SURGICAL DOCUMENTATION PRIMER

Communication is critical.
It should be efficient, effective and accurate.

DOCUMENTATION: RELATIONSHIP BETWEEN CLINICAL & BILLING ELEMENTS

Medical billing is a complex process that is rarely mastered in training. Unfortunately, there is also very little education in medical school about the financial and business aspects of medicine. Below are some considerations and information to provide some brief insight into the importance of accurate and complete documentation from a clinical and financial standpoint, as these two entities are intimately linked. As we all, at some point, will be tasked with managing fiscally-sound practices, these tips will help you understand a few of the nuances of writing informative and accurate documentation.

For most inpatient care, there is not much additional billing for the day-to-day care of patients who have undergone an operation. This care is bundled into the billing for the operation itself. For example, a patient undergoes a laparoscopic cholecystectomy, and stays 5 days in the hospital. Those 5 days of routine postoperative care won't incur any additional billing from the operative surgeon. Hospital costs will continue to add up during that time however. Insurance companies and third-party payers will likely flag this as something out of the ordinary, and may not pay for those days beyond the norm. The patient is then billed for the extra days directly by the hospital, creating a significant financial burden on the patient, and likely a major loss from the hospital standpoint. However, if the same patient undergoes a laparoscopic cholecystectomy and stays 5 days in the hospital for specific reasons that are well-documented in the progress notes, the third-party payer is much more likely to pay for those days. The operative surgeon doesn't bill any extra, but because the notes clearly delineate reasons for care each day, hospital and patient billing woes can be mitigated. Similarly, if the patient required a prolonged stay secondary to complex care, accurate documentation is essential to providing quality care in the future.

Evaluation and Management (E&M) codes are crucial for initial and subsequent encounter notes (i.e., admission, progress, and clinic) when a surgeon has not operated on a patient. All physicians utilize E&M codes/billing for some patients. A common example is with a patient who has a bowel obstruction, and is managed non-operatively. Because there is no operation, there is no bundled operative bill, so the daily progress notes are the only source of surgeon billing. Again, the details of the patient's treatment plan are crucial to ongoing care of the patient. Accurate and detailed documentation becomes even more important in the era of frequent hand-offs and transitions of care. The billing and coding system for E&M billing is complex, and changes from time to time based on institutional and governmental mandates. The specific guidelines from the Centers for Medicare and Medicaid Services can be found at www.cms.gov.

PATIENT HISTORY

The written documentation of the patient history should reflect the complexity of a given case. For example, if a focused history was taken for an established patient regarding abdominal pain, it would reflect a relatively low level of complexity. This is true even when an extensive workup was performed. However, if an established patient is seen with abdominal pain, and an extensive history was done as part of the workup, the patient's complexity increases according to third party payers – that is, of course, if it is documented well.

Each portion of the history – chief complaint, history of present illness, review of systems, and past medical, surgical, family and social history – has varying levels of billing complexity associated with it. The more elements that are present, the higher the note will bill. It is imperative that the note reflect the level of complexity, and that extra elements are not copied from previous notes or added only for the sake of billing. This cannot be overstated, as documentation practices such as this may constitute fraud.

Key Components of the History				
Type of History	**Chief Complaint**	**History of Present Illness**	**Review of Systems**	**Past Medical, Surgical, Family and Social History**
Problem Focused	Required	Brief 1-3 elements of HPI*	N/A	N/A
Expanded Problem Focused	Required	Brief 1-3 elements of HPI*	Problem Pertinent Only the system included in the HPI*	N/A
Detailed	Required	Extended 4 elements of HPI* or 3 chronic conditions	Extended System included in HPI* plus 2-9 additional systems	Pertinent History directly related to the problem in the HPI
Comprehensive	Required	Extended 4 elements of HPI* or 3 chronic conditions	Complete System included in HPI* plus 10 additional systems	Complete At least one element in each of the past medical/surgical, family and social histories

Adapted from Evaluation and Management Services, Department of Health and Human Services, Centers for Medicare & Medicaid Services, 2017.

HPI* = History of Present Illness

1. **Chief complaint**
    a. The chief complaint is a concise statement of the patient's main problem. This may be as brief as 1-2 words, or up to a complete sentence. Very often, this is in the patient's own words.
    b. A chief complaint must be included on all billable notes. Without it, the documentation may be rendered invalid by many payers.

2. **History narrative**
    a. The History of Present Illness (HPI) is a chronological narrative of the events associated with the present illness. For initial encounter/admission/consult, this includes the patient's signs and symptoms from their initial development until the present time. For subsequent encounter/progress notes, the HPI includes an interval history, since the patient was last examined, which is typically the previous calendar day, or the previous clinic visit. This is

the “S” of the classic soap note. For initial encounter/admission/consult notes, several key elements should be included:

i. Location
ii. Quality
iii. Severity
iv. Duration
v. Timing
vi. Context
vii. Modifying factors
viii. Associated signs and symptoms

b. From a billing standpoint, the HPI should include 1-3 elements for lower level billing, while a high billing level would require 4 elements of the above HPI list, or the status of at least 3 chronic conditions.

3. Review of Systems

a. The review of systems (ROS) is a comprehensive look at potential issues other than the patient’s main complaint. It includes review of the following systems:

i. Constitutional
ii. Eyes
iii. Ears, nose, mouth, throat
iv. Respiratory
v. Cardiovascular
vi. Gastrointestinal
vii. Genitourinary
viii. Musculoskeletal
ix. Integument
x. Neurological
xi. Endocrine
xii. Hematologic/lymphatic
xiii. Allergic/immunologic

b. From a billing standpoint, 3 separate tiers are associated with the ROS. A problem focused ROS, includes only one system, while an extended ROS includes review of 2-9 systems, and a comprehensive ROS includes all 14 systems.
c. In the past, verbiage such as “noncontributory,” to describe the entire ROS was allowed. This is no longer the case. A list of the systems should be documented as they were reviewed. Systems not reviewed should not be documented.

4. Past Medical, Surgical, Social and Family History

a. The surgical history is, unfortunately, often truncated in medical documentation. It is very important to elicit an accurate surgical history from patients, as it can have significant impacts on future surgical care.
b. Medical, family and social histories may also hold key information that, if missed, could negatively impact care. Smoking, alcohol, and illicit drug use have adverse effects from a surgical, as a well as medical, standpoint. As such, patients should always be asked to accurately define their use or abuse of these substances.
c. From a billing standpoint, the patient complexity can be accurately reflected by documenting elements of these areas.
d. A pertinent history consists of one item from any of these areas. A complete history consists of at least one item from all areas.

PHYSICAL EXAMINATION

Like the history elements, the physical exam has multiple levels of billing associated with it. The more elements and organ systems present, the higher the note will bill. Again, documentation of the actual exam performed is critical. Copying the physical exam findings from a previous note is unacceptable, and may constitute fraud. Care should be taken to examine organ systems important to the encounter. The cardiovascular and respiratory systems should be examined in almost every patient.

Key Components of the Physical Exam	
Type of Exam	**Perform & Document**
Problem Focused	1-5 elements total, in any number of organ systems
Expanded Problem Focused	At least 6 elements total, in any number of organ systems
Detailed	At least 2 elements, from each of 6 organ systems, or at least 12 elements in 2 or more organ systems
Comprehensive	At least 2 elements, from each of 9 organ systems

1. Each organ system in the examination should include at least two modifiers to qualify for comprehensive billing levels. For example, “Respiratory: Normal effort, clear to auscultation,” will suffice. However, if the two modifiers describe the same subsection (i.e., auscultation), they are not counted as a full examination of that particular organ system. In this example, “Respiratory: Clear to auscultation, no rhonchi, rales, or wheezes,” the organ system would not count toward comprehensive billing. While it has more information from a clinical standpoint, from a billing standpoint, it only describes auscultation.

2. In general, most organ systems can be evaluated by remembering the overly simplistic method of “look, listen, feel.” Palpation, auscultation, and appearance are important characteristics in the evaluation of the patient. Following this memorable method will not only fulfill most billing requirements, but more importantly, provide valuable information in the medical record.

3. Organ systems for billing include:
    a. Constitutional
    b. Eyes
    c. Ears, Nose, Mouth and Throat
    d. Neck
    e. Respiratory
    f. Chest/Breast
    g. Cardiovascular
    h. Gastrointestinal
    i. Skin
    j. Lymphatics
    k. Musculoskeletal
    l. Neurologic
    m. Psychiatric
    n. Genitourinary

Key Elements of the Physical Exam	
System	**Elements for Each Organ System**
Constitutional	• Any 3 of: heart rate, blood pressure, respiratory rate, temperature, height/weight • General appearance
Eyes	• Conjunctiva, lids • Pupils • Ophthalmoscopic examination
Ears, Nose, Mouth and Throat	• External appearance of ears and nose • Otoscopic examination • Hearing • Nasal mucosa • Lips, teeth, gums • Oropharyngeal examination
Neck	• Appearance of the neck • Masses • Thyroid
Respiratory	• Effort • Percussion • Palpation • Auscultation
Cardiovascular	• Palpation • Auscultation • Pulses • Aorta, carotid, femoral characteristics • Edema or varicosities
Chest	• Inspection of the breasts • Palpation of the breasts
Gastrointestinal	• Masses or tenderness • Liver, spleen • Hernia • Perineal examination
Genitourinary	• Digital rectal examination • External genitalia • Pelvic examination
Lymphatic	• Lymph nodes from 2 different areas (neck, axillae, groin, etc.)
Musculoskeletal	• Gait • Digits and nails • Range of motion • Strength and tone
Skin	• Inspection (rashes, lesions, etc.) • Palpation (induration, nodules, tenderness, etc.)
Neurologic	• Cranial nerves • Reflexes • Sensation • Glasgow Coma Score
Psychiatric	• Orientation • Memory • Mood and affect

Adapted from Documentation Guidelines for Evaluation and Management Services, Department of Health and Human Services, Centers for Medicare & Medicaid Services, 1997.

ASSESSMENT & PLAN

1. The assessment is the diagnosis or possible diagnoses undergoing treatment described in the note. The assessment is not a rewording of the HPI, but rather a synopsis of what the problem is, and the plan is the course of action taken to address it.

2. From a billing standpoint, the assessment is categorized based upon complexity. Four main areas are evaluated to determine the level of patient complexity: 1) number of real or potential diagnoses, 2) the amount or complexity of the data to be reviewed, 3) the risk to the patient, and 4) the difficulty in decision-making. Documentation should reflect these four areas.
    a. For example, if a patient is diagnosed with appendicitis, this may be relatively straightforward in most cases, and may bill at a lower level. However, if the patient has a history of Crohn's disease, a right-sided kidney transplant, and an ovarian mass – the diagnosis is not as clear, will likely require more workup, is at higher than average risk to the patient, and has a higher degree of complex decision-making. So, even though the patient may have appendicitis, there's much more that goes into making the assessment and plan. The documentation should reflect it clearly.

3. Plans differ from orders, and every plan should be linked to a diagnosis.
    a. Some examples include:
        i. Hypertension: continue home antihypertensive medications
        ii. Femur fracture: orthopedic fixation complete, non-weight bearing
        iii. Acute hypoxia: ambulate, wean oxygen as tolerated, employ respiratory adjuncts, continue bronchodilators."

4. For patients about to undergo surgery, it is important to document that the risks, benefits, and alternatives have been explained. Many will include specific risks that are well-outlined in the literature to further document that a clear discussion was had regarding the risk of surgery. Some institutions have other requirements prior to proceeding to surgery, such as documentation of signed informed consent. While others require specific timelines for which documentation is valid, such as a fully-documented H&P within 30 days prior to a procedure.

Complexity in the Assessment and Plan			
Number of diagnoses or management options	**Amount or complexity of data to be reviewed**	**Risk to the patient**	**Complexity of decision-making**
Minimal	Minimal or none	Minimal	Straightforward
Limited	Limited	Low	Low
Multiple	Moderate	Moderate	Moderate
Extensive	Extensive	High	High

Adapted from Documentation Guidelines for Evaluation and Management Services, Department of Health and Human Services, Centers for Medicare & Medicaid Services, 1997.

DISCHARGE SUMMARY

Discharge summaries are often more complex than they need to be – both for billing and clinical documentation purposes. Discharge summaries should be bulleted lists of diagnoses, treatments, consultations, and disposition planning. Long, narratives of the day-to-day occurrences during hospital stays are not necessary. Keep it brief and to the point, taking care to include the important elements below.

Key Elements of the Discharge Summary	
Dates of Service	• Admission date • Discharge date
Discharge Diagnoses	• Include all diagnoses treated during the hospital stay in a bulleted list
Procedures	• List of operations or procedures and dates
Consults	• List of consulting services and a 1-2 word reason for the consult. Reasons for consultation are most often a specific diagnosis
Hospital Course	• Brief narrative of major events. Even extended hospital stays should be only a few short paragraphs. Detailed events will be found in the daily progress notes.
Discharge Medications	• Include a bulleted list of medications, specifically noting changes • Include a list of medications that were discontinued
Follow-up Plan	• Include follow-up appointments for consultants as well as the primary team
Disposition and Condition	• Discharge location – such as home, rehabilitation, nursing facility, etc. • Discharge condition

Day of discharge planning is done for every patient that leaves the hospital, and documenting this effort is important. To fulfill the needs of discharge planning, providers must document that 1) medication prescriptions have been written, 2) follow-up appointments have been scheduled, 3) the plan has been communicated to the patient, and 4) the patient's questions have been answered. From a billing perspective, this results in additional coding, and it is just good clinical care to take the time to do this for our patients. Day of discharge services are billed at either less than or more than 30 minutes.

DOCUMENTATION EXAMPLES

Each surgical specialty has specific areas of emphasis in documentation. Below are some examples of comprehensive, complete notes, and possible data for each section.

Initial Encounter – Admission – Consult – New Clinic Patient Notes	
Chief Complaint	Abdominal pain
History of Present Illness	42 year-old female with sudden onset of sharp 9/10 epigastric abdominal pain that began several hours ago. It has been unrelenting, and nothing has made it better. She was sitting at her desk when it began. Any movement makes the pain worse. She has had mild epigastric pain, bloating and nausea for the last several days. Just prior to arrival, she vomited a small amount of blood. *(Focus on these elements: Location, Quality, Severity, Duration, Timing, Context, Modifying factors, Associated signs and symptoms)*
Past Medical History	Hypertension, GERD, hyperlipidemia, psoriasis
Past Surgical History	Cholecystectomy
Past Social History	Smoking, 1 pack per day for 20 years. Works as a clerk.
Past Family History	Father with diabetes
Medications	Hydrochlorothiazide Pepcid Simvastatin Methotrexate Naproxen
Review of Systems	• Constitutional: General malaise • Eyes: Normal • Ears, nose, mouth, throat: Normal • Respiratory: Normal • Cardiovascular: Hypertension • Gastrointestinal: 9/10 abdominal pain, sudden onset • Genitourinary: Normal • Musculoskeletal: Normal • Integument: Psoriasis plaques on the forearms • Neurological: Normal • Endocrine: Normal • Hematologic/lymphatic: Normal • Allergic/immunologic: Normal *(Note: Normal is sufficient. Avoid the use of outdated and trite terms, such as Neck: Soft, supple. Though these are valid terms to use, instead document, "Normal.")*
Physical Examination	• Constitutional: Heart rate 123, BP 102/85, T 38.1°C, RR 25 • Eyes: Sclera non-icteric, pupils normal • Ears, Nose, Mouth and Throat: Normal • Neck: Non-tender, non-palpable thyroid • Respiratory: Tachypneic, increased effort, clear to auscultation • Cardiovascular: Tachycardic, palpable radial pulses, no edema • Gastrointestinal: Generalized tenderness to palpation, positive rebound, peritoneal signs. No masses or hernias. • Skin: Erythematous and raised psoriatic plaques on anterior forearms

	• Musculoskeletal: Normal range of motion, strength and tone • Neurologic: GCS 15, normal cranial nerves • Psychiatric: Normal orientation and memory *(Note: At least 2 elements present for 9 or more organ systems – remember to inspect, palpate, listen appropriately to each organ system)*
Assessment	42 year-old female with sudden onset epigastric pain, likely secondary to perforated ulcer or hollow viscus.
Plan	Abdominal pain: Upright film demonstrates free intra-abdominal air consistent with perforation. Begin broad-spectrum antibiotics and IV fluid resuscitation in the ED. She has already received IV proton pump inhibitors. Have discussed the risks and benefits of surgery, which she understands. She is at increased risk for healing complications given her methotrexate use and current smoking status. Will proceed to the operating room emergently for diagnostic laparoscopy after a brief period of resuscitation. Hypertension: Hold home anti-hypertensives at this time, given acute illness. Hyperlipidemia: Hold statin until postop taking in PO. Psoriasis: Hold methotrexate.

Operative Note	
Surgeon	**Doctor, MD FACS**
Assistants	Doctor Medical Student
Procedure	1. Diagnostic laparoscopy 2. Laparoscopic vagotomy and pyloroplasty 3. Creation of pedicled omental flap 4. Placement of Blake drain
Indication	42 year-old female with sudden onset abdominal pain and free intra-abdominal air on x-ray. She arrived tachycardic and febrile, requiring emergent operation.
Anesthesia	General endotracheal
Findings	Approximately one liter of gastric contents and purulent fluid evacuated. An approximately 1 cm perforation of the pyloric channel was identified. This was debrided and biopsied, and a Heineke-Mikulicz pyloroplasty was performed, along with a truncal vagotomy.
Description	After informed consent was obtained, the patient was transported to the operating suite and placed supine on the operating room table. General anesthetic was induced. Patient was therapeutic on preoperative antibiotics prior to incision. After a standard prep and drape…etc.
Specimens	Pyloric channel ulcer biopsy
Drains	Blake drain
Fluids	1.6 L crystalloid
Estimated blood loss	75 mL
Complications	None
Plan	Admit to ward. Will remain NPO on IV antibiotics.

Subsequent Encounter – Daily Progress Notes	
Chief Complaint	Status post ulcer repair
Interval History	POD 1 from lap ulcer repair. Pain uncontrolled. No nausea. Ambulated once this morning.
Physical Examination	• Constitutional: Heart rate 96, BP 149/85, T 37.1°C, RR 15, SpO2 95% on 2L • Eyes: Sclera non-icteric, pupils normal • Ears, Nose, Mouth and Throat: Normal • Neck: Non-tender, non-palpable thyroid • Respiratory: normal effort, mild wheezing bilaterally • Cardiovascular: normal rate and rhythm, palpable radial pulses, no edema • Gastrointestinal: Incisions clean with minor erythema at umbilicus. Drain with serosanguinous output of 55 mL since the OR. • Skin: Erythematous and raised psoriatic plaques on anterior forearms • Musculoskeletal: Normal range of motion, strength and tone • Neurologic: GCS 15, normal cranial nerves • Psychiatric: Normal orientation and memory *(Note: At least 2 elements present for 9 or more organ systems – remember to inspect, palpate, listen appropriately to each organ system)*
Assessment	42 year-old female with perforated ulcer, status post pyloroplasty and vagotomy
Plan	Perforated ulcer: NPO for 5 days, keep NGT. IV proton pump inhibition. Plan for upper gi on POD 5 to ensure no leakage. Hypoxemia, COPD: Wean O2 as tolerated, add vibratory pep for atelectasis and bronchodilators for COPD. Hyperlipidemia: Resume statin once taking PO. Psoriasis: Hold methotrexate to improve wound healing. Acute blood loss anemia – multivitamin with iron, limit blood draws

Discharge Summary	
Dates of Service	• Admission date: 01/01/2019 • Discharge date: 01/06/2019
Discharge Diagnoses	• Perforated pyloric channel ulcer • Hypertension • Hyperlipidemia • GERD • Psoriasis
Procedures	• Diagnostic laparoscopy, pyloroplasty and vagotomy on 01/01/2019
Consults	• None
Hospital Course	• 42 year-old female with perforated ulcer underwent the procedure above on 01/01/2019. She was admitted to the ward post-operatively. Her PCA was discontinued on POD3, and she was transitioned to oral oxycodone prior to discharge. She remains on twice daily PPI, and has been instructed to stop smoking and to avoid NSAIDS. Her upper GI study was negative for leak on 01/05/2019. Her drain was removed and she was tolerating a regular diet prior to discharge.
Discharge Medications	Hydrochlorothiazide Simvastatin Esomeprazole Oxycodone Discontinued: Methotrexate – patient instructed to discuss further use with PCP Discontinued: Pepcid Discontinued: Naproxen Patient instructed on smoking cessation and not to take NSAIDS.
Follow-up Plan	• Follow up with Surgery on 01/21/2019 • Follow up with PCP in 1-2 weeks
Disposition and Condition	• Discharge to home in good condition
Day of Discharge Services	• Less than 30 minutes.

GENERAL DOCUMENTATION TIPS

1. Medical documentation serves 3 roles
    - Record of care
    - Billing
    - Legal documentation.
2. Notes should be brief, but accurately and effectively convey information.
3. Never document things that did not occur. For example, if reflexes were not examined, don't document that they were normal.
4. Similarly, don't do anything for the sole purpose of documentation and up-coding notes. This is substandard and frivolous care that should never be done, and may result in harm to the patient. This is especially important when performing procedures.
5. Copying and pasting from previous notes is not accurate documentation, and in some instances, may represent fraud. Never copy and paste the previous note, as it is highly unlikely that nothing has changed since last evaluating the patient.

REFERENCES

1. Evaluation and Management Services, Department of Health and Human Services, Centers for Medicare & Medicaid Services, 2017.
2. Documentation Guidelines for Evaluation and Management Services, Department of Health and Human Services, Centers for Medicare & Medicaid Services, 1997.
3. Hospital Discharge Day Management Services, Department of Health and Human Services, Centers for Medicare & Medicaid Services, 2016.
4. Kind AJH, Smith MA. Documentation of Mandated Discharge Summary Components in Transitions from Acute to Subacute Care. In: Henriksen K, Battles JB, Keyes MA, et al., editors. Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 2: Culture and Redesign). Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Aug.
5. www.cms.gov

AUTHOR

Jacob A. Quick, MD, FACS
University of Missouri, Columbia, MO

CONTRIBUTING AUTHORS

Maria A. Cassera, MSIV
Oregon Health and Science University, Portland, OR

Ethan Cottrill, MSII-GSI
Johns Hopkins University School of Medicine, Baltimore, MD

Dana Penfold, OMS III
Lake Erie College of Osteopathic Medicine – Bradenton, FL