Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Mythbuster: Op Note Scrutiny Focuses on More Than Just the Title

Plus: Bust this myth about same-day E/M services.

Myth: You should work twice as hard on the title of your physician's medical record than you should on the note itself, because the title is enough to justify the codes you report.

Reality: The physician must document the services he performs in the body of the record or an auditor would assume that he didn't perform the procedures.

For instance: Suppose the subject of the physician's note is "Alan Johnson's corticosteroid injection," but then he only dictates details about the diagnosis and E/M service (not an injection) in the body of his report.

Solution: You can report the E/M service but not the injection.

Explanation: Most coders and auditors do not use the title in their review of the documentation. If it is not indicated in the body of the note, it is presumed that it was something that wound up not happening. The body of the note should match the title as closely as possible to all the things done during the service session.

The documentation should include the location of the injection site, whether it was unilateral or bilateral, and the exact substance being injected. The report should name the medication and the quantity used so you'll be able to select the correct number of units of the applicable HCPCS code. In addition, you'll want to document any anesthetics used as well as whether the injection was made under guidance.

This advice goes both ways□just as you should document the entire procedure that the physician performs, you should also ensure that complete documentation exists for the E/M service so you can get paid for both separately identifiable procedures.