site of primary cancer and individually list all secondary sites. Example: Metastatic cancer to the left lower lobe lung from the left upper quadrant breast
Lytic lesions of L3 vertebra on spine films	**Bone metastasis to L3** (specify vertebral level)
CT scan shows enlarged periaortic lymph nodes	**Metastasis to periaortic lymph node** (specify location)
Neutrophils ↓, will give granulocyte colony stimulating factor	**Neutropenia, agranulocytosis** (specify if due to chemotherapy, drug-induced, or due to an infection)
WBC 3.0, temp 101, pulse 112, confusion, blood culture negative, neutrophilia	**Neutropenic sepsis**
WBC ↓, H/H ↓, platelets ↓	**Pancytopenia** (specify if due to chemotherapy or drug-induced [name specific drug])
1. Hgb 6.2, Hct 27.5, will transfuse 2 units PRBCs 2. Anemia, ↓ serum Fe	**Anemia** (specify type, if known or suspected, such as anemia of neoplastic disease, due to chemotherapy, aplastic anemia, acute or chronic blood loss anemia, hemolytic anemia, iron deficiency anemia, pernicious anemia)
Rectal hemorrhage, history of diverticulosis, anemia	**Blood loss anemia** (specify if acute or chronic); **diverticulosis with hemorrhage** (link the condition to the hemorrhage)

Clinical Terms (Needs clarification)	Diagnostic Statement (Accurate code may be assigned)
Leukemia	Specify acuity (acute, chronic); document specific type for example acute lymphoblastic, chronic lymphocytic of B-cell type, prolymphocytic of B-cell type, hair cell, adult T-cell; document in remission or in relapse
Myelodysplastic syndrome	Specify type such as with or without lesions, high grade with and without 5q deletion, preleukemia or leukemic
Pleural fluid on chest x-ray, thoracentesis positive for malignant cells	**Malignant pleural effusion**
Cough, CXR indicates pneumonitis. Patient s/p radiation treatment	**Radiation pneumonitis**
Patient nearing death, admitted for palliative care	Document steps in dying process (e.g., oliguria, acute renal failure, encephalopathy, coma, respiratory failure). Document all of the patient's underlying conditions on admission.
Will admit for pain control	**Intractable pain** from malignancy (document site affected such as right femur and underlying cause)
Emaciated, ↓ albumin, weight loss, BMI 16.5, nonhealing wounds, nutritional consult, ordered supplements, consider TPN	**Malnutrition** (specify type such as protein calorie, protein energy; document severity such as mild, moderate or severe or first, second or third degree)

HEMATOLOGY/ONCOLOGY

DOCUMENTATION IMPACTING MS-DRG & APR-DRG ASSIGNMENT AND SEVERITY/MORTALITY PROFILES

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.

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Points to Consider:

- Document all reasons for admission (e.g., chemotherapy, pain control, staging, treatment of primary site, treatment of secondary sites).
- Clarification whether the primary site is still present or under current treatment or has been previously resected or excised.
- Clarification of the term “metastasis.” Is the carcinoma metastatic from or to a site?
- Specification when admitting a patient for biological response modifiers (BRM) or immunotherapy vs. chemotherapy.
- Provide causes (probable/suspected) of presenting symptoms (e.g., headache, hemoptysis, fever, cough, chest pain, fatigue) while awaiting confirmative workup and response to treatment.
- Documentation should reflect any significant findings/diagnoses on chest x-rays (e.g., infiltrates, blunting, COPD, atelectasis, effusions, pneumothorax, fibrosis).
- Clarify if “SIRS due to an infection” indicates the patient has sepsis (systemic infection) or a localized infection.
- Do not document the term “urosepsis.” Instead clarify if the patient has a UTI or sepsis.
- Positive blood cultures are not required to document diagnosis of sepsis or suspected sepsis.
- When patient has multiple organ failure, list each organ failure individually.
- 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.

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

Common Severity/Mortality Drivers

- Acute renal failure
- Aplastic anemia
- Bacteremia
- C. difficile infection
- Electrolyte imbalances (hypo/hypernatremia, hypo/hyperkalemia, hypo/hypermagnesemia, hypo/hypercalcemia)
- Encephalopathy (specify type, acuity and cause)
- End stage renal disease
- Hypotension
- Leukemia
- Malnutrition (specify severity)
- Metastases to bone, brain, liver, lung, lymph nodes
- Neutropenia
- Pancytopenia
- Pleural effusion
- Pressure ulcer (include anatomic location, laterality and stage)
- Respiratory failure (specify acuity and presence of acidosis, hypoxia, and hypercapnia)
- Sepsis
- Thrush
- Tumor lysis syndrome
- UTI