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| Diagnosis/Procedure | PLEASE ALSO DOCUMENT |
| Adhesiolysis | Document the body part being released/freed. |
| Anemia | Acute/Chronic  Etiology-blood loss, disease process, drugs |
| Amputation | Specify: High (proximal portion), Mid (middle portion), or Low (distal portion) |
| Anastomosis | Document which specific part of the intestine is being anastomosed together |
| Biopsies | Indicate specific sites when multiple biopsies are performed. Avoid documentation of “multiple biopsies taken” or “done in the usual manner” |
| Colostomy | Indicate the “from”-descending colon |
| Complications | -Be sure to document fully and to clearly indicate intended or inherent vs accidental occurrences.  -If you believe an event is not routinely expected or is not inherent to the difficulty or nature of the procedure, explicitly document this in your op note so that the record accurately describes the patient’s condition and treatment and the complication can be properly coded, reported, and evaluated for future improvement opportunities.  --Document your surgical finding under the heading “Complications” and/or reference it as a complication in postoperative notes.  -Terms to indicate accident/complication: inadvertent, complicated by, accidental, unintentionally, iatrogenic.  -Terms to indicate non-accidental/inherent: to facilitate, necessary, required, intentional, inherent, integral, routinely expected. \*\*You should also document the reasons for describing an event as inherent (e.g. organs friable d/t prior radiation treatment, ileus secondary to pain medications) to further clarify the documentation. |
| Debridement | Specify whether it is **Non-excisional** (brushing, scrubbing, ultrasonic, or waterjet) **or** **Excisional** (cutting away of tissue).  - instrument used  - nature of the tissue removed (necrotic, non-viable tissue, etc.)  - appearance & size of the wound (down to fresh bleeding tissue, 7cm x 10 cm, etc.)  - depth of the debridement (skin, subcutaneous tissue, fascia, muscle, bone, etc.) |
| Fractures | Specify etiology of the fracture:  Traumatic  Nontraumatic- osteoporotic, pathologic, insufficiency, etc. |
| Ileus | Clarify if: expected due to \_\_\_\_\_\_\_\_\_; post op complication |
| Omentum | Specify: GREATER omentum or the LESSER Omentum. |
| Pancreatitis | Specify acuity: acute/chronic:  Specify etiology: Idiopathic, biliary, alcohol-induced, drug induced, etc. |
| “Postoperative” | Equates to a complication code in many instances. To a coder, “postoperative” is not a reference to time; the diagnosis that accompanies the term postoperative is often interpreted as a complication of the procedure. Use with caution. |
| Resection | Document specific site of the bowel being resected. E.g., ascending, transverse, sigmoid, rectum, duodenum, jejunum. |

Compliant Documentation Management Program

Please contact Clinical Documentation Specialists for any questions.

NAME AND EXTENSION/CELL NUMBER