

**DISSECTING AN OPERATIVE REPORT**

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PRESIDENT,  
ACCESS QUALITY CODING &  
CONSULTING, LLC

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**DISCLAIMER**

This material is provided to assist in education for coders. Every attempt has been made to ensure that accurate information is presented. Government regulations, as with coding can be ever-changing. There is no assurance that guidance will not/has not changed.

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**AGENDA**

1. Operative Report defined
2. Necessary components of an Operative Report
3. Steps to coding from an Operative Report

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**MEDICAL CODING**

Accurate medical coding provides a clear picture of:

1. What prompted the patient encounter?
2. What occurred during the patient encounter?

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**FINDING YOUR CODE**

1. Procedure or Service

- Diathermy
- Education Services

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**FINDING YOUR CODE**

2. Organ or other anatomic site

- Eye

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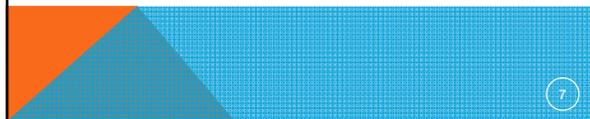
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**FINDING YOUR CODE**

3. Condition

Hemorrhoids



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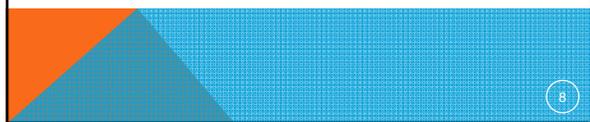
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**FINDING YOUR CODE**

4. Synonym

Digit: Phalanx/Finger

Digit: Phalanx/Toe



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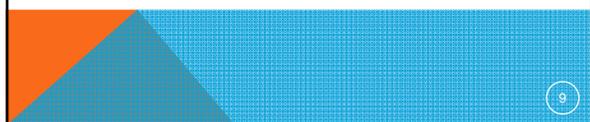
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**FINDING YOUR CODE**

5. Eponym

McVay Operation



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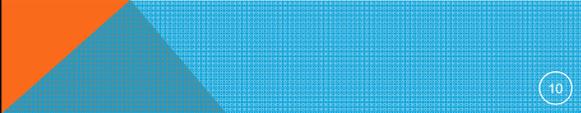
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**FINDING YOUR CODE**

6. Abbreviation  
DHT



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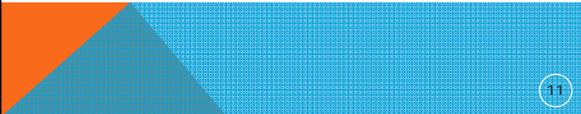
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**SURGICAL PACKAGE**

- Local infiltration, metacarpal, metatarsal, digital block, or topical anesthesia
- Subsequent to the decision for surgery
  - One related E/M encounter on the date immediately prior to or on the date of the procedure
- Immediate postoperative care



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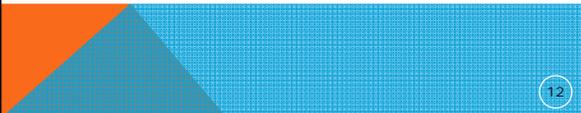
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**SURGICAL PACKAGE, CONTINUED**

- Writing orders
- Evaluating the patient in post anesthesia recovery



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**SURGICAL PACKAGE, CONTINUED**

- Also includes **typical** postoperative follow-up care
  - Medicare vs. Other carriers
  - Global postoperative days (0 days, 10 days, 90 days)



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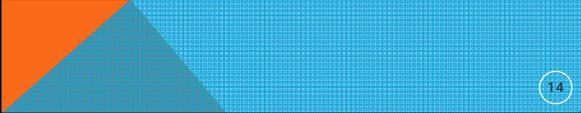
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**SURGERY GUIDELINES**

- Designated "Separate procedure" concept

**CPT 58720:** Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

**CPT 58150:** Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);



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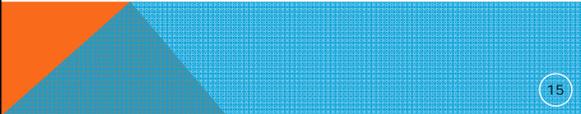
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**SURGERY GUIDELINES**

- **Multiple procedures at same operative session**

Modifier -51 has three applications, namely to identify:

- multiple, related surgical procedures performed at the same session;
- surgical procedures performed in combination, whether through the same or another incision or involving the same or different anatomy; and
- a combination of medical and surgical procedures performed at the same session.



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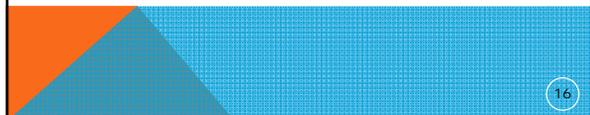
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**SURGERY GUIDELINES**

- Read the information at the beginning of each section



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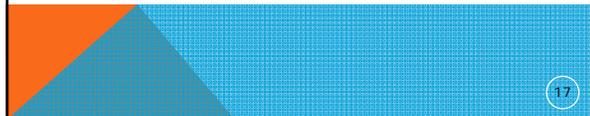
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**SURGERY GUIDELINES**

- Unlisted procedures



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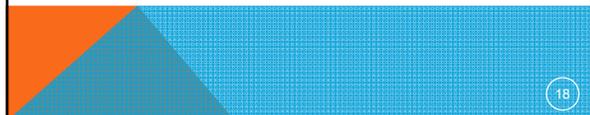
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**WHAT IS AN OPERATIVE REPORT?**

A document produced by a surgeon or other physician(s) who have participated in a surgical intervention, which contains:

- a detailed account of the findings
- the procedure used
- the specimens removed
- the preoperative and postoperative diagnoses
- names of the primary performing surgeon and any assistants



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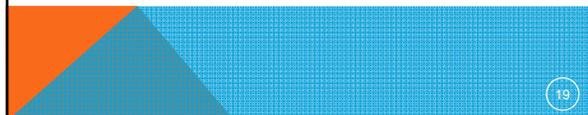
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**DID YOU KNOW???**

- Operative reports should be written or dictated immediately after an operative or other high risk procedure.
  
- An organization's policy, should define the timeframe for dictation and placement in the medical record.
  - Based on state law
  
- Postoperative management
  - Dictated operative report
  - Hand-written operative progress note.



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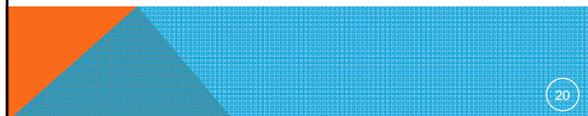
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**HANDWRITTEN OPERATIVE PROGRESS NOTE**

- Minimum comparative operative report documentation**
  - Name of primary surgeon and assistants
  - Procedures performed and description of each procedure findings
  - Estimated blood loss
  - Specimens removed
  - Postoperative diagnosis



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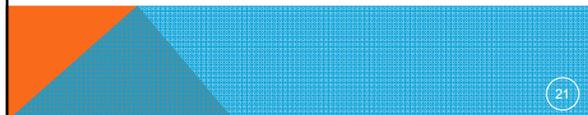
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**OPERATION PERFORMED: Colonoscopy**  
**INDICATION:** Rectal bleeding and chronic constipation

**OPERATIVE DETAILS:** After informed consent was obtained, the patient was taken to the operating room and placed in the left lateral decubitus position. The patient was then sedated by the anesthesiologist. The lubricated PCF-160 video colonoscope was inserted into the rectum and advanced to the cecum. The cecum was identified by visualization of the ileocecal valve as well as the components of the tenia coli. At this point, I began to slowly retract the scope. A 1.5 cm sessile polyp was identified in the area of the distal sigmoid colon. It was removed using snare technique and cautery. I then retroflexed the scope. The colon and rectum were desufflated and the scope removed. The polypectomy site was hemostatic. The patient tolerated the procedure well and left the operating room in good condition



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Coding only from "Operation performed" section: CPT 45378

**Coding from the full operative report: CPT 45385**




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**PROCEDURE:** Transrectal ultrasound needle biopsy of the prostate  
**INDICATION:** Elevated prostate-specific antigen  
**OPERATIVE DETAIL:** After appropriate consent, the patient was brought to the operating room. After induction of anesthesia he was placed in the lateral decubitus position. Transrectal ultrasound probe was introduced per rectum. A diagnostic ultrasound of the prostate was done. Permanent images were placed in the chart. The prostate was thoroughly visualized and measured. It measured 47mL. Under ultrasound guidance two core biopsies were taken from left base, mid, and apex, and also the right base, mid, and apex for a total of 12 core biopsies. He tolerated the procedure well. The probe was withdrawn. The patient was taken to the recovery room in stable condition.




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Coding from "Procedure only"- 55700. Unable to select appropriate u/s code with this description

Coding from the full Operative Report- 55700, 76872, and 76942




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**MISSING OPERATIVE REPORTS**

- Preferably, coding should wait until the full operative report is available
- Preliminary coding



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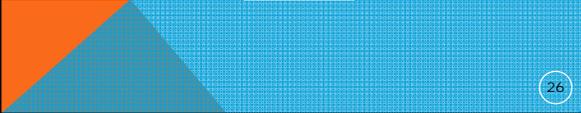
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**QUESTIONS**



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**CONTACT INFORMATION**

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**President, Access Quality Coding & Consulting, LLC**  
**904-777-9515**



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