Codify
BY AAPC

Outpatient Facility Coding Alert

You Be the Coder: Don't Leave Reimbursement on the Table With Incomplete Op Reports

Question: My physician performed a 38500, but did not document the closure. I inquired and he is opting not to include it in the operative report. Can I still bill out for the 38500 service?

Utah Subscriber

Answer: You should inform the physician that it's inappropriate practice to leave an operative report incomplete. In fact, you can even go as far as explaining to the physician you cannot properly code the procedure without documentation of the closure.

While the closure might seem like a trivial portion of the procedure, you've got to take into account each of the services included in code 38500 (Biopsy or excision of lymph node(s); open, superficial). Typically, a superficial biopsy or excision will involve a simple closure. If your physician has a basic knowledge of the procedural coding process, he may even argue that since it's a simple closure, it will be included in 38500 - which is true. However, he must also consider that when the Centers for Medicare and Medicaid Services (CMS) reimburses for 38500, they are including a simple closure in their relative value unit (RVU) determination. Therefore, in reporting code 38500 without closure documented, the physician would technically be billing for services not documented in the operative report.

Another equally valid reason why this should be sent back for an addendum is because you are otherwise making the assumption that a simple closure was performed. In the instance that the physician actually performed an intermediate closure, he would be leaving a substantial amount of reimbursement on the table - not to mention the fact that he'd be submitting an inaccurate code for the services rendered.