JATA

Documentation Tips – Surgery/Trauma

<u>Medical Necessity</u>: "<u>ADMIT" Note</u> should Detail the following:

- **Major Procedure(s)** [to be] done to specific **Organs/Body Areas**
- **Clinical Indication** (i.e. Diagnosis – NOT Symptom) for Procedure (If Needed: Use "probable, likely, suspected" (NOT"Rule Out")
- **Etiology** (If Known), relevant Clinical Findings/Past Med./Surg. Hx,
- "If pt. Not admitted, Pt. at risk for [List potential bad outcomes]" Due to Risk Factors + Co-Morbid Conditions + Past Surg. Problems

<u>[ALSO: "Place" Pt. in Observation--- if can't meet Admission Criteria]</u>

<u>1st Progress Note</u>: Problem List = ALL Acute + <u>Chronic</u> Co-morbidities (even if just continuing home meds); ALSO list Dxs in <u>DC Summary;</u>

- <u>NOTE: List all Medical Dxs ALSO, even if managed by Medical Team</u>

<u>Pearls for Admit Note / First Progress Note:</u>

- Note any Dx that makes Pt. higher risk for surgery/complications; Consult Anesthesia Notes and/or Medicine Consults to capture any **Present-on-Admission (POA) conditions**; Treat +/- Take Precautions.
- Note patient "Non-Compliance" or "Control Issues" w/ Medication e.g. Anti-Coagulation-Cardiac-Pulmonary-Diabetic-Renal Medication
- Note: Prior Probs. w/ Surgery, Anesthesia, Blood Transfus., Healing, Vent. Weaning, <u>Morbid Obesity</u> (incl. Wound Dehiscence/Infection), <u>Cachexia</u> / <u>Protein/Severe Malnutrition</u> (risk for fluid third-spacing),
- Check Need: DVT prophylaxis, Press. Ulcer Treatment/Precautions,
- **Utilize medical consults where appropriate to improve specificity of diagnoses, but document all diagnoses in *your* note as well….**

<u>Operative Notes / Procedure Notes</u>

- <u>Describe all components of a procedure</u> even if "routine,"--- Documenting all components may sometimes add "complexity" *(which may benefit your professional billing as well)*
- Document a Diagnosis/Indication--- even for Minor Procedures *(e.g. straight catheterization – for acute urinary retention)*

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Radiology Reports / Pathology Reports *(Coders do Not Read them)*

- If a radiology or pathology report specifies a Clinical Diagnosis---NOTE the Diagnosis in YOUR Progress Note (citing the Report)

Pearls for Surgical Documentation

- Document *"Adhesiolysis"* if performed in conjunction with another procedure, e.g., recurrent ventral hernia w/repair
- Document "*Peritonitis*", when present (MCC)
- Document "*Sepsis*" (defined as SIRS due to an infection) when present (MCC) [may even change PDx if present on admission]
- Document *"Excisional"* debridement, rather than "sharp," etc.
  - Describe extent, depth of procedure, and viable margins
- Avoid Term, *"Congestive Heart Failure/CHF"*- Adds No Severity
  - Use *"Chronic systolic, diastolic* or *combined* heart failure" = CC
  - Use "*Acute systolic, diastolic* or *combined* heart failure" = MCC
- Avoid Term, "Altered Mental Status"
  - Identify/Document/Treat a defined "Encephalopathy" [Toxic(Meds), Septic, Hepatic, Hypoxic, Hypoglycemic, Ischemic, Hyper/Hypotensive, Hyper/Hypo [Ca+/Na+], Hypo-Mg+/Phos+]

Conditions Arising During Hospitalization:

- Clearly describe your "**clinical impression**" of new hosp. conditions; Co-Morbidity = Anticipated/Expected Condition due to documented underlying illness/injury –or– an Expected Risk of the Procedure; Complication of Care = Unanticipated/Unexpected Condition or Event occurring Outside of the expected post-op clinical course

  E.g. "Acute Blood Loss Anemia (CC), expected, secondary to an underlying (condition) and/or the procedure itself…"

- ALERT: The term, ["Post-Op" may trigger "complication" coding---Explain etiologies (e.g. *exacerbation of essential hypertension (CC) vs.* the term *post-op hypertension*, which codes as a complication…)

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