Documentation Tips – General Surgery

Principal Diagnoses:

- A principal diagnosis (PDx) is the condition present on admission, requiring admission and treatment (may be more than one)
- Explain etiology where possible *(non-healing foot ulcer due to diabetic peripheral vascular disease)*

Secondary Diagnoses:

- Include *all* diagnoses present on admission which are in any way treated and/or monitored (re-exam, testing, meds, etc.)
  - This may be the only way to increase severity of illness
- Explain why the patient is at higher risk for surgery
- Utilize medical consults where appropriate to improve specificity of diagnoses, but document all diagnoses on *your* note as well

Conditions Arising During Hospitalization:

- Clearly describe your "**clinical impression**" as to whether the condition is expected/anticipated (e.g. due to an underlying illness and/or commonly occurring and therefore *not* a complication) *or* a complication of care (e.g. unanticipated and/or outside of the expected post-op clinical course)
  - *"Acute Blood Loss Anemia, expected, secondary to underlying (condition) and/or procedure"*
  - *Acute blood loss anemia* is a CC
- Consider documenting a diagnosis any time you do something procedurally to a patient (straight cath – *acute urinary retention;* CVC – hypovolemic shock)
- Beware of describing conditions in the post-op period as "post-op;" *post-op hypertension*, for example, codes as a complication – explain the etiology (e.g.*exacerbation of essential hypertension)*

Pearls for Surgical Documentation

- Describe Your "Clinical Impression" of diagnosis/etiology
  - Diagnoses are not always "certain"
  - You can use words like probable, likely, suspect, etc.
- Document "adhesiolysis" if performed in conjunction with another procedure, e.g., recurrent ventral hernia w/repair
- *Peritonitis* is an MCC
- *Sepsis* (defined as SIRS due to an infection) is an MCC, *or* may change the PDx if present on admission
- Document *severe malnutrition* – it not only adds severity as an MCC, it will likely prolong the post-op course thereby aligning the illness severity with length of stay
- Document "excisional" debridement, rather than "sharp," etc.
  - Higher RW MS-DRG, also a RAC audit target
  - Describe extent, depth of procedure, and viable margins
- Congestive Heart Failure
  - "CHF" no longer adds to severity
  - *Chronic systolic, diastolic* or *combined* heart failure adds severity via a minor comorbidity (CC)
  - *Acute systolic, diastolic* or *combined* heart failure adds severity via a *major* comorbidity (MCC)
  - Utilize your medical consultants for specificity
- Surgery
  - Describe *all* components of a surgical procedure even if "routine," as they sometimes add complexity (which may benefit your professional billing as well)
- X-ray Reports
  - If an x-ray report (routine chest film for example) demonstrates a clinical diagnosis, coders can't code from an "interpreting physician's report"
  - Document the condition in the progress notes
    - *e.g., Severe Interstitial Pulmonary Fibrosis*