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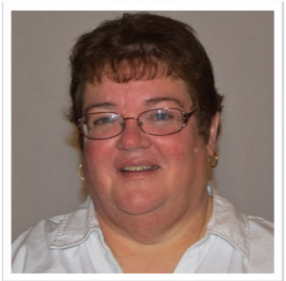

Lynn Anderanin CPC, CPB, CPMA, CPC-I, CPPM, COSC

Deciphering an Operative Report

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Deciphering an Operative Report for Optimal Reimbursement

Brought to you by
Lynn M. Anderanin CPC, CPB, CPMA, CPC-I, CPPM, COSC
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An Operative report……

- Is a legal document of a surgery
- Is used for coding and billing purposes
- Affects reimbursement of the procedures performed

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Contents of an Operative Report

- Patient demographics
- Facility information
- Date of service
- Pre and post operative diagnosis(es)
- Provider(s) information
- Procedures performed
- Anesthesia
- Blood loss
- Description of procedure(s) performed
- Signature of provider(s)

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Other Contents

- Complications
- Disposition
- Implants
- Indications
- Consent
- Plan
- Specimen(s)
- Findings
- Duration

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PATIENT: MR NUMBER:
REG NUMBER: DATE OF BIRTH:
DATE OF ADMISSION:
DATE OF DISCHARGE: DATE OF SERVICE: PATIENT LOCATION:

DICTATOR: DICTATION DATE: DICTATION TIME: TRANS DT and TM: JOB NUMBER: TRANS BY: STATUS :
HOSP. PROCEDURE NOTE

Adm: Att: Ref:
PREOPERATIVE DIAGNOSIS Ruptured left biceps tendon.

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POSTOPERATIVE DIAGNOSIS : Ruptured left biceps tendon. PROCEDURE PERFORMED:
Left distal biceps tendon repair with anchor.
Radial artery transposition.
SURGEON: ASSISTANT :
TYPE OF CASE: Clean. ESTIMATED BLOOD LOSS: Nil.
TOURNIQUET TIME: 82 minutes at 250 torr.
COMPLICATION: Compression of radial artery by biceps tendon repair.

INDICATIONS: The patient is a 45-year-old athletic trainer who was doing some lifting and felt a sudden pop in his left antecubital fossa. He had complete retraction of his biceps tendon and tear of the lacertus. Because of his loss of power supination, he presents now for repair.

DESCRIPTION OF PROCEDURE : The patient was taken to the operating room; the marked extremity was identified after a brachial plexus block was performed by Dr. Stephen Fraser. Surgical anesthesia was obtained, and the left upper extremity was prepped and draped in the usual free fashion for hand surgery.
Left arm elevated for exsanguination. Pneumatic tourniquet about the brachium was inflated to 250 torr. An oblique incision was made from the antecubital fossa across the obliquity of the pronator. Skin and subcutaneous tissues were divided sharply down through the fibers of the lacertus fibrosus as it inserted on to the pronator. The pronator was

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The Operative Report

PREOPERATIVE DIAGNOSIS: Balanoposthitis, phimosis.
POSTOPERATIVE DIAGNOSIS: Phimosis with posthitis without balanitis.
PROCEDURE PERFORMED:
SURGEON: Randolph Randolph, M.D.
ANESTHESIA GIVEN: 30 cc of 0.25% Marcaine (plain) as a field block at the base and with a portion distributed at the frenulum; monitored anesthesia care and then general anesthesia with LMA.
SPECIMENS REMOVED: Fragments of foreskin.
ESTIMATED BLOOD LOSS: 25-50 cc.
CONDITION OF PATIENT: Satisfactory.
FINDINGS: The patient was found to have massive edema of the foreskin without any evidence of purulence. No inflammatory changes were noted involving the glans penis.
DESCRIPTION OF THE PROCEDURE: After satisfactory placement in a supine position, the patient was induced with deep sedation. This monitored anesthesia care was provided by Dr. Abraham Lincoln and was maintained throughout the procedure. In an effort to make his job easier, I infiltrated the 30 cc of 0.25% Marcaine plain at about the base of the penis and at the area of the frenulum. The area was prepared with a thick jelly Betadine for good penetration and to keep the pubic hair away from the operative area. Dorsally, a straight clamp was passed across the edematous foreskin beginning at the level of the phimosis and the tissue was crushed. Along this relatively avascular line, the fine Metzenbaum scissors were used to divide the tissue to within about one centimeter of the glans. Similar incisions were made at three o'clock and nine o'clock

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and this produced wings of redundant markedly edematous penile skin. We were surprised to find no evidence of purulence and no inflammation of the glans penis nor the mucosa. A number of small bleeding points were noted around the shaft. These were clamped with fine hemostats and electrofulgurated. A few fine chromic sutures were placed to provide complete hemostasis. The cut edge of the mucosa and the skin was then reapproximated with interrupted vertical mattress and horizontal mattress sutures of 2- 0 chromic. There being sufficient resolution of the bleeding and the swelling seemed to respond as well to gentle pressure, and the application of an antibiotic ointment, Xeroform gauze, and a circumferential gentle pressure dressing, the patient was taken to the recovery area in satisfactory condition.

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Diagnosis(es) Codes

PREOPERATIVE DIAGNOSIS: Balanoposthitis, phimosis.

POSTOPERATIVE DIAGNOSIS: Phimosis with posthitis without balanitis.

- Always use the postoperative diagnosis(es)
- Query provider if description of diagnosis(es) is not enough

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What is missing?

- PROCEDURE PERFORMED:
- SURGEON: Randolph Randolph, M.D.
- ANESTHESIA GIVEN: 30 cc of 0.25% Marcaine (plain) as a field block at the base and with a portion distributed at the frenulum; monitored anesthesia care and then general anesthesia with LMA.
- SPECIMENS REMOVED: Fragments of foreskin.
- ESTIMATED BLOOD LOSS: 25-50 cc.
- CONDITION OF PATIENT: Satisfactory.
- FINDINGS: The patient was found to have massive edema of the foreskin without any evidence of purulence. No inflammatory changes were noted involving the glans penis.

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Procedure(s) Performed

- Lists procedure(s)
- Describes areas involved
- Identifies methods
- Summarizes the body of the operative report

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Indications

- Helps in defining degenerative, acquired, and congenital conditions from injuries.
- Gives additional information to support medical necessity for the procedure(s).

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Keywords

- Ablation
- Debridement
- Destruction
- Dilation
- Drainage
- -ectomy
- Exploration
- Fuse
- Implanted
- -oscopy
- -otomy
- -ostomy

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More Keywords

- Puncture
- Reconstruct
- Release
- Remove
- Repair
- Replace
- Shave
- Transfer

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Other Important Words

- Simple
- Intermediate
- Complex
- Limited
- Extensive
- Primary
- Secondary

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Some More Words

- Measurements
- Size
- Open
- Percutaneous
- Complete
- Incomplete

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The Body of the Report

- Describes in detail services performed
- Should be what is used to determine the coding
- Can also be helpful in diagnosis(es) coding

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The Body

DESCRIPTION OF THE PROCEDURE: After satisfactory placement in a supine position, the patient was induced with deep sedation. This monitored anesthesia care was provided by Dr. Abraham Lincoln and was maintained throughout the procedure. In an effort to make his job easier, I infiltrated the 30 cc of 0.25% Marcaine plain at about the base of the penis and at the area of the frenulum. The area was prepared with a thick jelly Betadine for good penetration and to keep the pubic hair away from the operative area. Dorsally, a straight clamp was passed across the edematous foreskin beginning at the level of the phimosis and the tissue was crushed. Along this relatively avascular line, the fine Metzenbaum scissors were used to divide the tissue to within about one centimeter of the glans. Similar incisions were made at three o'clock and nine o'clock and this produced wings of redundant markedly edematous penile skin. We were surprised to find no evidence of purulence and no inflammation of the glans penis nor the mucosa. A number of small bleeding points were noted around the shaft. These were clamped with fine hemostats and electrofulgurated. A few fine chromic sutures were placed to provide complete hemostasis. The cut edge of the mucosa and the skin was then reapproximated with interrupted vertical mattress and horizontal mattress sutures of 2- 0 chromic. There being sufficient resolution of the bleeding and the swelling seemed to respond as well to gentle pressure, and the application of an antibiotic ointment, Xeroform gauze, and a circumferential gentle pressure dressing, the patient was taken to the recovery area in satisfactory condition.

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Comparing the Procedures Listed to the Body

- Do they match?
- Is something missing?
- More procedures in the body

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Addendums

- Never change documentation
- Never cover documentation
- Strike-through the incorrect documentation ok, but you have to be able to still read it
- Addendums:
  - Describe the incorrect documentation
  - Add missed documentation
  - Must be signed and dated

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Signatures- CMS Guidelines

- https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/signature_requirements_fact_sheet_icn905364.pdf
- A signature is a mark or sign by the ordering or prescribing physician or NPP on a document signifying knowledge, approval, acceptance, or obligation.
- Can be handwritten or electronic
- Legible or can be validated by comparing to a signature log or attestation statement
- Must also be dated somewhere

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Modifiers

- Modifier 51
  - Used on procedures performed in the same level
  - Do not use on add-on codes
- Modifier 58
  - Procedures performed in different sessions on different days
- Modifier 59
  - Identifies multiple levels on add-on codes

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Modifiers 62 & 80

- CPT® guidelines for use in spine surgery
  - Not used on bone grafting
  - Not used on instrumentation
- Medicare has different guidelines
- Reimbursement varies by insurance company

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CPT Guidelines

62 Two Surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by appending modifier 62 to the single definitive procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may be reported by each co-surgeon, with modifier 62 appended. (See Appendix A).

- CPT

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Documentation for Co-Surgery

- Each surgeon should dictate an operative report describing their involvement in procedure
- The combination of both operative reports should document each procedure billed with the 62 modifier
- Procedures performed separately only need to documented by surgeon performing procedure

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Co-Surgery Communication

- Contact other physician's office
- Speak with coder regarding codes used for billing

NOTE: Your fees do not have to be the same. Use your normal fees to bill these procedures.

- Verify that other physician's office has used correct modifiers.

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Surgical Assistants

Surgeons document assistant at surgery services in the operative report. The assistant at surgery does not need to sign the operative report. The operative report shows the additional skilled services required based on the patient's medical needs and provided by the assistant at surgery. The operative report documentation must also show the medical necessity for the assistant at surgery services billed to Medicare and the patient.

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Surgical Assistant Example

I then had my assistant pull traction and internal rotation, and using a series of reduction clamps, I reduced the fracture anatomically. This was then held in position with a lag screw from anterior-superior to posterior inferior. This was 3.5-mm lag screw. This held the fracture anatomically reduced. Given the fact this is a very distal fracture fragment, it was extremely difficult to reduce, but we were able to reduce it anatomically. This was the reason why I used a locking plate, given the significant distal nature of the fracture.

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Conflicts

- Communicate with the physician the concerns
- Have the provider create addendums
- Contact compliance department if applicable

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Appeals

When a claim is incorrectly being denied an operative report can assist helping you show the insurance company where the description of the procedure(s) is documented.

- Always submit a signed operative report
- Confirm that there are no errors
- Don’t highlight but underline pertinent information

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Questions?

- Thank you for your attendance!
- Get your questions answered: info@pmimd.com

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