Thoracic Surgery
Best Practice Documentation

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Diagnoses

- Neoplasms
- Pleural Effusion
- Heart Valve Disorders
- CAD
- Intraoperative/ Postoperative Complications
- Hematoma due to a Procedure
- Pathology Findings

Procedures

- Procedure Objective
- Excision vs Resection
- Lysis of Adhesions
- Lymph Nodes
- Debridement
- CABG

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Neoplasms

- Identify specific site of the neoplasm
- Include laterality of site if applicable
- Specify the morphology of the neoplasm as malignant, benign, in situ or uncertain behavior
- Specify the cell type of the neoplasm (e.g. basal cell, B-cell, adenocarcinoma)
- Specify the documented sites as primary or as a metastatic site

Pleural Effusion

- Specify if malignant

Heart Valve Disorders

- Clearly identify the valve(s)
  - Aortic
  - Mitral
  - Pulmonary
  - Tricuspid
- Further define the condition
  - Insufficiency or regurgitation
  - Prolapse
  - Stenosis with or without insufficiency
- Provide the etiology if known
  - Rheumatic
  - Non-rheumatic
  - Congenital

Coronary Artery Disease

Best practice documentation is to specify all three of these key elements when documenting CAD:

- Specify artery
  - Native
  - Bypass graft
- With or without Angina, further defining the type of Angina
  - With Coronary Atherosclerosis (unstable or with documented spasm)
  - Unstable
  - Angiospastic
  - Following MI (specify type of MI and onset)
- Due to
  - Lipid rich plaque
  - Calcified coronary lesion

Intraoperative and Postoperative Complications

The terms **"Post Op"** and **"Status Post"** are considered vague and requires further clarification to determine if the condition is a complication.

Key elements for best practice documentation include:

- The affected body system
- The specific condition
  - Accidental laceration (of specified organ)
  - Atelectasis
  - Hematoma
  - Ileus
- Whether the condition is a/an
  - Complication of care or due to the procedure
  - Expected procedural outcome
- When the complication occurred
  - Intraoperative Complication
  - Postoperative Complication

Hematoma due to a Procedure

- Site of the hematoma
  - Depth
    - Skin
    - Subcutaneous tissue
    - Musculoskeletal
- Procedure associated with the hematoma
  - The clinical significance of the hematoma:
    - Considered a postoperative complication
    - An expected outcome
    - Unrelated to the procedure
      - Due to another chronic condition
      - Due to anticoagulants

Post-Op Complications Documentation Example

Insufficient Documentation

- Post-op ileus. POD #3.
- Patient VQ scan positive for pulmonary embolism. History of TKR two weeks ago.

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- S/P RHC POD # 3
  Negative BS, NGT
  Prolonged ileus 2/2 extensive adhesions.
- Post-Op patient developed a pulmonary embolism most likely resulting from immobility from recent TKR.

Pathology Findings

Best Practice Documentation:

- Pathology known prior to surgery should be documented and reinforced in the operative report and progress notes.
- Suspected, possible or likely pathology should be documented based on clinical judgment whenever possible.
- Pathology findings should be documented in a progress note, consult or discharge summary as soon as reviewed or made available.
- When pathology results are available after discharge it is appropriate and compliant to document them in the acute care legal medical record.

Procedure Objective

- Procedures performed on inpatients are assigned a 7 character ICD-10-PCS code.

Meaning of Characters for Medical and Surgical Procedures

The main section of ICD-10-PCS, the medical and surgical section, has the following meanings for the seven characters.

1	2	3	4	5	6	7
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier

- There are 31 root operations in the medical-surgical section. Proper character assignment for the root operation is dependent on the objective of the procedure. The intent of the procedure should be clearly evident within the documentation of the operative report.

- Examples of Root Operation: Excision, Resection, Bypass, Repair, Replacement.

Excision vs Resection

- **Excision** is defined as the cutting out or off, without replacement, *a portion* of a body part.
- **Resection** is defined as the cutting out or off, without replacement, *all* of a body part.
- When removing an organ or body part documentation must be clear as to the extent of the organ or body part removed.
  - For example:
    - *"total removal of left lower lobe of lung"*
    - *"biopsy of liver"*

Lysis of Adhesions

- Document the body part(s) being released/freed
  For example:
  - Jejunum
  - Ascending Colon
  - Gallbladder
  - Peritoneum

- Document the severity of adhesions
  - Complicated
  - Dense
  - Extensive, etc.

Lymph Node Chains

- Extent of excision/resection:
  - Entire lymph node chain
  - Portion of lymph node chain
- Anatomical Location of lymph node(s):
  - Head
  - Right/Left neck
  - Right/Left upper extremity
  - Right/Left axillary
  - Thorax
  - Right/Left internal mammary
  - Mesenteric
  - Pelvis
  - Aortic
  - Right/Left lower extremity
  - Right/Left inguinal

Debridement

Key Documentation Requirements for Debridements:

- Depth
  - Skin
  - Subcutaneous tissue/fascia
  - Muscle
  - Joint
  - Bone
- Type
  - Excisional / Sharp (cutting away of tissue)
  - Non-excisional (removal of devitalized tissue, necrosis, or slough by irrigating, scrubbing, washing , etc.
- Specify the type of instrument used (required for physician billing)

Debridement Documentation Example

Insufficient Documentation

- Bedside debridement of abdominal wound.

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- Bedside **excisional** debridement of **necrotic** abdominal **subcutaneous tissue using #14 scalpel .** Wound measures approximately 4 cm X 2.5 cm X 2.0. Packed with wet to dry gauze.

CABG

Key Documentation Requirements for CABG:

- Origination / Destination of grafts, such as:
  - Aorta to RCA
  - LIMA to LAD
- Type of graft used
  - Autologous artery
  - Autologous vein
  - Non-autologous vessel
- Number of sties bypassed
- Excision of autologous graft
  - Location
    - Saphenous vein (indicate greater vs lesser)
    - Radial artery
  - Laterality

Key Documentation Concepts

Best practice documentation requires you to hit all of the following key elements:

- Surgical approach
- Document the body part being resected/excised to the highest degree of specificity
  - Generalities: Lung biopsy
  - Specifics: Right Upper Lobe of Right Lung biopsied
- Include if total organ/body part was removed
  - Generalities: small bowel resection
  - Specifics: partial resection of duodenum or total excision/resection of the duodenum
- Device/Implants used

Take the Extra Step!

Document:

- ALL chronic conditions – present and stable but managed
- Significance of abnormal tests (i.e. UTI, electrolytes, echo)
- Clarify whether diagnoses are ruled in or ruled out
- Establish cause-and-effect relationships. Use terms such as "due to", "related to", "manifested by" (i.e. PICC line infection)
- Laterality, if applicable
- Explain the "why" and "because" to support medical necessity
- Any tobacco use, abuse, dependence, history of smoke exposure (i.e. second hand, occupational, etc.)
- Document Present on Admission (POA) status, especially if diagnosis isn't confirmed until day two or three of admission