

# ACCEPTABLE OPERATIVE REPORT # 1

This operative report follows the standards set by The Joint Commission and AAAHC for sufficient information to:

- identify the patient
- support the diagnosis
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Good Facial Plastic Surgery  
123 Main Street, Suite 200  
Springfield, USA 56789

PATIENT NAME: Anne Zeigler

DATE: July 6, 2011

PREOPERATIVE DIAGNOSIS: Bilateral upper eyelid dermatochalasis

POSTOPERATIVE DIAGNOSIS: Same

PROCEDURE: Bilateral upper lid blepharoplasty, (CPT 15822)

SURGEON: John D. Good, M.D.

ANESTHESIA: Lidocaine with 1:100,000 epinephrine

DICTATED BY: John D. Good, M.D.

This 65-year-old female demonstrates conditions described above of excess and redundant eyelid skin with puffiness and has requested surgical correction. The procedure, alternatives, risks and limitations in this individual case have been very carefully discussed with the patient. All questions have been thoroughly answered, and the patient understands the surgery indicated. She has requested this corrective repair be undertaken, and consent was signed.

The excess and redundant skin of the upper lids producing redundancy and impairment of lateral vision was carefully measured, and the incisions were marked for fusiform

excision with a marking pen. The surgical calipers were used to measure the supratarsal incisions so that the incision was symmetrical from the ciliary margin bilaterally.

The upper eyelid areas were bilaterally injected with 1% Lidocaine with 1:100,000 Epinephrine for anesthesia and vasoconstriction. The plane of injection was superficial and external to the orbital septum of the upper and lower eyelids bilaterally.

The face was prepped and draped in the usual sterile manner.

After waiting a period of approximately ten minutes for adequate vasoconstriction, the previously outlined excessive skin of the right upper eyelid was excised with blunt dissection. Hemostasis was obtained with a bipolar cautery. A thin strip of orbicularis oculi muscle was excised in order to expose the orbital septum on the right. The defect in the orbital septum was identified, and herniated orbital fat was exposed. The abnormally protruding positions in the medial pocket were carefully excised and the stalk meticulously cauterized with the bipolar cautery unit. A similar procedure was performed exposing herniated portion of the nasal pocket. Great care was taken to obtain perfect hemostasis with this maneuver. A similar procedure of removing skin and taking care of the herniated fat was performed on the left upper eyelid in the same fashion. Careful hemostasis had been obtained on the upper lid areas. The lateral aspects of the upper eyelid incisions were closed with a couple of interrupted 7 – 0 blue prolene sutures.

At the end of the operation the patient's vision and extraocular muscle movements were checked and found to be intact. There was no diplopia, no ptosis, no ectropion. Wounds were reexamined for hemostasis, and no hematomas were noted. Cooled saline compresses were placed over the upper and lower eyelid regions bilaterally,

The procedures were completed without complication and tolerated well. The patient was released in the company of her husband to return home in satisfactory condition. A follow-up appointment was scheduled, routine post-op medications prescribed, and post-op instructions given to the responsible party.

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John D. Good, M.D.

## ACCEPTABLE OPERATIVE REPORT # 2

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Elm Surgery Center  
987 Main Street  
Springfield, USA 56789

Patient Name: Carla Winters

Date of Surgery: July 7, 2011

Preoperative Diagnosis: Facial and neck skin ptosis  
Cheek, neck, and jowl lipotosis  
Facial rhytids

Postoperative Diagnosis: Same

Procedure: Temporal cheek-neck facelift (CPT 15828)  
Submental suction assisted lipectomy (CPT 15876)

Surgeon: John D. Good, M.D.

Anesthesia: General

Anesthesiologist: John Smith, M.D.

Dictated by: John D. Good, M.D.

This patient is a 65-year old female who has progressive aging changes of the face and neck. The patient demonstrates the deformities described above and has requested surgical correction. The procedure, risks, limitations, and alternatives in this individual

case have been very carefully discussed with the patient. The patient has consented to surgery.

The patient was brought into the operating room and placed in the supine position on the operating table. An intravenous line was started and anesthesia was maintained throughout the case. The patient was monitored for cardiac, blood pressure, and oxygen saturation continuously.

The hair was prepared and secured with rubber bands and micropore tape along the incision line. A marking pen had been used to outline the area of the incisions, which included the preauricular area to the level of the tragus, the post-tragal region, the post auricular region and into the hairline. In addition, the incision was marked in the temporal area in the event of a temporal lift, then across the coronal scalp for the forehead lift. The incision was marked in the submental crease for the submental lipectomy and liposuction. The incision in the post auricular area extended up on the posterior aspect of the ear and ended near the occipital hairline.

The areas to be operated on were injected with 1% Lidocaine containing 1:100,000 Epinephrine. This provided local anesthesia and vasoconstriction. The total of Lidocaine used throughout the procedure was maintained at no more than 500mg.

#### SUBMENTAL SUCTION ASSISTED LIPECTOMY

The incision was made, as previously outlined, in the submental crease in a transverse direction, through the skin and subcutaneous tissue, and hemostasis was obtained with bipolar cautery. A Metzenbaum scissors was used to elevate the area in the submental region for about 2 or 3 cm and making radial tunnels from the angle of the mandible all the way to the next angle of the mandible. 4 mm liposuction cannula was then introduced along these previously outlined tunnels into the jowl on both sides and down top the anterior border of the sternocleidomastoid laterally and just past the thyroid notch inferiorly. The tunnels were enlarged with a 6 mm flat liposuction cannula.

Then with the Wells-Johnson liposuction machine 27-29 inches of underwater mercury suction was accomplished in all tunnels. Care was taken not to turn the opening of the suction cannula up to the dermis, but it was rotated in and out taking a symmetrical amount of fat from each area. A similar procedure was performed with the 4 mm cannula cleaning the area. Bilateral areas were palpated for symmetry, and any remaining fat was then suctioned directly.

A triangular wedge of anterior platysma border was cauterized and excised at the cervical mental angle. A plication stitch of 3-0 Vicryl was placed.

When a satisfactory visible result had been accomplished from the liposuction, the inferior flap was then advanced over anteriorly and the overlying skin excised in an incremental fashion. 5-0 plain catgut was used for closure in a running interlocking

fashion. The wound was cleaned at the end, dried, and Mastisol applied. Then tan micropore tape was placed for support to the entire area.

## FACELIFT

After waiting approximately 10-15 minutes for adequate vasoconstriction the post auricular incision was started at the earlobe and continued up on the posterior aspect of the ear for approximately 2 cm just superior to the external auditory canal. A gentle curve was then made, and again the incision was carried down to and into the posterior hairline paralleling the hair follicles and directed posteriorly towards the occipital region. A preauricular incision was carried into the natural crease superior to the tragus, curved posterior to the tragus bilaterally then brought out inferiorly in the natural crease between the lobule and preauricular skin. The incision was made in the temporal area beveling parallel with the hair follicles. (The incision had been designed with curve underneath the sideburn in order to maintain the sideburn hair locations and then curved posteriorly.)

The plane of dissection in the hairbearing area was kept deep to the roots of the hair follicles and superficial to the fascia of the temporalis muscle and sternocleidomastoid. The dissection over the temporalis muscle was continued anteriorly towards the anterior hairline and underneath the frontalis to the supraorbital rim. At the superior level of the zygoma and at the level of the sideburn, dissection was brought more superficially in order to avoid the nerves and vessels in the areas, specifically the frontalis branch of the facial nerve.

The facial flaps were then elevated with both blunt and sharp dissection with the Kahn facelift dissecting scissors in the post auricular region to pass the angle of the mandible. This area of undermining was connected with an area of undermining starting with the temporal region extending in the preauricular area of the cheek out to the jawline. Great care was taken to direct the plane of dissecting superficial to the parotid fascia or SMAS. The entire dissection was carried in a radial fashion from the ear for approximately 4 cm at the lateral canthal area to 8-10 cm in the neck region. When the areas of dissection had been connected carefully, hemostasis was obtained and all areas inspected. At no point were muscle fibers or major vessels or nerves encountered in the dissection.

The SMAS was sharply incised in a semilunar fashion in front of the ear and in front of the anterior border of the SCM. The SMAS flap was then advanced posteriorly and superiorly. The SMAS was split at the level of the earlobe, and the inferior portion was sutured to the mastoid periosteum. The excess SMAS was trimmed and excised from the portion anterior to the auricle. The SMAS was then imbricated with 2-0 Surgidak interrupted sutures.

The area was then inspected for any bleeding points and careful hemostasis obtained. The flaps were then rotated and advanced posteriorly and then superiorly, and incremental cuts were made and the suspension points in the pre and post auricular

area were done with 2-0 Tycron suture. The excess and redundant amount of skin were then excised and trimmed cautiously so as not to cause any downward pull on the ear lobule or any stretching of the scars in the healing period. Skin closure was accomplished in the hairbearing areas with 5-0 Nylon in the preauricular tuft and 4-0 Nylon interrupted in the post auricular area. The pre auricular area was closed first with 5-0 Dexon at the ear lobules, and 6-0 Nylon at the lobules, and 5-0 plain catgut in a running interlocking fashion. 5-0 plain catgut was used in the post auricular area as well, leaving ample room for serosanguinous drainage into the dressing. The post tragal incision was closed with interrupted and running interlocking 5-0 plain catgut. The exact similar procedure was repeated on the left side.

At the end of this procedure, all flaps were inspected for adequate capillary filling or any evidence of hematoma formation. Any small amount of fluid was expressed post-auricularly. A fully perforated bulb suction drain was placed under the flap and exited posterior to the hairline on each side prior to the suture closure. A Bacitracin impregnated nonstick dressing was cut to conform to the pre and post auricular area and placed over the incision lines.

ABD padding over 4X4 gauze was used to cover the pre and post auricular areas. This was wrapped around the head in a vertical circumferential fashion and anchored with white micropore tape in a non-constricting but secured fashion. The entire dressing complex was secured with a pre-formed elastic stretch wrap device. All branches of the facial nerve were checked and appeared to be functioning normally.

The procedures were completed without complication and tolerated well. The patient left the operating room in satisfactory condition. A follow-up appointment was scheduled, routine post-op medications prescribed, and post-op instructions given to the responsible party.

The patient was released to return home in satisfactory condition.

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John D. Good, M.D.

## ACCEPTABLE OPERATIVE REPORT # 3

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Central Hospital  
456 Central Avenue  
Springfield, USA 56789

PATIENT NAME: David Vinson

DATE: July 11, 2011

PREOPERATIVE DIAGNOSIS: Nasal deformity, status post rhinoplasty

POSTOPERATIVE DIAGNOSIS: Same

PROCEDURE: Revision rhinoplasty (CPT 30450)  
Left conchal cartilage harvest (CPT 21235)

SURGEON: John D. Good, M.D.

ASSISTANT: None

ANESTHESIA: General

ANESTHESIOLOGIST: John Smith, M.D.

Dictated BY: John D. Good, M.D.

INDICATIONS FOR THE PROCEDURE:

This patient is an otherwise healthy 31 year old male who had a previous nasal fracture. During his healing, perioperatively he did sustain a hockey puck to the nose resulting in

a saddle-nose deformity with septal hematoma. The patient healed status post rhinoplasty as a result but was left with a persistent saddle-nose dorsal defect. The patient was consented for the above-stated procedure. The risks, benefits, and alternatives were discussed.

The patient was brought into the operating room and placed in the supine position on the operating table. An intravenous line was started and anesthesia was maintained throughout the case. The patient was monitored for cardiac, blood pressure, and oxygen saturation continuously.

#### DESCRIPTION OF PROCEDURE:

The patient was prepped and draped in the usual sterile fashion. The patient did have approximately 12 mL of Lidocaine with epinephrine 1% with 1:100,000 infiltrated into the nasal soft tissues. In addition to this, cocaine pledgets were placed to assist with hemostasis.

At this point, attention was turned to the left ear. Approximately 3 mL of 1% Lidocaine with 1:100,000 epinephrine was infiltrated into the subcutaneous tissues of the conchal bulb. Betadine was utilized for preparation. A 15 blade was used to incise along the posterior conchal area and a Freer elevator was utilized to lift the soft tissues off the conchal cartilage in a submucoperichondrial plane. I then completed this along the posterior aspect of the conchal cartilage, was transected in the concha cavum and concha cymba, both were harvested. These were placed aside in saline. Hemostasis was obtained with bipolar electrocauterization. Bovie electrocauterization was also employed as needed. The entire length of the wound was then closed with 5-0 plain running locking suture. The patient then had a Telfa placed both anterior and posterior to the conchal defect and placed in a sandwich dressing utilizing a 2-0 Prolene suture. Antibiotic ointment was applied generously.

Next, attention was turned to opening and lifting the soft tissues of the nose. A typical external columella inverted V gullwing incision was placed on the columella and trailed into a marginal incision. The soft tissues of the nose were then elevated using curved sharp scissors and Metzenbaums. Soft tissues were elevated over the lower lateral cartilages, upper lateral cartilages onto the nasal dorsum. At this point, attention was turned to osteotomies and examination of the external cartilages.

The patient did have very broad lower lateral cartilages leading to a bulbous tip. The lower lateral cartilages were trimmed in a symmetrical fashion leaving at least 8 mm of lower lateral cartilage bilaterally along the lateral aspect. Having completed this, the patient had medial and lateral osteotomies performed with a 2-mm osteotome. These were done transmucosally after elevating the tract using a Cottle elevator. Direct hemostasis pressure was applied to assist with bruising.

Next, attention was turned to tip mechanisms. The patient had a series of double-dome sutures placed into the nasal tip. Then, 5-0 Dexon was employed for intradomal

suturing, 5-0 clear Prolene was used for interdomal suturing. Having completed this, a 5-0 clear Prolene alar spanning suture was employed to narrow the superior tip area.

Next, attention was turned to dorsal augmentation. A Gore-Tex small implant had been selected, previously incised. This was taken to the back table and carved under sterile conditions. The patient then had the implant placed into the super-tip area to assist with support of the nasal dorsum. It was placed into a precise pocket and remained in the midline.

Next, attention was turned to performing a columella strut. The cartilage from the concha was shaped into a strut and placed into a precision pocket between the medial footplate of the lower lateral cartilage. This was fixed into position utilizing a 5-0 Dexon suture.

Having completed placement of all augmentation grafts, the patient was examined for hemostasis. The external columella inverted gullwing incision along the nasal tip was closed with a series of interrupted everting 6-0 black nylon sutures. The entire marginal incisions for cosmetic rhinoplasty were closed utilizing a series of 5-0 plain interrupted sutures.

At the termination of the case, the ear was inspected and the position of the conchal cartilage harvest was hemostatic. There was no evidence of hematoma, and the patient had a series of brown Steri-Strips and Aquaplast cast placed over the nasal dorsum. The inner nasal area was then examined at the termination of the case and it seemed to be hemostatic as well.

The patient was transferred to the PACU in stable condition. He was charged to home on antibiotics to prevent infection both from the left ear conchal cartilage harvest and also the Gore-Tex implant area. He was asked to follow up in 4 days for removal of the bolster overlying the conchal cartilage harvest.

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John D. Good, M.D.

## ACCEPTABLE OPERATIVE REPORT # 4

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Good Facial Plastic Surgery  
123 Main Street, Suite 200  
Springfield, USA 56789

Patient Name: Frances Thompson

Date: July 13, 2011

Preoperative Diagnosis: Malignant melanoma-in-situ, right lateral cheek

Postoperative Diagnosis: Same

Operation performed: Excision of right lateral cheek malignant melanoma (CPT 11642)

Surgeon: John D. Good, M.D.

Anesthesia: Local

Findings: 1.1cm x 0.6cm brown pigmented macular lesion of the right lateral cheek

Specimen: Right lateral cheek lesion

Indications: This is a 75 year-old woman for treatment of a right lateral cheek malignant melanoma-in-situ. She had a previous biopsy that revealed a melanoma-in-situ, lentigo maligna type. I had a long discussion with the patient regarding treatment options and we have elected to proceed with surgical excision with clearance of margins followed by staged reconstruction. The details, limitations, and ramifications of the above stated procedures were reviewed and all the patient's questions were answered. The patient decided to proceed with the surgery.

Operative Report: Pre-operative photographs were reviewed and all consents were previously signed. The patient was placed into a supine position on the operating table for patient comfort. The right cheek was examined. It demonstrated an ovoid lesion with brown pigmentation and central scarring as a result of the recent biopsy. The lesion measured 1.1 cm x 0.6 cm. 5mm margins were marked circumferentially around the lesion into normal appearing skin with the resulting defect of the right lateral cheek measuring 2.1 cm x 1.6 cm. The entire area was then infiltrated with 4cc of 1% lidocaine with 1:100,000 epinephrine. The cheek was then prepped and draped in standard fashion.

The #15 blade was used to make an incision in the skin along the marked lines. The depth of the excision was through the subcutaneous tissue down to the level of the subcutaneous fat. The lesion was removed in its entirety from superior to inferior. Careful attention was made for a homogenous tissue removal to the level of the subcutaneous fat across the entire specimen. Prior to removal, a short stitch was placed at the superior margin and a long stitch was placed left medial cheek. The specimen was then placed in formalin. The wound bed was then inspected and the bipolar cautery was used for hemostasis. A dressing was then placed over the wound consisting of bacitracin, non-stick telfa dressing and a sterile 2x2 dressing in preparation for margin evaluation and staged reconstruction.

The patient was delivered to the recovery room in good, stable condition. The patient tolerated the procedure well and was comfortable throughout. She was given all post-operative instructions and wound care was reviewed. She was instructed to use bacitracin over the wound and counseled regarding sun avoidance. Post op medication including pain control was given. A follow-up appointment was scheduled for staged reconstruction. The patient was discharged home in stable condition.

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John D. Good, M.D.

# ACCEPTABLE OPERATIVE REPORT # 5

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Central Hospital  
456 Central Avenue  
Springfield, USA 56789

DATE OF OPERATION: July 18, 2011

PATIENT NAME: Frances Thompson

PREOPERATIVE DX:

1. Right cheek open wound
2. Right cheek skin melanoma in situ

POSTOPERATIVE DX:

1. Right cheek open wound
2. Right cheek skin melanoma in situ

OPERATION PERFORMED:

1. Reconstruction of right cheek defect with rotation advancement flap (CPT 14040)
2. Surgical preparation of open cheek wound (CPT 15004)

ANESTHESIA: Monitored Anesthesia Care

COMPLICATIONS: None

DISPOSITION: The patient was discharged in stable condition to the recovery room.

INDICATION FOR PROCEDURE:

Mrs. Thompson is a 75 year-old woman who developed a lesion of her right cheek which was consistent with a melanoma in situ, lentigo maligna-type. She previously underwent excision of the lesion for clearance of surgical margins which was confirmed

and presents today for reconstruction of a right cheek defect. The details, limitations, ramifications, complications of the above-stated procedures were reviewed with the patient and her family. The patient elected to proceed with the procedure.

#### OPERATIVE PROCEDURE:

The patient was taken to the operating room and placed supine on the operating room table. Monitored Anesthesia Care was delivered and the dressing was taken off the right cheek. A right lateral cheek defect measuring 2.1 cm x 1.6 cm was seen and the operative plan for closure of defect was a rotation advancement flap. The surgical marking pen was used to convert the ovoid defect into a rhomboid defect.

A superiorly-based rhombic transposition flap was then marked in standard fashion with a plan to allow the superolateral skin and soft tissue to rotate and advance into position and close the wound. Local anesthesia of 1% lidocaine with 1:100,000 units epinephrine of a total of 6 ml was injected into the wound bed and to the area of the planned flap. The patient was then prepped and draped in standard fashion.

The procedure began with the #15 blade used to incise upon a marked incision line to create the rhomboid defect as planned. The wound bed was then irrigated copiously with bacitracin solution. Additionally, surgical preparation of the wound bed was performed with excision of the skin rim as well a debridement of the underlying soft tissue to create a granulating bed that would accept a transposition flap. Minor oozing was controlled with the use of the bipolar electrocautery. After preparation of the cheek wound was performed, the #15 blade was then used to incise upon the marked incision for the superiorly-based rhombic transposition flap. A Burrow's triangle was also marked out in the expected superior location for removal of this redundant tissue to prevent dog ear deformity. After the rhomboid flap was incised down to the level of the subcutaneous tissue, the first stitch was placed at the point of tension and was secured with the 4-0 Vicryl suture. This allowed the rhombic flap to rotate and advance into position to cover the wound and corners were tacked down with the use of the 5-0 PDS suture. The Burrow's triangle was then excised as expected with the use of the #15 blade and small areas of oozing were easily controlled with the use of the bipolar electrocautery. There was no excess tension found on the rotation flap and, therefore, the remainder of the subcutaneous sutures were placed to reapproximate the subcutaneous tissue and dermal tissue.

We then turned our attention to closure of the epidermis which was performed with the use of 6-0 Prolene with a combination of simple interrupted as well as running locking sutures. After the wound was closed in its entirety, it was cleaned and inspected. There were no areas of excess tension and the flap appeared to be well-vascularized. Therefore, bacitracin was then placed along the suture line and the drapes were then removed. The patient was then delivered in stable condition to the recovery room.

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John D. Good, M.D.

# ACCEPTABLE OPERATIVE REPORT # 6

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Elm Surgery Center  
987 Elm Street  
Springfield, USA 56789

## OPERATIVE REPORT

NAME: Jackie Pope

DATE OF OPERATION: July 26, 2011

DICTATING PHYSICIAN: J. Johnson, M.D.

ATTENDING PHYSICIAN: John D. Good, M.D.

PRIMARY SURGEON: Dr. John Good

ASSISTANT SURGEON: Dr. June Johnson

ANESTHESIA: Monitored Anesthesia Care

### OPERATIONS PERFORMED:

1. Bilateral blepharoplasty, upper lid. CPT Code 15822
2. Lateral brow lift. CPT Code 15824
3. Excision of a mid-forehead mole.

COMPLICATIONS: None

EBL: 20 mL

FLUIDS RECEIVED: 1200 mL

LOCAL ANESTHETIC: 0.5% Marcaine with epinephrine mixed with 2% Xylocaine with epinephrine 50:50, a total of 7 mL was used.

FINDINGS: The patient had lateral brow ptosis, lateral hooding with upper lid dermatochalasis, as well as a central mid-forehead mole.

INDICATIONS: This is a 62-year-old female, who has a functional visual deficit secondary to upper lid dermatochalasis with lateral hooding, as well as brow ptosis and a mole in the middle of her forehead. She requests removal of this mole. The patient was consented and brought to the Operating Room for the above-stated procedures.

PROCEDURE: The patient was brought to the Operating Room and placed in a supine position. Standard monitors were applied. Endotracheal intubation was achieved, and general anesthesia was administered.

The patient was rotated 180 degrees to the right, and standard prepping and draping was carried out for a bilateral temporal brow lift, bilateral upper lid blepharoplasty and excision of a midforehead mole. The forehead lift was carried out first in the temporal region. Incisions were marked bilaterally superior to the temporal hair tuft and carried with small extensions exiting the hair for around 1 cm into naturally occurring forehead rhytids. A # 10 blade was used to incise the previously marked skin ellipse making sure to bevel the blade in order to preserve hair follicles. Incisions were closed with running locking 5-0 nylon bilaterally. With the bilateral temporal forehead lift completed, attention was then turned to the upper lids.

The upper lids were marked in standard fashion taking care to leave 8 mm between the upper lid margin and the lower limb of the blepharoplasty incision, and this was carried out slightly lateral to the lateral canthus in a natural rhytid. The area was then injected with local, and a period of time elapsed prior to the first incision. The incision was made in the area that was marked for the left eye, and a cutaneous layer only was excised. A second separate portion of the orbicularis was then removed using sharp scissors, and hemostasis was carried out with Bovie cautery on low setting with Colorado needle tip. The orbital septum was opened, and the middle and medial fat pads were identified and this was excised conservatively. The medial fat pads were not addressed as aggressively as they were not as significant a contributor to his upper lid pathology. Once again, hemostasis was ensured, and the upper lid was closed with a running 7 – 0 locking nylon suture from the medial portion to the area in the region of the lateral canthus. The remainder of the incision was closed with 7 – 0 nylon vertical mattress sutures. With this eye complete, saline ice packs were placed, and our attention was directed to the contralateral eye.

In standard fashion just as with the left eye, the right eye was incised, de-epithelialized, and a muscle strip was taken. Hemostasis was carried out. The orbital septum was entered. The medial and middle fat pads were identified and excised conservatively, and hemostasis was then carried out. The skin was then closed in standard fashion with a 7-0 nylon running, locking medially to the lateral canthus, and the remainder of

the incision was closed with vertical mattress 7-0 nylon sutures. The dressing of the lateral aspect of the incision was Mastisol and Steri-Strips.

The midforehead mole was ellipsed in standard fashion with a 15-blade carried down to the subcutaneous layer. This was excised off and passed to the back table. A small amount of undermining was carried out in order to close the wound. Hemostasis was completed with Bovie-tip cautery. It was then closed with interrupted deep dermal 4-0 Vicryl and the skin was closed with 6-0 Prolene interrupted sutures. The dressing was completed with Steri-Strips and Mastisol.

The patient was then turned over to anesthesia, awakened without any difficulty, and transferred to the PACU in stable condition.

FOLLOW UP CARE:

The patient was sent home the same day with a comprehensive pre-prepared set of instructions for home care. She received pain medications, and a packet of supplies for wound care and eye care and was to return on POD #4 for suture removal and wound check.

Dr. Good was in the room throughout the entirety of the case.

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John D. Good, M.D.

Reviewed by:  
J. Johnson, M.D.  
J. Good, M.D.

# ACCEPTABLE OPERATIVE REPORT # 7

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Central Hospital  
456 Central Avenue  
Springfield, USA 56789

Patient Name: Kristin Orwell

Date of Birth: April 15, 1953

Date of Surgery: August 1, 2011

Preoperative Diagnosis:

1. Facial rhytids and facial laxity with mandibular jowling
2. Cervical laxity with platysmal banding
3. Upper eyelid dermatochalasis
4. Periocular, perioral and prejowl volume loss

Postoperative Diagnosis:

1. Facial rhytids and facial laxity with mandibular jowling
2. Cervical laxity with platysmal banding
3. Upper eyelid dermatochalasis
4. Periocular, perioral and prejowl volume loss

Procedure Performed:

1. Rhytidectomy (CPT 15828)
2. Submentoplasty with neck liposuction (CPT 15876)
3. Neck lift (CPT 15825)
4. Bilateral upper eyelid blepharoplasty (CPT 15822)
5. Autologous fat transfer to the lower eyelids, mid face, perioral and prejowl areas (CPT 15770)

Surgeon: John D. Good, M.D.

Anesthesia: General anesthesia

Anesthesiologist: James Little, M.D.

Complications: None

Disposition: The patient tolerated the procedure well with no evidence of complications.

Operative Indications: Ms. Orwell is a 60-year-old woman interested in cosmetic improvement for upper eyelids, lower eyelids, lower face and neck. She demonstrated evidence of multiple facial rhytids particularly along the mid cheek with laxity of the lower face, jowling and loss of mandibular definition. Additionally, she demonstrated aged appearance of the neck characterized by laxity of neck skin and platysmal banding. Her upper eyelids were characterized by moderate dermatochalasis and the lower eyelids perioral and prejowl areas were characterized by moderate volume loss. We discussed treatment options consisting of observation versus proceeding with surgery consisting of an upper eyelid blepharoplasty, autologous fat transfer to the lower eyelids, mid face, perioral and prejowl areas and a rhytidectomy with neck lift in order to help improve the appearance of these aged features. The details, limitations, ramifications, and complications of the above-stated procedures were reviewed in detail and the patient's questions have been answered. The patient understands these risks and wishes to proceed with the above-stated procedures.

Operative Procedure: Preoperative photographs were reviewed and all consents were signed. The patient was taken to the operating room as planned and laid supine. General anesthesia was induced and the patient in the table was rotated to 90 degrees. The attention was turned to the face. A surgical marking pen was used to design incisions symmetrically on both sides of the face as well as in the submental area. These facial incisions were first drawn on the right face beginning in the temporal tuft of hair and extending with a curvilinear fashion along the contours of the ear towards the tragus. The incision then continued along the posttragal area and around the contour of the ear lobule extending into the posterior auricular area for approximately 2 mm superior to the postauricular sulcus. The incision was then extended and faded into the postauricular hairline. A similar incision was drawn on the contralateral left side of the face. Additionally a 2.5 cm horizontal incision was marked out in the submental crease in an existing rhytid. The upper eyelid incisions were then drawn, which consisted of marking out the supratarsal crease. The distance between the incision and the lid line was measured and was found to be 10 mm. The incision was then carried in a curvilinear fashion in the supratarsal crease. Due to the evidence of lateral hooding, the incision then continued in a superolateral direction and the appropriate amount of skin to be removed was marked out with the pinch technique. A symmetric upper eyelid incision was drawn on the left side of the face. The last incisions drawn were those

marking out the areas of volume loss to the lower eyelid and mid face area, nasolabial mesolabial fold, prejowl sulcus, and hollowness of the bilateral cheeks.

The procedure began with harvesting the fat from the abdomen. The patient's abdomen was prepped with betadine and draped in the standard sterile fashion. Two small periumbilical incisions were marked and 1 cc of 1% lidocaine with 1:100,000 units of epinephrine was injected for local anesthesia and vasoconstriction. A #15 blade was used to make a stab incision on the marked out periumbilical incision sites. Tumescent solution consisting of two 20 cc syringes each filled with 15 cc of normal saline and 5 cc of 1% lidocaine with 1:100,000 units of epinephrine were placed with the liposuction cannula into the subcutaneous fat. This was dispersed evenly to the stab incisions on the right abdomen. The identical procedure was then performed to the stab incision on the left abdomen. Once the local tumescent solution was infused, 10 minutes were allowed to transpire for effect, next the small Tonnard multi-liposuction cannula was placed on a 10 cc syringe and with vigorous back and forth movement the fat was atraumatically liposuctioned from the abdomen with hand suction. This was done in a symmetric fashion and attention was paid to prevent irregularities. The details of the total amount of fat harvested plus the injection site were recorded and documented into the patient's chart. At the conclusion of the liposuction, a 5-0 chromic was used to close the two stab incisions in the periumbilical area. A 6 inch Ace wrap bandage was then placed around the patient's abdomen to provide support in the postoperative period.

Attention was then turned to the neck. Then 10 cc of 1% lidocaine with 1:100,000 units of epinephrine was injected to the submental incision as well as to the planned area of dissection in the anterior and lateral neck. The procedure began with a #15 blade used to incise upon the marked submental incision. Double prong skin hooks were placed superiorly and inferiorly for retraction purposes. The Bovie was used to continue dissection through the dermis and subcutaneous tissue. Curved Metzenbaum scissors were then used to elevate the skin and subcutaneous flap along the anterior aspect of the neck. Wide undermining was accomplished and the subcutaneous neck flap was raised in its entirety from just below the jaw line in the right towards just below the contralateral jaw line on the left. The flap was elevated in appropriate fashion preserving a small amount of adipose tissue for appropriate tissue thickness. After the flap was elevated, a 3 mm spatula liposuction was then inserted under direct observation and neck liposuction was performed in standard fashion under 27 mmHg of suction. This allowed optimal contouring removal of submental fat. The patient's neck was thin to begin with and there was a limited amount of submental fat, therefore caution was exercised here to avoid any dimpling of the skin or contour irregularities. Hemostasis was obtained with the use of a bipolar electrocautery. Inspection of the neck revealed there to be platysmal banding and significant dehiscence of the platysma. A small strip along the midline of the neck consisting of submental fat as well as small platysmal fibers were removed with the curved Metzenbaum scissors. After removal, attention was then turned to the platysmaplasty portion of the procedure. A 4-0 PDS suture was used to reapproximate the medial aspect of the platysmal muscle in its most inferior position. A running and locked 4-0 PDS suture was then continued superiorly to

reapproximate the medial aspects of the platysma in a corset pattern. The neck was then observed for hemostasis and the bipolar cautery was used. At the conclusion of the submentoplasty, the platysma had been reapproximated and the submental fat had been appropriately contoured.

Attention was then turned to closure of the submental incision which was performed with a running locked 6-0 Prolene suture. Ice pack was placed to this area and attention was turned to the right side of the face. Then 10 cc of 1% lidocaine with 1:100,000 units of epinephrine were injected to the right cheek, right jaw line and postauricular area. A #15 blade was then used to incise upon the marked incision line in the postauricular area and continuing along the postauricular hairline. Small double prong skin hooks were inserted and a #15 blade was used to elevate the postauricular skin flap. Dissection continued with Metzenbaum scissors over the medial aspect of the sternocleidomastoid muscle into the lateral aspect of the platysma and the previously dissected neck. At this point, a 4 x 4 gauze was placed for compression and attention was then turned to incising upon the marked incision lines on the anterior aspect of the face. This began at the temporal tuft of hair, extended along the contours of the ear into the post-tragal area and then along the course of the lobule. Dissection was then switched to curved Metzenbaum scissors and the skin, subcutaneous flap was elevated at the mid facial point along the cheek and then towards the jaw line. Small areas of oozing were easily controlled with bipolar electrocautery. No ear bleeding was noted. This flap was raised easily without any button holing or evidence of trauma.

At this point, the procedure continued with removal of 1.5 cm of SMAS beginning at the ear lobule and continuing around the ear towards the level of the tragus. This was removed sharply with curved Metzenbaum scissors. This allowed appropriate imbrication of SMAS during the next step of the procedure which was placement of cervical facial sutures. To this end, 2-0 Vicryl sutures were used to grasp the distal tissue and reapproximate this to the cut edges of SMAS in a secure fashion. The total of 5 sutures were used, two for the re-suspension of the lateral neck and 3 for the lower face. The skin was then laid down and adequate suspension of the soft tissue and neck had been achieved. Army-Navy retractors were placed and the flap was elevated an additional 0.5 cm in order to resist any dimpling from placement of the sutures. At this point, attention was then turned to removal of excess skin which was laid down along the ear and was gently elevated in the posterior superior direction. First, removal of the skin began at the temporal tuft where a single hook was placed and at the most anterior aspect of the incision and a #15 blade was used to excise the redundant skin in this area. Then 5-0 nylon suture was used at the key point and at the most superior aspect of the incision in simple interrupted fashion. A running locked 5-0 nylon suture was then used to reapproximate the curvilinear and temporal tuft incision.

Attention was then turned to the postauricular area where the skin was elevated in a superior fashion. A 5-0 chromic suture was used to reapproximate the more superior aspect of the postauricular incision. Excess skin was removed along the postauricular hairline and surgical clips were placed to reapproximate the skin here. The remainder

of the postauricular incision was closed with a running locked 5-0 chromic suture after placement of a small 8-French catheter drain. Attention was turned to appropriate placement of the ear lobule and skin was trimmed so that the air lobule was laid without any tension to the cut edges of the skin. Then 5-0 chromic suture was used to secure this key point. Attention was then turned to excision of the remainder of the skin to the area of tragus and to the anterior incision. The skin was removed in a standard fashion with a #15 blade and serrated face lift scissors. A running locked 6-0 Prolene suture was used to reapproximate the remainder of the incision along the contours of the ear and along the postauricular component.

At this point, ice was placed at the right side. Attention was turned to the contralateral left side. Again, 10cc of 1% lidocaine with 1:100,000 units of epinephrine was placed to the left face into the left lateral neck. The procedure was then performed in exact similar fashion to the right side of the face. Facial flaps were elevated in a standard fashion, small strip of SMAS tissue was removed and total of 5 sutures of 2-0 Vicryl were used to re-suspend the SMAS and to tighten the cervical facial layer. The excess skin was removed from the posterior post-tragal area as well as from the anterior aspect of the face in standard fashion without creating tension. The ear lobule key point was set and the skin was then closed in symmetric fashion with combinations of 5-0 nylon, 6-0 Prolene as well as 5-0 chromic suture. Prior to closure, a small 8-French suction catheter drain was placed. At the conclusion of the procedure, the head was then rotated back to the midline position and ice was placed to the left face. All wounds were inspected. There was found to be no evidence of any fluid collection or bleeding.

Attention was then turned to the upper eyelids. The #15 blade was used to incise upon the marked incision line after infiltration of 1 cc of 1% lidocaine with 1:100,000 units of epinephrine to the upper eyelid skin. A #15 blade was used to incise only through the skin level down to the subcutaneous tissue. The curved tenotomy scissors were then used with small pickups to remove the marked out skin beginning laterally and extending into the medial position. Careful attention was made to end the incision prior to the medial canthus in order to prevent webbing in this area. After removal of the redundant skin, hemostasis was achieved with the use of bipolar electrocautery. Based on preoperative photographic analysis, the decision was made not to remove any orbicularis oculi muscle and there was no evidence of any pseudoherniation of fats either in the medial, central or lateral upper eyelid pockets and therefore attention was turned to closure of the right upper eyelid. This was performed with 7-0 Prolene which began at the most medial aspect of the incision and then continued in a running unlocked fashion towards the lateral component. The most lateral component of the incision was tucked in a superior direction in order to address the lateral hooding that had been identified in the preoperative photographs. Attention was then turned to the contralateral left upper eyelid and the similar procedure as performed as just described.

Attention was then turned to the harvested fat. The syringes that had been previously obtained were capped and the fat was centrifuged. The dependent blood products were then removed and the oil supernatant layer was wicked away with sterile 4 x 4s. The fat

was then sterilely prepared into 1 cc tuberculin syringes with Tulip transfer hub. The patient was then placed into a 45-degree head-up position to assist with fat transfer. Entry points were marked out on the skin inferior to the area of periocular volume loss as well as entry points along the nasolabial fold, mesolabial fold and prejowl areas. Then 0.4 cc of 1% lidocaine with 1:100,000 units of epinephrine was injected into these entry points for local anesthesia and 18-gauge Nokor needle was used to create multiple small entry points for cannula placement.

Using multiple controlled back and forth motions, the fat transfer portion of the procedure began with a small amount of fat (0.05 cc) placed per each series of passes. A small amount of fat was delivered subcutaneously to the tissue of the lower eyelid and the majority of the fat was placed in the deeper plane above the periosteum of the infraorbital rim. Additional fat was placed into the arterial trough, and mid face areas. A total of 7 cc of fat was injected to the right lower lid and mid face area and a total of 6 cc of fat was injected to the left lower lid and mid face areas with the described technique. Attention was then turned to the perioral and prejowl areas. A similar placement of fat with the small 0.9 mm Tulip catheter was used with multiple controlled back and forth motions. The fat was delivered to the nasolabial fold, mesolabial fold, small areas of the lateral upper lip, the area of the inverted U near the mental crease into the cheek hollowing that had been noted along the anterolateral cheek. A total of 13 cc of fat was injected to the right lower face and a total of 12 cc of fat was injected to the left lower face with the described techniques. The fat was placed both to the periocular as well as perioral area going back and forth between the 2 sites in order to obtain the best symmetry to the lower eyelid, mid face, perioral and prejowl areas. At the conclusion of the procedure, the wounds were cleaned and facial dressing was placed along with bacitracin along the suture lines, 4 x 4 gauze was placed over the incision lines and 2-inch cotton was then placed on top of the gauze.

A 3-inch Kling was then used to carefully wrap the head from the occiput to the neck and along the base of the head to secure the dressing. The patient was then rotated back towards the anesthesiologist and was awakened from general anesthesia. She was then delivered to the recovery room in good stable condition.

After the patient was delivered to the recovery room, all postop instructions were reviewed. A next day follow-up appointment was made for removal of the face-lift dressing as well as for inspection of the wound. Additionally, a one week follow-up appointment was made for removal of all facial sutures. Postop medication was prescribed including an antibiotic as well as pain control medication. A postop instruction sheet for face-lift, blepharoplasty, and fat transfer was provided to the patient and detailed all appropriate wound care. All of the patient's questions were answered and she was discharged home with her husband in stable condition.

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John D. Good, M.D.

# **ACCEPTABLE OPERATIVE REPORT # 8**

**This operative report follows the standards set by The Joint Commission and AAAHC for sufficient information to:**

- **identify the patient**
- **support the diagnosis**
- **justify the treatment**
- **document the postoperative course and results**
- **promote continuity of care**

**This operative report also provides:**

- **name of facility where procedure was performed**
- **date of procedure**
- **patient history**
- **CPT code**

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Central Hospital  
456 Central Avenue  
Springfield, USA 56789

## **OPERATIVE REPORT**

**NAME:** Linda Nelson

**Date of Operation:** August 8, 2011

**Dictating Physician:** John D. Good, M.D.  
**Attending Physician:** John D. Good, M.D.

**Primary Surgeon:** Dr. John Good  
**Anesthetic:** General endotracheal

### **PREOPERATIVE DIAGNOSES:**

1. Deviated septum.
2. Nasal dyspnea
3. Inferior nasal turbinate hypertrophy
4. Acquired nasal deformity

### **POSTOPERATIVE DIAGNOSES:**

1. Deviated septum
2. Nasal dyspnea
3. Inferior nasal turbinate hypertrophy
4. Acquired nasal deformity

**EBL:** 25 mL

PROCEDURES PERFORMED:

1. Septo-rhinoplasty, CPT 30420

FINDINGS:

1. correction of severe septal deviation
2. hump removal
3. autospreader grafts
4. columellar strut
5. tip graft

FLUIDS RECEIVED: 1600 mL

URINE OUTPUT: 125 mL

INDICATIONS: This very pleasant 28-year-old patient had a large fractured septum, due to injury with a softball, which gave her difficulty breathing, mostly on her right side. She also had a very large hump in her mid dorsum that was mostly cartilaginous but part of it was bony due to a previous trauma. We therefore are taking her to the operating room in order to give her a better airway by straightening her septum and to give her a more appealing appearance.

PROCEDURE: The patient was brought to the operating room and placed in the supine position. She was placed under general anesthesia and intubated by a member of the anesthesiology unit. The head of the bed was turned 180 degrees, and the patient was prepped and draped in the sterile fashion. She was injected with a mixture of lidocaine and Marcaine with approximately 6 mL altogether. We injected in her septum and along her bony dorsum and thenasal sidewalls. We also injected the columella and the tip. We placed cocaine pledgets and allowed her to sit for five to ten minutes.

Once there was good vasoconstriction, we then used a #15 blade to perform a full transfixion incision. We then did a submucoperichondrial dissection on both sides of the septum elevating the mucoperichondrial flaps up off of the bone and cartilage down onto the floor. We then took a large portion of the quadrangular cartilage that was tortuous and excised it using a D-knife and #15 blade. We saved this cartilage for further use. We then created a swinging door by removing the redundant portion of the caudal strut inferiorly and then anchored it with a Wright stitch through the mucosa just superior to the crest in order to anchor it back onto the midline. We then closed the incision using 5 – 0 chromic interrupted sutures on both sides. We then used a #15 blade to make an inverted-V transcolumellar incision and connected this to bilateral marginal incisions to open the nose. Once we had sharply dissected up over the cartilaginous domes of the lower lateral cartilages, we then retracted the skin back and were able to view the upper laterals. We used blunt and sharp dissection to raise a skin/soft tissue envelope flap up over the entire dorsum of the nose up to the radix. We then dissected subperiosteally superiorly over the radix in order to facilitate bone and cartilage removal. Using a cottle

elevator, we dissected the mucosa off of the superior aspect of the septum on both sides and then cut sharply down through the upper lateral cartilages separating them from the septum. We then removed the cartilaginous hump with a #15 blade and used the upper lateral excess to create auto-spreader grafts, which were then anchored to the septum using 5 – 0 PDS suture. A rasp was then used to remove some of the excess bone from the bony dorsum. This created a very small but significant open roof deformity. We then did bilateral osteotomies using a 3mm unguarded osteotome in a continuous to close this open roof.

We used the septal cartilage and fashioned a columellar strut out of it. We placed this columellar strut and anchored it with a 5 – 0 PDS horizontal mattress suture. We then used a 5 – 0 chromic suture as a mucosal apposition stitch, which we then placed through the domes. Once this was accomplished, we divided the domes and separated it from the vestibular mucosa below, trimming excess cartilage as was necessary. We then reapproximated these with three interrupted 6 – 0 Prolene sutures bilaterally. We then performed a cephalic trim of the cartilages and then fashioned a tip graft from the septal cartilage and anchored this to the reconstituted domes. We then redraped the skin/soft tissue envelope and closed using interrupted 6 0 Ethilon sutures. We then closed the marginal incisions using 5 – 0 chromic suture interrupted. Doyle splints were then placed and anchored with a single 4 – 0 Prolene suture. Steri-Strips were then placed over the dorsum and an Aquaplast dressing was placed.

The patient tolerated the procedure well and was brought out of anesthesia, extubated and taken to the PACU for further recovery.

FOLLOW UP CARE: The patient was sent home the same day with a comprehensive pre-prepared set of instructions for home care specifically designed for perioperative rhinoplasty patients. She receive pain medications, and a packet of supplies for wound care and was to return on POD #4 for suture removal and wound check.

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John D. Good, M.D.

# UNACCEPTABLE OPERATIVE REPORT # 1

**This operative report does not provide:**

- **an adequate description of the procedures performed**
  - **name of facility where procedure was performed**
  - **CPT codes**
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PATIENT NAME: William Doe  
Visit Date: July 26, 2011  
Provider: Mutual Healthcare  
Location: Springfield, USA

Patient History: Mr. Doe is a 46-year-old male. He is here for chin implant, neck suction lipectomy, and rhinoplasty. Risks, benefits and potential complications discussed including but not limited to the following: facial nerve paralysis, hairline or earlobe distortion, skin burn, loosening of skin months later and asymmetry of the nose, pain, rejection of sutures or implants if used, skin injury and nasal congestion.

Past Medical History: Gastroesophageal Reflux Disease

Tobacco/Alcohol/Supplements: Does not apply

Allergies: No known drug allergies

Current Medications: Vicodin ES 7.5 mg/750mg

Procedures: Rhinoplasty, mentoplasty, and submental liposuction

Surgeon: R. Doctor, M.D.

Anesthesia: Local with sedation

Surgery: (Rhinoplasty) After the patient had signed the consent, he was brought into the OR and prepped and draped in the usual manner. The patient was injected with Xylocaine with Epi to the field of surgery. A 15 blade was used to make the incisions to elevate nasal skin. The periosteum was elevated with the Mckenty elevator. The dorsal cartilage was lowered using a knife. A rim incision was done and then a cephalic trim performed. Collumella graft used. Medial and lateral osteotomies were performed. Telfa and Bacitration was placed and cast applied. Tissue was not sent to pathology. Post-operative instructions were given. Additional procedures performed were: chin implant placed and suction of the neck performed. Dressings applied as necessary. He was discharged in a stable condition.

## UNACCEPTABLE OPERATIVE REPORT # 2

This operative report is listed as a septorhinoplasty but contains no information that would allow the Credentials Committee to assign credit for any description that relates to a rhinoplasty procedure. The description did not include reference to:

- medial or lateral osteotomies
- dorsal straightening
- alar reduction
- tip reduction
- any type of augmentation

This operative report also does not provide:

- name of facility where procedure was performed
  - date of procedure
  - patient history
  - CPT code
- 

PATIENT NAME: Roberta Doe

MEDICAL RECORD: #23333

SURGEON: Robert Doctor, M.D.

Preoperative Diagnosis: Nasal valve collapse, nasal septal deviation and nasal turbinate hypertrophy.

Postoperative Diagnosis: Same

Procedure: Functional septorhinoplasty, inferior turbinate cauterly, tonsillectomy

Anesthesia: General endotracheal

Findings: Caudal septum deviated to the left. More posteriorly the septum was deviated to the right with almost complete obstruction of her nasal airway. Her dorsum overall was deviated to the right.

Description of Procedure: The patient was brought to the operating room and placed supine on the OR table. General endotracheal anesthesia was introduced. Afrin was used to decongest the nose. 1% Lidocaine with 1:100,000 epinephrine was injected into the septum. A hemitransfixion incision was made. The caudal cartilage was deviated towards the left. Mucoperichondrial layer was elevated on the left-hand side having carried the incision through to the right-hand side approximately 1 cm behind the

caudal most aspect of the cartilage. Deviated areas of cartilage along the floor of the nose were removed. With the bowl of the septal spur inferiorly and the deviated areas of cartilage to the left the more caudal aspect which was deviated and buckled and returned to a more natural and normal position with improvement of her nasal airway on the left. Then two bony deviations to the right were removed. Hemostasis along the floor of the nose with an osteotome was used. At the conclusion the septum was found to fit in the midline with a drastic improvement in her nasal airway and a visibly improved nasal contour.

She was extubated and transferred to recovery in good condition with a nose pad applied over her nose.

## **UNACCEPTABLE OPERATIVE REPORT # 3**

**This operative report was deemed too minor by the Credentials Committee, with the procedure description not supporting the CPT code. Credit is not awarded for non-malignant, minor excisions that do not involve any repair or reconstruction.**

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PATIENT NAME: Thomas Doe  
Office/Outpatient Visit  
Visit Date: Friday, July 15, 2011  
Provider: Hometown Healthcare  
Location: Springfield, USA 56789

Primary Visit Diagnosis: Accessory Auricle, CPT 69110

Surgeon: Robert Doctor, M.D.

Description of Procedure: Mr. Doe comes in today for excision of preauricular accessory auricle on the right-hand side. Risks and benefits were explained. Informed consent was obtained. The patient arrived an hour early to have Emla cream applied. The patient was prepped with Betadine. The skin tag was snipped. Hemostasis was achieved with cautery. A Steri-Strip was applied. The patient tolerated the procedure well.

# UNACCEPTABLE OPERATIVE REPORT # 4

This operative report does not provide:

- name of facility where procedure was performed
  - patient history
  - pre-operative or post-operative diagnosis
  - adequate description of procedure performed
  - instructions and medications for patient's post-operative care
  - CPT code
- 

## FACELIFT

Dr. Robert Doctor

Patient: Jane Doe

The risks and benefits were reviewed with patient. Skin marker was used to mark incision lines. Local anesthesia carried out with Lidocaine 1% Epinephrine. The patient was prepped and draped in the usual manner.

Beginning on the left side, a left facelift incision was made beginning just below the temporal tuft of hair, continuing in the curve of the pre-auricular area, around the lobule and posteriorly over the mastoid. Using sharp and blunt dissection, a skin flap was elevated over the cheek and neck. Bleeding was controlled with hyfrecator cautery. The SMAS and platysma was then plicated posterosuperiorly with 2-0 nylon suture. The skin flap was repositioned. Skin was trimmed. The incision was closed with a running 5-0 nylon suture. The same was done on the right side to complete the surgery.

The incision lines were cleansed, steri-strips were applied along with antibiotic ointment. The patient left the office in satisfactory condition.

Physician signature: *R. Doctor*

Date: January 5, 2012