How to Code from an Operative Report

Reading an operative report can be a time consuming task. It can also be like detective work. As a coder, you have to get the diagnosis and procedure information from documentation in the chart. For this class, our focus is on the CPT or procedural information. In the “real world” you would have to get/code both diagnosis (es) and procedure(s).

How do you know what information is important? How do you translate text into CPT key words?

Focus on “action” terms (see below). You can begin by looking at the “procedure performed” section of operative report.

**Action terms – procedural terms:**

- Incision
- Excision
- Destruction
- Amputation
- Introduction
- Endoscopy
- Removal
- Repair
- Suturing
- Manipulation

Read the operative report below and then answer questions listed below the report:

**Preoperative Diagnosis:** Elevated prostate-specific antigen

**Postoperative Diagnosis:** Elevated prostate-specific antigen

**Procedure Performed:** Prostate needle biopsy

Anesthesia: None

Complications: None

Blood Loss: Less than 10 cc

Indications for Operation: The patient is a 65 year old gentleman who was found to have a PSA of 8.1. He was therefore consented for a prostate needle biopsy.
Details of Procedure: Patient walked to the operating room and climbed on the table. He moved into the lateral decubitus position. A digital rectal exam was performed. The prostate was smooth and firm with no palpable nodules. The ultrasound probe was then inserted into the rectum, and the prostate was visualized using the ultrasound. There were no suspicious lesions seen on the ultrasound. We then proceeded to check 10 prostate needle biopsy specimens. Two specimens were taken from the right base, two from the right mid, two from the right apex, followed by two from the left base, one from the left mid, and one from the left apex. We only took one specimen on the left mid and apex because of the patient’s discomfort. The patient was able to walk back to the postanesthesia care unit in stable condition. We will follow up on the pathology results and call the patient.

Questions

1. Why is this patient having this procedure?

_Elevated PSA_

2. What is the main surgical procedure?

_Biopsy of prostate_

3. What is the key term or action term used to index this procedure?

_The key term biopsy can be used._

_Alternatively, the key word prostate can be used._

4. When indexing key term biopsy, what are the references you find?

_Prostate 55700-55706_

5. When referring to the area in CPT coding manual, what information is needed from the physician documentation to assign a specific and correct CPT procedure code?

_The type of biopsy performed is needed at a minimum. The approach can be used to assign a specific CPT code and the use of additional equipment can be a factor for code assignment._

6. Per information in operative report, what CPT procedure code would you assign?

What is the complete CPT code description for the code you are assigning?

_55700_

_Biopsy, prostate; needle or punch, single or multiple, any approach_
The above questioning is a process known as abstracting which means the coder is abstracting specific information from physician/chart documentation to assign code(s). This process is the same for all coding, however, the questions asked will vary per body system and coding classification being used (CPT versus ICD).

Review the operative report below and posed abstracting questions:

Operative Report – Patient, Susan Raine

Preoperative Diagnosis: Lesion, skin of nose (left side)

Postoperative Diagnosis: Lesion, skin of nose

Procedure: Nasal cyst removal with primary closure

Anesthesia: Local

Brief History: Patient is an 84 year old male who presented to the clinic complaining of a 10 month history of a nasal cyst. Patient states that it has slowly increased in size and has been stable for the past couple of months. He presented to the clinic with the hope of having it removed. After full explanation of the risks and benefits of that procedure, the patient consented for the operation.

Details of Procedure: After consent, the patient was brought to the OR. Local anesthetic including 1% lidocaine was used subcutaneously to the nose. An elliptical market outlined the nasal area. Sterilely and incision was made around the 1 cm cyst-like lesion. Using the #15 blade, the cyst was undermined and removed in whole. Total excised diameter was 2.0 cm. Hemostasis maintained using Bovie electrocautery. The wound was closed with #5-0 PDS, then used for subcutaneous approximation of the transverse incision, #5-0 nylon was used to approximate the superficial epidermis edges. Bacitracin ointment was applied. Hemostasis was maintained successfully. The patient tolerated the procedure well. Pathology report identified lesion sebaceous adenoma.

What technique was used to remove the lesion?

What key elements are needed to assign a code?

What type of lesion was this; benign or malignant?
What was the excised diameter?

Review documentation to get answers to the above; if you have a question, please go to session forum.

What code would you assign?

11442 – size and type of lesion is a factor from documentation that coder abstracts to make correct code assignment

Type of lesion is benign

Size excised is 2.0 in diameter

Method of removal is excision

Note: there is NO code assigned for closure of skin after removal of cystic lesion, simple closure is included in code 11442, if physician had documented a more intense and/or layered closure of deeper subcutaneous skin, then an additional code for closure would be assigned from closure area at intermediate or complex level. The documentation in this operative report does not warrant assignment of an additional code for an advanced or intense level of closure; the closure documented in this operative report is simple