

ACCEPTABLE OPERATIVE REPORT #1

Patient Name: Jane Doe

Date: January 1, 2005

Preoperative Diagnosis: Bilateral upper eyelid dermatochalasis

Postoperative Diagnosis: Same

Procedure: Bilateral upper lid blepharoplasty, (CPT 15822)

Surgeon: Good, M.D.

Assistant: N/A

Anesthesia: Lidocaine with 1:100,000 epinephrine

Anesthesiologist: Smith

Dictated By: John Doe 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 a consent was signed.

The patient was brought into the operating room and placed in the supine position on the operating table. An intravenous line was started, and sedation and sedation anesthesia was administered IV after preoperative p.o. sedation. The patient was monitored for cardiac rate, blood pressure, and oxygen saturation continuously.

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 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.

John Doe Good, M.D.

This operative report follows the standards set by the JCAHO and AAAHC for sufficient information to identify the patient, support the diagnosis, justify the treatment, document the postoperative course and results, and promote continuity of care. It also includes the CPT code for procedural identification.

ACCEPTABLE OPERATIVE REPORT #2

Patient Name: Jane Doe

Date: January 8, 2005

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

Postoperative Diagnosis: Same

Procedure: Temporal cheek-neck facelift (CPT 15825)
Submental suction assisted lipectomy (CPT 15876)

Surgeon: John D. Good, M.D.

Assistant: None

Anesthesia: General

Anesthesiologist: Smith

Dictated By: John Doe 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 3cm and making radial tunnels from the angle of the mandible all the way to the next angle of the mandible. 4mm liopsuction 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 6mm flat liopsuction cannula.

Then with the Wells-Johnson liopsuction 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 liopsuction, 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 2cm 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 jawl. 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 4cm at the lateral canthal area to 8-10cm 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 home in satisfactory condition.

John Doe Good, M.D.

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ACCEPTABLE OPERATIVE REPORT #3

Patient Name: John Doe

Date: January 8, 2005

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: Smith

Dictated By: John Doe Good, M.D.

Indications for the Procedure:

This patient is an otherwise healthy 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.

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.

John Doe Good, M.D.

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ACCEPTABLE OPERATIVE REPORT #4

Patient Name: John Doe

Date: January 8, 2005

Preoperative Diagnosis: Squamous cell carcinoma of the scalp

Postoperative Diagnosis: Same

Operation Performed: Radical resection of tumor of the scalp (CPT 11643)

Excision of tumor from the skull with debridement of the superficial cortex with diamond bur.

Advancement flap closure, with total undermined area 18 centimeters by 16 centimeters (CPT 14300)

Surgeon: John D. Good, M.D.

Assistant: None

Anesthesia: General endotracheal anesthesia

Anesthesiologist: Smith

INDICATIONS: This is an 81-year-old male who has a large exophytic 7cm lesion of the anterior midline scalp which is biopsy-positive for skin malignancy, specifically, squamous cell carcinoma. This appears to be affixed to the underlying scalp.

PLAN: Radical resection with frozen sections to clear margins thereafter, with planned reconstruction.

CONSENT: I have discussed with the patient the possible risks of bleeding, infection, renal problems, scar formation, injury to muscle, nerves, and possible need for additional surgery with possible recurrence of the patient's carcinoma, with review of detailed informed consent with the patient, who understood, and wished to proceed.

FINDINGS: The patient had a 7cm large exophytic lesion which appeared to be invasive into the superficial table of the skull. The final periosteal margin which centrally appeared was positive for carcinoma. The final margins peripherally were all negative.

DESCRIPTION OF PROCEDURE IN DETAIL: The patient was taken to the operating room and there was placed supine on the operating room table.

General endotracheal anesthesia was administered after endotracheal tube intubation was performed by the Anesthesia Service personnel. The patient was thereafter prepped and draped in the usual sterile manner using Betadine Scrub and Betadine paint. Thereafter, the local anesthesia was injected into the area around the tumor. A ___ type excision was planned down to the periosteum. A suprapariosteal radical resection was performed.

It was obvious that there was tumor at the deep margin, involving the periosteum. The edges were marked along the four quadrants, at the 12 o'clock, 3 o'clock, 6 o'clock, and the 9 o'clock positions, and these were sent for frozen section evaluation. Frozen section revealed positive margins at one end of the resection. Therefore, an additional circumferential resection was performed and the final margins were all negative.

Following completion, the deep periosteal margin was resected. The circumferential periosteal margins were noted to be negative; however, centrally, there was a small area which showed tumor eroding into the superficial cortex of the skull. Therefore, the Midas Rex drill was utilized to resect approximately 1-2 mm of the superficial cortex of the bone at the area where the positive margin was located. Healthy bone was obtained however, it did not enter the diploic or marrow-containing bone in the area. Therefore, no bony margin was taken.

However, at the end of the procedure, it did not appear that the residual bone had any residual changes consistent with carcinoma.

Following completion of the bony resection, the area was irrigated with copious amounts of saline. Thereafter, advancement flaps were created, both on the left and the right side of the scalp, with the total undermined area being approximately 18cm by 16cm. The galea was incised in multiple areas, to provide for additional mobilization of the tissue. The tissue was closed under tension with 3-0 Vicryl suture deep in the galea and surgical staples superficially.

The patient was awakened from anesthetic, was extubated and was taken to the recovery room in stable condition.

DISPOSITION: The patient was discharged to home with antibiotics and analgesics, to follow-up in approximately one week.

NOTE: The final margins of both periosteal, as well as skin were negative circumferentially, around the tumor. The only positive margin was deep, which was a periosteal margin and bone underlying it was partially resected, as was indicated above.

John Doe Good, M.D.

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UNACCEPTABLE OPERATIVE REPORT #1

PATIENT NAME: John Doe
Office/Outpatient Visit
Visit Date: Wednesday, April 2, 2005
Provider: Hometown Healthcare
Location: Hometown

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

Objective:

Procedures: Rhinoplasty, mentoplasty, and submental liposuction
Surgeon: Jones, 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.

This operative report does not supply an adequate description of the procedures performed.

UNACCEPTABLE OPERATIVE REPORT #2

PATIENT NAME: Jane Doe

MEDICAL RECORD: #23333

SURGEON: Jones, 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.

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, or any type of augmentation.

UNACCEPTABLE OPERATIVE REPORT #3

PATIENT NAME: Jane Doe
Office/Outpatient Visit
Visit Date: Wednesday, April 4, 2005
Provider: Hometown Healthcare
Location: Hometown

Primary Visit Diagnosis: Accessory Auricle, CPT 69110

Surgeon: Jones, M.D.

Description of Procedure: Miss 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.

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

UNACCEPTABLE OPERATIVE REPORT #4

FACELIFT

Dr. _____

Patient: _____

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 reposition. 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: _____

Date: _____

This operative report does not provide: name of facility where procedure was performed, preoperative or postoperative diagnosis, adequate description of procedure performed, or instructions and medications for patient's postoperative care.