Case 1

Preoperative diagnosis: Rapidly enlarging suspicious lesion of patient's right forehead. 1.

Postoperative diagnosis: Rapidly enlarging suspicious lesion of patient's right forehead.

Operation performed: Wide local excision with intermediate closure of right forehead. 2.

Indications: The patient is a 78-year-old white male who recently in the last month or so noticed a rapidly enlarging suspicious lesion on the right side of his forehead.

Description of procedure: The patient was placed in the supine position on the table, was given no sedation. The area of his right forehead 3. was prepped and draped with Betadine paint in normal sterile fashion. The area to be excised was on the right side of 4. the patient's mid forehead. This had a maximum diameter of 1.1 cm. This had a 0.3 cm 5. margin designed for total resection of 1.7 cm. This was infiltrated with 1% Lidocaine with 6. Epinephrine. After waiting for hemostasis, it was excised, tagged, and sent for permanent pathology. The wound was then irrigated; several bleeders were tied off, and cauterized and closed in multiple layers 7. with inverted dermises of 3-0 Vicryl, a running subcuticular stitch of 4-0 Vicryl and a few 5-0 chromics. The total length of this incision was 3 cm. 8. This was covered with Steri-Strips, gauze, and tape. Patient tolerated this procedure with no complication and was sent home in stable condition.

9. **Final diagnosis**: Skin, right forehead, 10. wide local excision, keratoacanthoma, possible squamous cell carcinoma, 11. margins are free of tumor.

1. Indications for surgery.
2. An excision with intermediate closure was performed.
3. Location is the right forehead.
4. Greatest clinical diameter is 1.1 cm.
5. .3 cm margin on both sides (total .6 cm).
6. Total size of lesion is 1.7 cm.
7. Closure in multiple layers indicates an intermediate repair which is reported separately.
8. Repair length is 3 cm.
9. Location is right forehead.
10. Diagnosis is keroacanthoma.
11. Squamous cell carcinoma is possible. Possible diagnoses are not coded.

What are the CPT® and ICD-9-CM codes reported?

ICD-9-CM code: 238.2

CPT® codes: 12052, 11442-51

RATIONALE: CPT® code: This is an excision on the forehead of a 1.7 cm lesion (1.1 cm + 0.3 cm + 0.3 cm = 1.7 cm). To find in the CPT® Index, see excision/lesionskin/benign (keratoacanthoma is coded to neoplasm of uncertain behavior…unless specified as a carcinoma, excision in the CPT® is coded as benign). The code range you are directed to is 11400–11471. The code ranges are divided by location. Code range 11440–11446 is further divided by size. Code 11442 represents an excised lesion on the face measuring 1.1 to 2.0 cm. The repair is a layered closure indicating an intermediate repair. The repair can be reported separately since it is not a simple repair. In the CPT® Index see repair/skin/wound/intermediate, you are directed to code range 12031–12057. Code ranges are further defined by location. Code range 12051–12057 reports repairs on the face. This range is further defined by size. An intermediate repair of a 3 cm incision on the face is coded to 12052. Modifier 51 is necessary for the second procedure to indicate multiple procedures.

ICD-9-CM code: The diagnosis is stated as keratoacanthoma, possible squamous cell carcinoma (SCC). The SCC is considered possible and therefore not coded. To find the diagnosis code for keratoacanthoma, in the ICD-9-CM Index to Diseases see keratoacanthoma. You are directed to 238.2. Verification of 238.2 in the Tabular List confirms this is the diagnosis for a neoplasm of uncertain behavior of other and unspecified sites. Since we know it is on the forehead, in the Neoplasm Table see Skin/forehead. In the uncertain behavior column (as defined by the index in ICD-9-CM), forehead is coded to 238.2 as well. By nature, keratoacanthomas are difficult to distinguish from a squamous cell carcinoma, both clinically and in histology, making it uncertain behavior.

Case 2

Preoperative diagnosis: Basal cell carcinoma

Postoperative diagnosis: Same 1.

Operation: Mohs Surgery 2.

Indications: The patient has a biopsy proven basal cell carcinoma on the nasal tip 3. measuring 8 x 7 mm. 4. Due to its location, Mohs surgery is indicated. Mohs surgical procedure was explained including other therapeutic options, and the inherent risks of bleeding, scar formation, reaction to local anesthesia, cosmetic deformity, recurrence, infection, and nerve damage. Informed consent was obtained and the patient underwent fresh tissue Mohs surgery as follows.

STAGE I: 5. The site of the skin cancer was identified concurrently by both the patient and Dr. and marked with a surgical pen; the margins of the excision were delineated with the marking pen. The patient was placed supine on the operating table. 6. The wound was defined and infiltrated with 1% Lidocaine with epinephrine 1:100,000. All gross tumor was completely excised in a debulking stage using aggressive curettage and/or cold steel. With all visible gross tumor completely excised, an excision was made around the debulking defect. Hemostasis was obtained by spot electrodessication. A pressure dressing was placed. 7. Tissue was divided into two tissue blocks 8. which were mapped, color coded at their margins, and sent to the technician for frozen sectioning. Microscopic tumor was found persisting in none of the tissue blocks. Following surgery the defect measured as follows: 9. 10 x 13 mm to the subcutaneous tissue. Closure will be by Burrow's graft. 10.

1. Post-Operative diagnosis is the same as pre-operative diagnosis, which is Basal cell carcinoma.
2. Mohs surgery is performed.
3. Location is noted as the nasal tip.
4. The basal cell is 8 x 7 mm.
5. Stage 1.
6. Local anesthesia was used.
7. Noting the tumor has been removed, which supports Stage 1.
8. The tissue is divided into two tissue blocks.
9. Size and depth of the defect.
10. A Burrow's graft indicates an adjacent tissue graft.

Condition at termination of therapy: Carcinoma removed.

Pathology report on file.

What CPT® and ICD-9-CM codes are reported?

CPT® codes: 14060, 17311-51

ICD-9-CM code: 173.31

RATIONALE: CPT® codes: A Burrow's graft is a graft using adjacent tissue, meaning an adjacent tissue graft. To code, look in the CPT® Index for Burrow's Operation and you are directed to see Skin/Adjacent Tissue Transfer. Under Skin, Adjacent Tissue Transfer, you are directed to code range 14000–14350. Code selection is based on location and size. CPT® codes 14060 and 14061 represent an adjacent tissue transfer on the nose. The size is selected based on sq centimeters. The defect size is 10 x 13 mm. This must be converted to sq centimeters to determine the accurate code. 10 mm = 1 cm. 13 mm = 1.3 cm. To find the sq cm, you will need to multiply the width x length. 1 cm x 1.3 cm = 1.3 sq cm. The correct code is 14060 for 10 sq cm or less. In the CPT® Index, see Mohs Micrographic Surgery. You are directed to code range 17311–17315. 17311 reports Mohs of the head, up to five tissue blocks. The report indicates two tissue blocks were examined. The guidelines in the Mohs section remind us to code any graft separately. Modifier 51 is appended to report multiple procedures were performed.

ICD-9-CM code: The diagnosis is basal cell carcinoma of the nose. Basal Cell Carcinoma is a malignant neoplasm of the skin. In the Neoplasm Table, see nose/skin/basal cell carcinoma and see the primary column. The correct code is 173.31.

Case 3

Chief complaint: Cauliflower ear. 1.

History of present illness: The patient is a 15-year-old male who was seen by me two days ago with a hematoma of the right ear. He underwent incision and drainage and then bolster placement here. 2. He is here for planned removal of the bolster and follow-up.

Physical examination: Blood pressure is 100/80. Temperature is 97.4. Pulse is 60. HEENT: The patient's right ear was examined. The bolster was removed. He was found to have good resolution of most of the hematoma, however there is a small area of resolution just posterior to the helical roots. After discussing this with his mother we decided to repeat the drainage. 3. I attempted to do this through the old incision site, but was unsuccessful; 4. therefore I took a 20-gauge needle and drained the site with an aspiration of about a ½ cc of serosanguineous fluid. 5. The patient was not interested in having the bolster replaced. In addition, it would be difficult to place a bolster, as it is just posterior to the helical root.

Assessment and plan: I advised the patient and his mother that this could reaccumulate. I want them to call me immediately if it does reaccumulate. They are to monitor it closely. They were instructed that it is unclear whether he will have permanent injury to his pinna or not. He may have a cauliflower deformity, however our best chance of avoiding that is to monitor this closely and to redrain it if he has any reaccumulation. They were instructed to call me through the answering service immediately this weekend if they noticed any reaccumulation. Otherwise, he should follow-up with me on Monday.

1. Chief complaint for office visit.
2. Patient was in two days ago for a incision and drainage of a hematoma, it would be important to know that the patient is in a global period of 10 days.
3. There was a decision to repeat the drainage of the hematoma.
4. There was an unsuccessful attempt to drain the hematoma through an old incision site.
5. The provider performed a puncture aspiration.

What are the CPT® and ICD-9-CM codes reported?

CPT® code: 10160-58

ICD-9-CM code: 998.12

RATIONALE: CPT® code: To appropriately code this medical record, you have to first know what procedure was performed two days prior. An incision and drainage (I&D) with a bolster placement is coded by looking in the CPT® Index under Incision and Drainage/Ear, External. There is no mention of a complication, you look at simple, referring you to code 69000. CPT® code 69000 has a 10 day global period, we are still in the global period of the original procedure. Since we are still in the 10 day global period, this is considered a postoperative visit, the evaluation and management code is not reported separately. The provider decided to perform a second, related, procedure. The provider punctured the hematoma with a needle (puncture aspiration) and drained the hematoma. To find the code for drainage of the hematoma, in the CPT® Index see Drainage/Skin, you are referred to a series of codes, including code range 10120–10180. Puncture aspiration of a hematoma is correctly reported with CPT® code 10160. Modifier 58 is appended to indicate it is a planned and related procedure.

ICD-9-CM code: The patient has a hematoma at the incision site of the prior surgery. To find the diagnosis code, see the ICD-9-CM Index to Diseases for hematoma/post-surgical, you are directed to ICD-9-CM code 998.12. Verification in the Tabular List confirms 998.12 is for a hematoma complicating a surgery.

Case 4

Preoperative diagnosis: Segmental obesity of posterior thighs.

1. Postoperative diagnosis is used for coding.
2. Procedure performed.
3. General anesthesia.
4. Location identified.
5. Liposuction performed.
6. The procedure was also performed on the left side.

1. **Postoperative diagnosis**: Segmental obesity of posterior thighs.

Operative procedure: Posterior thigh lift with suction-assisted lipectomy of posterior
2. medial thigh, bilateral.

Clinical note:
This obese patient presents for the above procedure. She understood the potential risks and complications including, but not limited to, the risk of anesthesia, bleeding, infection, wound healing problems, unfavorable scarring, and potential need for secondary surgery. She understood and desired to proceed.

Procedure:
The patient was placed on the operating table in supine position. General anesthesia was
3. induced. She was positioned prone. The buttocks and thigh regions were prepped and draped in the usual sterile fashion. She had been marked in the awake, standing position, outlining the area for the incision along the gluteal crease that was in continuity with her
4. medial thigh lift scar and extended to the posterior axillary line. The posterior medial
5. thigh region was infiltrated with tumescent solution utilizing 750 mL. The liposuction was then accomplished, removing a total of 200 mL. The right side was addressed first. Then an incision was made along the gluteal crease at the desired site for the final incision. A posterior skin flap was elevated approximately 3 to 4 cm. Hemostasis was assured by electrocautery.

There was no residual flap or dead space and the fascia was closed at the deep level with 0 PDS and then in layers anatomically the closure was completed with 2-0, 3-0, and 4-0 PDS. Dermabond and Steri-Strips were applied. The medial third was also closed with a
6. running 4-0 plain gut. The same was then accomplished on the left side in similar fashion and steps, achieving a symmetric result, and closure was accomplished similarly. A compression garment was applied. The patient was awakened, extubated, and transferred to the recovery room in satisfactory condition. There were no operative or anesthetic complications.

What are the CPT® and ICD-9-CM codes reported?

CPT® code: 15879-50

ICD-9-CM code: 278.00

RATIONALE: CPT® code: The patient had a suction-assisted lipectomy, also known as liposuction. In the CPT® Index see Lipectomy/Suction assisted, or Liposuction, you are referred to code range 15876–15879. Code selection is based on location. This procedure was performed on the right and left posterior medial thighs, requiring use of 15879. The procedure was performed on both the right and left medial thighs (bilaterally) reported as 15879-50 or 15879-RT, 15879-LT.

ICD-9-CM code: The patient's diagnosis is Segmental obesity. In the ICD-9-CM Index see obesity/segmental. Segmental indicates the obesity is in segments instead of generalized. There is no subterm for segmental, so we default to obesity, unspecified 278.00.

Case 5

Preoperative diagnosis: Dermatochalasis of abdomen, diastasis recti.

1. Postoperative diagnosis is used for coding.
2. Procedure performed is abdominoplasty.
3. General anesthesia used.
4. Excessive skin.
5. Separation between the right and left sides of the rectus abdominis muscle.
6. Closure of the rectus abdominis muscle.
7. Excision of excessive skin.

1. **Postoperative diagnosis:** Dermatochalasis of abdomen, diastasis recti.

2. **Procedure performed:** Abdominoplasty.

Anesthesia: General.

Clinical note: The patient presents for the above procedure. She understood the potential risks and complications including but not limited to the risks of anesthesia, bleeding, infection, wound healing problems, unfavorable scaring, and potential need for secondary surgery, and she desired to proceed. She also understood the possibility of impaired circulation to the flaps and hematoma/seroma formation.

Procedure in detail: The patient was placed on the operating table in supine position. 3. General anesthesia was induced. The abdomen was prepped and draped in the usual sterile fashion and marked for abdominoplasty along the suprapubic natural skin crease. This coursed 36 cm in total. The umbilicus was also marked and the area was infiltrated with 100 cc of 0.5% Xylocaine with 1:200,000 epinephrine. After adrenaline effect, the incision was made. The flap was elevated to the umbilicus. The umbilicus was circumscribed and dissected free, with care taken to maintain a generous vascular stalk. Dissection was then taken to the subcostal margin as it tapered superiorly and narrowed the exposure. Hemostasis was obtained by electrocautery. There was still a lot of skin laxity 4. and it appeared that the ellipse of skin could be removed through the superior margin of the umbilicus. The flap was incised at the midline for greater exposure.

5. She had significant diastasis recti, which was then closed with interrupted mattress 6. sutures of 0 Ethibond, followed by a running suture of 0 Ethibond. She was placed in semi-flexed position and the ellipse of skin was excised to the superior margin of the 7. umbilicus in the midline. This gave an easy fit for the flap without undue tension. The #15 drains were placed through the mons area and secured with 3-0 Prolene. The skin was then closed at Scarpa fascia with sutures of 2-0 PDS. The umbilicus site was marked and a disc of skin was removed. The umbilicus was delivered and sutured with dermal sutures of 4-0 PDS and the skin with 5-0 fast absorbing plain gut. Deep dermal repair was completed with reabsorbable staples and the skin was closed with a subcuticular suture of 4-0 PDS. Steri-Strips were applied over Mastisol. An abdominal binder was placed.

The patient was awakened, extubated, and transferred to the recovery room in satisfactory condition. There were no operative or anesthetic complications. Estimated blood loss was less than 30 cc.

What are the CPT® and ICD-9-CM codes reported?

CPT® code: 15830, 15847

ICD-9-CM code: 728.84

RATIONALE: CPT® code: The first procedure performed was the removal of excess skin of the abdomen. An incision was made in the suprapubic natural skin crease, and the skin flap was elevated to the umbilicus. The umbilicus was dissected from the skin, and the skin flap continued to be elevated to the subcostal margin. The excessive skin was excised. Look in CPT® for Panniculectomy and you are referred to See Lipectomy. Look in the CPT® Index for Lipectomy/Excision and you are referred to 15830–15839. Code 15830, describes the removal of the excessive skin of the abdomen. The next procedure was the repair of the diastasis recti, also known as abdominal separation (right and left sides of the abdominal rectus muscle separate, because of increased pressure due to pregnancy, or obesity). An abdominoplasty is the repair of the abdominal muscles. Look in the CPT® Index for Abdominoplasty. You are referred to See Panniculectomy, and Excision 15830, 15847. You can also look under Repair/Abdominal Wall, and you are referred to 15830, 15847. Code 15847 is an add-on code, which is listed in addition to 15830 for the repair of the diastasis recti (abdominoplasty).

ICD-9-CM code: The term dermatochalasis means extra skin. This terminology is typically used in relation to the eyelid, not the abdomen. Dermatochalasis of abdomen is not found in your ICD-9-CM book; however, you can look under excess/skin/unspecified which codes to 701.9. Excess skin is a sign of Diastatsis recti; therefore this is the only diagnosis coded. In the ICD-9-CM Index to Diseases, look for diastasis recti and you are directed to ICD-9-CM code 728.84 which, relates to muscle weakness.

Case 6

Preoperative diagnosis: Hypoplasia of the breast.

1. Postoperative diagnosis is used for coding.
2. Breast augmentation performed bilaterally.
3. General anesthesia.
4. Left breast.
5. Prosthetic implant used on the left breast.
6. Right breast.
7. Prosthetic implant used on the right breast.

1. **Postoperative diagnosis:** Hypoplasia of the breast.
2. **Operative procedure:** Bilateral augmentation mammoplasty.
3. **Anesthesla:** General.

Operative summary: The patient was brought to the operating room awake and placed in a supine position where general anesthesia was induced without any complications. The patient's chest was prepped and draped in the usual sterile fashion. The patient had previous inframammary crease incisions on both left and right sides. The extent of the dissection would be to the sternal border within two fingerbreadths of the clavicle and
4. slightly beyond the anterior axillary line. The left breast was operated upon first. An incision was rnade in the inframammary crease going through skin, subcutaneous tissue, down to the muscle fascia. Dissection at the subglandular level was then performed until an adequate pocket was made according to the previous limits. After irrigation with normal saline and careful hemostasis, a Mentor Allergan silicone filled high profile
5. textured implant was used and placed into the pocket. It was 300 cc. The skin was then closed using 4-0 Vicryl in an interrupted fashion for the deep subcutaneous tissue 4-0 Monocryl in an interrupted fashion was used for the superficial subcutaneous tissue and the skin was closed using 4-0 Monocryl in a subcuticular fashion. Antibiotic ointment and Tegaderm were applied. The right breast was operated in a very similar fashion.
6. 7. The implant was a 340 cc silicone gel high profile textured implant from Allergan. Skin closure was the same. Both left and right breasts were very similar in size and shape. The patient had a bra applied. The patient tolerated this procedure well and left the operating room in stable condition.

What are the CPT® and ICD-9-CM codes reported?

CPT® codes: 19325-50 or 19325-RT, 19325-LT

ICD-9-CM code: 611.82

RATIONALE: CPT® codes: In the CPT® Index, look under breast/augmentation and you are directed to code range 19324–19325. The code selection is dependent upon whether implants were used. In this case, implants were used in both the right and left breasts. The correct code is 19325. The procedure was performed on both breasts necessitating the use of modifier 50 or modifiers RT and LT. If the provider supplied the breast implants, a HCPCS Level II code is reported (L8600 x 2).

ICD-9-CM code: The patient is diagnosed with hypoplasia of the breast. In the ICD-9-CM Index to Diseases, see hypoplasia/breast and you are directed to 611.82. Verification in the Tabular List confirms this is the correct code selection. Although the diagnosis is for both breasts, it is only reported once.

Case 7

Preoperative diagnoses: Dysplastic nevus, right chest.

Postoperative diagnoses: Dysplastic nevus, right chest.

Procedures performed:
Excision, dysplastic nevus, right chest with excised diameter of 1.2 cm and complex repair of 3 cm wound.

Anesthesia: Local using 20 cc of 1% lidocaine with epinephrine.

Complications: None.

Estimated blood loss: Less than 2 cc.

Specimens:
Dysplastic nevus, right chest sutured at superior tip, 12 o'clock for permanent pathology.

Indications for surgery: The patient is a 49-year-old white woman with a dysplastic nevus of her right chest, which I marked for elliptical excision in the relaxed skin tension lines of her chest with gross normal margins of around 0.3 cm and I drew my best guess at the resultant scar and she observed these markings well and we proceeded.

Description of procedure: We started with the patient prone. The area has been infiltrated with local anesthetic. The chest prepped and draped in sterile fashion. I excised the dysplastic nevus as drawn into the subcutaneous fat. Hemostasis achieved using the Bovie cautery. Defects were created at each of the wounds to optimize the primary repair. Thus, I considered a complex repair and the wound is closed in layers using 4-0 Monocryl and 5-0 Prolene. A loupe magnification was used. The patient tolerated the procedure well.

1. Post operative diagnosis is used for coding.
2. Excised diameter of the lesion on the chest is 1.2 cm.
3. Complex repair measured 3 cm.
4. Procedures performed are documented with size and type of surgery.
5. Local anesthesia.
6. The provider refers to the dysplastic nevus of the right chest.
7. Margins of the lesion were 0.3 cm.
8. The procedure is for excision of a dysplastic nevus on the chest.
9. Defects were created at each of the wounds.
10. Primary repair was used.
11. The wound repair is stated as complex.

What are the CPT® and ICD-9-CM codes reported?

CPT® codes: 13101, 11402-51

ICD-9-CM code: 216.5

RATIONALE: CPT® codes: The lesion is excision of a dysplastic nevus. A dysplastic nevus is an atypical mole which is usually benign. It is coded as benign unless pathology indicates malignant. In the CPT® Index see excision/skin/benign and you are directed to code range 11400–11471. The code selection is based on location (chest, which is the trunk) and size (1.2 cm). Code range 11400–11406 is for excisions performed on the trunk. 11402 is the correct code for a 1.2 cm excision on the trunk. The repair is stated as a complex repair measuring 3 cm using layered closure. A layered closure typically indicates an intermediate repair. However, the sentence before the complex repair states, "Defects were created at each of the wounds to optimize the primary repair," According to the guidelines in the repair section,creating a limited defect to repair a wound is considered a complex repair. To find in the CPT® Index, see repair/skin/complex and you are directed to13100–13160. Complex repairs of the trunk are coded with range 13100–13102 and are based on size of the repair. 13101 is the complex repair of the trunk for a 3 cm repair. Modifier 51 is appended to the second code to indicate more than one procedure is being performed in the same surgical session.

ICD-9-CM codes: The diagnosis is a dysplastic nevus, right chest. For the dysplastic nevus on the chest, look in the ICD-9-CM Index to Diseases for nevus and you are directed to see Neoplasm, benign, by site. Refer to the Neoplasm Table and find skin/chest. The benign code is 216.5.

Case 8

Preoperative diagnoses:

1. Basal cell carcinoma right temple.
2. Squamous cell carcinoma, left hand.

Postoperative diagnoses: Same

Procedures performed:

1. Excision basal cell carcinoma right temple with excised diameter of 2.2 cm and full thickness skin graft 4 cm^2.
2. Excision squamous cell carcinoma, left hand with rhomboid flap repair 2.5 cm^2.

Anesthesia: Local using 8 cc of 1% lidocaine with epinephrine and 3 cc of 1% plain lidocaine.

Indications for surgery: The patient is a 77-year-old white woman with a biopsy-proven basal cell carcinoma of right temple that appeared to be recurrent and a biopsy-proven squamous cell carcinoma of her left hand. I marked the lesion of her temple for elliptical excision in the relaxed skin tension lines of her face with gross normal margins of around 2–3 mm and I marked my planned rhomboidal excision of the squamous cell carcinoma of her left hand with gross normal margins of around 3 mm and I drew my planned rhomboid flap. She observed all these markings with a mirror so she could understand the surgery and agree on the locations and we proceeded.

Description of procedure: All areas were infiltrated with local anesthetic, that is the anesthetic with epinephrine. The face and left upper extremity were prepped, draped in sterile fashion. I excised the lesion of her right temple and left hand as drawn to the subcutaneous fat. Hemostasis achieved with Bovie cautery. It took a few more passes to get the margins clear from the basal cell carcinoma right temple. The wound had become very large by that time around quarter sized and I attempted to close the wound. I began with a 3-0 Monocryl. It was simply too tight and was deforming her eyelid. Thus I felt that we would have to close with a skin graft. I marked the area of her right clavicle for the donor site and this area prepped and draped in a sterile fashion. I infiltrated with a plain lidocaine. The full-thickness skin graft harvested and defatted using scissors. Meticulous hemostasis achieved in the donor site using the Bovie cautery. The skin graft inset into the temple wound using 5-0 plain gut suture. The skin graft was vented and then a Xeroform bolster was placed using Xeroform and nylon. The donor site was closed in layers using 4-0 Monocryl and 5-0 Prolene. My attention turned to the hand. The margins had been cleared from that region even though it did take 2 passes. I incised the rhomboid flap and elevated with a full-thickness subcutaneous fat. Hemostasis achieved in the wound and the donor site using Bovie cautery. The flap rotated in the defect. The donor site closed with flap inset in layers using 4-0 Monocryl and 5-0 Prolene. Loupe magnification was used. The patient tolerated the procedure well.

1. The postoperative diagnosis is the same as the pre-operative diagnosis, so the pre-operative diagnosis will be used for coding.
2. Right temple malignant lesion (Basal Cell Carcinoma) excised diameter of 2.2 cm.
3. Full thickness skin graft is 4 cm^2.
4. Excision malignant lesion left hand.
5. Flap repair of 2.5 cm2.
6. Anesthesia local.
7. Margins of temple excision.
8. Margins of hand excision.
9. Lesion on the right temple and left had were excised.
10. The right temple was excised outside of the parameters initially drawn.
11. The decision was made to repair with a skin graft due to the size of the wound.
12. Donor site is the right clavicle making this a free graft (when the skin is cut free of one area and moved to another for re-attachment).
13. The graft was full-thickness.
14. Skin graft inserted in the temple.
15. Here, we begin the description of the closure of the hand.
16. Additional margins were excised.
17. A rotation flap was used.

What are the CPT® and ICD-9-CM codes reported?

CPT® codes: 15240, 14040-51, 11643-59

ICD-9-CM codes: 173.31, 173.62

RATIONALE: CPT® codes: The excised lesion on the temple was 2.2 cm. To code, look in the CPT® Index for Excision/malignant, you are referred to code range 11600–11646. Narrowing down the location and the size, the correct code is 11643.

After excising the lesion on the temple, the physician performed a full thickness free graft (moving skin from the clavicle to the temple). To find in the CPT® Index, look under Skin, Grafts/Free and you are directed to 15157, 15200–15261, 15757. Free skin graft codes are selected based on the thickness of the graft, location and size. Full thickness free grafts are coded from range 15200–15261. The temple area is considered the forehead, or cheek area, both code to range 15240–15241 based on the size. The size in the procedure detail is stated as, "approximately the size of a quarter." Size is clarified in the procedures listed at the top as 4 sq cm^2. The correct code for this is 15240.

The hand lesion was excised and repaired with an adjacent tissue transfer. The guidelines for excisions tell us that excisions performed with adjacent tissue transfers should be reported with only the adjacent tissue transfer code (14000–14302). Adjacent tissue transfers are coded based on location and size. The correct code for the hand with a 2.5 cm^2 repair is coded with 14040.

Code 14040 requires modifier 51 to indicate it is a multiple procedure. The excision of a malignant lesion (11643) is included in an adjacent tissue transfer (14040). A modifier 59 is required on 11643 to indicate a separate site.

ICD-9-CM codes: The diagnoses listed are basal cell carcinoma right temple, and Squamous cell carcinoma, left hand.

To find basal cell carcinoma right temple, look in the ICD-9-CM Index for Carcinoma/Basal cell, you are directed to see Neoplasm/skin/malignant. In the Neoplasm Table, skin/temple which refers you to see also Neoplasm/skin/face/basal cell 173.31. For Squamous cell carcinoma, looking in the index squamous cell carcinoma does not indicate where to look for the code, but you are given a Morphology code M8070/3. The /3 on the Morphology code indicates to us it is a primary malignancy (Appendix A). Squamous cells are in the skin (just below the outer layer of the skin). Squamous cell carcinoma is a primary malignancy of the skin. In the Neoplasm Table, under skin/hand and you are referred to see also Neoplasm, skin, limb, upper. Skin/limb/upper/squamous cell carcinoma is coded as 173.62. Looking in the Tabular List verifies these are the correct code choices.

Case 9

Preoperative diagnosis: Right breast mass.

1. Postoperative diagnosis is used for coding.
2. Procedure to be performed.
3. "Appeared to be" would not be considered a definitive diagnosis.
4. The procedure was performed on the right breast.
5. Specific location of the breast mass.
6. Depth of incision.
7. Layered closure for intermediate repair.

1. **Postoperative diagnosis:** Right breast mass.

2. **Procedure:** Right breast lumpectomy.

Anesthesia: A 1% lidocaine with epinephrine mixed 1:1 with 0.5% Marcaine along with IV sedation.

Indications: The patient is a 23-year-old female who recently noted right breast mass. This has grown somewhat in size and we decided it should be excised.

3. **Findings at the time of operation:** This appeared to be a fibroadenoma.

Operative procedure: The patient was first identified in the holding area and the surgical site was reconfirmed and marked. Informed consent was obtained. She was then brought back to the operating room where she was placed on the operating room table in supine position. Both arms were placed comfortably out at approximately 85 degrees. All pressure points were well padded. A time-out was performed.

4. The right breast was prepped and draped in the usual fashion. I anesthetized the area in
5. question with the mixture noted above. This mass was at the areolar border at approximately the outer central to upper outer quadrant. I therefore made a circumareolar incision on the outer aspect of the areola. This was carried down through skin, subcutaneous
6. tissue and a small amount of breast tissue. I was able to easily dissect down to the mass itself. Once I was there, I placed a figure-of-eight 2-0 silk suture for traction. I then carefully dissected this mass out from the surrounding tissue. Once it was removed from the field, the traction suture was removed and the mass was sent in formalin to pathology. The wound was then inspected for hemostasis, which was achieved with electrocautery. I then reapproximated the breast tissue deep with interrupted 3-0 Vicryl suture and then another 3-0 Vicryl suture in the superficial breast tissue. The skin was then closed
7. in a layered fashion using interrupted 4-0 Monocryl deep dermal sutures followed by a running 4-0 Monocryl subcuticular suture. Benzoin, Steri-Strips and a dry sterile pressure were then applied. The patient tolerated the procedure well and was taken back to the short stay area in good condition.

What are the CPT® and ICD-9-CM codes reported?

CPT® code: 19301-RT

ICD–9-CM code: 611.72

RATIONALE: CPT® codes: The provider removed a mass from the outer central to upper outer quadrant. This is considered a lumpectomy. To find this code, look in the index under lumpectomy and you are guided to 19301–19302. 19301 is the correct code because a lymphadenectomy is not performed which is required to report 19302. Modifier RT is appended to report the procedure is performed on the right breast.

ICD-9-CM codes: The diagnosis from the operative report indicated this mass appeared to be a fibroadenoma. The use of the phrase "appeared to be" indicates the fibroadenoma is not a confirmed diagnosis. The diagnosis to code is a right breast mass. To find this in ICD-9-CM, look in the index for mass/breast and you are directed to code 611.72. Verification in the Tabular List confirms 611.72 is for a lump or mass in breast.

Case 10

Preoperative diagnosis: Necrotizing fasciitis.

Postoperative diagnosis: Necrotizing fasciitis.

Procedure: Wound excision and homograft placement with surgical preparation, exploration of distal extremity.

Findings and indications: This very unfortunate gentleman with liver failure, renal failure, pulmonary failure, and overwhelming sepsis was found to have necrotizing fasciitis last week. We excised the necrotizing wound. The wound appears to have stabilized; however, the patient continues to be very sick. On return to the operating room, he appears to have no evidence of significant healing of any areas with extensively exposed tibia, fibula, Achilles tendon, and other tendons in the foot as well as the tibial plateau and fibular head without any hope of reconstruction of the lower extremity or coverage thereof.

There was an area on the lateral thigh that we thought may be able to be closed with a skin graft eventually for a viable above-the-knee amputation.

Procedure in detail: After informed consent, the patient was brought to the operating room and placed in supine position on the operating table. The above findings were noted. Debridement sharply with the curved Mayo scissors and the scalpel were helpful in demonstrating the findings noted above. Because of the unviability of this area, it was felt that we would not perform a homografting to this area. However, the lateral thigh appeared to be viable and this was excised further with curved Mayo scissors. Hemostasis was achieved without significant difficulty and the homograft meshed 1.5:1 was then placed over the hemostatic wound on the lateral thigh. This was secured in place with skin staples.

Upon completion of the homografting, photos were also taken to demonstrate the rather desperate nature of this wound and the fact that it would require above-the-knee amputation for closure.

The wound was then dressed with moist dressing with incorporated catheters. The patient was taken back to the ICU in satisfactory condition

1. The necrotizing wound was excised the week before. We are still in the global period of the original surgery.
2. A return to the operating room indicates to look for possible modifiers.
3. Debridement of the wound.
4. The wound on the lateral thigh was excised to prep for homograft placement.
5. Homograft mesh placed.
6. They plan to return to the operating room for an above the knee amputation (AK).

What are the CPT® and ICD-9-CM codes reported?

CPT® codes: 15271-58, 15002-58-51

ICD–9-CM code: 728.86

RATIONALE: CPT® codes: A homograft of the lateral thigh was performed. A homograft is considered a skin substitute. To find this in the CPT® Index, look for Integumentary System/Skin Replacement Surgery and Skin Substitutes/Grafts/Skin Substitute Graft and you are referred to code range 15271–15278. The guidelines at the beginning of the Skin Replacement Surgery subsection confirm homograft is a type of skin substitute graft.

The code selection is based on the location and size. For the legs, 15271–15274 is the correct code range. The size is not stated, so you can only code the smallest size, 15271. The preparation of the wound (debriding and excising to prepare a clean and viable wound for graft placement) can also be coded when performed. There is indication in the note this was performed. To find in the CPT® Index, look for excision/skin graft/preparation of site and you are directed to code range 15002–15005. The code selection is based on location and size. The correct code is 15002.

This is a staged procedure. The wounds were excised the week before. They brought the patient to the operating room on this date to check the progress. They determined a homograft was needed and plan to perform an above the knee amputation when the wound on the thigh heals. A modifier 58 is appended to both surgery codes. A modifier 51 is needed on 15002 to indicate a multiple procedure.

ICD-9-CM code: The diagnosis is necrotizing fasciitis. Look in the ICD-9-CM Index for Fasciitis/necrotizing, you are directed to 728.86. In the tabular index, it states to use an additional code to identify gangrene or infectious organism. This is not stated as gangrene and there is no mention of the infecting organism; therefore, 728.86 is the only diagnosis code listed.