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The Anatomy of a Great Operative Report

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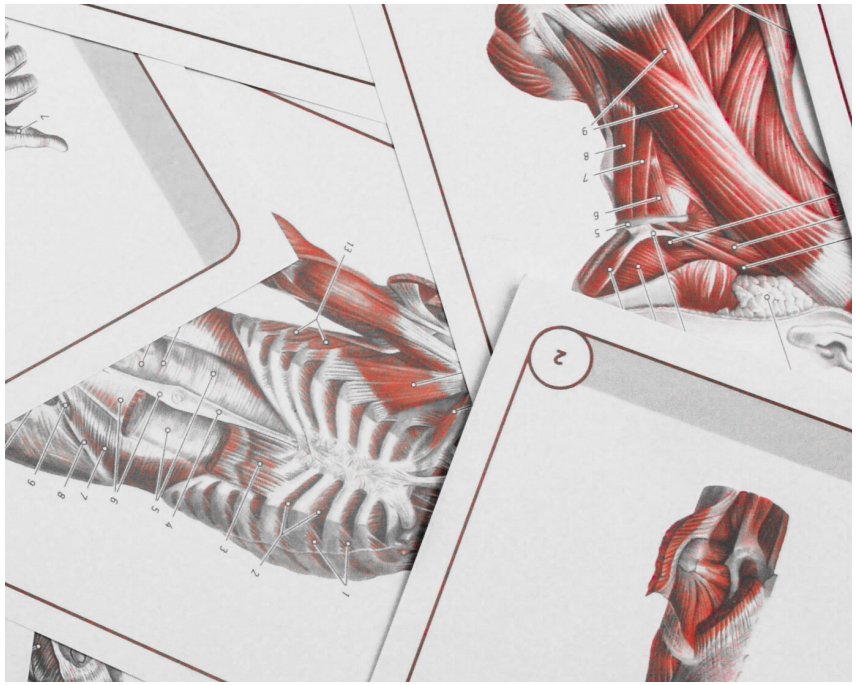
Introduction

It's important for a well-rounded auditor to be able to audit both E/M services and surgical procedures. Surgical cases can be just as complex as E/M services if you do not understand the right approach. For example, with E/M leveling, we are taught to read beyond the headers of a note. The same applies to auditing a surgical case. In this article I will guide you through the best way to dissect an operative report for proper auditing.

Tools of the Trade

One of the first things to have ready is the right tools. Just like your surgeon must have his surgical tools, we need to have ours too. An auditor's tools are your codebooks. The internet is one of my secondary tools, especially when looking up the definition of a word I don't know. A good coding software is also great, like 3M's Encoder or AAPC's Codify.



Anatomy books and posters are also helpful when you are trying to locate a certain organ or structure. If you're auditing for a specialty, like GI, GU, or cardiothoracic, you might want to invest in specialty-specific booklets or posters so you can drill down to the details. The CDR or AAPC's Procedure Desk Reference books are also very handy for surgical auditors. They describe in lay terms how a typical procedure is performed.

Last but not least, as you start your operative note auditing journey, you'll have to build your vocabulary. I've been auditing op notes for many years, and I still run across terms that I have to stop and review.

Not understanding the definition of a term may result in inaccurate coding. A few examples:

MARSUPIALIZATION is the surgical technique of cutting a slit into an abscess or cyst and suturing the edges of the slit to form a continuous surface from the exterior surface to the interior surface of the cyst or abscess. Sutured in this fashion, the site remains open and can drain freely.

EXTIRPATION is the complete removal or eradication of an organ or tissue and is a term usually used in cancer treatment or in the treatment of otherwise diseased or infected organs. The aim is to completely remove all cancerous tissue, which usually involves more tissue than just the organ itself.

ABLATION is the removal or destruction of a body part or tissue.

RESECTION usually indicates a partial removal of an organ.

DEBULKING is not the same as excision. It is the surgical removal of as much of a tumor as possible. Debulking may increase the chance that chemotherapy or radiation therapy will kill all the tumor cells. It may also be done to relieve symptoms or help the patient live longer.

Operative Note Header

There are 3 parts of an operative note, each containing its own set of information. The first part of a note is called the header. It contains these parts, which should be present, but do not have to be in a certain order:

The date and time of the procedure. Time isn't always easily found, but at the very least, the date should be documented on the note. Time can be important when determining coordination of care. Coordination of care means that more than one provider is seeing a patient on the same date of service. When auditing inpatient stays, we must look at the entire chart to be sure nothing overlaps. For example, if a provider states he saw a patient for critical care services at 9:10 a.m. for 45 minutes, but the operative start time shows 9:30 a.m., someone is not documenting correctly.

All the providers working on the patient during this procedure should be listed in the header, along with their credentials. It is important to know which providers were in the room performing services. You'll need this info to determine appropriate modifiers.

The type of anesthesia, such as general or conscious sedation must be documented. There are some codes in the CPT® book that are selected based on the type of anesthesia used, such as ear tubes.

The pre- and the post-op diagnoses should both be documented. Not one or the other, but both. The pre-op diagnoses indicate the reason for the surgery, it sets up the medical necessity. The post-op diagnosis is what was found during the procedure. We select diagnosis codes from the post-operative diagnosis.

The provider should then note the **name of the procedure being performed.** I find many times this is missing, so I'm required to read the operative report to figure out what was done. This can lead to errors, so the providers should list all the procedures they performed on this date. That doesn't mean we are going to bill for all of them! But it does set an auditor on the right track to confirm the proper codes.

Lastly, **any findings/complications** should be addressed. Remember that the op note is a legal document of the record of the surgery. Should a provider have to go to court regarding this surgery, would their note hold up to lawyer scrutiny? The more detailed they are of their findings and any complications or no complications, the better.

Operative Note Body

The most important section of the operative note is the body, or the description. The first section of the body includes the information prior to any incisions made or any scopes introduced. This information may include things like position of the patient, 'time-out' criteria, surgical tools, trays and counts, informed consent, medications and dosages administered, catheters, and prepping and draping. This list is NOT all-inclusive. Different procedures require different things. But again, remember this is a legal document. We hear horror stories of malpractice suits against providers for negligence. If a patient has a post-op infection for example, review of this part of the body may show that antibiotics were given pre-op. Obviously infections can happen; it is a normal risk for any procedure. The administration of pre-op antibiotics should help cut down on the number of infections, so it should be documented in the medications and dosages section.

From the moment the procedure begins, every single thing done should be documented, until the patient is turned over to recovery. Where and how were the incisions made? This would determine if the procedure is open, laparoscopic, or endoscopic. As you read through the note, ask yourself: are there excisions of organs/structures and how where they removed? Where they removed completely, partially, or were they marsupialized or ablated?

Time is important if the procedure takes significantly longer than normal; for example, in a situation where modifier 22 may be necessary. The provider would need to document very clearly how long the procedure should have taken, how long it did take, and why it was longer. Then, modifier 22 — increased procedural service — could be appended.

Were there complications? Did the procedure take a turn that normally wouldn't happen, such as, the patient had an altered anatomy and required a different process? Or the procedure had to be cut short due to extenuating circumstances? Perhaps the provider intended to perform a laparoscopic gallbladder removal, but had to convert to an open procedure instead – why? What method of wound closure or non-closure was used? We need to know these things for proper auditing.

Operative Note Footer

Finally, we have the footer. Parts of an operative note footer may include:

- Counts
- Blood Loss
- Drains
- Fluids
- Specimens
- Implants
- Disposition
- Attestation/Signatures

Some of these items may be mentioned in the Header, which is okay too. I've seen blood loss, drains, specimens, etc. documented in the header sections. As long as it's there, that's what we need. The most important piece here for auditors is in the attestation and/or signatures. The key element is that it is there, and it is timely. Timely signatures, especially on op notes, are crucial. Many of the clients I've worked with specify 72 hours or they won't bill the charges. Work with your compliance department and providers to set your own timeline.

As auditors, we play an important role to ensure accurate documentation and coding for all types of services. To do so, we must be well-versed in a variety of areas beyond Evaluation and Management. Understanding the intricacies of having the right tools, vocabulary, and knowledge of properly dissecting an operative report will ensure accuracy of your surgical claims.

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AUTHOR BIO

Lori has over 20 years of experience working in the business side of medicine. Lori began her career in patient accounts and then moved into billing and coding. She has served as a Billing Supervisor and Compliance Officer, where she wrote, maintained and trained employees and providers on fraud and abuse. In 2015, Lori received her MBA from Quincy University in Quincy, IL. Lori has traveled the country educating coders and physicians on complex coding topics such as Hem/Onc and E/M guidelines. Lori is the Member Relations Officer of AAPC's National Advisory Board and an active member of her local AAPC Chapter.