



# **Optum360 Learning: Coding from the Operative Report for ICD-10-CM and PCS**

**2017**

*Fifth Edition*

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2. If the operative report is not placed in the medical record immediately after surgery due to transcription or filing delay, then an operative progress note should be entered in the medical record immediately after surgery to provide pertinent information for anyone required to attend to the patient. This operative progress note should contain at a minimum comparable operative report information. These elements include; name of primary surgeon and assistants, findings, technical procedures performed, specimens removed, and postoperative diagnosis as well as estimated blood loss.
3. Immediately after surgery is defined as “upon completion of surgery, before the patient is transferred to the next level of care, for example the post anesthesia care unit.” This is to ensure that pertinent information is available to the next caregiver.

## OPERATIVE REPORTS

A major part of the medical record is the section devoted to the operative report. However, the operative report must do more than contribute to the development of surgery or provide mortality and morbidity information to statisticians. An operative report must outline the logic used in treating a patient and document why the particular type of surgery was performed, the steps involved, and the outcome. An adequate operative record provides pre- and postoperative information, as well as consent to treat forms and status reports when additional surgery is required after the initial surgery was performed. It serves as the basis for reimbursing the surgeon, surgical team, and inpatient or outpatient facility and as the official record for claims involving malpractice, worker's compensation, accidental trauma, or medical hardship.

Despite regulations, however, operative reports are seldom easy to interpret and code. Regardless of the physician's specificity about how a service was performed, coders must understand:

- How operative reports and notes are organized
- Availability of standard forms for recording information either in a written or electronic format
- The documentation required in the health record for each episode of care (e.g., diagnostic or therapeutic surgical care or procedural care)

## Organization

Organization of the health record (including operative reports) is determined by the hospital unless specified by accrediting agencies. However, the classification system used in organizing data is common among hospitals.

## Legal and Administrative Data

Administrative data belonging at the front of the health record include billing information specifying Medicare, Medicaid, and any supplemental insurance. Legal data generally cover specific patient orders such as signed conditions of participation (CoP), refusals of any specified procedures, living wills, and power of attorney.



## KEY POINT

According to Medicare's conditions of participation (CoP), a hospital must inform each patient, or when appropriate, the patient's representative (as allowed under HIPAA or state law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. A signed consent form must be in the patient's record prior to each surgery. CoP requires hospitals to develop policies that ensure each patient is informed of his or her rights in language that the patient understands (e.g., hospital must provide interpretation for those who speak a language aside from English or, for other reasons, require alternative methods of communication). The policies must cover any state or federal regulation notice regarding patient rights, including the right to an advance directive and notice of noncoverage.

The MS-DRG system relies on accurate diagnosis and procedure code assignment. Each case is assigned to a DRG. Each DRG has a relative weight assigned to it that is the same for all hospitals throughout the country and is updated each year. This relative weight is based on the complexity of the services expected to be required to treat that particular case. The DRG's relative weight is multiplied by the hospital's specific base rate, which is calculated based on several factors, including the wage index for that geographic area. The calculation of DRG relative weight times the hospital base rate determines the specific reimbursement rate for the case.

The DRG is determined by five variables:

1. The patient's principal diagnosis
2. The patient's secondary diagnoses, which include complication/comorbidities
3. Surgical and other invasive procedures
4. Sex of the patient
5. Discharge status

A hospital's Medicare population case complexity is measured by calculating the case-mix index, which is an average of all MS-DRG relative weights for the facility during a given period of time. The higher the case-mix index, the more complex the patient population and the higher the required level of resources used. Since severity is such an essential component of MS-DRG assignment and case-mix index calculation, documentation and code assignment to the highest degree of accuracy and specificity are of the utmost importance.

Review the following steps for accurate MS-DRG assignment:

#### Step 1

Assign the principal diagnosis based on the UHDDS definition: "That condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." If the diagnosis documented at the time of discharge is qualified as "possible," "probable," "suspected," "likely," "questionable," "still to be ruled out," or other similar terms indicating uncertainty, code the condition as if it existed or was established.

#### Step 2

Assign diagnosis codes for secondary conditions, defined as those conditions that required: clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring. Conditions that are designated as MCCs or CCs should be sequenced directly following the principal diagnosis.

#### Step 3

Assign procedure codes for all surgical procedures performed, as well as for other invasive procedures that may not have been performed in an operating room. For example, services provided in interventional radiology suites, cardiac catheterization rooms, or even provided at bedside may be designated as "valid non-OR procedures" and will affect MS-DRG assignment.

#### Step 4

Consider all required information (diagnosis and procedure codes, patient sex, and discharge status) when grouping the DRG. Note the medical diagnostic category (MDC) and MS-DRG initially grouped. Ensure that the MDC and MS-DRG



### KEY POINT

Medicare Severity-DRGs, enacted in October 2007, improve by 9.41 percent the explanation of variance of hospital resources used over the previous version of DRGs.



### KEY POINT

Under the MS-DRG system, physician documentation in the medical record must be specific because many chronic conditions are no longer designated as CCs. It is only when an acute exacerbation or an acute form of the disease process is documented and coded that the condition may be considered an MCC or CC and affect MS-DRG assignment.

- Other forms or reports filed in separate sections, depending on protocol established by the facility or physician's office

For example, a pathology report may clarify the type of tumor found in an operative session (e.g., benign or malignant) or further specify the nature of a condition. Confirm specimens (whether neoplastic tumors or not) excised with the pathology reports to ensure diagnostic specificity. Many payers take issue with nonspecific codes. Making diagnostic specificity a standard practice is an excellent preparation for ICD-10, in which the granularity of data required to code is further refined.

## UNDERDOCUMENTED OR INCORRECT INFORMATION

Information in the medical record can be underdocumented or incorrect as evidenced in a report where the operative report body does not agree with the heading or other chart documentation. Finding underdocumented or incorrect information requires the coder to seek information from outside of the operative report proper whether in an inpatient or outpatient setting.

### Underdocumented

#### **Example:**

- The operative progress note states a procedure was performed although the procedure is not listed in the heading of the operative report but detailed in the body of the report.

### Incorrect

#### **Example:**

- The operative report heading specifies the patient was a male and a hysterectomy was performed.
- The operative report states a female had a skiing accident, though the face sheet says a male was admitted to the hospital.
- The heading of the operative report indicates a procedure was performed on the left leg and the body of the operative report states the procedure was performed on the right leg.

When conflicts exist in the documentation of a medical record that may affect coding assignment and accuracy of the document, ask others in the office. Seek information from the medical records director, office manager, or other entity about when to request additional information from the surgeon. Coders should also seek guidance regarding the conditions necessary for an addendum to the medical record.

Physician office coders should make sure to receive a copy of any hospital record addendum that has been documented. A system must be in place when the document is received by the surgeon to prevent important information being filed without the coder's knowledge.

## CODE SELECTION

Although pre- and postoperative diagnoses and procedures are listed in the heading of the operative report, they alone may not contain the information



### KEY POINT

Room assignment can be used to look for complications or other conditions that may affect code assignment. One should ask, for example, why a patient was in an intermediate care or intensive care room. Are these rooms the only ones available, or are there other conditions present?

When there are conflicts in the documentation that may affect coding assignment and accuracy of the document, ask others in the office. Seek information from the medical records director, office manager, or other entity about when to request additional information from the surgeon. Coders should also seek guidance regarding the conditions necessary for an addendum to the medical record.

## OPERATIVE REPORT MDC 3—#4

### Preoperative diagnosis:

Chronic sinusitis. Deviated nasal septum. Turbinate hypertrophy.

### Postoperative diagnosis:

Same

### Procedure performed:

Endoscopic sinus surgery with bilateral total ethmoidectomies, nasal polypectomy bilateral nasoantral windows, and partial excision of the middle turbinates

### Procedure description:

The patient was identified, taken to the operating room, and placed in a neutral position. Smooth endotracheal anesthesia was induced. The patient was prepped and draped in the standard fashion. 1% lidocaine with 1:100,000 epinephrine was injected into the septum, uncinate process nasal polyps, and middle turbinates. Visualization with the sinus endoscope revealed a marked spur along the left septum impinging on the left inferior and the middle turbinate and a marked deviation of the superior septum to the right side precluding adequate visualization of the right middle turbinate. Therefore, a left hemitransfixation incision was performed, mucoperichondrial flaps elevated, 1.0 cm caudal and dorsal struts outlined and incised, and a portion of the perpendicular plate of the ethmoid, vomer, and quadrangular cartilage as well as a large maxillary crest spur were resected. The septum was shortened by approximately 1 mm to allow it to return to the midline, and the incision was closed with 4-0 chromic interrupted simple sutures.

Next, the left middle turbinate and middle meatus was identified, and a large polyp was seen to completely obstruct the middle meatus. The polyp was removed with power instrumentation and the insertion of the middle turbinate incised and the anterior two-thirds of the middle turbinate resected. The polyp was then further removed via the ethmoid sinus. The uncinate process was then infractionured and sharply resected, gaining entrance to the maxillary sinus. A large polyp was then noted to almost completely fill the maxillary sinus on the left side, and this was removed with curved power instrumentation.

The ethmoid sinus was then entered again, and a marked polypoid and thickened mucosa was noted throughout. The fovea ethmoidalis and laminal papyracea were identified and used as landmarks for the procedure. The basal lamella was entered and the posterior cells also opened wider. Thicken mucosa was noted in the sinuses as well. The sinoethmoidal recess was evaluated and was seen to be free of polypoid tissue. The posterior insertion of the turbinate was cauterized with bipolar cautery as was the anterior insertion. The same procedure was performed on the opposite side with similar findings, except only a small polyp was noted in the right maxillary sinus. Splints coated in ointment were sutured to the nasal septum with 3-0 Prolene. The throat pack that was placed at the beginning of the case was removed, and the patient was extubated and transported to the recovery room in good and stable condition.

**Code all relevant ICD-10-CM diagnosis and ICD-10-PCS procedure codes in accordance with official guidelines and coding conventions.**

### Diagnosis Codes:

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### Procedure Codes:

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### MS-DRG:

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## OPERATIVE REPORT MDC 3—#4

### Preoperative diagnosis:

Chronic sinusitis. Deviated nasal septum. Turbinate hypertrophy.

### Postoperative diagnosis:

Same

### Procedure performed:

Endoscopic sinus surgery with bilateral total ethmoidectomies, nasal polypectomy bilateral nasoantral windows, and partial excision of the middle turbinates

### Procedure description:

The patient was identified, taken to the operating room, and placed in a neutral position. Smooth endotracheal anesthesia was induced. The patient was prepped and draped in the standard fashion. 1% lidocaine with 1:100,000 epinephrine was injected into the septum, uncinate process nasal polyps, and middle turbinates. Visualization with the sinus endoscope revealed a marked spur along the left septum impinging on the left inferior and the middle turbinate and a marked deviation of the superior septum to the right side precluding adequate visualization of the right middle turbinate. Therefore, a left hemitransfixation incision was performed, mucoperichondrial flaps elevated, 1.0 cm caudal and dorsal struts outlined and incised, and a portion of the perpendicular plate of the ethmoid, vomer, and quadrangular cartilage as well as a large maxillary crest spur were resected. The septum was shortened by approximately 1 mm to allow it to return to the midline, and the incision was closed with 4-0 chromic interrupted simple sutures.

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The ethmoid sinus was then entered again, and a marked polypoid and thickened mucosa was noted throughout. The fovea ethmoidalis and laminal papyracea were identified and used as landmarks for the procedure. The basal lamella was entered and the posterior cells also opened wider. Thicken mucosa was noted in the sinuses as well. The sinoethmoidal recess was evaluated and was seen to be free of polypoid tissue. The posterior insertion of the turbinate was cauterized with bipolar cautery as was the anterior insertion. The same procedure was performed on the opposite side with similar findings, except only a small polyp was noted in the right maxillary sinus. Splints coated in ointment were sutured to the nasal septum with 3-0 Prolene. The throat pack that was placed at the beginning of the case was removed, and the patient was extubated and transported to the recovery room in good and stable condition.

**Code all relevant ICD-10-CM diagnosis and ICD-10-PCS procedure codes in accordance with official guidelines and coding conventions.**

### Diagnosis Codes:

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### Procedure Codes:

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### MS-DRG:

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**OPERATIVE REPORT MDC 8—#7****Preoperative diagnosis:**

Subtalar joint degenerative joint disease

**Postoperative diagnosis:**

Same

**Procedure performed:**

Subtalar joint fusion with external fixation device

**Procedure description:**

The patient was brought in the operating room and placed in a supine position. General anesthesia was administered. Once adequate levels of anesthesia had been obtained, a time-out was called with the patient identification and the proposed procedure being agreed upon by the surgical team and operating room staff. The left foot was prepped and draped in the normal sterile fashion to include a pneumatic tourniquet placed about the left ankle.

Attention was directed to the lateral sinus tarsi region, where a 10 cm linear-type incision was made and deepened using blunt dissection. Bleeders were cauterized as necessary, and neurovascular structures were retracted medially and laterally as necessary. Dissection was carried out using blunt and sharp technique, revealing the subtalar joint. The capsule was incised, exposing the posterior and middle facets. Using an osteotome and mallet, the cartilage and subchondral plate was removed adequately to allow for eversion of the calcaneus, once fusion of the talus and calcaneus was achieved. The joint surfaces were prepared using a smaller osteotome for a shingling effect.

At this time, Trinity demineralized bone matrix was introduced into the joint space. An ICOS screw was introduced percutaneously through the dorsal aspect of the talar neck. This was placed through the neck and into the posterior aspect of the calcaneus. Under fluoroscopic guidance, it was noted that adequate compression of the subtalar joint was achieved. A MiniRail was then placed across the subtalar joint. Two pins were placed in the calcaneus, and two pins were placed in the body of the talus. Using the MiniRail compression system, it was noted that the joint was further reduced. Incision was closed deeply, taking care to reattach the capsular structures, followed by reapproximation of the peroneal tendon sheaths, using Vicryl suture. Subcutaneous tissues were reapproximated using simple interrupted Vicryl suturing. The skin was closed using a running locking Prolene suture. At this time, the surgical site was dressed with Xeroform, 4x4 gauze, Kling, Coban, and an Ace wrap.

The patient was taken to the postoperative care unit where vital signs were stable and intact. It was noted that neurovascular status of the left foot remained intact. Patient was discharged to home once he emerged successfully, without incident, from general anesthesia.

**Code all relevant ICD-10-CM diagnosis and ICD-10-PCS procedure codes in accordance with official guidelines and coding conventions.**

**Diagnosis Codes:**


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**Procedure Codes:**


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**MS-DRG:**


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**DEFINITIONS**

**cul-de-sac.** Blind pouch, or cavity, such as the pouch of Douglas (retro uterine) or the conjunctival fornix, which is the loose pocket of conjunctiva between the eyelid and the eyeball that permits the eyeball to rotate freely.

**CODING AXIOM**

ICD-10-CM Official Guidelines for Coding and Reporting Section I.C.6.b.1:

A code from category G89 (Pain, not elsewhere classified) should not be assigned if the underlying (definitive) diagnosis is known, unless the reason for the encounter is pain control/management and not management of the underlying condition.

**Answers and Rationale****Preoperative diagnoses:**

Chronic pelvic pain, dysmenorrhea

**Postoperative diagnoses:**

Endometriosis of the posterior cul-de-sac and ovary,<sup>1,2</sup> chronic pelvic pain, dysmenorrhea

**Procedure description:**

Patient was taken to the operating room; prepped and draped in normal sterile fashion. Attention was turned to the abdomen. A 5 mm skin incision was made in the patient's umbilicus with scalpel. Veress needle was inserted and pneumoperitoneum was achieved. A 5 mm trocar and the laparoscope<sup>3,4</sup> were inserted. A separate 7-8 mm incision was made in the lower abdomen, and a 7-8 mm trocar was inserted through the incision. A probe was inserted, and the pelvic cavity was explored. The anterior cul-de-sac was normal. The posterior cul-de-sac showed 2 areas of endometriosis close to the uterosacral ligaments on both sides, which were cauterized with the bipolar cautery.<sup>2,4</sup> Another area of endometriosis was noted on the patient's left ovary, and this was cauterized as well.<sup>1,3</sup> All instruments were removed from the abdomen. Excellent hemostasis was noted. Sponge, lap, and needle counts were correct. The patient tolerated the procedure well and was taken to the recovery room in stable condition.

**Diagnosis Codes**

**N80.1 Endometriosis of ovary<sup>1</sup>**

**N80.3 Endometriosis of pelvic peritoneum<sup>2</sup>**

**Rationale for Diagnosis Codes**

The operative note specifies that the endometriosis discovered is in the posterior cul-de-sac and on the left ovary. According to the index for ICD-10-CM, the posterior cul-de-sac is coded to pelvic peritoneum. The chronic pelvic pain is not reported, according to guidelines section I.C.6.b.1, which states that codes from the G89 category (Pain, not elsewhere classified) should not be reported if the definitive diagnosis is known. It is also inappropriate to report the dysmenorrhea as this is routinely associated with endometriosis (section I.B.6).

**Procedure Codes**

**0U514ZZ Destruction of Left Ovary, Percutaneous Endoscopic Approach<sup>3</sup>**

**0U5F4ZZ Destruction of Cul-de-sac, Percutaneous Endoscopic Approach<sup>4</sup>**

**Rationale for Procedure Codes**

The procedures were performed using a laparoscope, making the approach character value 4. Two codes are necessary to report the cauterization of the endometriosis because two separate anatomical sites were treated. In the index, "Cauterization" refers to *Destruction* or "physical eradication of all or a portion of a body part by direct use of energy, force or a destructive agent."

**MS-DRG**

**743 Uterine and Adnexa Procedures for Nonmalignancy without CC/MCC RW 1.0090**

Both the diagnosis of endometriosis and the procedure for the cauterization of the ovary lesion drive the assignment of this MS-DRG. If only the procedure on the lesion of the cul-de-sac was reported, the result would be lower-weighted MS-DRG 747 Vagina, Cervix and Vulva Procedures without CC/MCC.