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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Differentiate Good vs Bad Documentation With 2 Hysterectomy Op Notes

Save these on-the-go documentation tips to ward against big mistakes.

You should never rely on the title of your surgeon's op note to choose the appropriate CPT® code otherwise, you could be setting yourself up for a denial. Compare these two hysterectomy operative reports and learn what makes a good and bad note and what to do about it.

Examine Example of Poor Documentation

Preoperative diagnosis: Uterovaginal prolapse
Postoperative diagnosis: Uterovaginal prolapse
Operation: Hysterectomy; anterior and posterior repair

Procedure: The patient was placed in a lithotomy position, and the perineum and vagina were prepped in the usual sterile manner. A tenaculum was placed on the lip of the cervix, and the cul-de-sac was entered. The bladder was pushed off the cervix and the lower uterine segment and the anterior cul-de-sac was entered. The uterosacral and cardinal ligaments and the uterine vessels were clamped, cut and ligated. The fundus of the uterus was inverted, and adnexal structures were clamped, cut and tied. The peritoneum was closed with a purse-string suture. The cystocele was repaired. The procedure was concluded, and vaginal packing was put into the vagina. The patient tolerated the procedure and was sent to recovery in good condition.

Why This Example Is a Bad Op Note

What you don't know: You cannot determine whether this is a vaginal hysterectomy or an abdominal. The physician left a whole piece of the operation unstated.

Moreover, "you only have minimal documentation of the repair" but you don't know if it's an anterior and posterior repair, says **Marvel Hammer, RN, CPC, CCS-P, ACS-PM, CHCO**, owner of MJH Consulting in Denver. "You also don't know whether he removed any ovaries or tubes. You have several potential codes in the 572xx code range, and without the detail you can't compliantly select a code."

In other words, you have to have your doctor document this information so that the documentation supports what you bill.

Action steps: You should "review any addendum reports," Hammer says.

If you still have questions, get clarification from the physician immediately. Your physicians should know that they can maximize their reimbursement for the work they did if they have good documentation. They should also understand that coding and billing staff will be coming directly to them for clarification when the notes do not make sense or have missing words.

Also, ask an experienced coder to explain what's generally done during a hysterectomy so you'll learn more about the procedure and what should be in the note.

Don't do this: You shouldn't code simply from the procedure title section. "You have to compare the title and the procedure detail to accurately report your provider's services," Hammer says.

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Always read the whole op note, experts say. Don't be tempted to only read the pre-op and post-op diagnosis and the type of operation the physician performed you can easily miss details and other billable services the doctor did not include in the summary.

Example of Good Documentation

Preoperative diagnosis: Uterovaginal prolapse
Postoperative diagnosis: Uterovaginal prolapse
Operation: Vaginal hysterectomy; posterior colporrhaphy

Procedure: Under general anesthesia, the patient was placed in a lithotomy position. The perineum and vagina were prepped and draped in the usual sterile manner. A tenaculum was placed on the posterior lip of the cervix, and cul-de-sac was entered without difficulty. The cervical mucosa was incised and reflected circumferentially. The bladder was pushed off the cervix, and the lower uterine segment and the anterior cul-de-sac were entered. The uterosacral and cardinal ligaments including the uterine vessels were clamped, cut and ligated. The fundus of the uterus was inverted, and the adnexal structures were clamped, cut and doubly tied. Inspection of the ovaries was negative. The peritoneum was closed with a purse-string suture.

Attention was then given to the posterior repair. A V-shaped incision was made from either side of the introitus toward the anus. The intervening skin and mucosa were removed, and the rectovaginal fascia was sutured across the midline. Using 0 chromic catgut, redundant posterior mucosa was excised and was closed with interrupted 0 chromic catgut sutures.

The procedure was concluded by repeated suturing of the mucosa in the perineal body, and the overlying skin was closed with continuous #3-0 Vicryl. Vaginal packing was placed. The patient tolerated the procedure well. Estimated blood loss was less than 500 ml. Sponge count was correct. The patient was sent to the recovery room in good condition.

Why This One's Better

You clearly have much more information here, particularly about the vaginal approach and the posterior repair, which are crucial for assigning the correct codes. You can also tell that the physician did not remove the tubes and ovaries because the physician did not cut the infundibulopelvic ligament, a prerequisite to removing the ovaries.

Tips: A good procedure note should be organized, have standard forms or recording information available in a written or electronic format, be accurate, be legible, and use only approved abbreviations. In other words, a good op note should follow the physician's hands through the procedure.

You should report the above example with:

- 618.4 (Uterovaginal prolapse, unspecified) for the pre/post-op uterovaginal prolapse diagnosis.
- 58260 (Vaginal hysterectomy, for uterus 250 g or less) for the procedure. Neither note contains the uterus weight, so you would choose the lesser code.
- 57250-51 (Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy; multiple procedures). You would append the multiple- procedure modifier to indicate to payers that this is a secondary procedure.

Keep in mind: Even the best examples still might need further information from the ob-gyn. In this case, the diagnosis could use further clarification. Otherwise, you risk the insurer denying the procedure due to an "unspecified" diagnosis code.

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