| **Instead of…** | **Consider…** | **Notes** |
| --- | --- | --- |
| Decompensated cirrhosis | **Chronic liver failure—specify type** | Specify etiology of cirrhosis (eg, alcoholic cirrhosis, hepatitis C cirrhosis, autoimmune hepatitis) |
| Coffee ground emesis | **Hematemesis** |  |
| Acute transaminitis | **Acute hepatitis****Shock liver** | Specify etiology of hepatitis or shock liver (eg, due to acute hepatitis C infection, due to acetaminophen toxicity) |
| Elevated PT/INR | **Coagulopathy—specify type/cause** | Specify type and cause of coagulopathy (eg, due to liver disease) |
| Elevated lactate | **Lactic acidosis** |  |
| Varices | **Specify anatomical location and with or without bleeding (esophagus, gastric, splenic)** | If GI bleed, make sure to link to the suspected source |
| AMS | **Encephalopathy with cause (eg, hepatic, toxic, anoxic), with or without coma** | If GCS given, specify each score: Eye, Verbal, Motor |
| Severe sepsis | **Sepsis due to—specify source****Document associated organ failure/dysfunction**  | Do not use “urosepsis”, rather “severe sepsis due to urinary tract infection complicated by acute kidney injury” |
| “Concern for”“Evidence of”“Empirically treated”“Risk for” | **“Probable”****“Likely”** |  |
| Pneumonia | **Etiology of pneumonia (eg, aspiration pneumonia, bacterial pneumonia, viral pneumonia)** |  |
| Chest pain | **Cause of chest pain when known (eg, MI, GERD, CAD)** |  |
| Na of 125 | **Hyponatremia** |  |
| Low Hgb/Hct | **Anemia** | Specify reason if known (eg, acute blood loss anemia, iron deficiency anemia, anemia of chronic disease due to ESRD, etc.) |
| AKI | **Indicate injury or insufficiency** | Specify reason if known (eg, acute kidney injury due to ATN) |
| Respiratory distress | **Acute or chronic; hypoxic or hypercapnic respiratory failure** | Specify whether or not on home O2 |
| CHF | **Acute, acute on chronic, or chronic; HFpEF or HFrEF** |  |
| CKD | **Stage I, stage II, stage III, stage IV, stage V/ESRD, if known** |  |
| Malnutrition | **Mild, moderate, or severe; protein‑calorie malnutrition** |  |
| Altered mental status | **Delirium, dementia, coma, or encephalopathy** |  |
| Anemia | **Acute blood loss anemia, pancytopenia 2/2 chemo anemia, anemia of chronic diseases, aplastic anemia 2/2 chemo, aplastic anemia, iron deficiency anemia** |  |
| Midline shift | **Cerebral edema** |  |
| DVT/PE | **Acute, chronic, or history of** |  |
| Debridement | **Excisional or non-excisional; include deepest layer of tissue debrided** |  |
| Overweight/obesity orUnderweight/weight loss | **Document Body Mass Index (BMI)** |  |
| Abdominal pain; nausea and vomiting | **Specify probable or known cause** |  |
| Syncope | **Specify probable or known cause** |  |
| Skin ulcers | **Document site, type, and stage** |  |

**Additional Tips:**

All diagnoses and conditions should be documented as to whether they are present on admission. Close attention should be paid to infections, infected lines, PE/DVT, decubitus ulcers, and traumatic injuries.

Document all secondary diagnoses if they meet one of the following criteria

* Clinically evaluated
* Diagnostically tested
* Therapeutically tested
* Case an increase in length of stay or nursing care

Document an associated diagnosis for any treatment provided during the current stay:

* Transfuse blood: Are you treating an anemia?
* IVFs: Are you treating dehydration/hypovolemic shock?
* Antibiotic Rx: Are you treating a pneumonia, UTI, or abscess?

Lab and test results alone do not equal a reportable diagnosis:

* Na-125 cannot be coded as hyponatremia
* Low Hgb/Hct cannot be coded as anemia
* Diagnoses found on labs/radiology/pathology reports cannot be coded as a secondary diagnosis

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