How to Code Medical Operative Reports

Before you begin coding, read through the medical record. Are there any terms you do not understand? Highlight unfamiliar words and research for understanding.

1. One way of quickly starting the coding process is by focusing on the procedures listed in the header. Although procedures listed in the header may not be listed correctly, it is a place to start. If you are not familiar with the procedure, do some research to understand more about the procedure. If you are a visual learner, you may want to search the internet for a video showing how the procedure is performed.

   What procedures are listed in the header of the report?

   _____

2. Look for key words — Key words may include locations and anatomical structures involved (cervical spine, humerus, lower extremity, organs), surgical approach (open, laparoscopic, percutaneous), procedure method (debridement, drainage, incision, repair, etc.), procedure type (open, closed, simple, intermediate, etc.), size and number, and the surgical instruments used during the procedure.

   What key words do you see specific to the procedures listed above?

   _____

3. Read the body — All procedures reported should be documented within the body of the report. Read the note in its entirety to verify the procedures performed. Procedures documented within the body of the report may not be listed in the header at all. The body may indicate a procedure was abandoned or complicated, possibly indicating the need for a different procedure code or reporting of a modifier.

   Does the body of the report support the procedures listed above? ☐ Yes ☐ No

4. Look for the procedure in the CPT® alphabetic index. The CPT® index is alphabetized with main terms organized by condition, procedure, anatomic site, synonyms, eponyms, and abbreviations. Information in the alphabetic index expands by sub terms listed alphabetically below each main term. The sub terms further clarify the main term by noting condition, procedure, or anatomic site. With each sub term is a listing of the CPT® code or code ranges located in the numeric section of the CPT® code book.

   What code(s) does the CPT® Alphabetic Index refer you to?

   _____

5. Look at each of the codes in the CPT® numeric section. Read all associated section guidelines, parenthetical statements, coding tips, decision trees, illustrations, etc. Cross out codes listed in #4 that do not match the approach or method used in the procedure. For the codes that are left, what is different about the codes?

   _____

6. 6. Refer to the documentation to determine the code based on the differences in #5.

   CPT® codes remaining: _____

7. Does the documentation support the remaining codes listed? ☐ Yes ☐ No

8. Step for Coding Multiple Procedures

   a. Select all procedure codes
   b. Check the codes against the NCCI (Columns 1 and 2) and the Mutually Exclusive Table for bundling and eliminate any bundled codes. If the codes can be reported together, modifier 59 can be appended to the code in the first column or the code in the second column. For consistency in the Legacy course, when the documentation supports the use of a modifier to report a bundled code, append the appropriate modifier to the column 2 code.
   c. Check the RVUs for the remaining codes and sequence by RVU, highest to lowest.

Medical Coding Worksheet Operative Reports

Before you begin coding, read through the medical record. Are there any terms you do not understand? Highlight unfamiliar words and research for understanding.

1. What procedures are listed in the header of the report?

_____

 2. What key words do you see specific to the procedures listed above?

_____

3. Does the body of the report support the procedures listed above?   ☐ Yes ☐ No

4. What code(s) does the CPT® Alphabetic Index refer you to?

_____

5. Look at each of the codes in the CPT® numeric section. Read all associated section guidelines, parenthetical statements, coding tips, decision trees, illustrations, etc. Cross out codes listed in #4 that do not match the approach or method used in the procedure. For the codes that are left, what is the difference between the codes?

_____

6. Refer to the documentation to determine the code based on the differences in #5. CPT® codes remaining: _____

7. Does the documentation support the remaining codes listed?

_____

8. Are any codes included in another code reported?   ☐ Yes ☐ No

9. Are any modifiers required for the codes?

_____

10. What codes are reported and in what sequence are they reported?

_____