Clinical Documentation is important for a variety of reasons. These include:

- Coding accuracy and precision,
- Documentation of the severity of illness,
- Justification for resources used in providing care,
- Improved continuity of care for the Veteran, and
- Reimbursement both from the VA and commercial payers.

Lack of accurate and complete documentation may not allow a Veteran to get benefits they deserve and also reflects on you as providers in other VA Medical Centers and Clinics read your notes when the Veteran either moves or seeks care at another facility. If your documentation allows the next provider seeing the Veteran to have a better starting point, especially for recurrence of common symptoms, that only helps the Veterans in getting timely care to help resolve those conditions and provides better utilization of resources to identify the underlying cause. Documentation that is not clear may result in a clarification request to allow for precise coding of the record and documentation of the care provided.

If you have any questions or concerns regarding documentation in the medical record, do not hesitate to contact the facility Clinical Documentation Improvement Specialist at the phone or email below. After all, we are here to serve those who have served.

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- When providing patient education not only document the information provided, but also the patients’ response to the education you provided. This is a Joint Commission standard.
- Make the link between conditions. If a patient has Diabetes Mellitus, do they have neuropathies, renal manifestations, or other issues related to that primary condition? If they have an encephalopathy, what is the underlying condition causing the encephalopathy? Links cannot be assumed or presumed and must be documented by the provider and better documents the clinical condition of the patient.
- Be very cautious with the use of abbreviations. The facility approved list is available under the tools menu in CPRS, but it is over 800 pages long and many abbreviations on that list have more than one meaning and mean different things in upper and lower case. Improper use of abbreviations can cause confusion and may require clarification. As a general rule:
  - Never use a slash (/) between diagnoses.
  - Abbreviations should never be used in the final diagnosis listing
  - If you aren’t sure, write it out.

- Acute vs. Chronic. It’s important to document conditions as Acute or Chronic, or even an Acute Exacerbation of a Chronic condition, such as CHF, COPD or Chronic Kidney Disease. This helps capture the severity of illness as well as precision in coding.

- Insufficiency vs. Failure. These two terms are often used synonymously in medical practice, but they do not mean the same thing and indicate different levels of severity.
  - Insufficiency more accurately describes an new change or an acute change in a chronic condition that can be treated as an outpatient or observation status and is expected to return to baseline with minimal intervention that cannot be staged or classified using established criteria.
  - Failure usually indicates something more serious or dramatic in nature which, if acute in nature, may require inpatient or critical care services and may have impact on other body systems. If chronic in nature, the condition will require continued care an monitoring and is not expected to improve in the long term. These conditions should be able to be staged or classified using existing standards.
**Documentation Tip Card:**

**Evaluation & Management (E/M): Level 1 (1995)**

- Minimum requirements for a level 1 exam are:
  - **S** - Chief Complaint: history of present illness; 1 of the 8 elements must be documented: location, duration, timing, severity, quality, context, modifying factors, associated symptoms (New patient).
  - **O** - Minimum of 1 body system/area (i.e. GI: GU: CV: Skin: Musculoskeletal, etc)
  - **A** - One minor problem identified (i.e. cold, insect bites, influenza, etc.*) or being seen for previously diagnosed problem that is stable or improving.
  - **P** - Minimal treatment required (i.e. injection, bed rest, and chest x-ray/lab tests)

*Many Veterans have multiple chronic conditions which may increase the level of care.*

**Code 99211 is the only E/M code available for use by non-providers. Providers would rarely assign a level of 99211.


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**Documentation Tip Card:**

**Evaluation & Management (E/M): Level 2 (1995)**

- Minimum requirements for a level 2 exam are:
  - **S** - Chief Complaint: history of present illness (1 of the 8 elements: location, duration, timing, severity, quality, context, modifying factors, associated signs/symptoms), One review of system taken from patient (New Patient)
  - **O** - Minimum of 2 body systems in detail (i.e. GI: GU: CV: Skin: Musculoskeletal (New Patient) OR minimum of 1 body systems/area examined (Established Patient)
  - **A** - One minor problem identified (i.e. cold, insect bites, influenza, etc.) or being seen for previously diagnosed problem that is stable or improving.
  - **P** - Minimal treatment required (i.e. injection, bed rest, and chest x-ray/lab tests)


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**Documentation Tip Card:**

**Evaluation & Management (E/M): Level 3 (1995)**

- Minimum requirements for a level 3 exam are:
  - **S** - Chief Complaint: history of present illness must include 4 of 8 elements at a minimum or 3 chronic conditions for New patient and 1 at a minimum for an Established patient.
    - Review of systems (verbal) (i.e. any problems such as weight loss, dizziness, etc.)
    - Past medical history (patients)
    - Family History
    - Social History (patients’ past medical history at a minimum)
  - **O** - Minimum of 2 body systems in detail (i.e. GI: GU: CV: Skin: Musculoskeletal (New Patient) OR minimum of 2 body systems/areas (Established Patient)
  - **A** - Conditions found - self-limiting or minor conditions (at a minimum) such as a chronic condition - patient stable, and/or new problem to the provider with no additional work-up planned.
  - **P** - Treatment recommendation usually a prescription drug, minor surgery with no identified risk factors, physical therapy, IV fluids without additives.


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**Documentation Tip Card:**


- Minimum requirements for a level 4 exam are:
  - **S** - Chief Complaint: history of present illness (must include 4 of 8 elements at a minimum or 3 chronic conditions.
    - Review of systems (verbal) (10 systems reviewed with patient)
    - Past medical history
    - Social or Family History (all 3 PFSH for New Patient, 1 PFSH for Established Patient)
  - **O** - At least eight body systems/areas systems (New Patient) OR at least 2 body systems/areas (Established Patient)
  - **A** - New problem to the provider - additional workup planned; one or more chronic problems with mild exacerbation; two or more stable chronic illnesses; acute complicated injury. Normally three or more diagnoses are documented.
  - **P** - Order/review tests; prescription drug therapy; elective minor surgery; invasive diagnostic tests (i.e. scopes)


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Acute Renal Failure
Other cause
Acute kidney injury
Unknown cause

When documenting these conditions it is important to document:

Acidosis and Alkalosis are important complications to capture in a patient's presentation, and coding precision:

Documenting as precisely as possible assists in continuity of care, documenting severity of illness, and coding precision: Abdominal pain is a symptom that normally represents an underlying condition. Some of the common underlying cause of abdominal pain include, but are not limited to:

Renal Calculus | Gastritis/Gastroenteritis | Appendicitis
---|---|---
Colitis | Diverticulitis/Diverticulosis | Pancreatitis
Cholecystitis | Ileus or Obstruction | Food Poisoning
Gastric Ulcers | Urinary Tract Infection | AAA Leak

This list goes on, but if you know or suspect a cause it’s important to document that. If you don’t know the cause, indicate what you are working up or ruling out.

Documenting Acute Kidney Injury

Documenting as precisely as possible assists in continuity of care, documenting severity of illness, and coding precision:

- Acute tubular necrosis
- Acute Renal Failure
- Acute kidney injury
- Other cause
- Unknown cause

Acute Kidney Injury Network (AKIN) staging system for Acute Kidney Injury

<table>
<thead>
<tr>
<th>AKIN Stage</th>
<th>Serum Creatinine criteria</th>
<th>Urine Output Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SCreat ≥ 26.4 mmol/L or SCreat ≥ 150—200% (1.5-2 fold) from baseline</td>
<td>&lt; 0.5 ml/h/1.73 m² for &gt;6h</td>
</tr>
<tr>
<td>2</td>
<td>SCreat &gt; 200—300% (&gt;2-3 fold) from baseline</td>
<td>&lt; 0.5 ml/h/1.73 m² for &gt;12h</td>
</tr>
<tr>
<td>3</td>
<td>SCreat &gt; 300% (&gt;3 fold) from baseline or SCreat ≥ 354 mmol/L with an acute rise of ≥ 44 mmol/L in &lt; 24h or initiated on Renal Replacement Therapy (irrespective of stage at time of initiation)</td>
<td>&lt; 0.3 ml/h/1.73 m² for 24 h or anuria for 12 h</td>
</tr>
</tbody>
</table>

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Documentation Tip Card: Documenting Acute Renal Failure

Documenting as precisely as possible assists in continuity of care, documenting severity of illness, and coding precision:

- Acute tubular necrosis
- Acute Renal Failure
- Acute kidney injury
- Acute Renal Insufficiency
- Other cause
- Unknown cause

### RIFLE Criteria

<table>
<thead>
<tr>
<th>Stage</th>
<th>Glomerular Filtration Rate</th>
<th>Urine Output Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>Serum Creatinine (SCr) increased 1.5 times or GFR decreased &gt;25%</td>
<td>&lt;0.5ml/kg/h for 6 hours</td>
</tr>
<tr>
<td>Injury</td>
<td>SCr increased 2.0 times or GFR decrease &gt;50%</td>
<td>&lt;0.5ml/kg/h for 12 hours</td>
</tr>
<tr>
<td>Failure</td>
<td>SCr increased 3.0 times or GFR decreased 75% or SCr &gt;3 mg/dL; acute rise ≥0.5 mg/dL</td>
<td>&lt;0.3 ml/kg/h for 24 h or anuria for 12 hours</td>
</tr>
<tr>
<td>Loss</td>
<td>Persistent Acute Renal Failure; complete loss of kidney function &gt; 4 weeks</td>
<td></td>
</tr>
<tr>
<td>End Stage</td>
<td>End Stage Renal Disease (ESRD) persisting &gt; 3 months</td>
<td></td>
</tr>
</tbody>
</table>

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Documentation Tip Card: Documenting Anemia

Documenting as precisely as possible assists in continuity of care, documenting severity of illness, and coding precision:

- Acute Blood Loss Anemia
- Expected Acute Blood Loss Anemia
- Anemia of Chronic Disease
- Iron Deficiency Anemia
- Aplastic Anemia
- Pernicious Anemia
- Chronic Blood Loss Anemia
- Anemia of unknown etiology
- Precipitous drop in Hemoglobin (20% from baseline not related to anemia)
  - Anemia secondary to antineoplastic or other drug therapy

Note: Postoperative Blood Loss Anemia is not coded as a complication; unless specified as a complication by the physician (per Coding Clinic)

If you are not sure of the cause of the anemia, please document what you suspect and are ruling in or out.

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Documentation Tip Card: Documenting Chest Pain

Documenting as precisely as possible assists in continuity of care, documenting severity of illness, and coding precision:

Chest pain is a symptom that normally represents an underlying condition. It is important to identify the underlying cause of any symptom to the best of your ability. Possible diagnoses include but are not limited to the following, but don’t forget there may be other causes or an unknown cause that you only suspect, and it is important to document your suspicions as well.

- Acute Myocardial Infarction
- Angina
- Coronary Artery Disease
- Gastroenteritis/Gastritis
- Pancreatitis
- Cholecystitis
- Gastroesophageal Reflux Disease
- Esophagitis
- Costochondritis
- Other or Unknown causes
  - (but don’t forget your suspicions or what you are working up or ruling out)

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Documenting Tip Card: Documenting Congestive Heart Failure

Documenting as precisely as possible assists in continuity of care, documenting severity of illness, and coding precision:

| Acute Systolic Heart Failure | Chronic Systolic Heart Failure |
| Acute Systolic and Diastolic Heart Failure | Chronic Systolic and Diastolic Heart Failure |
| Acute on Chronic Systolic Heart Failure | Left Heart Failure |
| Acute Diastolic Heart Failure | Chronic Diastolic Heart Failure |
| Acute on Chronic Diastolic Heart Failure | Systolic Heart Failure—Not Specified* |
| Congestive Heart Failure—Not Specified* | Diastolic Heart Failure—Not Specified* |

* If documenting something as “not specified”, indicate that you are unable to specify the type and why, such as a pending echocardiogram.

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Documenting Tip Card: Documenting Diabetes

Documenting as precisely as possible assists in continuity of care, documenting severity of illness, and coding precision:

For coding purposes, diabetes needs to be documented in a particular way.

For Type, Diabetes Mellitus needs to be identified as either:
- Type 1, or Type 2, or Secondary Diabetes
- For “Secondary Diabetes” specify the underlying cause

For Status it must be documented as either:
- Controlled, or Uncontrolled

Terms such as “insulin dependent”, “poorly controlled”, “brittle”, or “unstable” cannot be coded as uncontrolled and will require further clarification for accurate coding.

It is also important to document and link any associated conditions such as neuropathies, retinopathies, etc to ensure a complete and accurate picture of the patients condition.

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Stages of chronic kidney disease and clinical action plans:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>GFR</th>
<th>Clinical Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Kidney damage with normal or ↑ GFR</td>
<td>≥90</td>
<td>Diagnosis and treatment, slow progression, CVD risk reduction</td>
</tr>
<tr>
<td>2</td>
<td>Kidney damage with mild ↓ GFR</td>
<td>60-89</td>
<td>Estimating progression</td>
</tr>
<tr>
<td>3</td>
<td>Moderate ↓ GFR</td>
<td>30-59</td>
<td>Evaluating and treating complications</td>
</tr>
<tr>
<td>4</td>
<td>Severe ↓ GFR</td>
<td>15-29</td>
<td>Preparation for kidney replacement therapy</td>
</tr>
<tr>
<td>5</td>
<td>Kidney Failure</td>
<td>&lt;15</td>
<td>Kidney replacement therapy (if uremia present and patient desirable)</td>
</tr>
</tbody>
</table>

Documenting Tip Card: Documenting Malnutrition

Malnutrition in the context of:

<table>
<thead>
<tr>
<th>Energy Intake</th>
<th>Acute Illness or Injury</th>
<th>Chronic Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Moderate</td>
<td>Severe</td>
</tr>
<tr>
<td>&lt;75% of estimated energy requirement for &gt;7 days</td>
<td>≤50% of estimated energy requirement for ≥5 days</td>
<td>&lt;75% of estimated energy requirement for ≥1 month</td>
</tr>
<tr>
<td>Weight Loss from baseline</td>
<td>1-2% over 1 wk</td>
<td>&gt;2% over 1 wk</td>
</tr>
<tr>
<td></td>
<td>5% over 1 mo</td>
<td>&gt;5% over 1 mo</td>
</tr>
<tr>
<td></td>
<td>7.5% over 3 mo</td>
<td>&gt;7.5% over 3 mo</td>
</tr>
<tr>
<td>Body Fat Loss</td>
<td>Mild</td>
<td>Moderate</td>
</tr>
<tr>
<td>Muscle Loss</td>
<td>Mild</td>
<td>Moderate</td>
</tr>
<tr>
<td>Fluid Accumulation</td>
<td>Mild</td>
<td>Moderate to Severe</td>
</tr>
<tr>
<td>Reduced grip strength</td>
<td>NA</td>
<td>Measurably reduced</td>
</tr>
</tbody>
</table>

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**Documentation Tip Card: Documenting Obesity**

Documenting as precisely as possible assists in continuity of care, documenting severity of illness, and coding precision:

<table>
<thead>
<tr>
<th>Diagnosis**</th>
<th>Code</th>
<th>Definition (Per ICD-9-CM 2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight</td>
<td>278.02</td>
<td>BMI (body mass index) between 25 and 29.9</td>
</tr>
<tr>
<td>Obesity</td>
<td>278.00</td>
<td>BMI (body mass index) between 30.0 and 39.9.</td>
</tr>
<tr>
<td>Morbid (Severe) Obesity</td>
<td>278.01</td>
<td>Increased weight beyond limits of skeletal and physical requirements (125 percent or more over ideal body weight), as a result of excess fat in subcutaneous connective tissues. BMI of 40 or more.</td>
</tr>
</tbody>
</table>

**Both the BMI and the diagnosis must be documented in the note to accurately code the diagnosis.**

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**Documentation Tip Card: Documenting Pneumonia**

The VA splits pneumonia into simple and high cost. As such, it is important to document as much detail as possible about the condition when it is present. These include:

- Is it community vs. hospital acquired
- What type of pneumonia are you treating or do you suspect? Is it bacterial, viral, or due to aspiration or chemical exposure
- What are the complicating conditions that either precipitated the pneumonia or will impact treatment and expected outcomes. These may include malignancy, neutropenia, or complications and comorbidities such as CHF or COPD.
- Is it a hospice patient or does the patient have a terminal diagnosis and is a DNR?
- Where is the pneumonia located.
- Is the pneumonia a cause of or exacerbating other conditions such as sepsis, shock, or COPD. Remember too, you don’t need a positive chest x-ray to diagnose pneumonia if the clinical presentation supports the pneumonia diagnosis.

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**Documentation Tip Card: Documenting Respiratory Failure**

Documenting as precisely as possible assists in continuity of care, documenting severity of illness, and coding precision:

<table>
<thead>
<tr>
<th>Signs and Symptoms:</th>
<th>Acute: Develops over minutes to hours, Change in 2 or more ABG values and/or other physical symptoms.</th>
<th>Chronic: Develops over several days or longer, lasting more than 3 months, requires ongoing home treatment to maintain stable state and will decompensate without treatment.</th>
</tr>
</thead>
</table>
| Types: Hypoxicemic: | pH of ≤ 7.30; if history of COPD, pH ≤ 7.50  
(pO2 <60 with normal or low pCO2)  
PCO2 of ≥250 on room air  
pO2 of < 60 on room air RR of ≥ 24  
Alteration in mental status: anxiety  
Accessary muscle use  
Unable to speak in complete sentences  
Ventilator support required | “End Stage” COPD, polycythemia, cor pulmonale, or chronic hypoxemia documented  
Continuous home O2 required  
Chronic home mechanical vent used  
Invasive or non – (BiPAP, CPAP)  
Continuous or scheduled home nebulizers used  
Chronic oral steroids used continuously |

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**Documentation Tip Card: Documenting Respiratory Symptoms**

Documenting as precisely as possible assists in continuity of care, documenting severity of illness, and coding precision:

Respiratory distress, dyspnea, and hypoxia are symptoms and can have many underlying causes. It is important to identify the underlying cause of any symptom to the best of your ability. Possible diagnoses include but are not limited to the following, but don’t forget there may be other causes or an unknown cause that you only suspect, and it is important to document your suspicions as well.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>AMI</td>
</tr>
<tr>
<td>Acute COPD exacerbation</td>
<td>CVA</td>
</tr>
<tr>
<td>Asthma</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>Trauma</td>
</tr>
<tr>
<td>ESRD with fluid overload</td>
<td>CHF</td>
</tr>
<tr>
<td>Head injury</td>
<td>Overdose/poisoning</td>
</tr>
<tr>
<td>Acute Respiratory Failure</td>
<td>“inadequate exchange of O2 and CO2 by the lungs” which is life threatening and requires close monitoring and evaluation, with aggressive management.</td>
</tr>
</tbody>
</table>

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Documenting Signs & Symptoms

Documenting the underlying cause of a sign or symptoms as precisely as possible assists in continuity of care, documenting severity of illness, and coding precision. When a symptom, such as pain, is documented as the reason the Veteran is seeking care, it is important to link that symptom to the actual or suspected underlying cause.

For example:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Potential Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>Acute vs. Chronic, Location, Character, Suspected Cause</td>
</tr>
<tr>
<td>Confusion</td>
<td>Encephalopathy, Dementia, Intoxication, Stroke, ...</td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td>Acute asthma exacerbation, COPD exacerbation, Acute CHF...</td>
</tr>
<tr>
<td>Hyperkalemia</td>
<td>Renal Failure, Dehydration, ...</td>
</tr>
</tbody>
</table>

This list goes on, but if you know or suspect a cause it’s important to document that. If you don’t know the cause, indicate what you are working up or ruling out.

Detoxification of a patient from a chemical dependence, such as alcohol, is routinely performed in an outpatient setting unless there are other medical reasons that require closer monitoring. When inpatient monitoring is required for the patient, a more appropriate diagnosis may be “Withdrawal Syndrome”. Withdrawal Syndrome is defined as a set of symptoms that people have when they suddenly stop taking a substance after using a substance for a long period of time. Symptoms may range from mild shakiness and sweats to life threatening conditions such as respiratory distress, palpitations, severe headaches, and DT’s depending on the substance.

- It is important to document the substance the patient is withdrawing from, how often they used that substance prior to admission, and when they last took the substance.
- Equally important is documentation of all withdrawal symptoms including tremors, hallucinations (auditory, tactile, and/or visual), anxiety, agitation, diaphoresis and the symptoms link to the substance they are withdrawing from.