DOCUMENTATION AND DRG’S
A Physician’s Guide

- How DRG’s work
- How they affect you
- How you affect them
- What you should document in order to assure the most appropriate DRG for your patient:
  a) Generally
  b) Specifically
**TABLE OF CONTENTS**

- **DRG OVERVIEW**........................................................................................................4
- **HOW DO DRG’S WORK, HOW DO WE USE THEM?**............................................5
- **WHAT AFFECTS THE DRG?**................................................................................6
- **DEFINITIONS**..........................................................................................................7
- **PRINCIPAL DIAGNOSIS**
  - Specific documentation needs common to all principal diagnoses ..................8
- **SECONDARY DIAGNOSES**
  - Specific documentation needs common to all secondary diagnoses..............9, 10
- **LIST** complications and co-morbidities that can affect a DRG ....................11
- **PROCEDURES** documentation needs specific to all procedures .................12
- **SEVERITY-ADJUSTED DRG’S**...........................................................................13, 14
- **SPECIFIC DOCUMENTATION NEEDS**...............................................................15
- **COPD**....................................................................................................................16
- **PNEUMONIA**.........................................................................................................17
- **RESPIRATORY FAILURE**.....................................................................................18
- **U.T.I. and UROSEPSIS**.......................................................................................19
- **HYPERTENSION**....................................................................................................20
- **RENAL FAILURE**..................................................................................................21
- **DIABETES**............................................................................................................22
- **CARDIAC CONDITIONS**....................................................................................23
- **CVA OR TIA**..........................................................................................................24
- **OCCLUSION OF BLOOD VESSEL**......................................................................25
- **HIV INFECTION**...................................................................................................26
- **CANCER**...............................................................................................................27
- **OBSTETRICS**.........................................................................................................28
- **NEONATES**............................................................................................................29
- **FEVER**...................................................................................................................30
- **CHEST PAIN**.........................................................................................................31
- **POSITIVE CULTURES, ABNORMAL LABS**..........................................................32
- **STEREOTACTIC SURGERY**................................................................................33
- **DEBRIDEMENT**......................................................................................................34
- **POST-OPERATIVE ADEMISSION**......................................................................35
- **LYMPH NODE PROCEDURES**............................................................................36
Basic information on DRG’s:
What they are and how they work

General documentation needs to assure the appropriate DRG for your patient
DRG’s: How do they work? How do we use them?

- DRG’s GROUP PATIENTS WITH SIMILAR RESOURCE CONSUMPTION AND LENGTH-OF-STAY PATTERNS.

- THERE ARE over 500 DRG’s AVAILABLE.

- Next year some DRGs will be split into 4 levels (APR-DRGs).

- EACH DRG HAS A “RELATIVE WEIGHT”: the higher the relative weight, the greater the severity, to reflect the appropriate reimbursement to the hospital for each admission that has a DRG-based payer like Medicare. (and in some states, Medicaid, Blue Cross, and others)

- DRG’s ESTABLISH OUR CASE MIX INDEX. (An average of the relative weights of all of the hospital admissions). This is in turn is in indicator of the severity/complexity of patient population.

- DRG’s ARE USED FOR: determining hospital reimbursement, budgeting, managed care contracts, national and state quality of care reporting, physician profiling, case management, residency program justification, and more.
What affects the DRG assigned for your patient?

- **PRINCIPAL DIAGNOSIS**-think specificity
- **SECONDARY DIAGNOSES** – document diagnoses; not signs or symptoms
- **COMPLICATIONS**-think details
- **CO-MORBIDITIES**-think, thinking out loud
- **PRINCIPAL PROCEDURE**
- **AGE OF PATIENT**
- **SEX OF PATIENT**
- **DISCHARGE DISPOSITION**
CODING DEFINITIONS

- **Principal Diagnosis**: The condition, established after study, to be chiefly responsible for causing the admission of the patient to the hospital.

- **Complication**: A condition that arises during the hospital stay that prolongs or could potentially prolong the length of stay by at least one day.

- **Co-morbidity**: Pre-existing condition that, because of its presence with a specific diagnosis, causes or could potentially cause an increase in the length of stay by at least one day.

- **Principal Procedure**: A procedure performed for definitive treatment rather than for exploratory or diagnostic purposes, or that was necessary to treat a complication. The principal procedure is *usually* related to the principal diagnosis.
PRINCIPAL DIAGNOSIS:
What documentation is needed?

- **BE SPECIFIC!**

- **ADMITTED FOR MORE THAN ONE REASON?** (CHF and COPD; metastatic workup and chemotherapy)

- **ACUTE vs. CHRONIC?** (respiratory failure in an asthma patient; fluid overload in an ESRD patient; ARF in a patient with chronic renal insufficiency)

- **UNDERLYING CAUSE?** (Chest pain *due* to C.A.D., or osteomyelitis *due* to diabetic foot ulcer)

- **UNCONFIRMED DIAGNOSIS AT DISCHARGE?** When a condition is “Probable”, “possible”, or treated as if it exists: write exactly that. Examples: “fever, *probably due* to viral respiratory infection” or “*clinical sepsis, treated not ruled out*”
SECONDARY DIAGNOSES: What documentation is needed?

- **Document all diagnoses** that, on this admission, require: clinical evaluation, therapeutic treatment, diagnostic procedures, an extended hospital stay, or increased nursing care and/or monitoring.

- **Chronic Conditions**: list all current problems receiving care. (DM, CHF, AFib, COPD, HTN, ESRD, and so forth)

- **Giving Meds**? List the diagnosis associated with each medication. (e.g. "Lasix, xx/qd for control of CHF")

- **Ordering Lab Tests**? When you know or suspect a diagnosis associated with the problem, please document in the patient records. ("Urinalysis for suspected U.T.I." or "Sputum culture for probable gram negative pneumonia")

- **Ordering X-rays**? What do you suspect as a diagnosis? (e.g. "suspected pneumonia", "rule out aspiration", "probable CHF", etc.)

- **Positive Lab Results**? What do they mean? (e.g. low H & H...is this anemia or dehydration or neither? Elevated creatinine.....renal insufficiency? Urinary obstruction Positive urine rbc's....UTI? Kidney Stone? Hematuria?)

- **Heads Up**: As of October 2007, a **Present on Admission (POA)** indicator will be required to be reported for each secondary diagnosis. The purpose of the POA indicator is to identify which diagnoses were not present on admission to determine if these diagnoses were potentially preventable complications that occurred during the hospital stay. If secondaries are not appropriately documented when they are POA then we may not be able to code them as CC’s which will cause a lower weighted DRG assignment.
POA documentation tips:
  o Conditions that develop while the patient is in the ED, prior to admission, and during outpatient observation are considered Present on Admission.
  o Conditions suspected at the time of admission and subsequently confirmed during the hospitalization are considered Present on Admission.
  o Conditions that were clearly present, but not diagnosed, until after admission can be considered Present on Admission. E.g., a skin lesion is documented on admission and later diagnosed as malignant melanoma.

Present on Admission is defined as present at the time the order for inpatient admission occurs.

So, remember to document all secondary diagnoses and indicate if they were Present on Admission.
COMPLICATIONS AND COMOMORBIDITIES:

Documentation of the following diagnoses can increase the severity of illness, risk of mortality, and justify resources utilized for your patient.

Some examples, as the list is much longer:

- Diabetes: if documented as uncontrolled or insulin dependent
- COPD, emphysema
- Decubitus ulcer
- Angina
- Anemia due to blood loss
- Respiratory Failure
- Urinary Tract Infection
- Congestive Heart Failure
- Chronic or Acute Renal Failure
- Malnutrition
- Hyperkalemia, Hypernatremia
- Dehydration
- Pleural Effusion
- Pneumonia
- Hyponatremia, Hypovolemia
- Volume Overload
- Post-op complications: infection, graft failure, dehiscence, atelectasis, wound seroma or hematoma, ileus, urine retention
- Thrombocytopenia, coagulopathy
- Hematuria
- Atrial fib, flutter, heart blocks
- Drug/Alcohol-induced mental disorders
- Cirrhosis
- Seizure Disorder
SURGERIES AND PROCEDURES:
MAKE CERTAIN TO BE SPECIFIC, COMPLETE, AND LEGIBLE!

- Document who, what, when and how, and how much.
- What was the tissue? How did you get it? (e.g.: Lung bx. Or only bronchus bx.? Did you do a scope, open, or closed procedure? Did you incise, excise, cauterize, or laser ablate? Skin excision only or also muscle/fascia/soft tissue?)
- “I&D” – is this “incision and drainage”, or “incision and debridement”? Or do you mean “excisional debridement”? Or all of the above?
- Be as specific as possible: it determines intensity of service as well as reimbursement for both physician’s and hospital billing.
- List the Attending M.D. and resident legibly to assure that you receive credit for performing the procedure.
“SEVERITY-ADJUSTED” DRG’S

- Determined by secondary diagnoses
- Indicate how sick your patients really are
- Justify greater resource consumption
- Improve your “physician profile”
APR-DRG’s: determine severity of illness/risk of mortality

385 Severity Adjusted DRG’s as compared to 579 CMS DRG’s for reimbursement

Each APR-DRG is split into 2 groups, with 4 grades of severity in each group

<table>
<thead>
<tr>
<th>Severity of Illness</th>
<th>Risk of Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Mild</td>
<td>1 Mild</td>
</tr>
<tr>
<td>2 Moderate</td>
<td>2 Moderate</td>
</tr>
<tr>
<td>3 Severe</td>
<td>3 Severe</td>
</tr>
<tr>
<td>4 Extreme</td>
<td>4 Extreme</td>
</tr>
</tbody>
</table>
Specific documentation needs

- Common diseases and disease processes; specific documentation needs for each.

- Symptoms that may be assigned to more appropriate DRG’s with more specific documentation. This is a principal diagnosis shift.

- Procedures that may have technical documentation requirements to assure the appropriate DRG and justify resource consumption.
COPD: asthma, emphysema, bronchitis

- Acute Exacerbation…what is it?
- Respiratory failure, status asthmaticus, bleb, pneumonia?
- If pneumonia… is it bacterial? Which bug? (staph, gram neg rod, voice your suspicion-NH acquired, possible pseudomonas, etc.) Viral? Is it aspiration pneumonia, interstitial pneumonia?
- Are there other contributing pathologies? (e.g. pleural effusion, congestive heart failure, volume overload, congenital problems, or chronic diseases like fibrosis or T.B.)
- Specify: acute, chronic, Acute-on-chronic when they apply. COPD vrs interstitial lung dx vs asthmas matters, be specific, mention etiology.
PNEUMONIA

- ALWAYS document the suspected cause. (e.g. “Pneumonia due to HIV infection”, “interstitial pneumonia”, “probable Pseudomonas Pneumonia”, “Pneumonia likely due to Staph.”) Remember that sputum cultures may well be negative if the patient was on outpatient antibiotics.

- Different organism and different etiologies can result in different DRG’s, severity of illness, risk of mortality, and hospital resources consumed.

- Unlike outpatient billing, inpatient accounts reimburse for “suspected, probable, possible” diagnoses based on resources used.

- If a problem is treated presumptively, it is coded unless it has been ruled out, and reimbursed accordingly. (e.g. “pneumonia suspected due to gram negative organism” in a patient who has failed outpatient abx., or “suspected aspiration pneumonia:” in a nursing home patient with confusion and/or dysphagia and aspiration problems from an old CVA).
RESPIRATORY FAILURE

• What caused the respiratory failure? This can determine your final DRG! (e.g. “respiratory failure due to acute exacerbation of COPD”, “respiratory failure due to CHF”, or “respiratory failure due to CHF and pneumonia”).

• The patient need not be on a ventilator; your diagnosis can be based on medical criteria including respiratory rate and arterial blood gases.

• “Arrest” is not synonymous with “Failure” for coding and DRG assignment. Is the “cardiorespiratory arrest” actually “respiratory failure” and “cardiac arrest”?

• There is no way to code, or to assign a DRG, for “Multi-Organ System Failure”… each organ system must be listed separately.
U.T.I. and ‘UROSEPSIS’

- The diagnosis of “Urosepsis” is coded and reimbursed the same as is a “U.T.I.” … it is considered to be an unspecified infection of ONLY the urinary system.

- “Septicemia and (or due to) a U.T.I.” should be documented as separate diagnoses. This greatly affects severity of illness, risk of mortality, and can affect hospital reimbursement as well.

- “Clinical sepsis” in your patient with other signs and symptoms of sepsis should always be documented, even in the absence of positive blood cultures.

- Also document related complications that may arise: urine retention, ARF, pyelonephritis, and the like.
HYPERTENSION

- Is this benign or malignant hypertension?
- “Uncontrolled” does not designate malignant hypertension.
- Which of the patient’s systems/systems does the hypertension affect?
  - (Hypertensive Renal Disease,
    - Hypertensive Heart Disease,
    - Hypertensive Encephalopathy)
- What caused the hypertension? (e.g. renal artery stenosis, PCKD, chronic pyelonephritis, hyperthyroidism)
RENAL FAILURE

- What caused the renal failure? (e.g. diabetes, hypertension, SLE, PCKD, radio-opaque dye, other?)

- Is this Acute, Chronic, or Acute and Chronic failure?

- What does “near-ESRD” mean to you? It will be coded as “renal insufficiency” unless you further specify.

- If your transplant patient is admitted, is it due to a complication of the transplant?

- What is that complication…ATN, CMV, ARF, rejection, infection, other?

- Remember to document related diagnoses if you treat, evaluate or monitor them, or if they extend the hospital stay. Include volume overload, electrolyte imbalances, urine retention, and the like.

Azotemia that is likely reversible, such as volume depletion can be ARF.
Is this type 1 (insulin deficient) or type 2 (insulin resistant)?

Is the diabetes “uncontrolled” or does it have “poor control” on this admission?

“Insulin-controlled” or “currently insulin-requiring” do not mean “insulin-dependent” for coding or DRG assignment.

Adult-onset diabetes can still be “insulin-dependent” if it is now a permanent requirement for treatment.

Is this patient’s cellulitis/foot ulcer/osteo/ESRD/etc. due to the diabetes?

Even more critical: is it due to Diabetic neuropathy? Diabetic PVD? Diabetic nephropathy or cardiomyopathy?

ALWAYS document the above conditions when they apply!!
Secondary diagnoses that are cardiovascular in origin can have significant impact on severity, mortality risk, and reimbursement issues.

Always document the conditions on the list to the right if they are treated, evaluated, monitored, or if they increase hospital stay or nursing care/monitoring.

- Hypertensive heart disease
- Post-myocardial infarction syndrome
- Septal thrombus…is this Acute or Chronic?
- Cardiomyopathies…be specific! Cause?
- Cardiogenic shock, shock not due to trauma
- V-tach, PSVT, A-fib, A-flutter, V-fiv or V-flutter
- Congestive Heart Failure, Acute Cor Pulmonale
- Angina- stable, unstable, prinzmetal?
- Asystole, Cardiac arrest, Heart blocks (Mobitz, A.V., Trifascicular…be specific!)
- Acute Renal Failure
- Pulmonary embolus or infarction
- Myocarditis, Endocarditis
- Valve disorders – prolapse, insufficiency, regurgitation
CVA OR TIA

- Is this due to (or probably due to) an infarct? Thrombus? Embolism? Hemorrhage?
- Is it (probably?) due to cerebral atherosclerosis, stenosis or insufficiency?
- Do you know (or suspect) a specific site of the obstruction? (e.g. cerebral artery; pre-cerebral or carotid artery)
- If the “TIA” symptoms last more than 72 hours, is this really a CVA?
- Always document residuals still present at discharge.
ARterial or VENous 
OCRCLUSION

- What do you suspect is causing the occlusion?
- Thrombus?
- Atherosclerosis or plaque?
- Stricture or stenosis?
- External compression (e.g. tumor or lymphadenopathy)?
- Diabetic vascular disease?
• Is the reason for admission caused by the HIV infection? (e.g. “fever probably due to HIV” or “recurrent community-acquired pneumonia due to HIV”)

• Please list at least one time all coexisting problems being treated, evaluated, monitored, or extending the hospital stay. (e.g. candidiasis, PCP, cryptococcosis, dehydration, diabetes, etc.)

• Please document the current T-cell or CD4 count if known.

• List once each admission, the primary site and all current metastatic sites being addressed on this admission. Be specific…use “mets, to bladder, colon and liver (or applicable sites)”, NOT “abdominal mets.”!

• Is the cause of the symptoms at admission known or suspected? (e.g. “urine retention due to bladder cancer at UVJ” or “urine retention probably due to external compression from peritoneal mets.”)

• Remember to document all secondary conditions being treated or monitored. Include CHF, COPD, AODM, anemia (blood loss?), electrolyte imbalances, infections, coagulopathies, and so forth.

(BTW-Our current data suggest an increased mortality in our cancer patients and this could be influenced by a lack of secondary diagnoses permitting appropriate risk stratifications.)
• What is the ACUTE reasons for admission…preeclampsia? Gestational diabetes? Preterm labor? Dehydration?

• Is the reasons for admission unrelated to the pregnancy? (e.g.: “patient with broken ankle for ORIF, 18 wk. incidental pregnancy” or “patient with second degree burns to ankle, 22 wk. pregnancy unaffected by injury.”)

• Specify when diagnoses have their origin in the postpartum period. (e.g. “postpartum uterine atony” or “postpartum” fever) These are coded, and reimbursed, differently than if they are not specified as ante- or post-partum.

• Did your patient have insufficient prenatal care? Is she a high-risk patient?

• Document all diagnoses that you monitor/evaluate/treat. (e.g. endometritis, venereal diseases, preeclampsia, all anemias, UTI, other infections, placenta problems (retained, abruptio, etc.), diabetes and hypertension (gestational or chronic?). What is the diagnosis for “+ GBBS” or “+ WBC’s in urine”?

• Document post-operative problems as well. (e.g. wound dehiscence, hematoma, seroma, or infection; spinal headache, ileus or atelectasis)
• Is the infant Preterm? Is this *Extreme* Prematurity?

• If baby has respiratory problems, *specify* whether they are due to: HMD, RDS, TTN, apnea (of prematurity?), meconium aspiration syndrome, pneumonia, pneumothorax, anemia, hypoplastic lung, and so forth. Document all that apply.

• Is the baby hypoglycemic? Hypovolemic? ("hypoperfusion" cannot be coded-please specify further if possible) Hypocalcemic? Other transient electrolyte imbalances?

• Why are you “ruling-out sepsis”? Maternal chorio? Symptomatic baby? *Did you rule it out?* If not, document as “clinical sepsis” if you continue to treat it as such even in the absence of positive blood cultures. If it isn’t sepsis, document what you believe to have caused the baby’s symptoms instead.

• Do feeding problems extend the hospital stay? Does any other diagnosis extend the stay?

• Are maternal drugs or meds. Affecting the infant? How?

• Are there any cogenital infections, or *suspected* infections? Be specific… pneumonia, conjunctivitis viral syndrome, etc.

• Heart murmur… insignificant or functional? Probable PDA? OR does it need follow-up because it is still undiagnosed at discharge?

• Conditions having “implications for future healthcare needs” in *newborns only* must also be coded.
• Is the cause of the fever known, or suspected, at discharge? If so, please be sure to specify in your discharge progress note and discharge summary. For example: “Fever, probably due to subacute bacterial infection” or “Fever, suspect due to viral syndrome”… or to gastroenteritis, or influenza, or to the diagnosis that, in your medical opinion, is its most likely cause of fever in this patient.

• Was the suspected cause ruled-in, ruled-out, or still suspected at discharge? For example: “Patient admitted to rule out sepsis. Cultures negative at 36 hours; sepsis ruled out. Fever probably due to chronic sinusitis and viral URI.”

• “Suspected, not ruled out” is coded as if it exists in an inpatient setting, because it consumes resources as if it does exist.

• In the event that a particular cause is not “known or suspected” at discharge, it is acceptable to use a differential list in addition to the diagnosis of fever.

• In a patient admitted for “neutropenic fever”, are you actually admitting the patient to treat a “suspected bacterial infection”?

• Accurate information results in accurate severity-of-illness indicators, and can also increase hospital reimbursement.
• At discharge, state clearly in the record what you believe, or suspect, to have caused the patient’s chest pain.

• Was it (probably?) due to angina? Unstable angina?

• If so, what caused the angina? An M.I.? If not, is it due to underlying C.A.D.? If your patient has minimal or no C.A.D., do you instead suspect the anginal pain to be caused by anemia? Vasospasm? Hypertension?

• ASC (acute coronary syndrome) for coding purpose codes to Unstable Angina. If a patient’s chest pain is not due to CAD, please indicate the cause of the chest pain (GERD, musculoskeletal, esophageal spasm, etc)

• If the chest pain is probably not due to angina, is it still cardiac in origin? A small non-q wave M.I. as evidenced by Troponin I results? Alcoholic cardiomyopathy? Chronic ischemic heart disease? Some type of arrhythmia?

• If the chest pain is of non-cardiac origin, what is, in your opinion, the probable cause? G.E.R.D.? Hiatal hernia? Dyspepsia? Peptic ulcer disease? Costochondritis? Musculoskeletal strain? Psychogenic chest pain or psychogenic angina?

• Remember: document as the diagnostician that you are… and state the PROBABLE CAUSE of the chest pain for which the patient was admitted.
• In order for the DRG assignment to reflect the appropriate severity of illness of your patient, there must be an associated DIAGNOSIS, documented by a physician, in this admission of the medical record.

• “+ GBBS”… Is this an infection? Of what site? Is this a colonization? Is it suspected to be a contaminant only?

• “++ wbc’s, ++ rbc’s & bacteria in urine”… Is this a U.T.I.? An infection due to indwelling Foley catheter? A kidney stone? Other? Neither?

• “++ Hep B/C”… Is this a current infection? If so, is it “Active” or “in Remission”? Are you treating, monitoring, or evaluating it in some manner on this admission? Or is it only a “history of” or “exposure to” Hepatitis?

• “PIH with proteinuria”… please document as “preeclampsia” if this is actually the condition that you’re treating.

• A “down-arrow” or an “up-arrow” is not a diagnosis with Na or K values… it merely designates an abnormal lab value. If you mean clinical Hyponatremia or Hyperkalemia, please document as such. The same applies to hematocrits as well as to other laboratory results in general.
STEREOTACTIC SURGERY

- Is this **radiosurgery**?
- Is it a “closed” procedure? (burr hole access only)
- Is it electrocautery? Excision? Destruction by laser?
- If this is an excision, is a **total** excision of the lesion in question, or is it a **partial** (debulking) excision only?
- Is this a **biopsy only**, rather than an excision of the lesion itself?
• What are you debriding… skin/subcutaneous tissue? Fascia? Muscle? Bone? All of the above?

• Is this a debridement of an open fracture?

• Is this SHARP or EXCISIONAL debridement?

• To affect DRG assignment as a procedure, the debridement of skin and subcutaneous tissue must be (a) done by a physician, and (b) documented as excisional or sharp debridement in a procedure note. (Need not be done in the O.R.)
POST-OPERATIVE ADMISSION

- ALWAYS document why you converted an outpatient procedure or surgery to an inpatient admission.

- Was the patient admitted as an inpatient for post-op urine retention? FEVER? Atelectasis? Nausea/vomiting due to meds? Arrhythmia? Other problem unrelated to surgery? (e.g. diabetes or hypertension control)

- Was the inpatient admission for surgical aftercare only? (e.g. pain control, uncomplicated anesthesia recovery)

- Do not use “Status post surgery” as a reason to admit from day surgery or outpatient observation. Be specific.

- Would it be more appropriate to assign to 23-hour observation, and then reevaluate the need for admission?
When you write your procedure note, specify clearly the particulars.

Is this a simple node biopsy?

Is it a simple node excision?

Is it a “radical” (neck or other) dissection?

Is it a regional excision? (With node, skin, subcutaneous tissue and fat)

If this is excisional, are you also taking muscle? Fascia? Omentum? Other?

Procedure variations can affect both severity and reimbursement indicators…always be as specific as possible!

Examples of common communication gaps:

<table>
<thead>
<tr>
<th>Unable to code</th>
<th>Acceptable to code</th>
</tr>
</thead>
<tbody>
<tr>
<td>LUL infiltrate</td>
<td>LUL pneumonia</td>
</tr>
<tr>
<td>HBG 5.2, transfused</td>
<td>Acute or Chronic blood loss anemia</td>
</tr>
<tr>
<td>Emaciated, total protein/albumin low, nutritional supplements started</td>
<td>Malnutrition</td>
</tr>
<tr>
<td>ABG 7.22/68/44, will treat accordingly</td>
<td>Respiratory failure, acidosis, alkalosis etc</td>
</tr>
<tr>
<td>Will rehydrate pt</td>
<td>dehydraton</td>
</tr>
<tr>
<td>Bp 70/40 on dopamine for support</td>
<td>shock</td>
</tr>
<tr>
<td>Cardiac enz elevated, ekg positive</td>
<td>Acute MI</td>
</tr>
<tr>
<td>No overt CHF, will continue lasix and dig</td>
<td>Compensated chf</td>
</tr>
<tr>
<td>Unable to void, I/O yielded 600cc</td>
<td>Urinary retention</td>
</tr>
<tr>
<td>Sputum with G- rods, will start rocephin</td>
<td>Questionable gram negative pneumonia</td>
</tr>
</tbody>
</table>