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Part B Insider (Multispecialty) Coding Alert

Part B Mythbuster: Don't Confuse Facility's Documentation Rules With Surgeon's Report

Concentrate on your physician's thorough note rather than comparing with the facility, experts say.

Myth: When your surgeon performs surgery in a hospital, you should coordinate your coding with the hospital's records.

Reality: Although that rule is smart for surgeries performed in ambulatory surgical centers (ASCs), it isn't true for facility-based surgeries. When it comes to coding for your surgeon's work, stick to your physician's documentation as a guide regarding what to report, and don't stress about what the facility documents.

A reader contacted the Insider and said that her surgical practice waits for typewritten operative reports before billing for the doctor's role in the surgery--but the corresponding hospital-based coder told her they just use handwritten operative notes that are in the charts when they do not receive the dictated operative reports in time to bill the surgery. She asked whether CMS has documentation requirements that state that the notes must be in a specific format before she can submit the claim, because she doesn't want to be billing different codes for the surgery than the facility is reporting.

Here's the lowdown: The facility is governed by a different set of rules than the office-based surgical coder, says **Suzan Berman, CPC, CEMC, CEDC,** senior manager of coding education and documentation compliance in the Physician Services Division with UPMC in Pittsburgh.

Facility regs: "The Joint Commission wants an immediate post-op note written after the surgery," she says. "The facility can bill from this as they are billing a different 'type' of service. They are billing for essentially the room, the staff, the equipment, etc." The Joint Commission's documentation rules can be found at www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=215&StandardsFAQChapterId=13.

What constitutes immediate: According to the Joint Commission, the operative report must be written or dictated "immediately after an operative or other high risk procedure," and defines "immediately after surgery" as "upon completion of surgery, before the patient is transferred to the next level of care."

Physician regs: The surgeon's chart will include detailed documentation based on the specifics of the surgery that she performed and documented. "It must be thorough and contain all the required elements about equipment count, sedation, pre- and post-op diagnoses, indications, description of the procedure, attestations, signature, etc.," Berman says. "The coder can then assign a proper service code to the description the physician provides."

Bottom line: The Part B coder should continue to select the appropriate code from the surgeon's documentation, and if the notes aren't thorough, take it up with the physician directly.

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