Baptist Health

May/June 2022

UP TO CODE

CLINICAL DOCUMENTATION NEWSLETTER

NEWS YOU CAN USE

DOCUMENT Morbid Obesity for BMI > 40
DOCUMENT Severe Obesity for BMI 35 – 39.9 if there is one or more significant co-morbidities related to obesity present such as Type 2 DM, HTN, CAD, smoker, sleep apnea, hyperlipidemia

SEPSIS KORNER

CODE SEPSIS COMING SOON to BMC South and PBH Emergency Rooms!
Remember, sepsis is a life-threatening medical emergency. Early recognition and treatment with antibiotics and crystalloid fluids is key to preventing worsening symptoms and death.

When it comes to sepsis, remember IT'S ABOUT TIME ™
Temp >100.9 or < 96.8
Infection - may have signs and symptoms of infection
Mental Decline - confused, sleepy, difficult to rouse
Extremely Ill - severe pain, discomfort, shortness of breath

DOCUMENTATION

If you are treating a patient for a possible infection, not yet confirmed or exact source not yet identified, document any of the following positive qualifiers of infection:

- Possible
- Probable
- Rule out
- Differential Diagnosis
- Suspected
- Suspicious for
- Likely
- Concern for

Documentation of "source of infection is not yet determined" would not be considered documentation of possible infection per CMS guidelines. Be sure to timestamp documentation of infection so a more accurate presentation time of severe sepsis (time zero) can be identified.

In the ER, documentation of infection will be considered documented at the time you saw the patient if you do not timestamp it.

DOCUMENTATION PEARLS

CEREBRAL EDEMA AND COMPRESSION: RECOMMENDED TERMINOLOGY

– Cerebral Edema, Vasogenic edema, Cerebral (brain) compression, Cerebral Herniation. **Please distinguish traumatic from atraumatic causes.**
Terms to AVOID: Mass effect, Midline shift, Space occupying lesion, effacement.

FUNCTIONAL QUADRIPLEGIA:

the lack of ability to use one's limbs (unable to perform any ADLs including feeding oneself) **or to ambulate due to extreme debility or frailty caused by another medical condition without physical injury or damage to the spinal cord.** Common causes are severe end-stage dementia, advanced progressive neuro-degenerative disorders (like MS, ALS, Cerebral Palsy, Huntington's disease), crippling arthritis, profound intellectual disability.

CDC DEFINITIONS TO DIFFERENTIATE HIV DIAGNOSIS:

HIV INFECTION: HIV positive without AIDS
HIV DISEASE/AIDS: HIV positive person with a past or present occurrence of either of the following: Absolute DC4+ T-lymphocyte count < 200 or an AIDS-defining condition such as pneumocystis pneumonia, certain lymphomas, systemic candidiasis, other unusual bacterial, fungal, parasitic, viral infections, HIV wasting syndrome

ENCEPHALOPATHY RECOMMENDED TERMINOLOGY:

Toxic encephalopathy due to [medication or toxic substance]
Metabolic encephalopathy
Toxic-metabolic encephalopathy
Septic encephalopathy
Hepatic encephalopathy
Uremic encephalopathy
Delirium due to [toxic / metabolic] encephalopathy
Dementia complicated by acute encephalopathy
Terms to AVOID:
Altered mental status - represents a non-specific, non-diagnostic symptom
Alert, awake and oriented – frequently used incorrectly when the patient is actually encephalopathic
Delirium only – classified as a non-specific symptom; delirium due encephalopathy is preferred and recommended by DSM-5
Drug-induced delirium only – does not reflect the severity impact of "toxic encephalopathy"
Hypoxic encephalopathy (coded as anoxic brain injury) when due to acute hypoxemia – use metabolic instead
Unspecified encephalopathy – without specifying the type