General Surgery Documentation Tips

- Note all known "present on admission" diagnoses in the H&P or pre-op note/ Consult
- A Valid Secondary Diagnosis is one which is being monitored, evaluated, treated, utilizes resources, prolongs the expected stay, or requires diagnostic procedures

Post Surgical Conditions

- Do NOT use the words, "post-operative" unless to indicate which day it is following surgery. This term allows a complication code to be assigned to the surgeon without further clarification by the surgeon
  If there is a complication in a case, the surgeon should be the one to determine if that is so!
- Be aware that the "complications" section of your operative note may be coded as such. Occurrences which are not complications should be noted under " findings" and circumstances which made the case more difficult to perform should also be noted under "findings"

Anemia

- Is it a valid secondary diagnosis?
- Note when it is due to Acute blood loss
- Note when it occurs as an expected outcome of the surgery or injury/ disease **OR** when it is a complication
- Note when it was POA/ present before surgery, and the cause, if known
- Note if there is a chronic anemia and what it is due to

Atelectasis—Is it a valid secondary diagnosis? Was it present on admission? Is it a true complication?

Urinary Retention/ Malnutrition— Same as above

Ileus: Use this term when bowel recovery has not occurred within the expected timeframe and requires additional efforts, which makes it a valid secondary diagnosis. Is it a complication? Was it POA?

Acute Respiratory Failure—If ARF was not POA, note in the post-operative period if d/t the surgery, is 'expected' or a 'complication', and/or if Chronic Respiratory Failure is present, such as might be d/t COPD, CLD d/t BPD, CF, etc. Don't call it AcuteRespFailure (or let anyone else call it that) if the patient has a pre-existing condition which requires 'prolonged ventilator management', i.e. COPD, CRespF, some transplant patients, or airway protection, and does not meet criteria for ARespF— it may be called a "complication"

Hypovolemia—caused by dehydration or blood loss? Valid secondary dx? shock present?(Hypovolemic or Hemorrhagic)

Surgical Conditions

Gallbladder/ Bile Duct Issues—Note w/wo calculus, w/wo obstruction, w/wo cholecystitis/ cholangitis (acute/ chronic?)

Pancreas Issues—Note pancreatitis (acute/chronic), due to, pseudocyst (acute/chronic), failed medical management, etc.

Hernia repair—Note location/name, laterality, w/wo obstruction, w/wo gangrene

Appendicitis—Note Acute or Chronic, generalized or localized peritonitis, w/wo perforation, w/wo abscess

Abdominal Pain—Note Acute/ tenderness/ rebound/ rigidity, — quadrant, epigastric, periumbilical

Skin wounds surgically treated— Note location, laterality,

- Present on Admission? size, depth, assoc. infection, etc.
- If Pressure Ulcer, note stage, if stageable

Lysis of Adhesions— Usually considered "part" of procedure; To document additional efforts of adhesiolysis:

- Note Obstruction present or not d/t adhesions
- Note when adhesions are the cause of pain or dysfunction
- Note when they prevent the surgeon from access to area of intended surgery
- Note when they require lysis before operation can proceed
- State extended amount of OR time required

Excisional Debridement

Important: The procedure note must include each of these:

- Removal of devitalized tissue by sharp dissection
- The instrument used: scalpel, scissors, etc.
- Excision to "viable margins"
- Note the lesion's dimensions
- Note the deepest layer of tissue which was removed

If this was done in the ER, OR, bedside, etc. and the above information is not in the note, a "non-excisional" debridement will be what is coded— don't let this happen!

Bowel Resection— Name the location and the disease process that made the procedure necessary: Obstruction, Volvulus, Abscess, Intussusception (what into what?), Fistula, Acute Vascular Insufficiency, Perforation, IBD, Congenital functional disorders, etc.

- Note specific part of bowel removed

GI Bleeding— Note hematemesis, hematochezia, melena "Rectal Bleeding" indicates a lesion in the rectum is bleeding. After study, indicate specifically what is the source of bleeding, if found, and link to anemia, if present, and state if felt to be an acute or chronic blood loss issue

Trauma Documentation

Note: Specific anatomic location of injury
Laterality and Dominant side, when applicable
Severity of injury
With or without LOC
With or without hemorrhage
With or without perforation
Traumatic vs. non-traumatic
Open vs. closed wound
Displaced vs. non-displaced
Associated injuries to other body parts
i.e. nerves, blood vessels, muscles, tendons
Extent of injury

Fractures

- Open vs. closed; Gustilo classification for open fractures
- Location and Laterality
  Displaced vs. non-displaced
  Laceration/contusions of internal organs
  Length/size of laceration

Brain Injury

- Traumatic
  Laterality
  Location (subarachnoid/ intracerebral/ subdural/ epideral)
  Acute vs. subacute vs. chronic
- Concussion
  With or without LOC
  Duration of loss of consciousness

Burns

Depth (first, second, third degree)
Extent: % of total body surface area
Agent (heat, electricity, chemical, radiation)

Shock— Type of shock—hemorrhagic, hypovolemic, cardiogenic, septic/SIRS

Spinal cord injury

Location injured, mechanism of injury
Type of injury (i.e. central or anterior cord syndrome, concussion and edema, transection)
Level of injury and degree (partial transection, complete)

Malignant Neoplasm—Note:

- Specific type, specific site
- Primary or metastatic
- Laterality, if appropriate
- Note if under treatment, post-resection/ chemo/ radiation, metastases and location of mets (be as specific as to site as possible)
- **Important:** Pathology reports cannot be used to code the specifics of any disease. The SURGEON/ attending must note these in order for severity to be captured. A "mass" that is resected is not malignant until the SURGEON states so. If not known at the time of the discharge summary, an addendum done after the d/c summary has been completed is required for complete and accurate documentation to provide appropriate Mortality/ Complication/LOS metrics.

Breast Disease— Note:

- Laterality
- Dysplasia
  - Cystic Disease— solitary/ diffuse
  - Fibroadenosis
  - Mammary duct ectasia
- Inflammatory Disease
  - Abcess (location)
  - Mastitis (acute/ subacute
- Gynecomastia
- Other disorders: Fissure/ fistula of nipple, atrophy, ptosis, hypoplasia, Mastodynia, Galactorrhea

ACS—"the Surgeon who is the Attending must be aware of all risk factors that add to the potential of an adverse outcome and must take into account all co-morbid conditions." Include these in your surgical notes at least once—it says you are aware!