Overview

In this session, you will learn:

- How to skillfully and successfully break down an operative report
- How to recognize key words and phrases to maximize coding opportunities
- Resources for researching your clues
- Communicating effectively with your providers

Disclaimer – I am the sum of those that have invested in me over the years. If anything sounds like something you’ve heard somewhere else, it might be. I give credit to those that have influenced me, even if I don’t know who it was or when!
### Identifying the Puzzle

- **Sort the puzzles**

  Arrange your daily work (surgical notes) into similar groups. This will help maximize your coding time and help minimize jumping from one section of the book to another with each new note.

  - ENT
  - Neurosurgery
  - Cardiology

### Breaking down the note

- **Know the parts – The Box**

  - NCCI
  - CMS
  - Payer Rule
  - CPT Guidelines
  - ICD-9 Guidelines
Breaking down the note

• Know the parts – The Picture

  Illustrated Medical Dictionary
  Anatomy Books or Sites
  Clinical Explanations (i.e.
  Specialty Coding Guides or
  Coder’s Desk Reference)
  Specialty Publications

Breaking down the note

• Know the parts – The Corners

  Reason for the Procedure
  Specialty
  Site or Approach
  Coding Changes/Guidelines
Breaking down the note

• Know the parts – The Frame/Outline

  Patient Information
  Surgeon Name
  Assistant/Co-Surgeon Name
  Date of Surgery
  Facility Information

Breaking down the note

• Know the parts – The Center Pieces

  Body of the Surgical Note:
  Provides details for CPT selection and
  for ICD-9 additions or changes
Breaking down the note

• Know the parts

Breaking down the note

• Know the parts

PREPROCEDURE DIAGNOSIS: Acute respiratory failure with poor peripheral intravenous access.

POSTPROCEDURE DIAGNOSIS: Acute respiratory failure with poor peripheral intravenous access.

PROCEDURE PERFORMED: Right femoral central line placement.

ESTIMATED BLOOD LOSS: 20 ml.

DESCRIPTION OF PROCEDURE: The patient had been transferred early in the morning of June 1, 2008, with an episode of acute respiratory failure with poor peripheral intravenous access and required vasopressors. The decision was made to obtain a central line placement. The patient was in the supine position. Initially, attempts were made at performing a right subclavian central line placement. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. A 14-gauge fine needle could be inserted into the right subclavian vein. A guidewire was placed through the needle. The skin and subcutaneous tissues in the right upper arm were then anesthetized. Multiple attempts were made to access the right internal jugular vein, but despite multiple passes, we were unable to locate the vein. We then advanced a fine needle into the right femoral vein and advanced a guidewire through the bevel of the needle. The tip of the guidewire was positioned at the depth of 15 cm of the skin. A 7-French triple-lumen catheter was then inserted into the right femoral vein to a depth of 15 cm of the skin. Dark venous blood could be aspirated from all three ports. All ports flushed easily. The line was sutured in place with 3-0 silk suture and a sterile dressing was applied. The patient tolerated the line well and a chest x-ray is pending at this time to rule out a pneumothorax from the previous line attempts.

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Breaking down the note

• Know the parts

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Breaking down the note

• Know the parts

**PREPROCEDURE DIAGNOSIS:** Acute respiratory failure with poor peripheral intravenous access.
**POSTPROCEDURE DIAGNOSIS:** Acute respiratory failure with poor peripheral intravenous access.

**PROCEDURE PERFORMED:** Right femoral central line placement.

**SURGEON:** Michael Smith, M.D.
**ANESTHESIA/MEDICATIONS:** Local.
**ESTIMATED BLOOD LOSS:** 20 mL.
**SPECIMENS:** None.

**INDICATIONS FOR PROCEDURE:** The patient is a 82-year-old white female who had been transferred early in the morning of June 1, 2008, with an episode of acute respiratory failure requiring ventilator management. She presented with poor peripheral intravenous access and required vasopressors. The decision was made to perform a right subclavian central line placement. The skin and subcutaneous tissues in the right infraclavicular area were anesthetized with 1% lidocaine. A 14-gauge fine needle could be inserted into the right subclavian vein. A guidewire was passed without significant difficulty. However, we could not advance a line over the guidewire, presumably due to an acute angle under the clavicle. We then advanced a right internal jugular line. The skin and subcutaneous tissues in the right lower neck were anesthetized with 1% lidocaine. Multiple attempts were made to access the right internal jugular vein, but despite multiple passes of the needle, we could not localize the vein. Her neck was very obese and she had a weak carotid pulse. At this point, we made the decision to place a right femoral line. We then inserted a right femoral line. The skin and subcutaneous tissues in the right lower neck were anesthetized with 1% lidocaine. Multiple attempts were made to access the right femoral vein, but despite multiple passes of the needle, we could not localize the vein. The vein was dilated with the dilator and then a 7-French triple-lumen catheter was inserted into the right femoral vein to a depth of 15 cm of the skin. Dark venous blood could be aspirated from all three ports. All ports flushed easily. The line was secured into place with 3-0 silk suture and a sterile dressing was applied. The patient tolerated this well and a chest x-ray is pending at this time to rule out a pneumothorax, from the previous line attempts.

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**Puzzle Box**

**Billing Coding Regulations**

**Puzzle Picture**

**Coding/Medical Resources**

**Puzzle frame/outline**

**Header Information**

**Corner Pieces**

**Reason for procedure**

**Approach/Site**

**SPECIALTY**

**Code Changes/Guidelines**

**Center Pieces**

**Body of the note**

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Breaking down the note

• Start with the borders

When you begin to work a puzzle, you want to identify the scope or borders first. This makes filling in the picture a little easier since you know the framework of the final view.

Breaking down the note

• Start with the borders

- Specialty
- Code Changes
- Reason for the Procedure
- Approach

Date of Service
History/Indication for surgery
Pre-Op Diagnosis
Post-Op Diagnosis
Procedures performed
Complications
Breaking down the note

• Start with the borders

PREOPERATIVE DIAGNOSIS: Traumatic Arthroscopy, left knee, with a laceration greater than 20 cm about the lateral aspect of the thigh less than 50 cm as well as traumatic laceration, left ankle.

POSTOPERATIVE DIAGNOSIS: Left knee arthroscopy with lateral thigh laceration greater than 20 cm, less than 50 cm and the left ankle traumatic arthroscopy measuring approximately 6 cm.

PROCEDURE: DEBRIDEMENT AND IRRIGATION, LEFT KNEE/THIGH GREATER THAN 20 CM, LESS THAN 50 CM, DEBRIDEMENT AND IRRIGATION, LEFT OPEN ANKLE, INCLUDING MUSCLE & CN.

ANESTHESIA: General endotracheal anesthesia.
Breaking down the note

• Start with the borders

• Start with the borders

63012: Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar.

63015 is laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g. Spinal stenosis).

63020: Laminotomy (hemilaminectomy) with decompression of nerve root(s), including partial facetectomy, foraminotomy and/ or excision of herniated intervertebral disc.

61510: …Supratentorial

61518: …Infratentorial
Breaking down the note

- Start with the borders

Key words and phrases can add coding opportunities
Breaking down the note

• Sort and assemble the middle pieces
  – Watch for compartment change or side changes

Debridement of the type I SLAP tear was performed using the 4.5-mm shaver. Once the SLAP tear was debrided, the hook probe was used to evaluate the remainder of the labrum, and there was no evidence of tearing off the glenoid. **Next, attention was turned to the rotator cuff.**

The 4.5-mm shaver was used to debride the flap tear on the articular side. Once the flap tear of the supraspinatus was debrided, copious amounts of irrigation were performed.

Breaking down the note

• Sort and assemble the middle pieces
  – A separate incision was made…
  – Next, an incision was made…

These are flags for potential coding opportunities.

Not all cases with separate incisions will have bundling issues. Consult your CCI guidelines.
Breaking down the note

• Sort and assemble the middle pieces
  
  – Reason for the surgery?

PROCEDURAL DIAGNOSIS: Mangled left hand status post traumatic amputations of digits 4, 5, and 6 and partial amputations of digits 1, 2, and 3.

PROGRESSIVE DIAGNOSIS: Mangled left hand status post traumatic amputations of digits 2, 3, and 6 and partial amputations of digits 1, 2, and 3.

PROCEDURE: DEBRIDEMENT AND IRRIGATION OF MANGLED LEFT HND OTP

It should be noted that the skin flaps were largely viable with healthy bleeding tissue and there is a small amount of hematoma evacuated from the wound beds of residual digits 3 and 4. Next, the wound was copiously irrigated and debrided to include skin, muscle, tendons, and bone and repeat interval closure of the skin flaps was performed using 3-0 prolene in an interrupted fashion.

The patient tolerated the procedure well without complications. The wound was then dressed with Xeroform, left, cast padding, HBO pads, and then a splint was applied for comfort. The patient tolerated the procedure well, and was extubated and transferred back to PACU.

Breaking down the note

• Sort and assemble the middle pieces
  
  – How deep did the surgeon work?

The patient had confirmation of return of the bone to acceptable alignment with fluoroscopy. Next, we turned our attention to closure using monofilament to re-close the surgical incision site leaving the traumatic wound open.

The patient was dressed in a sterile fashion and drains were removed. He was then transferred to PACU in stable condition.

Please note that the debridement was performed in the skin, subcutaneous tissue and layers of the bone. Major contaminates were found involving all 3 of these layers consisting of a small amount of dirt. The wound was pristine and debrised free prior to closure.
Breaking down the note

• Sort and assemble the middle pieces
  – Did the surgeon move to other locations?

Attention was turned to the chronic bucket-handle tear of the lateral meniscus. Next the bucket-handle tear of the lateral meniscus was evaluated. There was significant scarring around the bucket-handle tear. An attempt at reduction was performed and it was irreducible. After multiple attempts at reducing the wear at the patellofemoral joint. No evidence of patellofemoral maltracking. Next, the camera was swung to the medial compartment. A spinal needle was used to localize the anteromedial portal. There was no evidence of chondral wear in the medial compartment and no evidence of meniscal pathology. Next the tear was evaluated and there was evidence of complete...
Breaking down the note

• Sort and assemble the middle pieces
  – What body area is the surgeon working?

Breaking down the note

• Watch out for trick pieces
  For example: Tendon Repairs

  ➢ It’s important to identify primary versus secondary – it won’t always be obvious.
  ➢ The timeline to determine secondary will depend on the tendon being repaired.
  ➢ You may have to research further in the patient record or history to discover the date of the injury
Breaking down the note

• Watch out for trick pieces

For example: Lesion Excisions

- Excision size is the lesion plus margin.

For example: Lesion Excisions

- 5 cm excised diameter
  - 2 cm margin + 1 cm lesion + 2 cm margin = 5 cm excised diameter

- 2.4 cm excised diameter
  - 0.2 cm margin + 2.0 cm lesion + 0.2 cm margin = 2.4 cm excised diameter

A woman who presents for excision of scalp lesions. The right scalp lesion measures approximately 1.5 cm in length and is approximately 0.5 cm wide. The left scalp lesion also measured 1.5 cm in length and is about approximately 0.5 cm wide. The patient noticed the left scalp lesion approximately 1 year ago and had an episode of bleeding and ulceration. She reports that this lesion has grown in size. She also noted a smaller lesion on the right scalp about 2 months ago, which also has increased in size. The patient has a history of skin cancers given that she used to work as a roofer. She now presents for excision of these 2 scalp lesions. The risks, benefits, and alternative treatments were discussed with the patient including...
Breaking down the note

• Watch out for trick pieces

For example: Spine – segment versus space

Segment = 2 vertebrae separated by an intervertebral disc

Per Internet Search findings

Per CPT, a vertebral segment represents a single complete vertebral bone with its associated articual processes and laminae.
Breaking down the note

• Watch out for trick pieces

For example: Spine – segment versus space
A perfectly coded surgical note created by the hands of a skilled coder!

Resources for Research

- NCCI
- Specialty Coding Companion Books
- Specialty Societies
Resources for Research

- AMA (CPT Assistant, CPT Manual, CPT Errata)
- Illustrated Medical Dictionary
- Coder’s Desk Reference (Ingenix)

Resources for Research

- Google or any other search engine
- CMS or other payer policies
- AAPC and other discussion forums or discussion with your colleagues
Communication Basics

• Open communication with your Providers is the key to effectively identifying or locating your missing puzzle pieces

Communication Basics

There are three main pieces to every communication puzzle:

• Language
• Trust
• Personality
Communication Basics

• Language
  – Accent
    • Speed plays a part. We hear and listen at the same speed we speak.
  – Jargon
    • Be careful not to use acronyms or terms the listener may not be familiar with.

Communication Basics

• Trust
  – Without trust, effective communication is nothing more than a dream
Communication Basics

• Emotional Trust
  – The person feels you understand what they are feeling.

• Intellectual Trust
  – The person believes you understand what they are saying.

Personalities

• You're just minutes away from uncovering surprising details about yourself and how you interact with others!

• The Rockhurst SELF Quiz is a fun, quick assessment of people's interaction styles. Your quiz answers will reveal which of the four styles of interaction is most like you. You'll find out if you're a Social, an Efficient, a Loyal, or a Factual. The answers are revealing and surprising!

• Your results will break down your unique interaction style and what it means for you and those around you. In addition, you'll get tons of ideas and tips for working with others — especially those who fall into another category!

• It's a great tool for understanding and working effectively with diverse personalities, as well as finding out fun facts about who you are!

http://www.nationalseminarstraining.com/selfquiz/indexHP.cfm
Thank You!