Clinical documentation is required to meet compliance with Medicare and other regulatory standards, for accurate coding, and to reflect the overall severity/acuity of illness and risk of mortality. Below are some important key elements to keep in mind when documenting the diagnosis of pneumonia.

**Documentation to Support Pneumonia Diagnosis**

A physician must determine the diagnosis of pneumonia and document the specific cause of the pneumonia (if known). If the specific clinical information is not documented in the medical record, the HIM Coding Staff and/or Clinical Documentation Improvement Specialist shall seek clarification or “query” the physician. When completing the required documentation for pneumonia, it is important to note the clinical findings substantiating pneumonia, including the results of the chest x-ray, sputum culture, white blood cell count, and temperature of the patient, etc.

**Aspiration Pneumonia**

When treating a patient with a diagnosis of aspiration pneumonia, it is necessary for the clinical documentation to substantiate a diagnosis of pneumonia and not just “aspiration.” It is necessary for the physician to link the term “aspiration pneumonia” to any causative organisms, such as “Staphylococcus pneumonia” and/or a precursor (causal) event (i.e. choking, coughing, dysphagia, vomiting), which may have contributed to the aspiration pneumonia. For example, “Aspiration pneumonia due to *staphylococcus*”.

**Candidal Pneumonia**

When documenting a patient with candidal pneumonia, include in the documentation the clinical significance in regards to the treatment (e.g., Diflucan) for the patient. Sometimes this requires a positive culture finding. The physician must document the relationship of a candidal pneumonia diagnosis to a positive or negative sputum culture for yeast (e.g., “sputum positive and consistent with candidal pneumonia”).

**Lobar pneumonia**

Lobar pneumonia is a synonym for pneumococcal pneumonia.

Reference: Merck Manual and AHA Coding Clinic
always write what's right!

Pneumonia Due To More Than One Organism

If the physician states the pneumonia is due to more than one organism and the organisms are identified, each type of pneumonia should be specifically documented and linked to the causative organism to reflect the severity of the patient. For example, “pneumonia due to pseudomonas”.

Pneumonia Due To ‘Other Specified Bacteria’ Or ‘Unspecified Bacteria’

Pneumonia (due to other specified bacteria) should have documentation that specifies the other organism cultured. The diagnosis of “bacterial pneumonia” cannot be collected solely on the basis of a gram stain. A sputum gram stain finding of gram-positive cocci is not necessarily indicative of a bacterial pathogen and should be further specified by the physician if clinically significant. If the physician documents that the patient has a bacterial pneumonia without further specification, “bacterial pneumonia, unspecified” will be assigned as the diagnosis for that case. If known, the physician should always specify the etiology or organism responsible for the pneumonia (e.g., Ecoli pneumonia).

Postobstructive Pneumonia

Postobstructive pneumonia is classified as “pneumonia, organism unspecified”, when no cause is documented by the physician. If a causative organism of the pneumonia is identified and documented, then the more specific pneumonia code will be assigned. The postobstructive process (i.e. tumor, foreign body, etc.) must also be documented and coded, if known.

Streptococcal Pneumoniae Pneumonia

Streptococcal pneumoniae pneumonia was formerly known as Diplococcus pneumonia in ICD-9-CM data collection. It is referred to as pneumococcus. Streptococcal pneumoniae is the most common cause of community acquired pneumonia (CAP).

Thank you for your attention to this important subject. If you need or would like additional education or inservicing relating to clinical documentation, compliance and/or coding, please contact your hospital HIM Department, Clinical Documentation Improvement staff, Case Mgmt. or the CHW Corporate Coding HIM Compliance Department at (415) 438-5721.

Diagnostic data collection is based solely upon physician documentation. Your clinical documentation illustrates the level of care that we all provide our patient population and is the reflection of our clinical quality and the resulting clinical outcomes.