Policy

Procedural services can be performed in various places of service (office, clinics, emergency departments, operating rooms, inpatient rooms, etc.). Procedures also vary in degree of complexity. Regardless of where a procedure is performed or whether it is considered a major or minor procedure, all procedures must be documented and memorialized in the patient medical record. Using a standardized core documentation elements to capture the details of the procedural service, will help to ensure that claims submitted for reimbursement will be adequately supported by the procedural note.

1. **Procedure Note – Core Elements Policy:**

In addition to standard patient identifiers (name, medical record number, and date of birth), and the service location (facility name and room identifier), the following ten (10) elements are considered core requirements for any procedure performed unless explicitly not applicable to the service provided.

| Name(s) of primary surgeon/ physician and assistants | • Primary Surgeon  
• Co-Surgeons  
• Assistant Surgeons  
  o Residents/Fellows  
  o Physician Assistants |
| Pre-operative diagnosis | The pre-operative diagnosis or diagnoses are assigned to the patient before the surgical procedure and support the reason for the surgery. The Preoperative Diagnosis is, in the opinion of the surgeon, the diagnosis that will be confirmed during surgery. |
| Post-operative diagnosis | The postoperative diagnosis records the diagnosis or diagnoses discovered or confirmed during the surgery. Often it is the same as the pre-operative diagnosis. |
| Name of the procedure performed | Itemized list of procedures performed, stated narratively (do not list CPT code). |
| Indications for the procedure | This narrative statement provides the reason and clinical necessity of the procedure. It is important to state any previous, related surgery on the same or different structure/wound, and if applicable, why patient is being brought back to the OR, or if there is a planned future procedure or surgery. |
| Full description of the procedure | Full written account that describes the details of the procedure including but not limited to, type and induction of anesthesia, patient positioning, set-up and use of specific tools and special equipment (e.g., stereotactic navigation, robot), approach, required implants (specific brand name), and specific activities of each surgeon when more than one surgeon is involved to define their role in the surgery. These paragraphs should expand on the specifics for each procedure performed and clearly state laterality and details for the procedure for each side or site. The details of each lesion removed including removal site, laterality and size will be stated in this section of the operative report. |
| Complexity/Intra-operative complications | Summarize the added complexity or any intra-operative complications. These are also explained in more detail in the full description of the procedure. Conversely, if there were no complications or complexities, that is to be stated in the operative report. |
Findings of the procedure

<table>
<thead>
<tr>
<th>Specimens removed during the procedure</th>
<th>Document the clinically significant observations confirmed or discovered during the procedure.</th>
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<tbody>
<tr>
<td>Any removal of all tissues, foreign bodies, instrumentation, etc. (whether or not submitted to pathology) should be documented in the procedure report.</td>
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<tr>
<td>Estimated blood loss</td>
<td>Any blood loss during the procedure should be estimated as to volume and documented in the procedure note.</td>
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2. **Procedure Note – Timing of Documentation Policy:**

The procedural or operative report must be written or dictated immediately after the operation or other high-risk procedure is performed. Immediately is defined as upon completion of surgery, and before the patient is transferred to the next level of care.

If the operative report is not placed in the medical record immediately after surgery due to a transcription or filing delay, then a Brief Op Note should be entered in the medical record immediately after procedure/surgery to provide pertinent information for anyone required to attend to the patient.

At a minimum, the brief op note should contain the following elements:

- Name of the primary surgeon and assistants
- Procedures performed and a description of each procedure & findings
- Estimated blood loss
- Any specimens removed
- Post-operative diagnosis

3. **Procedure Note – Signature/Authentication Policy:**

Procedure notes are not considered complete and authentic until signed by the physician who performed the service. The purpose of the rendering provider’s signature on the patient’s procedure note is to demonstrate that associated services indicated and submitted for billing have been accurately and fully documented, reviewed and authenticated. It also serves to confirm that the provider has certified the service(s) to be the medically necessary when submitted to a third-party payer.

**Purpose**

Clinical documentation in the patient’s medical record is used to facilitate provider communication in support of patient care. The patient’s medical record is also used by patients and payers to verify billed services. The purpose of this policy is to outline the medical record documentation requirements for procedural services.

**Scope**

The scope and applicability of this policy includes each clinical provider who performs, codes, and bills for any procedural services. The policies and procedures outlined herein are intended to be a guide for ensuring that each procedure performed by a Weill Cornell Medicine (WCM) provider is thoroughly and properly documented and will support medical coding, billing, and reimbursement processing.

**Definitions**

Minor Procedure – In clinical terms, minor procedures are those that are minimally invasive, low risk, or considered superficial. In billing terms, under Center for Medicare and Medicaid (CMS) Teaching Physician Guidelines, minor procedures are those procedures that are short in duration (5 minutes or less per Teaching Physician Guidelines). Under CMS fee schedule definitions, minor procedures are those with a zero-day or 10-day global period.
Major Procedure – In clinical terms, major procedures are those that are invasive requiring an operation within or upon the contents of the abdominal, pelvic, cranial, or thoracic cavities, or a procedure which given the locality, condition of the patient, level of difficulty, or length of time to perform, constitutes a significant risk to the patient. In billing terms, under CMS Teaching Physician Guidelines, major procedures are those that are 5 minutes or greater in duration. Under CMS fee schedule definitions, major procedures are those with a 90-day global period.

Procedure

Compliance with this Policy

The Compliance Department will review on an annual basis and update this Policy as needed.

Contact Information

Direct any questions about this policy to the Clinical Compliance and Privacy Office:

- Telephone: (646) 962-6930
- Email: Compliance@med.cornell.edu

Reports of non-compliance to this policy or any other compliance matter must be reported to the CPO:

- Telephone: (646) 962-6930
- Email: Compliance@med.cornell.edu
- OR via the Anonymous and Confidential Hotline: (866) 293-3077 OR www.hotline.cornell.edu

References

Policy Approval

Version History

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<th>Author</th>
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