EvidenceCare

Documentation Tips

Physician Documentation Drives Medical Necessity

Documentation must support that the patient's condition is severe enough to warrant the need for services that can only be furnished safely in the hospital.

- Inpatient (INPT) admissions must include reason for hospitalization as well as supporting documentation which may include:
  - Complex medical history / comorbidities
  - Severity of signs and symptoms
  - Current medical needs
- Observation (OBS) status must include reason for stay in the hospital:
  - Risk of adverse event if sent home
  - Reason for need for continued monitoring
  - Supportive clinical data (vital signs / lab abnormalities)

Keys for Success

1. Condition at time of decision = criteria to select
   - Select criteria that reflects current status at time of admission decision (labs, vital signs, condition).
2. Supportive documentation
   - Use AdmissionCare to place documentation of guideline and criteria selected into H&P/Progress note in chart. Ensure your notes support the criteria selected.
   - Altered mental status must be different from baseline
   - Abnormal or unstable vital signs need to be sustained
   - O2 sat on room air
   - Risk / Severity Scores
3. Think in ink
   - If it isn't in the medical record, it didn't happen
   - Example:
     - If strong suspicion of CVA due to gait impairment, evaluation must be noted in the medical record
     - If patient has recurrent seizures, this must be documented

Examples of Supportive Documentation

- Sustained abnormal vital signs (tachypnea, hypotension, hypertension, hypoxemia)
- Continued pain documented despite emergency room and/or observation care.
- Always document any dyspnea, aphasia, dysphasia, lethargy, confusion, etc.
- Altered mental status and document if different from baseline.
- Further testing needed to diagnose post-emergency room care.
- Risk of adverse event if sent home.
- Use AdmissionCare criteria to help guide documentation.