

2019

Medical Coding Training: CPC®

Practical Application Workbook—Answer Key



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Regarding HCPCS Level II

HCPCS Level II codes and guidelines discussed in this book are current as of press time. The 2017 code set for HCPCS Level II were unavailable when published.

Clinical Examples Used in this Book

AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides, exams, and workbooks are *actual*, *redacted* office visit and procedure notes donated by AAPC members.

To preserve the *real-world* quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially, they are as one would find them in a coding setting.

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Contents

Chapter 1 The Business of Medicine	1
Chapter 2 Medical Terminology and Anatomy Review	5
Chapter 3 Introduction to ICD-10-CM	7
Chapter 4 ICD-10-CM Coding Chapters 1–11	11
Chapter 5 ICD-10-CM Coding Chapters 12–21	19
Chapter 6 Introduction to CPT®, Surgery Guidelines, HCPCS Level II, and Modifiers	29
Chapter 7 Integumentary System	33
Chapter 8 Musculoskeletal System	45
Chapter 9 Respiratory, Hemic, Lymphatic, Mediastinum, and Diaphragm	57
Chapter 10 Cardiovascular System	67
Chapter 11 Digestive System	81
Chapter 12 Urinary System and Male Genital System	93
Chapter 13 Female Reproductive System	105

Chapter 14	
Endocrine and Nervous System	117
Chapter 15	
Eye and Ocular Adnexa, Auditory Systems	131
Chapter 16	
Anesthesia.....	143
Chapter 17	
Radiology	155
Chapter 18	
Pathology and Laboratory	169
Chapter 19	
Evaluation and Management	181
Chapter 20	
Medicine	201



Exercise 1

1. What type of profession, other than coding, might a skilled coder enter?

Answer: Consultants, educators, medical auditors

2. What is the difference between outpatient and inpatient coding?

Answer: Outpatient coders focus on assigning CPT®, HCPCS Level II, and ICD-10-CM codes. They work in provider offices, outpatient clinics and facility outpatient departments. Outpatient facility coders also work with ambulatory payment classifications (APCs).

Inpatient hospital coding focuses on a different subset of skills, where coders work with ICD-10-CM and ICD-10-PCS. These coders also assign Medicare severity-diagnosis related groups (MS-DRGs) for reimbursement. Outpatient coders usually have more interaction throughout the day and must communicate well with providers; inpatient coders tend to have less interaction throughout the day.

3. What is a mid-level provider?

Answer: Mid-level providers include physician assistants (PA) and nurse practitioners (NP). Mid-level providers are known also as physician extenders because they extend the work of a physician.

4. Discuss the different parts of Medicare and what each program covers.

Answer:

- Medicare Part A helps to cover inpatient hospital care, as well as care provided in skilled nursing facilities, hospice care, and home healthcare.
- Medicare Part B covers two types of services: 1) Medically necessary provider services that are needed to diagnose or treat a medical condition and that meet accepted standards of medical practice; and 2) preventive services to prevent illness or detect it at an early stage. Medicare Part B is an optional benefit for which the patient pays a premium, an annual deductible and generally has a 20% co-insurance except for preventive services covered under healthcare law. Coders working in provider offices code mainly Medicare Part B claims.
- Medicare Part C, also called Medicare Advantage, combines the benefits of Medicare Part A, Part B and sometimes Part D. The plans are managed by private insurers approved by Medicare and may include preferred provider organizations, health maintenance organizations, etc.
- Medicare Part D is a prescription drug coverage program available to all Medicare beneficiaries for a fee. Private companies approved by Medicare provide the coverage.

5. Evaluation and management (E/M) services are often provided in a standard format. One such format is SOAP notes. What does SOAP represent?

Answer:

S—Subjective — The patient’s statement about his or her health, including symptoms.

O—Objective — The provider assesses and documents the patient’s illness using observation, palpation, auscultation, and percussion. Tests and other performed services may be documented here as well.

A—Assessment — Evaluation and conclusion made by the provider. This is usually where the diagnosis(es) for the services are found.

P—Plan — Course of action. Here, the provider will list the next steps for the patient, whether ordering additional tests, taking over the counter medications, etc.

6. What are five tips for coding operative (OP) reports?

Answer:

1. Diagnosis code reporting — Use the post-operative diagnosis for coding unless there are further defined diagnoses or additional diagnoses found in the body or op report findings. If a pathology report is available, use the findings from the pathology report for the diagnosis.
2. Start with the procedures listed — One way to start the research process quickly is by focusing on the procedures listed in the header. Read the note in its entirety to verify the procedures performed. Procedures listed in the header may not be listed correctly and procedures documented within the body of the report may not be listed in the header at all; however, it is a place to start.
3. Look for key words — Key words may include locations and involved anatomical structures, surgical approach, procedure method (debridement, drainage, incision, repair, etc.), procedure type (open, closed, simple, intermediate, etc.), size and number, and the surgical instruments used during the procedure.
4. Highlight unfamiliar words — Research for understanding.
5. Read the body — All reported procedures should be documented within the body of the report. The report’s body may indicate a procedure was abandoned or complicated, possibly indicating the need for a different procedure code or reporting of a modifier.
7. What is medical necessity and what tool can you refer to for the medical necessity of a service?

Answer: The term medical necessity relates to whether a procedure or service is considered appropriate in a given circumstance. Tools to determine medical necessity include national coverage determinations (NCDs), local coverage determinations (LCDs), and commercial payer policies.

8. What are common reasons Medicare may deny a procedure or service?

Answer:

- Medicare doesn’t pay for the procedure/service to treat the patient’s condition.
- Medicare doesn’t pay for the procedure/service as frequently as proposed.
- Medicare doesn’t pay for experimental procedures/services.

9. Under the Privacy Rule, the minimum necessary standard does NOT apply to what type of disclosures?

Answer:

- Disclosures to or requests by a healthcare provider for treatment purposes.
- Disclosures to the individual who is the subject of the information.
- Uses or disclosures made pursuant to an individual's authorization.
- Uses or disclosures required for compliance with the HIPAA Administrative Simplification Rules.
- Disclosures to the U.S. Department of Health & Human Services (HHS) when disclosure of information is required under the Privacy Rule for enforcement purposes.
- Uses or disclosures required by other law.

10. What are seven key components of an internal compliance plan?

Answer:

- Conducting internal monitoring and auditing through the performance of periodic audits.
- Implementing compliance and practice standards through the development of written standards and procedures.
- Designating a compliance officer or contact(s) to monitor compliance efforts and enforce practice standards.
- Conducting appropriate training and education on practice standards and procedures.
- Responding appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate government entities.
- Developing open lines of communication, such as (1) discussions at staff meetings regarding how to avoid erroneous or fraudulent conduct; and (2) community bulletin boards to keep practice employees updated regarding compliance activities.
- Enforcing disciplinary standards through well-publicized guidelines.



1. Diagnosis: Calcification left basal ganglia
Where are the basal ganglia located?
Answer: Cerebral Cortex
2. Diagnosis: Vesicoureteral reflux
What is this a reflux of?
Answer: Urine backflow from bladder into ureters
3. Documentation: The posterior vaginal fornix and outer cervical os were prepped with a cleansing solution.
In this statement, what does “os” stand for?
Answer: Ostium (opening)
4. Hysterosalpingogram report: “Right cornual contour abnormality.”
Where is the cornua found anatomically for this case?
Answer: The cornua are where the fallopian tube connect to the uterine fundus.
5. Surgical procedure: Myringotomy
What anatomic location is being operated on?
Answer: Ear
6. Documentation: There was no cleft of the uvula or submucosal palate by visual and palpable exam.
What is being examined?
Answer: Oral cavity
7. Documentation: Recession of left inferior rectus muscle, 5 mm
What anatomic location is being operated on?
Answer: Eye
8. Diagnosis: Kyphosis
What anatomic location does this diagnosis most often refer to?
Answer: Thoracic Spine

9. Documentation: Suprapatellar recess showed no evidence of loose bodies or joint pathology.

What anatomic location does this refer to?

Answer: Knee (above the patella)

10. Colles' fracture

What anatomic location does this refer to?

Answer: Wrist



Exercise 1

Directions: Using the ICD-10-CM code book locate the diagnosis codes for the following conditions.

1. Fever

Answer: R50.9

Rationale: In the ICD-10-CM Alphabetic Index, look for Fever. There is no additional information provided. The default code is R50.9. Review the code in the Tabular List to verify the code accuracy.

2. Chronic non-intractable common migraine headache with status migrainosus

Answer: G43.701

Rationale: Determine the main term which is headache. In the ICD-10-CM Alphabetic Index, look for Headache/migraine (type) (*see also* Migraine). In the same index, Migraine (idiopathic)/common directs you to *see* Migraine, without aura. Migraine/without aura/chronic/not intractable/with status migrainosus directs you to code G43.701. Review the code in the Tabular List to verify the code accuracy.

3. Otitis media left ear

Answer: H66.92

Rationale: The main term is otitis. In the ICD-10-CM Alphabetic Index, look for Otitis/media. There is no additional information provided. You are referred to H66.9-. The dash indicates an additional character is required for a complete code. Review the code in the Tabular List for the 5th character. Under subcategory H66.9 you will see Otitis Media NOS listed. The 5th character is 2 indicating the infection is in the left ear. This is an infection of the middle ear (media).

4. Epigastric pain

Answer: R10.13

Rationale: The main term is pain. In the ICD-10-CM Alphabetic Index, look for Pain/epigastric, epigastrium. You are referred to R10.13. Review the code in the Tabular List to verify the code accuracy.

5. Acute asthma exacerbation

Answer: J45.901

Rationale: The main term is asthma. In the ICD-10-CM Alphabetic Index, look for Asthma, asthmatic/with/exacerbation (acute) J45.901. Review the code in the Tabular List to verify the code accuracy. Note: There is a category note for J45 to use additional code to identify exposure to, use of, or dependence of tobacco. This is coded if known.

6. Acute myocardial infarction

Answer: I21.9

Rationale: The main term is infarction. In the ICD-10-CM Alphabetic Index, look for Infarct, infarction/myocardium, myocardial (acute) (with stated duration of 4 weeks or less) I21.9. Refer to the Tabular List. This is the correct code, even though there is no stated duration in the question, because code I21.9 lists Myocardial infarction (acute) NOS under the code. Note: There is a category note for I21 to use additional code, if applicable, to identify exposure to, use of, dependence of tobacco, or status post tPA in another facility. This is coded if known.

7. Hypertensive heart disease

Answer: I11.9

Rationale: The main term is disease. In the ICD-10-CM Alphabetic Index, look for Disease, diseased/heart (organic)/hypertensive and you are directed to see Hypertension, heart. Hypertension, hypertensive/heart directs you to I11.9. Review the code in the Tabular List to verify the code accuracy. Note: There is a category note for I10-I15 to use additional code to identify exposure to, use of, or dependence of tobacco. This is coded if known.

8. Syncope

Answer: R55

Rationale: Look for Syncope in the ICD-10-CM Alphabetic Index. You are referred to R55. Review the code in the Tabular List to verify the code accuracy.

9. Nausea and vomiting

Answer: R11.2

Rationale: Nausea and vomiting are both main terms. In the ICD-10-CM Alphabetic Index, look for Nausea/with vomiting or Vomiting/with nausea. You are referred to R11.2. Review the code in the Tabular List to verify the code accuracy.

10. GERD

Answer: K21.9

Rationale: GERD is an acronym for gastroesophageal reflux disease. The main term is disease. This diagnosis can be located in the index under the acronym or the main term. In the ICD-10-CM Alphabetic Index, look for GERD (gastroesophageal reflux disease) or look for Disease/gastroesophageal reflux (GERD). You are referred to K21.9. Review the code in the Tabular List to verify the code accuracy.

11. Chlamydial inflammation of the testes

Answer: A56.19

Rationale: Inflammation and chlamydia are both main terms. In the ICD-10-CM Alphabetic Index, look for Inflammation, inflamed, inflammatory/testes, which directs you to *see* Orchitis. Orchitis is the inflammation of the testes. Look for Orchitis/chlamydial or Chlamydia, chlamydial/orchitis. You are referred to A56.19. Review the code in the Tabular List to verify the code accuracy. Under code A56.19, chlamydial orchitis is listed.

12. Sickle-cell anemia

Answer: D57.1

Rationale: The main term is anemia. In the ICD-10-CM Alphabetic Index, look for Anemia/sickle-cell – see Disease, sickle-cell. Disease, diseased/sickle cell directs you to D57.1. Review the code in the Tabular List to verify the code accuracy. Sickle-cell anemia NOS is listed as an inclusion term under D57.1. Note: There is a category note under D57 to use an additional code for any associated fever. This is coded if known.

13. Ruptured spleen (not due to an injury)

Answer: D73.5

Rationale: The main term is ruptured. From the ICD-10-CM Alphabetic Index look for Rupture, ruptured/spleen/nontraumatic. You are referred to D73.5. Review the code in the Tabular List to verify the code accuracy. The diagnosis documents the rupture of the spleen was not due an injury, also called nontraumatic. Splenic rupture, nontraumatic is listed as an inclusion term under D73.5.

14. Cellulitis of the arm

Answer: L03.119

Rationale: The main term is cellulitis. In the ICD-10-CM Alphabetic Index, look for Cellulitis/arm – see Cellulitis, upper limb. Look for Cellulitis/upper limb and you are referred to L03.11-. The dash indicates another character is required for a complete code. Review the code in the Tabular List to report the 6th character and verify the code accuracy. The diagnosis does not specify if the cellulitis is in the left or right arm, so report L03.119.

15. Chest mass

Answer: R22.2

Rationale: The main term is mass. In the ICD-10-CM Alphabetic Index, look for Mass/chest. You are referred to R22.2. Review the code in the Tabular List to verify the code accuracy.

16. Novel H1N1 flu

Answer: J10.1

Rationale: The main term is flu. In the ICD-10-CM Alphabetic Index, look for Flu there are no subentries for Novel or H1N1. It does instruct you to see also Influenza. Look for Influenza/novel (2009) H1N1 influenza. You are referred to J10.1. Review the code in the Tabular List to verify the code accuracy. There is a use additional code note for associated pleural effusion or sinusitis, if applicable.

17. Uncontrolled diabetes with diabetic cataracts

Answer: E11.36

Rationale: The main term is diabetes. In the ICD-10-CM Alphabetic Index, look for Diabetes, diabetic/with/cataract. You are referred to E11.36. Review the code in the Tabular List to verify the code accuracy. The term uncontrolled is not a factor in code selection for diabetes under ICD-10-CM. There is a note to use an additional code under category E11 to identify if the diabetes is controlled with insulin, oral antidiabetic drugs, or oral hypoglycemic drugs if known.

18. Left, outer cheek abrasion, initial encounter

Answer: S00.81XA

Rationale: The main term is abrasion. In the ICD-10-CM Alphabetic Index, look for Abrasion/cheek. You are referred to S00.81-. Review the code in the Tabular List to assign the 7th character and to verify the code accuracy. Because this code needs seven characters, the letter X is used as a placeholder for the 6th character, and the 7th character A is reported because the injury is an initial encounter.

19. Acute cholecystitis with chronic cholecystitis

Answer: K81.2

Rationale: The main term is cholecystitis. In the ICD-10-CM Alphabetic Index, look for Cholecystitis/acute/with/chronic cholecystitis. You are referred to K81.2. Review the code in the Tabular List to verify the code accuracy. Two codes are not reported for the acute and chronic cholecystitis because there is a combination code that fully identifies all the elements documented in the diagnosis.

20. Right eyebrow laceration, subsequent encounter

Answer: S01.111D

Rationale: The main term is laceration. In the ICD-10-CM Alphabetic Index, look for Laceration/eyebrow and you are directed to *see* Laceration, eyelid. Look for Laceration/eyelid, and you are referred to S01.11-. Review the code in the Tabular List to report 6th and 7th characters and to verify the code accuracy. S01.111D is the correct code to report because the laceration is on the right side. The 7th character D is reported to indicate subsequent encounter.



Case 1

Progress Note

This patient is a 50-year-old female who began developing **bleeding, bright red blood per rectum**^[1], approximately two weeks ago. She is referred by her family physician. She states that after a bowel movement she noticed blood in the toilet. She denied any prior history of bleeding or pain with defecation. She states that she has had an **external hemorrhoid**^[2] that did bleed at times but that is not where this bleeding is coming from. She is presently concerned because a close friend of hers was recently diagnosed with rectal carcinoma requiring chemotherapy that was missed by her primary doctor. She is here today for evaluation for a colonoscopy.

Physical examination, she appears to be a well appearing 50-year-old, white female. Abdomen is soft, non-tender, non-distended.

Assessment: 50-year-old female with **rectal bleeding**^[3].

Plan: We'll schedule the patient for an outpatient colonoscopy. The patient was made aware of all the risks involved with the procedure and was willing to proceed.

^[1] Patient's presenting complaint.

^[2] This is reported by the patient, but not documented in the exam or assessment, so it is not coded.

^[3] Report the code documented in the assessment.

What diagnosis code(s) are reported?

ICD-10-CM Code: K62.5

Rationale: In the ICD-10-CM Alphabetic Index, look for Bleeding/rectum, rectal. You are referred to K62.5. Verify the code in the Tabular List.

Case 2

Preoperative Diagnosis: Bilateral profound sensorineural hearing loss.

Postoperative Diagnosis: **Bilateral profound sensorineural hearing loss.**^[1]

Procedures Performed:

1. Placement of left Nucleus cochlear implant.
2. Facial nerve monitoring for an hour.
3. Microscope use.

Anesthesia: General.

Indications: This is a 69-year-old woman who has had **progressive hearing loss**^[2] over the last 10–15 years. Hearing aids are not useful for her. She is a candidate for cochlear implant by FDA standards. The risks, benefits, and alternatives of procedure were described to the patient, who voiced understanding and wished to proceed.

Procedure: After properly identifying the patient, she was taken to the main operating room, where general anesthetic was induced. The table was turned to 180 degrees and a standard left-sided post auricular shave and injection of 1% lidocaine plus

1:100,000 epinephrine was performed. The patient was then prepped and draped in a sterile fashion after placing facial nerve monitoring probes, which were tested and found to work well. At this time, the previously outlined incision line was incised and flaps were elevated. A subtemporal pocket was designed in the usual fashion for placement of the device. A standard cortical mastoidectomy was then performed and the fascial recess was opened exposing the area of the round window niche. The lip of the round window was drilled down exposing the round window membrane. At this time, the wound was copiously irrigated with Bacitracin containing solution, and the device was then placed into the pocket. A 1 mm cochleostomy was made, and the device was inserted into the cochleostomy with an advance off stylet technique. A small piece of temporalis muscle was packed around the cochleostomy, and the wound was closed in layers using 3-0 and 4-0 Monocryl and Steri-Strips. A standard mastoid dressing was applied. The patient was returned to anesthesia, where she was awakened, extubated, and taken to the recovery room in stable condition.

[1] Report the postoperative diagnosis.

[2] The diagnosis is documented as the indication for the surgery.

What diagnosis code(s) are reported?

ICD-10-CM Code: H90.3

Rationale: The patient has bilateral sensorineural hearing loss. In the ICD-10-CM Alphabetic Index, look for Loss (of)/hearing (*see also* Deafness). Look for Deafness/sensorineural/bilateral which directs you to H90.3. Verify code selection in the Tabular List.

Case 3

CC: HTN

Interval History: No new complaints.

Exam: NAD. 130/80, 84, 22. Lungs are clear. Heart RRR, no MRGs. Abdomen is soft, non-tender. No peripheral edema.

Impression: **Stable HTN**^[1] on current meds.

Plan: No changes needed. RTC in six months with labs.

[1] Patient is diagnosed with hypertension.

What diagnosis code(s) are reported?

ICD-10-CM Code: I10

Rationale: In the ICD-10-CM Alphabetic Index, look for Hypertension, hypertensive. You are referred to code I10. Verify the code selection in the Tabular List.

Case 4

Subjective: Low-grade fever at home. She has had some lumps in the abdominal wall and when she injects her insulin; it does seem to hurt there. She stopped four of her medications including Neurontin, Depakote, Lasix, and Premarin, and, overall she feels quite well. Unfortunately, she has put on 20 pounds since our last visit.

Objective:

HEENT: Tympanic membranes are retracted, but otherwise clear. The nose shows significant green rhinorrhea present. Throat is mildly inflamed with moderate postnasal drainage.

Neck: No significant adenopathy.

Lungs: Clear.

Heart: Regular rate and rhythm.

Abdomen: Soft, obese, and non-tender. Multiple lipomas are palpated.

Assessment:

1. Diabetes mellitus, type 1.^[1]
2. Diabetic neuropathy.^[1]
3. Acute sinusitis.^[1]

Plan: At this time, I have recommended the addition of some Keflex for her acute sinusitis^[2]. I have given her a chair for the shower. They will not cover her Glucerna anymore so a note for that will be required.

^[1] The definitive diagnoses are reported.

^[2] Provider treated the acute sinusitis.

What diagnosis code(s) are reported?

ICD-10-CM Codes: E10.40, J01.90

Rationale: The patient is diagnosed with type 1 diabetes. The patient has diabetic neuropathy, which is a diabetic manifestation. In the ICD-10-CM Alphabetic Index, look for Diabetes, diabetic/type 1/with/neuropathy which directs you to E10.40. To locate the code for acute sinusitis, look in the Alphabetic Index for Sinusitis/acute which directs you to J01.90. Verify code selection in the Tabular List.

Case 5

Preoperative Diagnosis: Cataract, left eye.

Postoperative Diagnosis: Cataract, left eye, Presbyopia^[1]

Procedure:

1. Cataract extraction with IOL implant.
2. Correction of presbyopia^[2] with lens implantation.

Procedure Detail: The patient was brought to the operating room under neuroleptic anesthesia monitoring. A topical anesthetic was placed within the operative eye and the patient was prepped and draped in usual manner for sterile ophthalmic surgery. A lid speculum was inserted into the right infrapalpebral space. A 6-0 silk suture was placed through the episclera at 12 o'clock. A subconjunctival injection of non-preserved lidocaine was given. A peritomy was fashioned from 11 o'clock to 1 o'clock with Westcott scissors. Hemostasis was achieved with the wet-field cautery. A 3 mm incision was made in the cornea and dissected anteriorly with a crescent blade. The anterior chamber was entered at 12 o'clock and 2 o'clock with a Super sharp blade. Non-preserved lidocaine was instilled into the anterior chamber. Viscoelastic was instilled in the anterior chamber and using a bent 25-gauge needle, a 360-degree anterior capsulotomy was performed using Utrata forceps. The capsulotomy was measured and found to be 5.5 mm in diameter. Using an irrigating cannula, the lens nucleus was hydrodissected and loosened. Using the phacoemulsification unit, the lens nucleus was divided and emulsified. The irrigating/aspirating tip was used to remove the cortical fragments

from the capsular bag, and the posterior capsule was polished. Using a curette to polish the anterior capsule, cortical fragments were removed from the anterior lens capsule for 270 degrees. The irrigating/aspirating tip was used to remove the capsular fragments. The anterior chamber and capsule bag were inflated with viscoelastic and using a lens inserter, a Crystalens was then placed within the capsular bag and rotated to the horizontal position. The viscoelastic was removed with the irrigating/aspirating tip and the lens was found to be in excellent position with a slight posterior vault. The wound was hydrated with balanced salt solution and tested and found to be watertight at a pressure of 20 mm Hg. Topical Vigamox was applied. The conjunctiva was repositioned over the wound with a wet field cautery. The traction suture and lid speculum were removed. A patch was applied. The patient tolerated the procedure well and left the operating room in good condition.

^[1] Report the postoperative diagnosis.

^[2] Patient is also diagnosed with presbyopia.

What diagnosis code(s) are reported?

ICD-10-CM Codes: H26.9, H52.4

Rationale: The patient is diagnosed with a cataract and presbyopia. In the ICD-10-CM Alphabetic Index, look for Cataract. The type of cataract is not specified so the only option is to use the unspecified code. You are referred to H26.9. For the additional diagnosis, look in the Alphabetic Index for Presbyopia which is reported with H52.4. Verify both codes in the Tabular List.

Case 6

Subjective: Here to follow up on her atrial fibrillation^[1]. No new problems. Feeling well. Medications are per medication sheet. These were reconstituted with the medications that she was discharged home on.

Objective: Blood pressure is 110/64. Pulse is regular at 72. Neck is supple. Chest is clear. Cardiac normal sinus rhythm.

Assessment: Atrial fibrillation, currently stable.^[2]

Plan:

1. Prothrombin time to monitor long term use of anticoagulant^[3].
2. Follow up with me in one month or sooner as needed if she has any other problems in the meantime. Will also check a creatinine and potassium today.

^[1] Patient returns for a follow-up visit for atrial fibrillation.

^[2] Report a code for the definitive diagnosis.

^[3] Status code reported for long term use of anticoagulants and to monitor the level.

What diagnosis code(s) are reported?

ICD-10-CM Code: I48.91, Z79.01, Z51.81

Rationale: In the ICD-10-CM Alphabetic, look for Fibrillation/atrial or auricular (established) which directs you to I48.91. Next, look in the Alphabetic Index for Long-term (current) (prophylactic) drug therapy (use of)/anticoagulants which directs you to Z79.01. Verify both codes in the Tabular List. Under category code Z79 there is an instructional note to report code Z51.81 for therapeutic drug level monitoring.

Case 7

Follow-up Visit: The patient has some **memory problems**^[4]. She is hard of hearing. She is legally blind. Her pharmacist and her family are very worried about her memory issues. She lives at home, family takes care of laying out her medications and helping with the chores, but she does take care of her own home to best of her ability.

Exam: Pleasant elderly woman in no acute distress. She has postop changes of her eyes. TMs are dull. Pharynx is clear. Neck is supple without adenopathy. Lungs are clear. Good air movement. Heart is regular. She had a slight murmur. Abdomen is soft. Moderately obese. Non-tender. Extremities: no clubbing or edema. Foot exam shows some bunion deformity but otherwise healthy. Light touch is preserved. There is no ankle edema or stasis change. Examination of the upper arms reveals good range of motion. There is significant pain in her shoulder with rotational movements. It is localized mostly over the deltoid. There is no other deformity. There is a very slight left shoulder discomfort and slight right hip discomfort.

Impression:

1. **Dementia**^[3]
2. **Right shoulder pain**.^[3]
3. **Benign hypertensive cardiovascular disease**.^[3]
4. **Type 2 diabetes, good control**.^[2] Most recent A1C done today is at 5.9%. Liver test normal. Cholesterol 199; LDL a little high at 115.

Plans:

1. I offered her and her family neuropsychological evaluation to **evaluate for dementia**^[4]. Her system complex is consistent with dementia, whether it be from small vascular disease or Alzheimer's is unknown. At this point, they would much rather initiate treatment than go through an exhaustive neuropsychological test.
2. For the shoulder, we decided on **right deltoid bursa aspiration injection**^[5]. She has had injection for bursitis in the past and prefers to go this route. She will ice and rest the shoulder after injection.
3. Follow up in 3 months.

Procedure: Aspiration injection right deltoid bursa. The point of maximal tenderness was identified, skin was prepped with alcohol. A 25-gauge, 1 ½-inch needle was advanced to the humerus and then aspirated. 1 cc of 0.25 % Marcaine mixed with 80 mg Depo-Medrol was deposited. Needle was withdrawn. Band-Aid was applied. Post injection she had marked improvement; increased range of motion consistent with good placement of the medication. She was started on Cerefolin, plus NAC and Aricept starter pack was given with email away script. Follow-up in 3 months and we will reassess her dementia at that time.

^[4] A presenting problem.

^[2] Provider documents the type of diabetes and that it is controlled.

^[3] Report codes for all definitive diagnoses that were treated.

^[4] Recommendation for evaluation to determine the cause of dementia.

^[5] Treatment documented for right shoulder pain.

What diagnosis code(s) are reported?

ICD-10-CM Codes: F03.90, M25.511, I11.9, E11.9

Rationale: The patient has multiple diagnoses. It's important to report the diagnoses that the provider treated during the encounter and any chronic conditions that affect the care of the patient. The provider documents that the patient has dementia. The provider is not sure of the cause. Look in the ICD-10-CM Alphabetic Index for Dementia which directs you to F03.90. The provider performs a joint injection to treat the patient's right shoulder pain. In the Alphabetic Index, look for Pain(s)/joint/shoulder which directs you to M25.51-. Turn to the Tabular List for the 6th character to indicate the right shoulder, M25.511. The patient is also diagnosed with benign hypertensive cardiovascular disease. The provider reviewed the labs (cholesterol and LDL) to monitor this condition. In the Alphabetic Index, look for Hypertension, hypertensive

(benign)/cardiovascular/disease (arteriosclerotic) (sclerotic) – *see* Hypertension, heart. Look for Hypertension, hypertensive (benign)/heart which directs you to I11.9. The last diagnosis listed is controlled type 2 diabetes. In the ICD-10-CM Alphabetic Index, look for Diabetes, diabetic/type 2 which directs you to code E11.9. Verify codes in the Tabular List.

Case 8

S: The patient presents today for reevaluation and titration of carvedilol for his **coronary artery disease and hyperlipidemia**^[1]. His weight is up 7 pounds. He has quit smoking. He has no further cough and he states he is feeling well except for the weight gain. He states he doesn't feel he's eating more, but his wife says he's eating more. We've been attempting to titrate up his carvedilol to 25 mg twice a day from initially 6.25 mg. He has tolerated the titration quite well. He gets cephalgias on occasion. He states he has a weak spell but this is before he takes his morning medicine. I updated his medical list here today. I gave him samples of Lipitor.

O: Weight is 217, pulse rate 68, respirations 16, and blood pressure 138/82. HEENT examination is unchanged. His heart is a regular rate. His lungs are clear.

A: 1. CAD^[2]
2. Hyperlipidemia^[2]

P: 1. The plan is samples of Lipitor, using the two months' supply that I have given him.
2. We've increased his Coreg to 25 mg bid. He'll recheck with us in six months.

^[1] Patient returns for treatment of CAD and hyperlipidemia.

^[2] Select the codes for the definitive diagnoses.

What diagnosis code(s) are reported?

ICD-10-CM Codes: I25.10, E78.5, Z87.891, Z79.899

Rationale: In the ICD-10-CM Alphabetic Index, look for Disease, diseased/artery/coronary which directs you to I25.10. The patient also has hyperlipidemia. In the Alphabetic Index, look for Hyperlipemia, hyperlipidemia which directs you to E78.5. There is an instructional note under category code I25 which states to use an additional code to identify exposure to/history of/use of/or dependence of tobacco. The documentation indicates that the patient quit smoking. He has a history of tobacco use, reported with Z87.891. This is found by looking in the Alphabetic Index for History/personal (of) nicotine dependence. Because there is reevaluation of medication the patient is taking for CAD and hyperlipidemia, code Z79.899 is reported. Look in the Alphabetic Index for Long-term (current) (prophylactic) drug therapy (use of)/drug, specified NEC Z79.899. Verify the codes in the Tabular List.

Case 9

Operative Report

Preoperative Diagnoses: Splenic abscesses and multiple intra-abdominal abscesses, related to HIV, AIDS, and hepatitis C

Postoperative Diagnoses: **Splenic abscesses and multiple intra-abdominal abscesses, related to HIV, AIDS, and hepatitis C**^[1]

Operative Procedure:

1. Exploratory laparotomy with drainage of multiple intra-abdominal abscesses.
2. Splenectomy.
3. Vac Pak closure.

Findings: This is a 42-year-old man who was recently admitted to the medical service with a splenic defect and found to have a splenic vein thrombosis. He was treated with antibiotics and anticoagulation. He returned and was admitted with a CT scan

showing mass of left, upper quadrant with abscesses surrounding both sides of the spleen^[2], as well as multiple other intra-abdominal abscesses below the left lobe of the liver in both lower quadrants and in the pelvis. The patient has a psychiatric illness and was difficult to consent and had been anticoagulated with an INR of 3. Once those issues were resolved by psychiatry consultation and phone consent from the patient's father, he was brought to the operating room.

Operative Procedure: The patient was brought to operating room, and a time out procedure was performed. He was already receiving parenteral antibiotics. He was placed in the supine position and then given a general endotracheal anesthetic. Anesthesia started multiple IVs and an arterial line. A Foley catheter was sterilely inserted with some difficulty requiring a Coude catheter. After the abdomen was prepped and draped in the sterile fashion, a long midline incision was made through the skin. This was carried through the subcutaneous tissues and down through the midline fascia using the Bovie. The fascia was opened in the midline. The entire left upper quadrant was replaced with an abscess peel separate from the free peritoneal cavity. This was opened, and at least 3 to 4 L of foul smelling crankcase colored fluid were removed. Once the abscess cavity was completely opened, it was evident that the spleen was floating within this pus^[3] as had been predicted by the CT. This was irrigated copiously and the left lower quadrant subhepatic and pelvic abscesses^[4] were likewise discovered containing the same foul smelling dark bloody fluid. All of these areas were sucked out, irrigated, and the procedure repeated multiple times.

We thought it reasonable to go ahead with the splenectomy. The anatomic planes were obviously terribly distorted. There was no clear margin between stomach, spleen, colon spleen, etc., but most of the dense attachments were to the abscess cavity peel. Using this as a guide, the spleen was eventually rotated up and out to the point where the upper attachments presumably where the short gastric used to reside were taken via Harmonic scalpel. The single fire of a 45 mm stapler with vascular load was taken across the lower pole followed by two firings of the echelon stapler across the hilum. This controlled most of the ongoing bleeding. Single bleeding site below the splenic artery was controlled with two stitches, one of 3-0 Prolene and the other of 4-0 Prolene. Because of diffuse ooze in the area and the fact that the patient would be scheduled for a return visit to the operating room tomorrow to reinspect the abscess cavities, it was elected to leave two laparotomy pads in the left upper quadrant and Vac Pak the abdomen. The Vac Pak was created using blue towels and Ioban dressings in the usual fashion with 10 mm fully perforated flat Jackson-Pratt drains brought out at the appropriate level. The patient was critical throughout the procedure and will be taken directly to the intensive care unit, intubated, with a plan for re-exploration and removal of the packs tomorrow. The patient received four units of packed cells during the procedure, as well as albumin and a large volume of crystalloid. There were no intraoperative complications noted and the specimen sent included the spleen. Cultures from the abscess cavity were also taken.

^[1] Postoperative diagnoses are reported.

^[2] The location of the abscesses are on both sides of the spleen.

^[3] Confirms the location of the abscess.

^[4] Location of abscesses.

What diagnosis code(s) are reported?

ICD-10-CM Codes: B20, D73.3, K65.1, B19.20

Rationale: The patient is diagnosed with abscesses on the spleen and intra-abdominal cavity (related to his HIV), AIDS and hepatitis C. According to ICD-10-CM guideline I.C.1.a.2, if a patient is admitted for an HIV-related condition, the principal diagnosis is B20, followed by additional diagnosis codes for all reported HIV-related conditions. In the ICD-10-CM Alphabetic Index, look for AIDS which directs you to B20. In the Tabular List, category B20 instructions say to use additional code(s) to identify all manifestations of HIV infection. The spleen and abdominal abscesses are HIV-related conditions. In the Alphabetic Index, look for Abscess/spleen which directs you to D73.3. Next, look in the Alphabetic Index for Abscess/intra-abdominal (*see also* Abscess, peritoneum) which directs you to K65.1. The diagnosis for hepatitis C is relevant and is reported because hepatitis C may have an impact on the patient's recovery. In the Alphabetic Index, look for Hepatitis/C (viral). There is no additional information regarding the hepatitis which makes B19.20 the only option. Verify all codes in the Tabular List.

Case 10

Dear Dr. Smith,

Mr. Martin was seen in the office for continued management of his breast cancer. He's having some increasing pain in his breast^[1] which is due to the cancer^[2]. He is also complaining of neck pain. It does not seem to be worse at night; it seems to be worse with activity. He has no other symptoms. Otherwise his review of systems is unremarkable. He's had no constitutional symptoms.

On physical exam, he is alert and oriented. Eyes: EOMI, PERRLA, no icterus. The heart had a regular rate and rhythm; S1, S2 within normal limits. The lungs are clear to auscultation and percussion. The abdomen was soft, without masses or organomegaly. He was tender to palpation over the left anterior iliac crest. Otherwise, he had no point tenderness over his musculoskeletal system. Neck: Supple. No tenderness, no enlarged lymph nodes in the neck.

Assessment: Adenocarcinoma of the left breast, positive estrogen receptor status. Neck pain.^[3]

Plan: The plan is to continue the Tamoxifen at this time. His laboratory studies were reviewed and were essentially unremarkable; however, we'll obtain bone scan to ascertain the extent of his disease^[4].

Sincerely,

John Smith, M.D.

^[1] This indicates the patient's main reason for the office visit.

^[2] Neoplasm related pain.

^[3] This is the definitive diagnosis that is reported.

^[4] This is a male patient.

What diagnosis code(s) are reported?

ICD-10-CM Codes: C50.922, G89.3, M54.2, Z17.0, Z79.810

Rationale: The patient is being seen for the management of adenocarcinoma of the left breast. In the ICD-10-CM Alphabetic Index, look for Adenocarcinoma which refers you to see also Neoplasm, malignant, by site. Go to the Table of Neoplasms, look for breast and locate the code in the Malignant Primary column which directs you to C50.9-. Refer to the Tabular List for the 5th and 6th characters. This is a male patient and the cancer is in the left breast, which makes C50.922 the correct code to report. The provider documents that the pain is due to cancer. In the Alphabetic Index, look for Pain(s)/acute/neoplasm related which directs you to G89.3. Verify the code in the Tabular List. Both acute and chronic are in parentheses, which indicate these are supplementary words that may be present or absent in the diagnosis without affecting the code number to which it is assigned. ICD-10-CM guideline I.C.6.b.5 indicates that this code is assigned regardless of whether the pain is acute or chronic. The same guideline also states that when the reason for the admission/encounter is management of the neoplasm and the pain associated with the neoplasm is also documented, code G89.3 may be assigned as an additional code. In the Alphabetic Index, look for Pain(s)/neck NEC and you are directed to code M54.2. There is an instructional note under category code C50 to use an additional code to identify the estrogen receptor status. Look for Status/estrogen receptor/positive which directs you to Z17.0. The patient is continuing with tamoxifen; look for Long-term (current) (prophylactic) drug therapy (use of)/tamoxifen (Nalvadox) which directs you to Z79.810



Case 1

Office Note:

RE: Injection, strapping of foot and ankle.

Chief Complaint: Heel pain,^[1] 6 months' duration. No inflammation, no heat.

Diagnosis: Heel spur.^[2]

Treatment: Weight reduction, injection of Celestone, Xylocaine plain, pulses good, DTR, vibration and temp normal.

Orthotics suggested; better shoes suggested. Lawyer by trade. Criminal trial attorney. Referred by his partner. Discussed diet, orthotic shoes. Return if need be in 61 days.

^[1] Patient complaint.

^[2] Definitive diagnosis. The heel pain is a symptom of a heel spur.

What diagnosis code(s) are reported?

ICD-10-CM Code: M77.30

Rationale: The patient is diagnosed with a heel spur. The heel pain is a symptom of the heel spur and should not be reported separately. In the ICD-10-CM Alphabetic Index, look for Spur, bone/calcaneal. The calcaneous is the heel. You are referred to M77.3-. In the Tabular List, assign the 5th character. Report M77.30, because the documentation does not indicate if the spur is in the right or left heel.

Case 2

Reason for Consult: Acute renal failure.^[1]

HPI: The patient was followed in the past by my associate for CKD, with baseline creatinine of 1.8 two weeks ago. Found to have severe ARF this morning associated with acidosis and moderate hyperkalemia after presenting to the ER with complaint of dehydration.^[2] The patient is admitted under observation status to the hospitalist service and the renal team is called for a consult.

ROS: Cardiovascular: Negative for CP/PND. GI: Negative for nausea; positive for diarrhea. GU: Negative for obstructive symptoms or documented exposure to nephrotoxins. All other systems reviewed and are negative.

PFSH: Negative family history of hereditary renal disease and negative history of tobacco or ETOH abuse.

Exam: Constitutional: 99/52, 18, 102. NAD. Conversant. Eyes: anicteric sclera, no proptosis, PERRL. ENMT: Normal aside from somewhat dry mucus membranes. Cardiovascular: RRR, no MRGs, no edema. Respiratory: Lungs CTA, normal respiratory effort. GI: NABS, no HSM. Skin: Warm and dry, decreased turgor. Psychiatric: A&OX3 with appropriate affect.

Labs: BUN = 99, creatinine = 3.6, HCO₃ = 14, K = 5.9.

Impression

1. New, acute renal failure, due to dehydration. ^[3]
2. Underlying stage III CKD. ^[3]
3. Mild hypotension. ^[3]

Plan

1. Bolus with another liter of NS wide open.
2. Then start D5W with 3 amps of HCO₃ at 150 cc/hr.
3. Repeat labs in eight hours.
4. Further diagnostic testing will be ordered if there is no improvement of volume repletion.

^[1] Indication for the visit.

^[2] These conditions were diagnosed by another physician in the emergency room.

^[3] Code the definitive diagnoses documented by the provider.

What diagnosis code(s) are reported?

ICD-10-CM Codes: N17.9, E86.0, N18.3, I95.9

Rationale: The patient is diagnosed with acute renal failure due to dehydration. In the ICD-10-CM Alphabetic Index, look for Failure, failed/renal/acute. You are referred to N17.9. Next, look for Dehydration. You are referred to E86.0. The provider documents the second diagnosis, Stage III CKD. Look for Disease, diseased/kidney/chronic/stage 3 (moderate). You are referred to N18.3. The last documented diagnosis is Hypotension. Look for Hypotension. You are referred to I95.9. Verify all codes in the Tabular List.

Case 3

Progress Note

Chief Complaint: Multiple ulcers.

Subjective: The patient returns, accompanied by her caregiver, who states that she believes the ulcers have gotten “about as good as they are going to.” The edema of the leg seems to be controlled much better.

Objective: Exam reveals marked improvement of the edema ^[1] of both lower legs, the right is better than the left. All of the ulcers are now extremely superficial and seem to almost be partial thickness skin. ^[2] There is no cellulitis. The only uncomfortable area seems to be on the sole of the left foot where there are considerable bony abnormality and/or tophaceous deposits, which have distorted the bottom of her foot dramatically. To relieve the left foot pain, ^[3] a sole nerve block posterior to the lateral malleolus is carried out with a 50:50 mixture of 1% lidocaine with epinephrine and .5% Marcaine. Following this, she gets good relief from the pain of the lateral posterior part of the foot. The legs are cleansed with Hibiclens and multi-layer compression wraps are reapplied by the PA.

Assessment: Ulcers are on the feet. ^[4] Edema is in the lower extremities. Foot pain ^[5] is treated with a nerve block. Fantastic course to date, thanks to her caregiver.

Plan: Continue with wound care as before. Return to the office in six to eight weeks; at which time, assuming everything is going well, we could set up an OR time for panniculectomy. She appears to understand and is willing to proceed.

^[1] The edema is improving.

^[2] The ulcers are healing.

- ^[3] Location of the foot pain. Patient had foot pain likely due to tophaceous deposits which are an indication of gout. This is not a definitive diagnosis documented by the provider. Code the symptom.
- ^[4] Location of the ulcer.
- ^[5] Report the codes for the definitive diagnoses. Procedure performed for foot pain.

What diagnosis code(s) are reported?

ICD-10-CM Codes: L97.521, L97.511, R60.0, M79.672

Rationale: The patient is diagnosed with ulcers on the feet, and the exam documents that the ulcers are superficial and pertain to the skin, but there is no indication whether the ulcers are pressure ulcers or decubitus ulcers. In the ICD-10-CM Alphabetic Index, look for Ulcer/foot and you are referred to *see* Ulcer, lower limb. Ulcer/lower limb/foot/left/with skin breakdown only and Ulcer/lower limb/foot/right/with skin breakdown only. Both codes must be reported separately as there is not a bilateral code available. You are referred to both L97.521 and L97.511. There was no evidence of necrosis indicated. Although it's improving, the patient still has edema. In the Alphabetic Index, look for Edema, edematous/legs. You are referred to R60.0. The patient also has foot pain which is treated with a nerve block. In the Alphabetic Index, look for Pain(s)/foot-*see* Pain, limb, lower. Under Pain(s)/limb/lower/foot, you are referred to M79.67-. You need to assign a 6th character to indicate which foot is in pain. The exam in the case note documents the left foot, M79.672. Verify all codes in the Tabular List.

Case 4

Subjective: The patient presents today after having a **cabinet fall on her**.^[1] She states the people who put in the cabinet missed the stud by about two inches. The patient complains of **cephalgias**,^[2] primarily occipital, extending up into the bilateral occipital and parietal regions. The patient denies any vision changes, any taste changes or any smell changes. The patient has marked amount of **tenderness across the superior trapezius**.^[3]

Objective: Her weight is 188, which is up 5 pounds from last time, blood pressure 144/82, pulse rate 70, respirations are 18. She has full strength in her upper extremities. DTRs in the biceps and triceps are adequate. Grip strength is adequate. Heart is a regular rate. Lungs are clear.

Assessment:

1. **Cephalgia**.^[4]
2. **Thoracic somatic dysfunction**.^[4]

Plan: The plan at this time is to send her for physical therapy three times a week times four weeks for cervical soft tissue muscle massage, as well as upper dorsal. We'll recheck her in one month.

^[1] This describes how the injury occurred.

^[2] Patient complaint.

^[3] Patient complaint.

^[4] Select codes for definitive diagnosis.

What diagnosis code(s) are reported?

ICD-10-CM Codes: R51, M99.02, W20.8XXA

Rationale: The patient is diagnosed with cephalgia (headache) and thoracic somatic dysfunction. In the ICD-10-CM Alphabetic Index, look for Cephalgia, cephalalgia (*see also* Headache). Look for Headache. You are referred to R51. ICD-10-CM codes from subcategory G44.3- for *Post-traumatic headache* are not assigned during the initial phase of an injury and documentation does not indicate post-traumatic headache. Because this is during the acute phase of this injury, a G44.3- code is

not reported. Next, look in the Alphabetic Index for Dysfunction/somatic/thoracic region. You are referred to M99.02. An external cause code is reported to indicate how the injury occurred. In the ICD-10-CM External Causes of Injuries Index, look for Hit, hitting (accidental) by- *see* Struck by; Struck (accidentally) by/object/falling. You are referred to W20.8. When verifying the code in the Tabular List, there is an instructional note that an appropriate 7th character is to be added to each code from category W20. The correct code is W20.8XXA. There is no indication where the accident occurred or the activity being performed, so an external cause code to report the place of occurrence or the activity cannot be assigned. Verify the codes in the Tabular List.

Case 5

Chief Complaint: Right shoulder injury. ^[1]

Mode of Arrival: Private vehicle.

History of Present Illness: The patient is a 59-year-old male who states that just prior to arrival he was going into a supermarket when the revolving door suddenly slammed on him. It caught him across the right side of his chest anteriorly and posteriorly. ^[2] He was unable to liberate himself from the door, and an employee had to help him out. He denies any current shortness of breath, although did say he had the wind knocked out of him. He complains of pain in the anterior and posterior chest wall, posteriorly medial to the scapula. He denies any numbness, tingling or weakness in his right arm; however, he does state that it seems to be painful and difficult for him to either lift or even drop his arm. He again denies any numbness, tingling or weakness distally. He denies any injury to his head or neck; although, he had a temporary episode of spasms on the left side of his neck. He has not taken anything for pain.

Review of Systems: Negative for fevers, chills or unintentional weight loss. No neck pain, numbness, tingling, weakness, nausea, vomiting, shortness of breath, hemoptysis or cough. All other systems have been reviewed and are negative except as noted.

Physical Examination:

General: The patient is awake and alert, lying comfortably in the treatment bed. He is nontoxic in appearance.

Vital Signs: Temperature = 98.3, pulse = 81, respirations = 16, blood pressure = 134/81, pulse oximetry = 95% on room air.

HEENT: The head is normocephalic and atraumatic.

Neck: Non-tender to palpation in the posterior midline. The trachea is midline. There is no subcutaneous emphysema. There is no tenderness over the paraspinal muscles.

Heart: Regular rate and rhythm without murmurs.

Lungs: Clear to auscultation bilaterally without wheezes, crackles or rhonchi. The chest wall does expand symmetrically.

Thorax/Chest Wall: Demonstrates mild tenderness anteriorly and demonstrates distinct tenderness posteriorly along the medial aspect of the scapula. No bruising or ecchymosis is noted on the skin of the chest wall. Patient keeps his right shoulder lowered. There is no deformity noted. There is no tenderness over the right clavicle. No bony deformity is noted there. There is no subcutaneous emphysema of the chest wall.

Extremities: Warm and dry without clubbing, cyanosis or edema. Grip strength is 5/5 bilaterally. Patient can flex and extend all fingers without difficulty. He can pronate and supinate at the elbow. He complains of pain in the shoulder when he flexes and extends at the elbow. Normal radial and ulnar pulses are appreciated in the bilateral upper extremities. Capillary refill is brisk. Sensation is normal in all nerve distributions in the bilateral arms.

Abdomen: Soft, non-distended. Non-tender.

Diagnostics: Two views of the chest, PA and lateral, and three views of the right shoulder were obtained. ED course: The patient received a total of 2 mg of Dilaudid for pain, 1 mg of sublingual Ativan. His arm was placed in a sling. This was well tolerated and the patient was discharged home.

Medical Decision Making: It appears the patient has an anterior chest wall and a posterior chest wall contusion. The exact reasoning why he has so much difficulty moving the shoulder is unclear at this time, as he is completely neurologically intact from what I can tell. He can adduct and abduct at the shoulder, as I have seen him do it as he was moving around to be examined. X-rays demonstrate no evidence of fracture or dislocation. At this point, I am discharging the patient home, having him use ice packs, doing prescriptions for pain medications and having him return for new or worsening symptoms.

Impression:

1. **Anterior and posterior chest wall contusion.** ^[3]
2. **Right shoulder injury.** ^[3]

Plan: Discharge home. Return for new or worsening symptoms. Sling for comfort.

^[1] Patient's complaint.

^[2] Location of the chest injury.

^[3] Report codes for the definitive diagnosis.

What diagnosis code(s) are reported?

ICD-10-CM Codes: S20.221A, S20.211A, S49.91XA, W23.0XXA, Y92.512

Rationale: The patient is diagnosed with anterior and posterior chest wall contusions and a right shoulder injury. In the ICD-10-CM Alphabetic Index, look for Contusion/chest (wall) – *see* Contusion, thorax; Contusion/thorax (wall)/back and Contusion/thorax (wall)/front. Because there are sub-terms for contusions on the anterior (front) and posterior (back) of the chest, two codes are reported. You are referred to S20.22- and S20.21-. Look in the Tabular List for the 6th and 7th characters. The History of Present Illness documentation states that it was on the right side of the chest, so your 6th character is 1. Letter A is the 7th character due to the injury being seen as an initial encounter. Codes S20.221A and S20.211A are reported. Next, look for Injury/shoulder. You are referred to S49.9-. Look in the Tabular List for the additional character to complete the code. The diagnosis indicates the injury is on the right shoulder, S49.91XA. An external cause code is reported to identify how the injury occurred. In the ICD-10-CM External Cause of Injuries Index, look for Caught/between/objects (moving) (stationary and moving). You are referred to W23.0. In the Tabular List, there is an instructional note that tells you to report the appropriate 7th character to each code from category W23.0. Because this code only has 4 characters, use two X placeholders before adding the 7th character. This is an initial injury; A is reported as the 7th character. An external cause code is also be reported to indicate the location of the accident which, in this case, is a supermarket. In the External Cause of Injuries Index, look for Place of occurrence/supermarket. You are referred to Y92.512. Verify all codes in the Tabular List.

Case 6

Preoperative Diagnosis: Congenital hydrocephalus.

Postoperative Diagnosis: **Congenital hydrocephalus.** ^[1]

Clinical History: The patient is a 2-month-old boy who was born and was IUGR. He did well for the first several weeks; however, he then developed a large head. Mom noticed full fontanelle arid in the last week or so, and they have noticed the eyes have decreased mobility. He tends to stare straight and has some trouble looking up and even to the sides bilaterally, so she reported it to her pediatrician. Pediatrician ordered a CT scan and referred the patient. I saw the patient yesterday in clinic. We ordered an MRI; MRI was done this morning. Initial read shows the **congenital hydrocephalus** ^[2]; however, it is not a Dandy-Walker. We had a discussion with the family about risks, benefits, potential complications and different procedures. We talked about a third ventriculostomy; however, given the patient's age and the fact it was hydrocephalus, he has elected to go with the shunt. Family is comfortable with this and will bringing him to the OR today for shunting.

^[1] Report the definitive diagnosis.

^[2] The diagnosis is confirmed.

What diagnosis code(s) are reported?**ICD-10-CM Code:** Q03.9

Rationale: The condition is documented as congenital hydrocephalus. In the ICD-10-CM Alphabetic Index, look for Hydrocephalus/congenital. You are referred to Q03.9. According to ICD-10-CM guideline I.C.17, report congenital conditions as long as they exist. Verify the code in the Tabular List.

Case 7

HPI: 20-year-old female, estimated gestational age 25.3 weeks,^[1] who presents with red staining after wiping with toilet paper^[2] this afternoon. No abdominal pain. Contractions: Negative. Fetal movement: Present.

ROS:**Constitutional:** Negative.**Headache:** Negative.**Urinary:** Negative.**Nausea:** Negative.**Vomiting:** Negative.**Past medical/Family/Social History:****Medical History:** Negative.**Surgical History:** Negative.**Social History:** Alcohol: Denies. Tobacco: Denies. Drugs: Denies.**Exam:****General Appearance:** No acute distress.**Abdomen:** Soft. Non-tender.**Vagina:** Blood clots size: 1.5 cm and amount 2. Discharge: Pink. No hyphae, BV, or TRICH, and CX not irritated.**Cervix:** Deferred.**Uterus:** Fundal height: 24 cm.**MDM:** Labs: FFN, UA R+M, C+S, GC/chlamydia, CBC, type and RH, DAU. Labs reviewed and WNL.**Ultrasound:** Negative for placenta previa.**Notes:** Patient continues with contractions mildly, but does not feel it. Patient given Celestone I/M. D/C and to return tomorrow for repeat Celestone injection.**Diagnosis:** Threatened premature labor.^[3]

^[1] Patient is pregnant.

^[2] Patient's complaint.

^[3] Report the definitive diagnosis.

What diagnosis code(s) are reported?

ICD-10-CM Code: O47.02, Z3A.25

Rationale: The patient is diagnosed with threatened premature labor. The patient did not deliver, and in the HPI of the case note, the patient is 25.3 weeks pregnant. According to the ICD-10-CM guidelines I.B.11, when a condition is documented as threatened, look for the condition under the main term threatened. In the ICD-10-CM Alphabetic Index, look for Threatened/labor (without delivery)/before 37 completed weeks of gestation. You are referred to O47.0. Go to the Tabular List to complete the code. The correct code is O47.02, as the patient is in her second trimester. There is a use additional code instructional note at the beginning of this ICD-10-CM chapter that states to also report the weeks of gestation. Look in the Alphabetic Index for Pregnancy/weeks of gestation/25 weeks Z3A.25.

Case 8

This 67-year-old Medicare patient is seen for a **screening Pap and pelvic examination**^[1] at our office today. She is an established patient and is **complaining of abnormal vaginal discharge**^[2] on and off for approximately three weeks. She denied any trauma. Patient is not sexually active and her LMP was 10 years ago. She denies any chest pain, shortness of breath or urinary problems. Patient had Pap and pelvic exam one year ago and is requesting a Pap and pelvic exam today. Patient was presented with an ABN, which was signed.

Past Medical History: Two vaginal deliveries, one in 1965 and another in 1967. Allergies, unknown. Medications include Micardis 80 mg for hypertension. She does not smoke or drink. She is married and lives with her husband.

Examination: Vital signs: BP = 125/70, pulse = 85, respirations = 20. Height = 5' 5". Weight = 135 lbs. Well-developed, well-nourished female in no acute distress.

HEENT: Pupils equal, round and reactive to light and accommodation. Extraocular muscles are intact.

Neck: Thyroid not palpable. No jugular distention. Carotid pulses are present bilaterally.

Breasts: Manual breast exam reveals no masses, tenderness, or nipple discharge. The breasts are asymmetrical with no nipple discharge.

Abdomen: No masses or tenderness noted. No hernias appreciated. No enlargement of the liver or spleen.

Pelvic: Vaginal examination reveals no lesions or masses. Discharge is noted and a sample was collected for testing and sent to an outside laboratory for testing. No bleeding noted. Examination of the external genitalia reveals normal pubic hair distribution. The vulva appears to be within normal limits. There are no lesions noted. A speculum is inserted. There is no evidence of prolapse. The cervix appears normal. A cervical smear is obtained and will be sent to pathology. The speculum is removed and a manual pelvic examination is performed. It appears that the uterus is smooth and no masses can be felt. Rectal examination is within normal limits. Screening occult blood is negative. Uterus is not enlarged. Urinary: Urethral meatus is normal. No masses noted for urethra or bladder.

Assessment and Plan: **Routine Pap and pelvic: vaginal discharge.**^[3] Patient had Pap and pelvic examination one year ago. Patient was sent to our in-house lab for blood draw today, and she is to follow-up in one week for lab results.

^[1] The patient presents for a screening gynecological exam.

^[2] Patient also has a complaint.

^[3] Patient presented for a screening exam and was treated for a complaint.

What diagnosis code(s) are reported?

ICD-10-CM Codes: Z01.411, N89.8

Rationale: According to ICD-10-CM guideline I.C.21.c.5, when a patient presents for a screening exam or test, first list the diagnosis code for the screening. If any problems are diagnosed during the course of the screening, report an additional diagnosis for the problem. In the ICD-10-CM Alphabetic Index, look for Examination/gynecological/with abnormal findings, referring you to Z01.411. The gynecological exam did have an abnormal finding of vaginal discharge. Next, look for Discharge (from)/vaginal referring you to N89.8. Verify both codes in the Tabular List.

Case 9**Preoperative Diagnosis:**

1. 2 cm transverse laceration of right forehead. ^[1]
2. 3 cm stellate laceration of right upper eyelid. ^[2]
3. 3 cm trap door laceration of right lower eyelid. ^[3]

Operative Diagnosis:

Operation Performed: Multiple-layer closure of above lacerations totaling 8 cm.

Anesthesia: Local.

Preoperative Note: This patient is a 64-year-old white female. She has a very difficult time ambulating, doing so with a walker and intermittently sitting. This evening, unfortunately, she fell from her motorized wheelchair that was moving and struck the right side of her forehead. ^[4] She was brought to the emergency department where she was thoroughly evaluated by Dr. Tim and is in the process of getting C-spine films, and is accordingly in a cervical spine support. I was called to evaluate and treat these lacerations due to their extensive and complex nature. The lacerations are as described above. Forehead laceration is linear, deep, but otherwise uneventful. ^[5] The upper right eyelid laceration is approximately 3 cm in length and the medial aspect of it is somewhat dusky because it is very thin and devoid of vasculature. The lower eyelid laceration is trap door and somewhat deep. It also becomes very thin at the medial aspect; however, there appears to be no duskiness. It seems to be well vascularized. ^[6] In any event, we chose to immediately repair these with local anesthesia.

Details of Operative Procedure: Approximately a total of 6 ml of 2% lidocaine with 1:100,000 epinephrine was infiltrated into the three wounds. They were then thoroughly cleansed with soap, and closure was begun on the upper eyelid. We used 6-0 Vicryl subcutaneous sutures to attach the flap back into position, and once this was accomplished, we used individual 6-0 Prolene sutures on the skin to complete the closure. Attention was then turned to the right lower eyelid laceration where essentially an identical procedure was done. The wounds were somewhat similar in that they were flaps pedicled to the lateral towards the medial. Again, we used 6-0 Vicryl subcutaneous and 6-0 Prolene individual skin sutures. Finally, attention was turned to the forehead laceration, which was similarly closed with these same sutures, 6-0 Vicryl subcutaneous and 6-0 Prolene on the skin. The wounds were then dressed with Bacitracin ophthalmic. Patient was instructed to keep them moist at all times and to not let crust form. She was also instructed on the appropriate analgesics to be taken orally and given my office number for a follow-up appointment. At the end of the procedure, she was then sent back to X-ray for CT scan of her C-spine.

^[1] Open wound of the forehead.

^[2] Open wound of the upper eyelid.

^[3] Open wound of the lower eyelid.

^[4] The injury is a result of a fall.

^[5] The forehead laceration is not indicated as complex.

^[6] The eyelid lacerations do not appear to be complicated.

What diagnosis code(s) are reported?

ICD-10-CM Codes: S01.111A, S01.81XA, V00.811A

Rationale: The patient has multiple lacerations. In the ICD-10-CM Alphabetic Index, look for Laceration/eyelid. You are referred to S01.11-. A review in the Tabular List reveals that you need to report 6th and 7th characters. The correct code is S01.111A to indicate the laceration is on the right eyelid without foreign body, and this is the initial encounter. Although there are two lacerations of the eyelid, both the upper and lower are reported with the same code and according to the ICD-10-CM guidelines I.B.12, it is only reported once. The code for the eyelids is sequenced first because they were the longest in length. Next, look for Laceration/forehead, you are referred to S01.81-. When verifying the code in the Tabular List, you are instructed to report a 7th character to indicate the type of encounter. The correct code is S01.81XA. An external cause code is reported to identify how the injury occurred. Documentation in the preoperative note indicates the patient fell from her motorized wheelchair. In the ICD-10-CM External Cause of Injuries Index, look for Fall, falling/out of/wheelchair/powered – see Accident, transport, pedestrian, conveyance, specified type NEC; look for Accident/transport/pedestrian/conveyance/wheelchair (powered)/fall. You are referred to V00.811. In the Tabular List, a 7th character is assigned. The complete code is V00.811A. The location where the accident occurred is not documented, so an additional external cause code is not reported. Verify all the codes in the Tabular List.

Case 10**Preoperative Diagnosis:**

Right forearm radial shaft fracture with possible mild distal radioulnar joint subluxation.

Postoperative Diagnosis:

Right forearm radial comminuted shaft fracture with possible mild distal radioulnar joint subluxation. ^[1]

Anesthesia: Axillary block with general anesthesia.

Operation: Right radius fracture open reduction and internal fixation with closed reduction distal radioulnar joint.

Indications: This is a 22-year-old male who sustained a right forearm fracture injury as indicated above and in the medical records and office notes.

Description of Procedure: The patient was placed under axillary block in the holding area, followed by general anesthesia in the operating room. Patient identification, correct procedure, and site were confirmed. Antibiotics were provided in an appropriate fashion preoperatively.

A dorsal/posterior approach to the fracture was performed with a standard recommended incision, location and technique. The interval between the extensor carpi radialis brevis and extensor digitorum communis was developed. The extensor pollicis brevis and the abductor pollicis were gently retracted one way or the other to expose the fracture site, and the fracture was just beneath this area. ^[2] The radial sensory nerve was identified and protected throughout the procedure. The fracture was exposed with minimal soft tissue stripping. The bone holding forceps were placed on either side of the fracture, the overriding fracture was manipulated with gentle traction, and the fracture reduced. ^[3] This effectively reduced the distal radioulnar joint. ^[4]

A small fragment, Synthes DCP locking plate was utilized to fix the fracture. Eight holes were utilized. Due to the nature of the fracture and the anatomy, there were three screws distal, four screws proximal, and the last hole was at the area of the fracture. Initially to achieve satisfactory bone to plate contact, three lag screws were required and these were placed initially. This was followed by placement of the remaining screws that were utilized proximal and distal to the fracture site to be locking screws. Intraoperative X-rays utilizing the C-arm were performed throughout the procedure to guide fracture reduction and hardware replacement. Final X-rays demonstrated excellent alignment of the fracture in the distal radioulnar joint. Excellent coaptation of the bony surfaces was obtained.

Final irrigation of the wound was performed. The wound was closed in layers in a standard fashion. Splints were applied. Total tourniquet time was approximately 60 minutes. The patient tolerated the procedure well and went to the recovery room in satisfactory condition. Sponge and needle count is correct x2. Estimated blood loss is minimal.

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- 11 The postoperative diagnosis is reported. The subluxation is described as possible and should not be coded.
 - 12 A fracture is confirmed.
 - 13 The displaced fracture is manipulated and reduced.
 - 14 Location of the fracture.
-

What diagnosis code(s) are reported?

ICD-10-CM Code: S52.351A

Rationale: In this case, the patient is diagnosed with a right forearm shaft radius fracture. The postoperative diagnosis indicates it is a comminuted fracture. The subluxation is documented as probable and should not be coded. In the ICD-10-CM Alphabetic Index, look for Fracture, traumatic/radius/shaft/comminuted (displaced). There is no indication the fracture is open, so it is coded as closed according to ICD-10-CM guidelines I.C.19.c. ICD-10-CM guideline I.C.19.c also indicates that a fracture not indicated whether displaced or not displaced should be coded to displaced. You are referred to S52.35. In the Tabular List, 6th and 7th characters are reported. The complete code is S52.351A.



Exercise 1

Look up the procedures in the CPT[®] code book and list the CPT[®] code. No modifiers are necessary for this exercise.

1. Pyloroplasty

Answer: 43800

Rationale: In the CPT[®] Index, look for Pyloroplasty.

2. Deep biopsy of soft tissue of the ankle

Answer: 27614

Rationale: In the CPT[®] Index, look for Biopsy/Ankle or for Ankle/Biopsy and you are directed to 27613, 27614, and 27620. 27620 is for an arthrotomy. 27613–27614 are both for biopsies; but, one is superficial and the other is deep.

3. Osteotomy, humerus, with internal fixation

Answer: 24400

Rationale: In the CPT[®] Index, look for Osteotomy/Humerus and you are directed to 24400–24410. Code 24400 indicates “with or without internal fixation”.

4. Renal biopsy, percutaneous, needle

Answer: 50200

Rationale: Renal means kidney. In the CPT[®] Index, look for Kidney/Biopsy and you are directed to 50200, 50205. You may also look for Biopsy/Kidney and you are directed to code range 50200–50205. Code 50205 is for an open surgical procedure biopsy. 50200 is for a needle or trocar biopsy. A trocar is a surgical instrument with a sharp point which is used to create a hole in the body which can be used to introduce surgical tools. Because the biopsy utilizes a needle percutaneously, or through the skin, the correct code selection is 50200.

5. Destruction of a malignant lesion on the face with a lesion diameter of 1.2 cm

Answer: 17282

Rationale: In the CPT[®] Index, look for Destruction/Lesion/Skin/Malignant and you are directed to 17260–17286. Code range 17260–17286 is for the destruction of a malignant lesion by any method. The codes are further subdivided based on anatomical site. Code range 17280–17286 is used for lesions on the face. Code selection is then based on the size of the lesion. Code 17282 is used for a lesion with a diameter of 1.1 to 2.0 cm.

6. Emergency endotracheal intubation

Answer: 31500

Rationale: In the CPT[®] Index, look for Intubation/Endotracheal Tube and you are directed to code 31500. Verification of 31500 confirms it is for an emergency procedure.

7. Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age

Answer: 94012

Rationale: In the CPT® Index, look for Spirometry and you are directed to code range 94010–94070. Reading the descriptors will help you determine the correct code selection.

8. An electrolyte panel is performed on an 86-year-old for dizziness

Answer: 80051

Rationale: In the CPT® Index, look for Panel and you are directed to see Blood Tests; Organ or Disease-Oriented Panel. An electrolyte panel is a blood test that measures the levels of electrolytes and carbon dioxide in the blood. Look for Blood Tests and there is a subterm for Panels/Electrolyte, which directs you to code 80051.

9. A frontal and lateral chest X-ray is performed in the office for a patient with chest pain

Answer: 71046

Rationale: In the CPT® Index, look for X-ray/Chest and you are directed to code range 71045–71048. Viewing the descriptors, code 71046 is for two views.

10. The performance measure code for history obtained regarding new or changing moles

Answer: 1050F

Rationale: In the CPT® Index, look for Performance Measures/Melanoma/History/Moles and you are directed to code 1050F.

Exercise 2

List the CPT® or HCPCS Level II modifier(s) for the definition given.

1. Decision for surgery

Answer: Modifier 57

2. Increased procedural service

Answer: Modifier 22

3. Physical status modifier for a patient with a severe systemic disease

Answer: Modifier P3

4. Right hand, thumb

Answer: Modifier F5

5. Unrelated evaluation and management services by the same physician or other qualified healthcare professional during a postoperative period

Answer: Modifier 24

6. Staged or related procedure or service by the same physician or other qualified healthcare professional during the postoperative period

Answer: Modifier 58

7. Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service

Answer: Modifier 25

8. Left foot, great toe

Answer: Modifier TA

9. Waiver of liability statement on file (goes with ABN)

Answer: Modifier GA or GU

GA-Waiver of liability statement issued as required by payer policy, *individual case*

GU-Waiver of liability statement issued as required by payer policy, *routine notice*

10. Reduced services

Answer: Modifier 52



Case 1

Preoperative Diagnosis: Basal cell carcinoma.

Postoperative Diagnosis: Same. ^[1]

Operation: Mohs micrographic 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 doctor 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. The area identified for excision was cleaned, draped and infiltrated with 1% lidocaine with epinephrine 1:100,000. ^[6] The area of the tumor and margins were marked for excision. Additional soft tissue markings were created to keep the specimen oriented with the excision site. ^[7] Hemostasis was obtained by electrocautery. A pressure dressing was placed. The tissue was divided into two tissue blocks ^[8] which were mapped, color coded at their margins, and sent to the technician for frozen sectioning. The surgeon examined the tissue and no microscopic tumor was found persisting in the tumor margins on the tissue blocks. Following surgery, the defect measured 10 x 13 mm to the subcutaneous tissue. ^[9] Closure will be done by the Dr. Hill from Plastics with a Burow's graft. ^[10]

Condition at Termination of Therapy: Carcinoma was removed.

Pathology report is on file.

^[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 Burow's graft is not reported because it was performed by a different provider.

What CPT® and ICD-10-CM codes are reported?

CPT® code: 17311

ICD-10-CM code: C44.311

Rationale: CPT® codes: In the CPT® Index, look for Mohs Micrographic Surgery. You are directed to 17311–17315. The report indicates a single stage was performed with two tissue blocks prepared and examined. CPT® code 17311 is correct to indicate the first stage of Mohs surgery of the head (this includes the nose), with up to five tissue blocks. Mohs is not size specific so there is no need to convert mm to cm here. The Burrow’s graft is not coded as a different provider is doing it.

ICD-10-CM code: The diagnosis is basal cell carcinoma of the nose. Basal cell carcinoma is a malignant neoplasm of the skin. Basal cell carcinoma occurs in the bottom layer of the Epidermis, the Stratum Basale. From the ICD-10-CM Alphabetic Index, look for Carcinoma/basal cell (pigmented) referring you to *see also* Neoplasm, skin, malignant. Go to the Table of Neoplasms, look for Neoplasm, neoplastic/nose, nasal/skin/basal cell carcinoma/Malignant Primary column referring you to C44.311. Verify code selection in the Tabular List.

Case 2

Chief Complaint: The patient is a 42-year-old female with infected right **axillary hidradenitis**.^[1]

Procedure Note: With the patient in supine position and under general anesthesia, the right axilla was prepped and draped in the usual sterile fashion. A skin incision was made in the axilla to excise most of the hidradenitis tracts. **The incision was carried down through the subcutaneous tissue. The underlying subcutaneous tissue was excised.**^[2] Bleeding points were controlled by means of electrocautery. The **subcutaneous tissues were closed in intermediate layers**^[3] with a suture of 2-0 Vicryl. The skin edges were stapled together and a dry sterile dressing was applied. The patient tolerated the procedure well.

^[1] The diagnosis to report, and the location of the hidradenitis.

^[2] The excision went to the subcutaneous tissue.

^[3] The repair was intermediate.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 11450-RT

ICD-10-CM code: L73.2

Rationale: CPT® code: Look in the CPT® Index for Hidradenitis/Excision referring you to 11450–11471. These codes are chosen by the location and type of repair. Procedure note documents the hidradenitis being removed from the axilla and the repair is intermediate. The code description of 11450 indicates a simple or intermediate repair is included. CPT® code 11450 is the correct code to report. Modifier RT can be reported to indicate that the procedure was performed on the right axilla.

ICD-10-CM code: In the ICD-10-CM Alphabetic Index, look for Hidradenitis (axillaris), (suppurative). You are referred to code L73.2. Verify code selection in the Tabular List. The operative note indicates the sweat glands are infected. The word suppurative refers to an infected area that is producing pus. Another term for a wound or area that is pus producing is suppurative or suppurating.

Case 3

Preoperative Diagnosis: Right breast mass, lower outer quadrant.

Postoperative Diagnosis: **Right breast mass, lower outer quadrant.**^[1]

Procedure: **Right breast lumpectomy.**^[2]

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 a right breast mass (lower outer quadrant). This has grown somewhat in size and we decided it should be excised.

Findings at the Time of Operation: This appeared to be a fibroadenoma.^[3]

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.

The right breast^[4] was prepped and draped in the usual fashion. I anesthetized the area in question with the mixture noted above. This mass was at the areolar border at approximately the outer central to lower outer quadrant.^[5] I made a circumareolar incision on the outer aspect of the areola. This was carried down through skin, subcutaneous tissue, and a small amount of breast tissue.^[6] 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 carefully dissected this mass out from the surrounding tissue, along with a margin of healthy breast 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 re-approximated the deep breast tissue with interrupted 3-0 Vicryl sutures and another 3-0 Vicryl suture in the superficial breast tissue. The skin was then closed in a layered fashion^[7] using interrupted 4-0 Monocryl deep dermal sutures, followed by a running 4-0 Monocryl subcuticular suture. Benzoin, Steri-Strips, and dry sterile pressure were applied. The patient tolerated the procedure well and was taken back to the short stay area in good condition.

^[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.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 19301-RT

ICD-10-CM code: N63.13

Rationale: CPT® code: 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 CPT® Index for 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. Append modifier RT to report that the procedure is performed on the right breast. Although the Anesthesia line indicates IV sedation, there is no documentation of the independent observer or the amount of time so conscious sedation is not reported. A layered closure is included with CPT® code 19301, so the repair would not be reported separately.

ICD-10-CM code: 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 of the lower outer quadrant. Look in the ICD-10-CM Alphabetic Index for Mass/breast and you are directed to see also Lump, breast. Look for Lump/breast/right/lower outer quadrant, and you are directed to code N63.13. Verification in the Tabular List confirms code selection.

Case 4

Preoperative Diagnosis: Segmental obesity of posterior thighs.

Postoperative Diagnosis: Segmental obesity of posterior thighs. ^[1]

Operative Procedure: Posterior thigh suction-assisted lipectomy of posterior medial thigh, bilateral. ^[2]

Clinical Note: This obese patient presents for the above procedure. She understood the potential risks and complications including 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 induced. ^[3] Once she was asleep, she was turned and 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 incision area, along the gluteal crease that was in continuity with her medial thigh lift scar and extended to the posterior axillary line. The right posterior medial thigh ^[4] region was infiltrated with tumescent solution utilizing 750 ml. The liposuction ^[5] was then accomplished, removing a total of 200 ml. 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 anatomical layers the closure was completed with 2-0, 3-0, and 4-0 PDS. Dermabond and Steri-Strips were then applied. The medial third was also closed with a running 4-0 plain gut. The same was then accomplished on the left side ^[6] 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.

^[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.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 15879-50 or 15879-RT, 15879-LT

ICD-10-CM code: E66.8

Rationale: CPT® code: The patient had a suction-assisted lipectomy, also known as liposuction. In the CPT® Index look for Lipectomy/Suction Assisted, or Liposuction, directs you to 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-10-CM code: The patient's diagnosis is segmental obesity. Look for Obesity in the ICD-10-CM Alphabetic Index. Segmental indicates the obesity is in segments instead of generalized. There is no sub-term for segmental, so look for Obesity/specified type NEC. The NEC (not elsewhere classifiable) indicates we do know the type of obesity (segmental) but that there is not a more specific code. You are referred to code E66.8. Verify code selection in the Tabular List. There is an instructional note for category E66 to report an additional code to identify the body mass index if known. This is not known, so it cannot be reported.

Case 5

Preoperative Diagnosis: Hypoplasia of the breast.

Postoperative Diagnosis: Hypoplasia of the breast. ^[1]

Operative Procedure: Bilateral augmentation mammoplasty. ^[2]

Anesthesia: General. ^[3]

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 the left and right sides. The extent of the dissection would be to the sternal border within two fingerbreadths of the clavicle and slightly beyond the anterior axillary line. The **left breast** ^[4] was operated upon first. An incision was made 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 and Allergan silicone-filled, high-profile, textured implant was used and placed into the pocket.** ^[5] It was 300 cc. The skin was 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** ^[6] was operated on in a very similar fashion. **The implant was a 340 cc silicone gel, high-profile, textured implant from Allergan.** ^[7] 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.

^[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 filled to 300cc.

^[6] Right breast.

^[7] Prosthetic implant used on the right breast filled to 340cc.

What are the CPT® and ICD-10-CM codes reported?

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

ICD-10-CM code: N64.82

Rationale: CPT® codes: In the CPT® Index, look for Breast/Augmentation and you are directed to code range 19324–19325. The code selection depends on 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.

ICD-10-CM code: The patient is diagnosed with hypoplasia of the breast. In the ICD-10-CM Alphabetic Index, look for Hypoplasia, hypoplastic/breast (areola), and you are directed to N64.82. 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 6

Preoperative Diagnosis: Rapidly enlarging suspicious lesion on patient's right side of forehead. ^[1]

Postoperative Diagnosis: Rapidly enlarging suspicious lesion on patient's right side of forehead.

Operation Performed: Wide local excision with intermediate closure of the right side of forehead. ^[2]

Indications: The patient is a 78-year-old white male who noticed within the last month or so 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, and was given no sedation. The area, his right forehead, was draped and prepped with Betadine paint in normal sterile fashion. The area to be excised was on the right side of the patient's mid forehead^[3]. This lesion had a maximum diameter of 1.1 cm^[4] with a 0.3 cm margin^[5] designed for total resection of 1.7 cm.^[6] The area for excision was infiltrated with 1% lidocaine with epinephrine. Careful dissection of the lesion was carried down through the dermis into the subcutaneous tissues. After waiting for hemostasis, it was excised, tagged, and sent for permanent pathology. The wound was irrigated; several bleeders were cauterized. The defect was closed in multiple layers^[7] with 3-0 Vicryl, a running subcuticular stitch of 4-0 Vicryl and a few 5-0 chromics. The total length of this closure was 3 cm.^[8] This was covered with Steri-Strips, adaptic gauze, and tape. Patient tolerated this procedure with no complication and was sent home in stable condition.

Final Diagnosis: Skin, right forehead,^[9] wide local excision, keratoacanthoma,^[10] 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 keratoacanthoma.

^[11] Squamous cell carcinoma is possible. Possible diagnoses are not coded.

What are the CPT® and ICD-10-CM codes reported?

ICD-10-CM code: L85.8

CPT® codes: 12052, 11442-51

Rationale: CPT® code: CPT® guidelines indicate that intermediate or complex repair closures with an excision of benign or malignant lesions can be reported separately. The repair is a layered closure where more than one layer is closed and the wound extended into the subcutaneous tissues indicating an intermediate repair. The repair can be reported separately. In the CPT® Index look for Repair/Skin/Wound/Intermediate, you are directed to 12031–12057. Code ranges are further defined by location. 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. Next report the excision of the lesion. 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). In the CPT® Index, look for Excision/Lesion/Skin/Benign. You are directed to 11400–11471. The code ranges are divided by the location of the excision. This lesion was located on the face and so we would look to the CPT® numeric code range of 11440–11446. This code range is further divided by size. The correct CPT® code is 11442. Modifier 51 is necessary for the second, lower valued procedure to indicate which procedure to reduce because there are multiple procedures.

ICD-10-CM codes: The diagnosis is stated as keratoacanthoma, possible squamous cell carcinoma (SCC). The SCC is documented as possible, so it should not be coded. Look in the ICD-10-CM Alphabetic Index for Keratoacanthoma. You are directed to L85.8. Verifying your code selection in the Tabular List, you will confirm that a keratoacanthoma is simply a thickening of the epidermis and is not classified as a non-cancerous or cancerous lesion. In this case if you code strictly from the documentation in the procedure note L85.8 is the correct diagnosis code and would be considered benign in the absence of a pathology report showing any cancerous cells.

Case 7

Preoperative Diagnoses: Large Dysplastic nevus, right chest.

Postoperative Diagnoses: Large Dysplastic nevus, right chest. ^[1]

Procedures Performed: Excision, dysplastic nevus, right chest ^[2] with diameter of 1.2 cm and 0.5 cm margins on each side ^[3] and complex repair of 4.0 cm wound. ^[4]

Anesthesia: Local ^[5] using 20 cc of 1% lidocaine with epinephrine.

Complications: None.

Estimated Blood Loss: Less than 2 cc.

Specimens: Dysplastic nevus, right chest with suture 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, ^[6] which I marked for elliptical excision in the relaxed skin tension lines of her chest with gross normal margins of around 0.5 cm. ^[7] 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 supine. The area has been infiltrated with local anesthetic. The chest prepped and draped in sterile fashion. I excised the dysplastic nevus ^[8] as drawn into the subcutaneous fat. Hemostasis was achieved using the Bovie cautery. To optimize the primary repair ^[9] extensive undermining was done to pull wound edges together and retention sutures were used to keep it closed. ^[10] This constituted a very a complex repair technique due to skin tension. ^[11] The wound was closed in layers using 4-0 Monocryl and 5-0 Prolene. A loupe magnification was used. The patient tolerated the procedure well.

Addendum: Pathology report confirms it is benign.

^[1] Post-operative diagnosis is used for coding.

^[2] Procedures performed are documented with size and type of surgery.

^[3] Excised diameter of the lesion on the chest is 1.2 cm with 0.5 cm margins on each side for total excision size 2.2 cm.

^[4] Complex repair measured 4.0 cm.

^[5] Local anesthesia.

^[6] The provider refers to the dysplastic nevus of the right chest.

^[7] Margins of the lesion were 0.5 cm.

^[8] The procedure is for excision of a dysplastic nevus on the chest.

^[9] Primary repair was used.

^[10] Complex repair because extensive undermining was required to pull wound edges together and retention sutures were used to keep it closed.

^[11] The wound repair is stated as complex.

What are the CPT® and ICD-10-CM codes reported?**CPT® codes:** 13101, 11403-51**ICD-10-CM code:** D23.5

Rationale: CPT® codes: The lesion is excision of a dysplastic nevus. A dysplastic nevus is an atypical mole, which has a high possibility of being a premalignant melanoma. It is coded as benign unless pathology indicates malignancy. In the CPT® Index look for Excision/Skin/Lesion, Benign, and you are directed to CPT® numeric code section 11400–11471. The code selection is based on location (chest, which is the trunk) and size (2.2 cm). Code range 11400–11406 is for excisions performed on the trunk. 11403 is the correct code for a 2.2 cm excision from the trunk.

The repair is stated as a complex repair measuring 4.0 cm using layered closure. A layered closure typically indicates an intermediate repair; however, the operative note states, “To optimize the primary repair **extensive undermining was done to pull wound edges together and retention sutures were used to keep it closed.** This constituted a very a **complex repair**” According to the subsection guidelines in the repair section, extensive undermining and use of retention sutures constitute a complex repair. In the CPT® Index, look for Repair/Skin/Wound/Complex, and you are directed to 13100–13160. 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 4 cm repair. Modifier 51 for multiple procedures is appended to the second code to indicate more than one procedure were performed during the same surgical session.

ICD-10-CM codes: The diagnosis is a dysplastic nevus, right chest. In the ICD-10-CM Alphabetic Index, look for Nevus/dysplastic and you are directed to see Neoplasm, skin, benign. Go to the Table of Neoplasms look for Neoplasm, neoplastic/skin NOS/chest (wall) directs you to see also Neoplasm, skin, trunk. Look for Neoplasm, neoplastic/skin NOS/trunk NEC/Benign column directs you to code D23.5. Verify code selection in the Tabular List.

Case 8**Preoperative Diagnosis:** Panniculus, diastasis recti.**Postoperative Diagnosis:** Panniculus, diastasis recti. ^[1]**Procedure Performed:** Abdominoplasty. ^[2]**Anesthesia:** General.

Clinical Note: The patient has had multiple pregnancies, with diastasis recti occurring with the last pregnancy. She has had long term problems with low back pain and constipation because of the diastasis recti to the point where child care and every day activities are limited. Since having her last child she has also developed a pannus causing significant chaffing and irritation, which at times results in bleeding and infection. She is here today for the above procedure. She understood the potential risks and complications including the risks of anesthesia, bleeding, infection, wound healing problems, unfavorable scarring, and potential need for secondary surgery. She wanted 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. General anesthesia was induced. ^[3] 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, and it appeared that an ellipse of skin could be removed ^[4] through the superior margin of the umbilicus. The flap was incised at the midline for greater exposure.

She had significant diastasis recti, ^[5] which was closed with interrupted mattress sutures ^[6] 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 umbilicus in the midline. ^[7] 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.

-
- 11 Postoperative diagnosis is used for coding.
 - 12 Procedure performed is abdominoplasty.
 - 13 General anesthesia used.
 - 14 Excessive skin.
 - 15 Separation between the right and left sides of the rectus abdominis muscle.
 - 16 Closure of the rectus abdominis muscle.
 - 17 Excision of excessive skin.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 15830, 15847

ICD-10-CM codes: E65, M62.08

Rationale: CPT® codes: The diastasis recti and pannus have caused ongoing chronic problems interfering with everyday life for the patient. The first procedure performed was the removal of excess skin of the abdomen also known as a panniculectomy. The operative report indicates 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, 15847. CPT® code 15830 is correct for the surgery documented.

The next procedure was the repair of the diastasis recti, also known as abdominal separation (when the right and left sides of the rectus abdominus muscle separates, because of increased pressure and stretching due to pregnancy, or obesity). An abdominoplasty involves the removal of excess skin and fat from the middle and lower abdomen and repair of the abdominal muscles and fascia. Look in the CPT® Index for Abdominoplasty/Excision, Skin and Tissue. 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) and it includes umbilical transposition and fascial plication. There is no modifier 51 appended to the add-on code, as they are by definition exempt. Code 15830 is for the panniculectomy and the add-on code 15847 for the abdominoplasty.

ICD-10-CM codes: In the ICD-10-CM Alphabetic Index, look for Panniculus adiposus (abdominal) E65. Diastasis recti is a separation between the right and left sides of the rectus abdominis muscle. The codes listed for Diastasis/recti (abdomen) are for complicating delivery or congenital; neither of those codes are correct for this case. Look in the Alphabetic Index for Diastasis/muscle/specified site NEC referring you to M62.08. Verify code selection in the Tabular List.

Case 9

Preoperative Diagnosis: Necrotizing fasciitis.

Postoperative Diagnosis: Necrotizing fasciitis.

Procedure: Planned return to the OR to assess wound closure options. 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. At that time we excised the necrotizing wound.^[1] The wound appears to have stabilized; however, the patient continues to be very sick. On return to the operating room,^[2] 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 is an area on the lateral thigh that we may be able to close with a skin graft 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. Sharp debridement^[3] 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.^[4] Hemostasis was achieved without significant difficulty. The homograft was meshed 1.5:1 and then placed^[5] over the hemostatic wound on the lateral thigh. This was secured in place with skin staples.

Upon completion of the homografting, photos were taken to demonstrate the rather desperate nature of this wound and the fact that it would require above-the-knee amputation for closure.^[6]

The wound was dressed with a 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 was placed.

^[6] They plan to return to the operating room for an above-the-knee amputation (AK).

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 15002-58, 15271-58-51

ICD-10-CM code: M72.6

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 Skin Substitute Graft/Legs and you are referred to CPT® numeric section 15271–15274. 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. Skin substitute graft codes are chosen based on the location and size of the defect. 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. In the CPT® Index, look for Excision/Skin Graft/Site Preparation and you are directed to code range 15002–15005. The code selection is based on location and size. The correct code is 15002. The default is to the smallest size again since the size and depth of the wounds were not provided.

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 are planning to perform an above-the-knee amputation when the wound on the thigh heals. Modifier 58 is appended to both surgery codes. Modifier 51 is needed on 15271 to indicate multiple procedures were performed.

ICD-10-CM code: The initial diagnosis was necrotizing fasciitis. Necrotizing fasciitis is a bacterial infection that moves rapidly along fascial planes destroying tissue as it goes. Muscle bundles are surrounded by connective tissue called fascia. This infection is lethal if left unchecked. Look in the ICD-10-CM Alphabetic Index for Fasciitis/necrotizing, you are directed to M72.6. In the Tabular List, it states to use an additional code to identify the causative organism. There is no mention of the infecting organism; therefore, M72.6 is the only diagnosis code listed.

Case 10

Preoperative Diagnoses:

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

Postoperative Diagnoses: Same.

Procedures Performed:

1. Excision of basal cell carcinoma right temple, with excised diameter of 2.2 cm ^[2] and full thickness skin graft 4 cm². ^[3]
2. Excision squamous cell carcinoma, left hand, ^[4] with rhomboid flap repair 2.5 cm². ^[5]

Anesthesia: Local, ^[6] using 8 cc of 1% lidocaine with epinephrine to the right temple and 3 cc of 1% plain lidocaine to the left hand.

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. ^[7] I also marked my planned rhomboidal excision of the squamous cell carcinoma of her left hand with gross normal margins of around 3 mm, ^[8] 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 (the anesthetic with epinephrine). The face and left upper extremity were prepped and draped in normal sterile fashion. I excised the lesion of her right temple and left hand ^[9] as drawn to the subcutaneous fat. Hemostasis was achieved with Bovie cautery. It took a few more passes to get the margins clear from the basal cell carcinoma on the right temple. ^[10] 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. I felt that we would have to close with a skin graft. ^[11] I marked the area of her right clavicle for the donor site, ^[12] and I prepped and draped this area in a sterile fashion. I infiltrated with a plain lidocaine. I harvested and defatted the full-thickness skin graft ^[13] using scissors. I achieved meticulous hemostasis in the donor site using the Bovie cautery. The skin graft was inset into the temple ^[14] wound using 5-0 plain gut suture. The skin graft was vented, and a xeroform bolster was placed using xeroform and nylon. The donor site was closed in layers using 4-0 Monocryl and 5-0 Prolene. I then turned my attention to the hand. ^[15] The margins had been cleared from that region, even though it did take two passes. ^[16] I incised the rhomboid flap and elevated it with a full-thickness subcutaneous fat. Hemostasis was achieved in the wound and donor site using Bovie cautery. The flap rotated into ^[17] the defect. The donor site was 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 cm².

^[4] Excision malignant lesion left hand.

^[5] Flap repair of 2.5 cm².

^[6] Anesthesia local.

^[7] Margins of temple excision included in excised diameter as size of lesion is not stated.

^[8] Margins of hand excision documented as 3 mm but lesion size not documented.

- 9] Lesion on the right temple and left hand were excised.
- 10] The right temple was excised outside of the initially drawn parameters.
- 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 was inserted into the temple defect.
- 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-10-CM codes reported?

CPT® codes: 15240, 14040-51, 11643-59

ICD-10-CM codes: C44.319, C44.629

Rationale: CPT® codes: The excised lesion on the temple was 2.2 cm. To code, go to the CPT® Index and look for Excision/Skin/Lesion, Malignant, directs you to 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 the code in the CPT® Index, look for Skin/Grafts/Free, and you are directed to 15050-15157, 15200–15261, 15757. Free skin graft codes are selected based on three criteria. First the code is determined by the thickness of the graft, then the location of the recipient site, and finally the size of the recipient site. Full thickness free grafts are coded from CPT® numeric section 15200–15261. The temple area is considered part of the forehead, or cheek area, both are included in the description of codes 15240–15241. 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. The correct code for this is 15240.

The hand lesion was excised and repaired with an adjacent tissue transfer. In adjacent tissue transfers a portion of the flap is left intact to maintain blood supply. The subsection guidelines for adjacent tissue transfer and rearrangement indicate lesion excisions performed with adjacent tissue transfers should not be separately reported (14000–14302). Adjacent tissue transfers are coded based on location and size. The correct code for the hand repair with a graft of 2.5 cm² is 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). The procedures were performed at a separate site; therefore, modifier 59 is necessary to append to 11643.

ICD-10-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-10-CM Alphabetic Index for Carcinoma/basal cell, and you are directed to *see also* Neoplasm/skin/malignant. In the Table of Neoplasms, look for Neoplasm, neoplastic/skin NOS/temple, which refers you to *see also* Neoplasm, skin, face. Look for Neoplasm, neoplastic/skin NOS/face NOS/basal cell carcinoma referring you to C44.310. When reviewing this code in the Tabular List, note that code C44.310 is for unspecified part of the face, but the operative note indicates that the temple has the basal cell carcinoma. Code C44.319 indicates other parts which is more accurate to report. Squamous cells are in the skin (just below the outer layer of the skin). Squamous cell carcinoma is a primary malignancy of the skin. Repeat the same process in the Table of Neoplasms to find the code for squamous cell carcinoma for the hand. In the Table of Neoplasms, look for Neoplasm, neoplastic/skin NOS/hand, and you are referred to *see also* Neoplasm, skin, limb, upper. Look for Neoplasm, neoplastic/skin NOS/limb NEC/upper/squamous cell carcinoma, and you are referred to C44.62-. In the Tabular List, 6th character 9 indicates the left hand. Report code C44.629.



Case 1

Preoperative Diagnosis: Painful L2 vertebral non-traumatic compression fracture.

Postoperative Diagnosis: Painful L2 vertebral non-traumatic compression fracture. ^[1]

Name of Operation: L2 kyphoplasty. ^[2]

Findings Preoperatively: She had compression fractures at T11 and L1 for which she previously underwent a kyphoplasty. She initially had very good results, but then developed back pain once again. The repeat MRI two weeks later showed that she had fresh high intensity signal changes in the body of L2 and some scalloping of the superior end plate, consistent with a compression fracture at L2. ^[3] After some preoperative discussions and patience to see if she would get better, she was admitted to the hospital for L2 kyphoplasty when she did not improve. At surgery, L2 had some scalloping of the superior end plate. Most of the softness was in the back part of the vertebral body.

Procedure: The patient was taken to the operating room and placed under general endotracheal anesthesia ^[4] in a supine position. She was then placed prone on the Jackson table and her back was prepped and draped in the usual sterile fashion. Using biplane image intensifiers, the skin incision sites were marked. 0.5% Marcaine with epinephrine was injected. Initially on the left side, A Kyphon trocar was passed down to the superior lateral edge of the pedicle, through the pedicle, and into the vertebral body in the usual fashion. ^[5] The drill was placed into the vertebral body followed by the Kyphon bone tamp. In a similar fashion, the same thing was done on the other side. Balloons were inflated uneventfully. The balloons were then deflated and removed, and the cement (when it was in the doughy state) was injected into the two sides in the usual fashion. ^[6] This was done carefully and sequentially to make sure there were no cement extrusions, which, after inspection, there were none. There was a good fill to the vertebral body edges, up towards the superior end plate, and across the midline. The bone filling devices were removed, and the trocars were removed. Pressure was applied after which the skin was sutured with 4-0 nylon. Band-Aids were applied and she was taken to recovery in stable condition.

Complications: There were no complications.

Blood Loss: Minimal blood loss.

Counts: Sponge and needle counts were correct.

^[1] The postoperative diagnosis is used for coding.

^[2] This is the working procedure until the report is read.

^[3] The diagnosis is confirmed in the body of the report.

^[4] The type of anesthesia utilized is documented within the report. General anesthesia was used.

^[5] This describes the approach to the defect. It is percutaneous using trocars.

^[6] This describes how the area is enlarged and the cement is placed in a kyphoplasty procedure.

What are the CPT® and ICD-10-CM codes reported?**CPT® Code:** 22514**ICD-10-CM Code:** M48.56XA**Rationale:**

CPT® Code: In the CPT® Index, look for Kyphoplasty, you are directed to the range of codes 22513–22515. 22514 is the correct code based on the location. Radiologic supervision and interpretation is included in codes 22513–22515 and is not reported separately.

ICD-10-CM Code: In the ICD-10-CM Alphabetic Index, look for Fracture, pathological/compression (not due to trauma). You are instructed to see also Collapse, vertebra. Look for Collapse/vertebra/lumbar region, and you are directed to M48.56-. In the Tabular List, a 7th character is required. This is an initial encounter for the fracture treatment. A placeholder X is reported as the 6th character, followed by the 7th character A for initial treatment.

Case 2**Operative Report****Preoperative Diagnosis:** Comminuted left proximal humerus fracture.**Postoperative Diagnosis:** Comminuted left proximal humerus fracture. ^[1]**Operative Procedure:** Open treatment of left proximal humerus. ^[2]**Anesthesia:** General. ^[3]**Implants:** DePuy GLOBAL® FX®, stem size 10 with a 48 x 15 humeral head. ^[4]

Indications: The patient is a 66-year-old female who sustained a traumatic severe comminuted proximal humerus fracture. ^[5] The risks and benefits of the surgical procedure were discussed. She stated that she understood and desired to proceed.

Description of Procedure: On the day of the procedure, after obtaining informed consent, the patient was taken to the main operating room where she was prepped and draped in the usual sterile fashion in beach chair position after administering general anesthesia. Standard deltopectoral approach was used. ^[6] The cephalic vein was taken laterally with the deltoid. Dissection was carried out down to the fracture site and the fracture was identified. The fragments were mobilized and the humeral head fragments were removed. Once this was done, the stem was prepared up to a size 10. ^[7] A trial reduction was carried out with the DePuy trial stem and implant head. ^[8] This gave good range of motion with good stability. Sutures down to and through the shaft were placed in key positions for closure of the tuberosities. The shaft was prepared and cement was injected into the shaft. The implant was placed. Once the cement was hardened, the head was placed on Morse taper and then reduced. A bone graft was placed around the area where the tuberosities were being brought down. ^[9] The tuberosities were tied down with a suture previously positioned. This gave excellent closure and coverage of the significant motion at the repair sites. The wound was thoroughly irrigated. The skin was closed with Vicryl over a drain and staples in the epidermis. A sterile dressing and sling were applied. The patient was taken to recovery in stable condition. There were no immediate complications.

^[1] The postoperative diagnosis is used for coding.

^[2] The working procedure until the report is read.

^[3] General anesthesia is used.

^[4] This is an indication that a prosthesis was introduced into the joint.

^[5] This is confirmation of the diagnosis. The proximal end of the humerus is the shoulder area.

^[6] The approach is documented within the body of the operative report.

- ^[7] This further explains the comminuted fracture.
 - ^[8] Placement of the prosthesis is described.
 - ^[9] Bone grafts are common in prosthetic placement. A matrix is provided where new bone can grow and further stabilize the prosthesis. These are not reported separately.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® Code: 23616-LT

ICD-10-CM Code: S42.202A

Rationale:

CPT® Code: In the CPT® Index, look for Fracture/Humerus/Open Treatment, and you are directed to codes 23615, 23616 in the numeric section. A humeral prosthesis was inserted to repair the fracture, which is reported with 23616. Modifier LT is appended to indicate the left humerus.

ICD-10-CM Code: The diagnosis is listed as a traumatic comminuted left proximal humerus fracture. In the ICD-10-CM Alphabetic Index, look for Fracture, traumatic/humerus/proximal end, which directs you to *see* Fracture, humerus, upper end, then you will be directed to S42.20-. In the Tabular List, the 6th character 2 is reported for the left side and 7th character A indicates initial encounter for closed fracture. There is no mention if the fracture is closed or open, and according to ICD-10-CM guidelines we are instructed to choose the closed fracture code. There is no documentation of the circumstances surrounding the injury so the external cause codes are not reported.

Case 3

Operative Report

Preoperative Diagnosis: Plantar fasciitis, left foot.

Postoperative Diagnosis: Same as preoperative diagnosis. ^[1]

Procedures: Plantar fasciotomy, left heel. ^[2]

For informed consent, the more common risks, benefits, and alternatives to the procedure were thoroughly discussed with the patient. An appropriate consent form was signed, indicating the patient understands the procedure and its possible complications.

This 61-year-old male was brought to the operating room and placed on the surgical table in a supine position. Following anesthesia, the surgical site was prepped and draped in the normal sterile fashion. Attention was directed to the left heel where, utilizing a #11 blade, a stab incision was made, taking care to identify and retract all vital structures. The incision was deepened to the medial band insertion of the fascia. The fascia was then incised and avulsed from the calcaneus. ^[3] The surgical site was flushed with saline. Next, 1 cc of Depo-Medrol was injected in the operative site. The site was dressed with a light compressive dressing. Excellent capillary refill to all of the digits was observed without excessive bleeding noted.

Hemostasis: None.

Estimated Blood Loss: Minimal.

Injectables: Agent used for local anesthesia was 5.0 cc Marcaine 0.5% with epinephrine.

Pathology: No specimen sent.

Dressings: Applied Bacitracin ointment. Site was dressed with a light compressive dressing.

Condition: Patient tolerated the procedure and anesthesia well. Vital signs were stable. Vascular status was intact to all digits. Patient recovered in the operating room.

-
- ^[1] The postoperative diagnosis is used for coding.
 - ^[2] This is the working procedure until the report is read.
 - ^[3] The description of the fasciotomy is found within the body of the report.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® Code: 28008-LT

ICD-10-CM Code: M72.2

Rationale:

CPT® Code: Look in the CPT® Index for Fasciotomy/Foot, which directs you to 28008. Append modifier LT to reflect the laterality as left.

ICD-10-CM Code: Look for Fasciitis/plantar in the ICD-10-CM Alphabetic Index, and you are directed to M72.2. Verification in the Tabular List confirms this is the correct code.

Case 4

Preoperative Diagnosis: Painful hardware, left foot.

Postoperative Diagnosis: Painful hardware, left foot. ^[1]

Procedure Performed: Removal of hardware, left foot. ^[2]

Anesthesia: Sedation and local.

Drain: None.

Estimated Blood Loss: Minimal.

Indications for Procedure: The patient is status post metatarsal fracture, treated with internal fixation. Patient has suffered pain due to hardware for the past six months. ^[3] Patient's pain has been unresponsive to conservative treatment. We discussed the above-mentioned surgery, along with the potential risks and complications, and the patient understood and wished to proceed.

Description of Procedure: With the patient supine on the operating table after the successful induction of anesthesia, the left foot was prepped and draped in the usual sterile fashion. In the area of the screw heads, 0.5% Marcaine was injected, both on the lateral side of the foot and the dorsal midfoot, administering about 5 ml in each area. Small 0.5 cm incisions through the skin were made and blunt dissection was carried down to the screw heads. The screws were removed with the screwdrivers. ^[4] The incisions were irrigated and closed with simple 4-0 nylon sutures. A sterile compression dressing was applied. The patient was taken to the recovery room in satisfactory condition.

Material Sent to Laboratory: None.

Complications: None.

Condition on Discharge: Satisfactory.

Discharge Diagnosis: Painful hardware, left foot.

Discharge Plan:

Discharge instructions were discussed with the patient. A copy of the instructions was given to the patient, and a copy was retained for the medical record. The following items were discussed: diet, activity, wound care, medications, when to call the physician, and follow-up care.

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- ^[1] The postoperative diagnosis is used for coding.
 - ^[2] This is the working procedure until the report is read.
 - ^[3] The diagnosis is confirmed in the body of the report.
 - ^[4] The removal of hardware is described.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® Code: 20680-LT

ICD-10-CM Code: T84.84XA, G89.18

Rationale:

CPT® Code: Look in the CPT® Index for Removal/Fixation Device, you are directed to code range 20670–20680. The code selection in the numeric section is based on whether the implant (hardware) is superficial or deep. In the description of 20680, screws are considered deep; the correct code is 20680. Modifier LT is appended to indicate the procedure is on the left foot.

ICD-10-CM Code: The diagnosis is stated as painful hardware, left foot. In the ICD-10-CM Alphabetic Index, look for Pain(s)/due to device, implant or graft (*see also* Complications, by site and type, specified NEC)/fixation, internal (orthopedic) NEC, directing you to code T84.84-. Verify the code in the Tabular List. A placeholder X is used for the 6th character and 7th character A is reported for active treatment, making the correct code T84.84XA. ICD-10-CM guideline I.C.6.b.3.b states, “Postoperative pain associated with a specific postoperative complication (such as painful wire sutures) is assigned to the appropriate code(s) found in Chapter 19, Injury, poisoning, and certain other consequences of external causes. If appropriate, use additional code(s) from category G89 to identify acute or chronic pain (G89.18 or G89.28).” ICD-10-CM guideline I.C.6.b.3 states, “The default for post-thoracotomy and other postoperative pain not specified as acute or chronic is the code for the acute form.” In the Alphabetic Index, look for Pain(s)/postoperative NOS or Pain(s)/acute/postprocedural NEC; both refer you to code G89.18. Turn to the Tabular List to verify code accuracy.

Case 5

Preoperative Diagnosis: Right ankle triplane fracture.

Postoperative Diagnosis: Right ankle triplane fracture. ^[1]

Procedure: Open reduction and internal fixation (ORIF), right ankle triplane fracture. ^[2]

Anesthesia: General endotracheal. ^[3]

Complications: None.

Specimen: None.

Implant Used: Synthes 4.0 mm cannulated screws.

Indications for Procedure: The patient is a pleasant 15-year-old male who fell and sustained a right ankle triplane fracture. This was confirmed on both X-ray and CT scan. The indications for ORIF were explained to the patient, as well as the possible risks and complications, which include infection, bleeding, stiffness, hardware pain, the need for hardware removal, and there is no guarantee of a functional ambulatory result. The patient and family understood and wished to proceed.

Procedure in Detail: The patient was brought back to the operating room and placed on an operating table, given a general anesthetic without any complications, and given preoperative antibiotics per usual routine. He had the right lower extremity prepped and draped in the usual sterile fashion, with alcohol prep followed by routine Betadine prep.

Under X-ray guidance,^[4] a pointed reduction clamp was placed from the anterolateral corner of the distal tibia^[5] to the medial side, and I reduced the triplane fracture.^[6] It was confirmed on both AP and lateral X-ray images the gap was reduced. The patient then had guidewires taken from the Synthes 4.0 mm cannulated screw set. One was placed medially along the epiphysis on the anterior half of the epiphysis and parallel to the joint to catch the lateral aspect of the epiphysis. One screw was placed above the physis from anterior to posterior to capture that spike. Once the wires were in the appropriate position, the length was measured and partially threaded 4.0 mm cancellous screws were selected so all threads were across the fracture site.^[7] The appropriate length screws were placed, confirmed by an X-ray to be in good position. The fracture was anatomically reduced, and the ankle joint was anatomic. The patient had wounds copiously irrigated. Closure was done with interrupted horizontal mattress 3-0 nylon suture. The patient had a sterile compressive dressing applied, was placed into a three-sided posterior mold splint, was extubated, and brought to the recovery room in stable condition. There were no complications. There were no specimens. Sponge and needle counts were equal at the end of the case.

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- ^[1] The postoperative diagnosis is used for coding.
 - ^[2] This is the working procedure until the report is read.
 - ^[3] The type of anesthesia utilized is provided. General anesthesia was used.
 - ^[4] Radiologic guidance was used.
 - ^[5] Documentation within the body of the report further specifies the fracture and treatment were of the distal tibia.
 - ^[6] The fracture was reduced.
 - ^[7] Internal fixation was accomplished with screws.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® Codes: 27827-RT

ICD-10-CM Code: S82.391A, W19.XXXA

Rationale:

CPT® Codes: In the CPT® Index, look for Fracture/Tibia/Distal, and you are directed to code range 27824–27828. The procedure performed was open treatment with internal fixation (ORIF). The treatment was of the distal tibia, making 27827 the correct code selection. Appending modifier RT reflects laterality as right.

ICD-10-CM Code: A triplane ankle fracture refers to a fracture in the distal tibia in three planes. In the ICD-10-CM Alphabetic Index, look for Fracture, traumatic/tibia (shaft)/distal end, which refers to *see* Fracture, tibia, lower end. Look for Fracture, traumatic/tibia (shaft)/lower end/specified NEC, and you are directed to S82.39-. In the Tabular List, the complete code is S82.391A, using the 6th character 1 for the right tibia and the 7th character A for the initial encounter. The injury is the result of a fall. Look in the Index to External Causes for Fall, falling (accidental) W19.-. In the Tabular List, a 7th character is required for a complete code. Placeholder X is needed for the 4th, 5th, and 6th characters, followed by 7th character A for the initial encounter, resulting in a final code of W19.XXXA.

Case 6

Preoperative Diagnosis: Comminuted intra-articular distal radial Colles' fracture, left wrist.

Postoperative Diagnosis: Comminuted intra-articular distal radial Colles' fracture, left wrist.^[1]

Procedure: Application of a uniplane, external fixation and closed reduction of left distal radial fracture under fluoroscopy.^[2]

Anesthesia: General endotracheal.^[3]

Description of the Procedure: After induction of adequate general anesthesia, the patient's left upper extremity was routinely prepped and draped into a sterile field. The extremity was elevated and exsanguinated with an Esmarch bandage. The tourniquet was inflated to 300 ml of mercury. We placed two half pins distally over the dorsoradial aspect of the second metacarpal. The first was placed in freehand technique making an incision, spreading with a hemostat, and then placing the half pin. The second pin was placed identically by using the pin guide. Similarly, we placed pins in the dorsoradial aspect of the distal third of the radius.^[4] We connected these two pins with clamps, and then under C-arm control, we reduced the fracture.^[5] All pins are now attached to the external fixation. This fracture at both the dorsal and volar comminution^[6] and intraarticular fractures was significantly shortened and telescoped. We obtained the best reduction possible, and tightened down the clamps to the bars. The pin tracks were dressed with Xeroform and 2 x 2 gauze, and volar 3 x 15 plaster splints were applied. The tourniquet was allowed to deflate during application of the dressing. Total tourniquet time was 14 minutes. There were no intraoperative complications.

-
- ^[1] The postoperative diagnosis is used for coding.
 - ^[2] This is the working procedure until the report is read.
 - ^[3] The type of anesthesia utilized is provided. General anesthesia was used.
 - ^[4] The external fixation component of the procedure is further described.
 - ^[5] This supports the closed reduction under fluoroscopy.
 - ^[6] The comminuted aspect of the diagnosis is confirmed.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® Codes: 20690-LT, 25605-51-LT

ICD-10-CM Code: S52.532A

Rationale:

CPT® Codes: This is a repair of a Colles' fracture. Look in the CPT® Index for Fracture/Radius/Colles and you are directed to code range 25600–25605. In the numeric section, code 25605 is correct because a reduction (manipulation) was performed. This code does not include the external fixation. Look in the CPT® Index for External Fixation/Application/Uniplane, and you are referred to code 20690. Modifier LT is appended to both codes to indicate it is the left wrist. Modifier 51 is reported on the second CPT® code to indicate more than one procedure was performed during the same surgical session. Fluoroscopy is included in the procedure.

ICD-10-CM Code: Look in the ICD-10-CM Alphabetic Index for Fracture, traumatic/Colles', you are directed to *see* Colles' fracture. Look for Colles' fracture, and you are directed to subcategory code S52.53-. Verification in the Tabular List indicates a 7th character is needed. The Colles' fracture was on the left wrist, requiring 6th character 2, and the 7th character A is for the initial encounter for a closed fracture making the code S52.532A. The circumstances surrounding the injury are unknown, so the external cause codes are not reported.

Case 7

Operative Report

Preoperative Diagnosis: Dislocation of right elbow.

Postoperative Diagnosis: Dislocation of right elbow with medial epicondyle fracture.^[1]

Operative Procedure: Closed reduction of elbow dislocation with a closed reduction of medial epicondyle fracture.^[2]

Anesthesia: General.^[3]

Indications: This is a 12-year-old male who had an injury, sustaining a **dislocation of his right elbow and medial epicondyle fracture.** ^[4] The risks and benefits of surgical treatment were discussed with the family, who stated they understood and wanted to proceed.

Description of Procedure: On the day of the procedure, after obtaining informed consent, the patient was taken to the main operating room where general anesthesia was induced. Once he was under adequate anesthesia, **the reduction maneuver was performed. The elbow was reduced and was stable.** ^[5] Through full range of motion, there was noted to be a slight crepitus on the medial elbow and some mobility was felt in the medial epicondyle. Examination under **C-arm imagery** ^[6] revealed a concentric reduction of the elbow, but with mildly unstable medial epicondyle fracture. **When the elbow was held in the appropriate position, the medial epicondyle was well reduced in an acceptable position.** ^[7] **It was elected to treat this non-surgically. A long arm splint was applied.** ^[8] The patient was awakened from anesthesia and taken to recovery in stable condition with no immediate complications.

-
- ^[1] The postoperative diagnosis is used for coding.
 - ^[2] This is the working procedure until the report is read.
 - ^[3] The type of anesthesia utilized is provided. General anesthesia was used.
 - ^[4] The diagnosis is confirmed in the body of the report.
 - ^[5] There is no indication the skin was cut, which reflects a closed method of reduction.
 - ^[6] C-arm imagery indicates fluoroscopy was used.
 - ^[7] Manipulation of the medial epicondyle supports closed reduction of the fracture.
 - ^[8] This is showing the fracture was reduced and set.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® Codes: 24565-RT, 24605-51-RT

ICD-10-CM Codes: S42.441A, S53.104A

Rationale:

CPT® Codes: Look in the CPT® Index for Fracture/Humerus/Epicondyle/Closed Treatment, and you are directed to code range 24560–24565. The code selection in the numeric section is based on whether manipulation is used. 24565 is the correct code for the treatment of the fracture.

The second procedure performed is the reduction of the dislocated elbow. Look in the CPT® Index for Dislocation/Elbow/Closed Treatment, and you are directed to 24600 and 24605. In the numeric section, code 24605 is the correct code because general anesthesia was used. Typically, the reduction of a dislocation would be included in the fracture repair, but because treatment is directed at two different sites of the elbow, each procedure is reported separately by appending modifier 51 to the second code to show more than one procedure was performed. Modifier RT is used on both codes to indicate the procedures were performed on the right elbow.

ICD-10-CM Codes: The diagnosis is stated as dislocation of the right elbow with medial epicondyle fracture. The fracture is a more severe diagnosis, so it will be coded first. The medial epicondyle is the bony protrusion on the inside of the elbow and is part of the distal end of the humerus. Look in the ICD-10-CM Alphabetic Index for Fracture, traumatic/humerus/internal epicondyle, you are directed to *see* Fracture, humerus, lower end, epicondyle, medial. Look for Fracture, traumatic/humerus/lower end/epicondyle/medial (displaced) and you are directed to S42.44-. The fracture was displaced because it had to be reduced back into place. In the Tabular List, it states a 7th character is required. The fracture was on the right elbow and this is the initial encounter for closed fracture, so the code is S42.441A. For the dislocation of the elbow, look in the Alphabetic Index for Dislocation/elbow/traumatic, and you are directed to S53.10-. Documentation identifies the dislocation as located on the medial epicondyle, but there is no documentation of what part of the elbow was dislocated. In the Tabular List, report the 6th character of 4 to reflect the right elbow and the 7th character A for the initial encounter. The complete code for the dislocated right elbow is S53.104A. The circumstances surrounding the injury are not known, so the external cause codes are not reported.

Case 8

Preoperative Diagnosis: Right long finger trigger finger.
Left shoulder impingement/subacromial bursitis.

Postoperative Diagnosis: Right long finger trigger finger.
Left shoulder impingement/subacromial bursitis. ^[1]

Procedures: Right long finger trigger release.
Injection of the left shoulder with Xylocaine, Marcaine, and Celestone via anterior subacromial approach.

Anesthesia: General. ^[2]

Complications: None.

Estimated Blood Loss: Minimal.

Replacement: Crystalloids.

Description of Procedure: The patient was taken to the operating room where he was given general anesthesia. The right upper extremity was prepped and draped in the usual sterile fashion. While draping, the left shoulder was prepped with Betadine; and through an anterior subacromial approach, the left shoulder was injected with 1 cc of Xylocaine, 1 cc of Celestone, and 1 cc of Marcaine. ^[3] The patient tolerated the procedure well.

Meanwhile, the right hand had been prepped and draped. It was exsanguinated with an Esmarch bandage, and the tourniquet inflated to 250 mmHg. I made an incision over the A1 pulley ^[4] in the distal transverse palmar crease, about an inch in length. This was taken through skin and subcutaneous tissue. The A1 pulley was identified and released in its entirety. Care was taken to avoid injury to the neurovascular bundle. ^[5] The wound was irrigated with antibiotic saline solution. The subcutaneous tissue was injected with Marcaine without epinephrine. The skin was closed with 4-0 Ethilon suture. A clean dressing was applied. The patient was awakened and taken to the recovery room in stable condition.

^[1] The postoperative diagnosis is used for coding.

^[2] The type of anesthesia utilized is provided. General anesthesia was used.

^[3] Documentation confirms the left shoulder injection.

^[4] The A1 pulley is a flexor tendon pulley.

^[5] The release of the nerve is described, which is a trigger finger release.

What are the CPT® and ICD-10-CM codes reported?

CPT® Codes: 26055-F7, 20610-51-LT

ICD-10-CM Codes: M65.331, M75.52

Rationale:

CPT® Codes: The most complicated procedure is the right long finger trigger release. Look in the CPT® Index for Trigger Finger Repair, and you are directed to 26055. In the numeric section, the descriptor reads *Tendon sheath incision, (eg, for trigger finger)*. For the shoulder injection, look in the CPT® Index for Injection/Joint, and you are directed to codes ranging from 20600–20611. The code selection in the numeric section is based on the joint and if an ultrasound was used. The shoulder is considered a major joint and ultrasound was not used, making 20610 the correct code. Modifier 51 is appended to the injection to indicate multiple procedures were performed. Modifier F7 is appended to the trigger finger release to reflect the right long finger and modifier LT is appended to the shoulder injection to reflect the left shoulder. The procedures were performed under general anesthesia, which is an indication this case was performed in a facility. The drugs are reported by the facility, not the physician.

ICD-10-CM Codes: The diagnoses were stated as right long finger trigger finger and left shoulder impingement/subacromial bursitis. For the trigger finger, look in the ICD-10-CM Alphabetic Index for Trigger finger/middle finger, and you are directed to M65.33. In the Tabular List, the 6th character 1 is reported for the right finger. For the left shoulder, look in the Alphabetic Index for Bursitis/shoulder, and you are directed to M75.5-. In the Tabular List, the 5th character 2 is reported for the left shoulder. There is no Alphabetic Index entry for impingement of the shoulder. Bursitis can be a cause of shoulder impingement (or rub).

Case 9

Procedure Performed in Office.

Preoperative Diagnosis: Right-sided thoracic pain.

Postoperative Diagnosis: Right-sided thoracic pain.^[1]

Operation: Trigger point injection^[2] into the right-sided thoracic spine musculature, into the rhomboid major, rhomboid minor, and levator scapular muscles.^[3]

Procedure: The patient was seated on the bed. He has metastatic right lung cancer^[4]. The risks of the procedure, including bleeding, infection, nerve damage, and no guarantee of symptom relief were explained. The patient agreed to the procedure and the informed consent was signed.

I palpated for areas of maximal tenderness. Five points were marked over the right-sided thoracic paraspinal musculature. I then cleaned off his back with chlorhexidine x2. Then I used a 25 gauge 1.5-inch needle on a 10 cc controlled syringe with 40 mg/ml Depo-Medrol. After negative aspiration, 1 cc was injected into each point. A total of four points were injected.^[5] A total of 4 cc (160 mg) was used.^[6] The patient tolerated the procedure well. Band-Aids were not placed. The patient was not bleeding.

We are refilling the patient's pain medication. He is seeing an oncologist and gets Percocet 7.5/500. He takes four a day, providing him with pain relief. We will dispense to him today a three-week supply. We are going to dispense 84. He is to return to the office in two weeks, at that time we will get a urine specimen for follow up. Emphasized to the patient, once again, that he had to bring his pills to every appointment, according to the opioid contract.

^[1] The postoperative diagnosis is used for coding.

^[2] This is the working procedure until the report is read.

^[3] It is documented as three muscles receiving injections.

^[4] This represents a secondary diagnosis for the visit.

^[5] This verifies the trigger points injected.

^[6] This is the amount of the drug used.

What are the CPT® and ICD-10-CM codes reported?

CPT® Codes: 20553, J1030 x 4

ICD-10-CM Codes: M54.6, C78.01

Rationale:

CPT® Codes: In the CPT® Index, look for Injection/Trigger Point(s)/Three or More Muscles, directing us to 20553. Verification of code in the numeric section confirms 20553 is the correct code selection. The drug used for the procedure is reportable since it was provided in an office. Looking in the HCPCS Level II code book at the Table of Drugs and Chemicals

for Depo-Medrol, we are directed to Methylprednisolone acetate, code J1030 for each 40 mg. Verify code selection in the Tabular List. Code J1030 is reported with 4 units: 40 mg x 4 = 160 mg.

ICD-10-CM Codes: Look in the ICD-10-CM Alphabetic Index for Pain(s)/thoracic spine, and you are directed to M54.6. The patient also has metastatic lung cancer. Look in the Alphabetic Index for Cancer, and you are referred to Neoplasm, by site, malignant. Go to the Table of Neoplasms and look for Neoplasm, neoplastic/lung. The code in the column for Malignant Secondary is C78.0-. In the Tabular List, the 5th character 1 is reported to indicate the right lung. There is no mention that the pain is neoplasm related so a code from category G89 is not reported.

Case 10

Preoperative Diagnosis: Left Achilles' tendon rupture.

Postoperative Diagnosis: Left Achilles' tendon rupture. ^[1]

Operation Performed: Open Left Achilles' tendon repair. ^[2]

Anesthesia: General anesthesia. ^[3]

Indications: The patient is a 25-year-old male who was playing basketball when he was hit by another player and felt a pop in the back of his ankle approximately two months ago. Examination reveals a positive Thompson test, but no plantar flexion on squeezing the calf. There is a palpable defect in the Achilles' tendon. There is swelling in this region and neurovascular examination is intact. Given these clinical findings, the patient is taken to the operating room for the aforementioned procedure.

Description of Procedure: Following induction of general anesthesia the patient was placed prone on the operating table and all bony prominences were well-padded. The patient received a 1 g dose of Ancef. Under tourniquet control of 250 mmHg, a longitudinal incision was made followed by opening up the paratenon of the Achilles' tendon. An obvious rupture was noted. ^[4] The hematoma was evacuated and the ends were then debrided with a Metzenbaum scissors. A No. 2 FiberWire® was placed in a Bunnell-type fashion in both the proximal and distal portions of the Achilles' tendon. A No. 2 Orthocord was then used and placed in a running fashion along the proximal and distal portions of the Achilles' tendon. A total of four sutures were used. These were then tied together to re-approximate the tendon with no significant tension on the repair. ^[5]

A secure repair was noted. The ends of the repair were further augmented with a 2-0 Vicryl suture. The wound was thoroughly irrigated with antibiotic irrigation solution. The fascial plane was closed with a 2-0 Vicryl suture, followed by closing the skin with a 2-0 in subcuticular fashion. Approximately 10 cc of 0.5% Marcaine was injected for postoperative pain control. A routine dressing was applied to the extremity, and it was placed into a short leg cast ^[6] with the foot slightly plantar-flexed. The anterior aspect of the cast was then univalved. The tourniquet was deflated for a total tourniquet time of 42 minutes.

The patient was awakened in the operating room breathing spontaneously and taken to the recovery room in stable condition.

^[1] The postoperative diagnosis is used for coding.

^[2] This is the working procedure until the report is read.

^[3] The type of anesthesia utilized is provided. General anesthesia was used.

^[4] Rupture of the Achilles' tendon is verified.

^[5] The repair of the Achilles's tendon with sutures is described.

^[6] A short leg cast was applied.

What are the CPT® and ICD-10-CM codes reported?

CPT® Code: 27650-LT

ICD-10-CM Codes: S86.012A, W50.0XXA, Y93.67, Y99.8

Rationale:

CPT® Code: In the CPT® Index, look for Achilles Tendon/Repair, you are directed to code range 27650–27654. Verification in the numeric section identifies 27650 as the correct code. Append modifier LT to reflect to the laterality as left.

ICD-10-CM Codes: In the ICD-10-CM Alphabetic Index, look for Rupture, ruptured/tendon (traumatic), you are directed to *see* Strain. Look for Strain/tendon, which refers you to *see* Injury, muscle, by site, strain. Look for Injury/Achilles tendon/strain, and you are directed to S86.01-. When verifying in the Tabular List, you will notice you need a 6th character 2 to identify the left side and the 7th character A to indicate this is the initial encounter. The resulting code is S86.012A. External cause codes are reported to describe the circumstances of the injury. The patient was playing basketball and was hit by another player. Go to the Index to External Causes and look for Hit, hitting (accidental) by, you are directed to *see* Struck by. Look for Struck (accidentally) by/other person(s), referring to W50.0-. Turn to the Tabular List to complete the code: W50.0XXA. Next, look for Activity/basketball, which directs you to code Y93.67. Because documentation indicates the patient was playing a sport, report an external cause status code. Look for Status of external cause/recreation or sport not for income or while a student, referring you to code Y99.8. Turn to the Tabular List to verify the code accuracy. The location of the activity is not documented and not reported.



Case 1

Preoperative Diagnosis: Malignant neoplasm glottis.

Postoperative Diagnosis: Malignant neoplasm glottis. ^[1]

Procedure: An incision is made low in the neck. The trachea is identified in the middle and an opening is created to allow for the new breathing passage. A tracheostomy ^[2] tube is inserted and secured with sutures. The patient tolerated the procedure well and was sent to recovery without complications.

^[1] Diagnosis to report for the procedure.

^[2] This is the performed procedure.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 31600

ICD-10-CM code: C32.0

Rationale:

CPT® code: In the CPT® Index, look for Tracheostomy/Planned, which guides you to codes 31600–31601. An emergency tracheostomy is reported when the procedure is performed for a serious medical condition that arises suddenly and requires immediate care and treatment. An example of an emergency tracheostomy is in the emergency department when an unscheduled tracheostomy is performed on a patient who cannot breathe and will die if immediate medical attention to facilitate breathing is not performed.

There is no indication in the note that this was an emergency tracheostomy, so report a planned tracheostomy. Report code 31600, because age was not documented in the note.

ICD-10-CM code: In the ICD-10-CM Alphabetic Index, look for Neoplasm, neoplastic referring you to see also Table of Neoplasms. Go the Table of Neoplasms and look for Neoplasm, neoplastic/glottis/Malignant Primary (column), referring you to code C32.0. In the Tabular List, there is an instructional note under category code C32 that states to use an additional code to identify alcohol or tobacco use. Documentation in the operative note does not give us that information so there is no reporting an additional code in this case.

Case 2

Preoperative Diagnosis: Left vocal cord tumor.

Postoperative Diagnosis: Left vocal cord tumor. ^[1]

Name of Procedure: Direct laryngoscopy with microscope, removal of tumor. ^[2]

Anesthesia: General.

Complications: None.

Specimens: Left vocal cord tumor to pathology. ^[3]

Blood Loss: Less than 10 ml.

Technique: Patient was brought to the operative suite and comfortably positioned on the table. General endotracheal anesthesia was induced. The bed was turned 90 degrees clockwise. The alveolar guard was placed over the upper alveolus to protect the teeth. Appropriate drapes were placed. The anterior laryngoscope was inserted and direct laryngoscopy ^[4] was performed with no abnormal findings other than the above-described tumor. The scope was suspended, and using the operating microscope ^[5] the anterior vocal cord tumor was removed. The mucous membrane posterior to the tumor was carefully incised and Reinke's space was entered. Careful dissection allowed mucous membrane elevation off of the anterior vocal cord up to the commissure, with what appeared to be complete excision of the tumor. ^[6] Minimal bleeding was noted. The area was sprayed with Cetacaine spray. The scope was gently removed. The teeth were evaluated and found to be free of injury. The drapes and instruments were removed. The patient was returned to anesthesia for care, allowed to awaken, extubated, and transported in stable condition to the recovery room. The patient tolerated the procedure well.

Findings: Patient is a pleasant 77-year-old white female with a history of the above-noted diagnoses. Operative findings included an otherwise normal larynx with the exception of the left anterior vocal cord tumor. ^[7] It was fairly soft.

^[1] Report this diagnosis if no further positive finding are found in the operative note.

^[2] Indication of type of laryngoscopy being performed.

^[3] Tumor was sent to pathology.

^[4] Placement of the direct laryngoscope.

^[5] Operating microscope is used.

^[6] Removal of the tumor.

^[7] This is confirmation to report a tumor on the vocal cord.

What CPT® and ICD-10-CM codes are reported for this procedure?

CPT® code: 31541

ICD-10-CM code: D49.1

Rationale:

CPT® code: For this case, the tumor is on the left vocal cord in the larynx, and it's removed by direct laryngoscopy using an operating microscope. In the CPT® Index, look for Laryngoscopy/Direct, which refers you to codes 31515–31571 or you can narrow the search further by looking for Larynx/Tumor/Excision/Endoscopic, which refers you to 31540, 31541. A laryngoscope is a type of endoscope. Review the codes; code 31541 is the correct code to report for the performed procedure.

ICD-10-CM code: The tumor was on the vocal cord. Look in the ICD-10-CM Alphabetic Index for Tumor, and you are instructed to — *see also* Neoplasm, unspecified behavior, by site. Turn to the Table of Neoplasms and look for Neoplasm, neoplastic/vocal cords (true)/Unspecified Behavior column, which refers you to D49.1. Verify code selection in the Tabular List.

Case 3

Preoperative Diagnosis: Loculated left pleural effusion, chronic.

Postoperative Diagnosis: Loculated left pleural effusion, ^[1] chronic.

Procedure Performed: Attempted, ultrasound guided thoracentesis.

Description of Procedure: The patient was prepped and draped in the sitting position. Using ultrasound guidance^[2] and 1% lidocaine, the thoracic catheter was introduced into the pleural space where we encountered very thick fibrous type pleura.^[3] The catheter was advanced, and we were unable to aspirate fluid. The catheter was removed. Sterile dressings were applied. Chest X-ray will be obtained for follow-up. Patient tolerated the procedure well.

^[1] Report this diagnosis for this procedure.

^[2] Imaging guidance is performed.

^[3] The placement of the catheter in the pleural cavity to perform the thoracentesis.

What are the CPT® and ICD-10-CM codes for this procedure?

CPT® code: 32555-LT

ICD-10-CM code: J90

Rationale:

CPT® code: The physician performed all the steps for a thoracentesis and was unable to aspirate any fluid from the pleural cavity (the space between the lungs and the chest wall). A thoracentesis is performed by puncturing the chest wall with a needle using ultrasound guidance to drain the fluid trapped in the pleural space. In the CPT® Index, look for Thoracentesis/with Imaging Guidance, which refers you to 32555. This case does not require a modifier to report the inability to aspirate fluid when an attempt was made and unsuccessful. The surgeon completed all requirements of the code specification.

Ultrasound guidance was performed to place the needle in the pleural cavity, which is included when reporting 32555. Append modifier LT to indicate the procedure was performed on the left side.

ICD-10-CM code: Pleural effusion (too much fluid collected in the plural space) was the reason for the surgical procedure. In the ICD-10-CM Alphabetic Index, look for Effusion/pleura, pleurisy, pleuritic, pleuropericardial, which guides you to code J90. Verify code selection in the Tabular List.

Case 4

Preoperative Diagnosis: Mass, right upper lobe.

Postoperative Diagnosis: Carcinoma, right upper lobe.^[1]

Procedure Performed: VATS, right superior lobectomy.

Description of Procedure: Under general anesthesia, after a double-lumen tube intubation, the right lung was collapsed and the right side up is oriented so the patient is in the left lateral decubitus position. We prepped and draped the patient in the usual manner and gave antibiotics. Then two 1 cm incisions were made along the posterior and mid axillary line at the ninth and seventh intercostal spaces. The lung was deflated and a camera was inserted.^[2] A longer (6 cm) incision was made along the fourth intercostal space anteriorly. We then freed up some adhesions at the top of the lung, both in the superior area away from the tumor and in the anterior mediastinal area. The tumor seemed to be in the right upper lobe.^[3] The dissection began by ligating the superior pulmonary vein and its branches, and the upper lobe was freed up. The small fissure was incomplete, and I proceeded with the lobectomy. The pulmonary artery branches were then ligated. The bronchus was ligated, as well. The superior branches to the upper lobe were ligated with Endo GIA. The lobe was freed up and sent to pathology. The wound was then closed in layers. A chest tube was placed to suction, and the patient was sent to recovery in stable condition. Pathology confirmed carcinoma.^[4]

^[1] Report this diagnosis if no further positive findings are found in the operative report.

^[2] VATS.

^[3] Tumor is in the right lung.

^[4] Indication to report the right lobe of the lung as cancerous.

What CPT® and ICD-10-CM codes are reported?

CPT® code: 32663-RT

ICD-10-CM code: C34.11

Rationale:

CPT® code: For this case, the physician is removing the upper lobe from the right lung through an endoscope (VATS - examining the inside of the chest cavity through an endoscope by using a video camera through an incision between two ribs, and inserting a trocar into the chest cavity). In the CPT® Index, look for Thoracoscopy/Surgical/with Lobectomy, which guides you to code 32663. Append modifier RT to indicate the procedure is being performed on the right lung.

ICD-10-CM code: Do not code “mass of the lung” because the operative report indicates a specific diagnosis was established. Pathology confirms carcinoma in the right upper lobe of the lung. In the ICD-10-CM Alphabetic Index, look for Carcinoma, and you are referred to *see also* Neoplasm, by site, malignant. Go to the Table of Neoplasms and look for Neoplasm, neoplastic/lung/upper lobe/Malignant Primary (column), which guides you to code C34.1-. In the Tabular List, 5th character 1 is reported for the right lung. The complete code is C34.11.

Case 5

Preoperative Diagnoses:

1. Sarcoid of lymph nodes ^[1]
2. New onset paratracheal adenopathy ^[1]

Postoperative Diagnoses:

1. Sarcoid of lymph nodes
2. New onset paratracheal adenopathy

Procedure Performed: Mediastinotomy. ^[2]

Description of Procedure: The patient was brought to the operating room and placed in supine position. IV sedation and general anesthesia was administered by the anesthesia department. The neck was prepped in standard fashion with betadine scrub, sterile towels, and drapes. A standard linear incision was made over the trachea. ^[3] We were able to dissect down the pretracheal fascia into the mediastinum without difficulty. The extensive adenopathy was immediately apparent just below the innominate artery on the right paratracheal side. One exceedingly large lymph node was identified and biopsied extensively. ^[4] The specimen was sent to pathology. Hemostasis was obtained without difficulty. The region was infused with a Marcaine, lidocaine, and epinephrine mixture. The wound was closed in layers. The skin was closed with subcutaneous stitches and covered with Dermabond. The patient tolerated the procedure well and was taken to the recovery room in stable condition.

^[1] Report these diagnoses if no further positive findings are found in the operative note.

^[2] Indication of what procedure is being performed.

^[3] Procedure performed with the anterior cervical approach.

^[4] Biopsy performed.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 39000

ICD-10-CM codes: D86.1, R59.0

Rationale:

CPT® code: For this case, a mediastinotomy (an incision into the mediastinum) with a biopsy was performed. In the CPT® Index, look for Mediastinotomy/Cervical Approach, referring you to code 39000. The operative note documents that the neck was prepped and an incision was made over the trachea. That indicates a cervical approach was performed for the procedure. A thoracic approach is if the physician made an incision across the chest area. Code 39000 is reported for mediastinotomy with the performed biopsy.

ICD-10-CM codes: The first diagnosis to report is sarcoid, which is a disease in which granulomas (nodules of inflamed tissue) form in the lymph nodes, lungs, skin, and other areas. In this case, the nodule was identified on a lymph node near the trachea. In the ICD-10-CM Alphabetic Index, look for Sarcoid which directs you to *see also* Sarcoidosis. Look for Sarcoidosis/lymph nodes guiding you to code D86.1. For the second diagnosis, look in the Alphabetic Index for Adenopathy (lymph gland)/localized, which guides you to code R59.0. Report the localized code, because the operative report indicates paratracheal adenopathy. Verify code selection in the ICD-10-CM Tabular List.

Case 6

Preoperative Diagnosis: Grade 3 squamous cell carcinoma of penis with inguinal lymphatic metastasis.

Postoperative Diagnosis: Grade 3 squamous cell carcinoma of penis with inguinal lymphatic metastasis. ^[1]

Procedure Performed: Laparoscopic ^[2] bilateral pelvic lymphadenectomy.

Description of Procedure: The patient is placed in supine position with thigh abduction. A 1.5 cm incision was made 2 cm distally of the lower vertex of the femoral triangle. The second incision was made 2 cm proximally and 6 cm medially. Two 10 mm Hasson trocars were inserted in these incisions. The last trocar was placed 2 cm proximally and 6 cm laterally from the first port. ^[3]

Radical endoscopic bilateral pelvic lymphadenectomy was performed. ^[4] The main landmarks — adductor longus muscle medially, the sartorius muscle laterally, and the inguinal ligament superiorly — were well visualized. The retrograde dissection using a harmonic scalpel was started distally near the vertex of the femoral triangle towards the fossa ovalis, where the saphena vein was identified, clipped, and divided, towards the femoral artery laterally. After the procedure, one can identify the skeletonized femoral vessels and the empty femoral channel, showing that the lymphatic tissue in this region was completely resected.

The surgical specimen was removed through the first port incision. A suction drain was placed to prevent lymphocele, and was kept until the drainage reached 50 ml or less in 24 hours. Patient tolerated the procedure well and was transferred to recovery in stable condition.

^[1] Report this diagnosis if no further positive findings are found in the operative note.

^[2] Indication the procedure is being performed through a laparoscope.

^[3] Confirmation the procedure is being performed through a laparoscope.

^[4] Bilateral pelvic lymphadenectomy.

What CPT® and ICD-10-CM codes are reported?

CPT® code: 38571

ICD-10-CM codes: C77.4, C60.9

Rationale:

CPT® code: For this case, the surgeon is performing a surgical laparoscopic removal of lymph nodes on both sides of the pelvis. In the CPT® Index, look for Laparoscopy/Lymph System/Lymphadenectomy, which guides you to codes 38571-38573. Code 38571 is the correct code because documentation indicates only the pelvic lymph nodes were removed and it is bilateral by description.

ICD-10-CM codes: According to ICD-10-CM guidelines, I.C.2.1.2 indicates: When an encounter is for a primary malignancy with metastasis and treatment is directed toward the metastatic (secondary) site(s) only, the metastatic site(s) is designated as the principal/first listed diagnosis. The primary malignancy is coded as an additional code.

The patient has cancer of the penis (primary site) that has metastasized to the inguinal lymph nodes (secondary site). In this case, the secondary site of the cancer is listed as the first diagnosis because of the procedure to remove the lymph nodes in the inguinal (pelvic) area.

In the ICD-10-CM Alphabetic Index, look for Carcinoma - *see also* Neoplasm, by site, malignant. Go to the Table of Neoplasms and look for Neoplasm, neoplastic/lymph, lymphatic channel NEC/gland (secondary)/inguina, inguinal/Malignant Secondary (column), which guides you to code C77.4. Next, look for Neoplasm, neoplastic/penis/Malignant Primary (column), which guides you to code C60.9. Verify the codes in the Tabular List.

Case 7

Preoperative Diagnosis: Recurrent pleural effusion, stage IV right lung cancer.

Postoperative Diagnosis: Recurrent pleural effusion, stage IV right lung cancer. ^[1]

Procedure Performed: Video-assisted thoracoscopy, ^[2] lysis of adhesions, talc pleurodesis.

Procedure: Patient was brought to the operating room and placed in supine position. IV sedation and general anesthesia were administered, per the anesthesia department. A double-lumen endotracheal tube was placed, per anesthesia. The position was confirmed by bronchoscopy. The patient was placed in the decubitus position with the right side up. The chest was prepped in the standard fashion with ChlorPrep, sterile towels, sheets, and drapes. A small incision is made between two ribs and a standard port placement was utilized to gain access to the thoracic cavity. The endoscope is inserted into the chest cavity. We had excellent isolation of the lung; however, we had poor exposure because there were a number of fibrous adhesions, a few were actually very dense. We immediately evacuated approximately 700 ml of fluid; ^[3] however, once we entered the chest, we encountered a number of loculated areas. We did not break down the adhesions. We gained enough exposure to do a complete talc pleurodesis. After lysing of adhesions, ^[4] we were confident that we had access to the entire thoracic cavity. Eight grams of talc were introduced into the right thoracic cavity and strategically placed under direct vision. ^[5] The chest tubes were then placed. The wounds were closed in layers. The patient tolerated the procedure well and was taken to the recovery room in stable condition.

^[1] Report this diagnosis if no further positive findings are found in the note.

^[2] Indication the procedure is being performed by Video Assisted Thoracic Surgery (VATS.)

^[3] Indication of pleural effusion (fluid around the lung, in the pleural space).

^[4] Removal of the adhesions to get to the thoracic cavity was necessary to perform the pleurodesis is not reported separately.

^[5] Pleurodesis.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 32650-RT

ICD-10-CM codes: J90, C34.91

Rationale:

CPT® code: Pleurodesis refers to the creation of adhesions between the parietal and visceral layers of the pleura. When the two layers stick to each other it results in obliteration of the pleural cavity preventing subsequent pleural effusions. In this case talc was used as an irritant to create sticky surfaces which will adhere to each other. In the CPT® Index, look for Pleurodesis/Thorascopic, referring you to 32650 or look for VATS referring you to *See* Thoracoscopy. The physician is performing a video-assisted surgical thoracoscopy (VATS-examination of the inside of the chest cavity through an endoscope using a video camera). Modifier RT is reported because the procedure was performed on the right side.

ICD-10-CM codes: The procedure was performed due to the patient having a recurrent pleural effusion (fluid around the lung). In the ICD-10-CM Alphabetic Index, look for Effusion/pleura, pleurisy, pleuritic, pleuropericardial, guides you to code J90. Pleural effusion is not a disease, but rather a complication of an underlying illness, in this case from lung cancer. If cancer cells are present in the fluid, then malignant pleural effusion is reported (J91.0). There is no documentation that supports the effusion is malignant. In the Alphabetic Index, look for Cancer - *see also* Neoplasm, by site, malignant. Go to the Table of Neoplasms, look for Neoplasm, neoplastic/lung/Malignant Primary (column), guides you to code C34.9-. In the Tabular List, the complete code C34.91 is reported because the right lung is affected by the lung cancer.

See ICD-10-CM guidelines I.C.2.I.4 indicates, when the reason for the admission/encounter is to manage a complication associated with a neoplasm and treatment is aimed at the complication, the complication is coded first, followed by the appropriate codes for the neoplasm. In this case the pleural effusion (J90) was related to the Stage IV right lung cancer (C34.91). Pleural effusion can be a life-threatening condition where fluid builds up in the closed sac around the lung and can cause respiratory failure if left untreated. The cancer had been identified in a previous encounter based on the diagnostic statement. The treatment was totally focused on resolving the effusion.

Case 8

Preoperative Diagnosis: Carcinoma, right lung and bronchus intermedius.

Procedure Performed: Bronchoscopy.

Description of Procedure: Two liters of oxygen were supplied nasally. The right nostril was anesthetized with two applications of 4% lidocaine and two applications of lidocaine jelly. The posterior pharynx was anesthetized with two applications of Cetacaine spray. The Olympus PF fiberoptic bronchoscope was introduced into the patient's right nostril.^[1] The posterior pharynx, epiglottis, and vocal cords were normal. The trachea and main carina were normal. The entire tracheobronchial tree was then visually examined and the major airways. No abnormalities were noted on the left side. There was, however, extrinsic compression of the posterior segment of the right upper lobe. There also appeared to be a submucosal tumor involving the bronchus intermedius between the right upper lobe and right middle lobe.^[2] Multiple washings, brushings, and biopsies^[3] were taken from the right upper lobe bronchus and bronchus intermedius. The specimens were sent for cytology and routine pathology. The patient tolerated this without complications.

^[1] Indication the procedure is being performed with a bronchoscope.

^[2] Tumor location.

^[3] Surgical bronchoscopy with biopsies and brushings.

What CPT® and ICD-10-CM codes are reported?

CPT® codes: 31625, 31623-51

ICD-10-CM code: C34.81

Rationale:

CPT® codes: For this case, report two surgical bronchoscopy codes. The first code to report is for removing the samples of bronchial tissue for study. In the CPT® Index, look for Bronchoscopy/Biopsy, referring you to 31625–31629, 31632, 31633. Code 31625 is the correct code, since there is no documentation about going through the bronchial wall (transbronchial) to take the biopsies. The second code is indexed under Bronchoscopy/Brushing/Protected brushing, referring you to code 31623. Append modifier 51 to this code to indicate an additional procedure code was performed at the same surgical session by the same physician.

ICD-10-CM code: In the ICD-10-CM Alphabetic Index, look for Carcinoma - *see also* Neoplasm, by site, malignant. In the Table of Neoplasms, look for Neoplasm, neoplastic/lung/overlapping lesion/Malignant Primary (column), which guides you to code C34.8-. In the Tabular List, the 5th character is 1 for the right lung. The complete code is C34.81.

Case 9

Preoperative Diagnosis: Pedestrian in a MVA involving a car, left pneumothorax.

Postoperative Diagnosis: Pedestrian in a MVA involving a car, left pneumothorax. ^[1]

Procedure: Bronchoscopy, left VATS, ^[2] wedge resection.

Procedure: Patient was brought into the operating room and placed in supine position. IV sedation and general anesthesia was administered, per the anesthesia department. A single lumen endotracheal tube was placed for bronchoscopy, per anesthesia. Due to the nature of the trauma, ^[3] we were interested in ruling out a bronchial tear. The bronchoscope was introduced into the mouth and passed into the throat without difficulty. There was no evidence of sanguineous drainage or bronchial trauma noted to the left mainstem. There were copious amounts of secretions noted and removed without difficulty. The right mainstem was also cannulated and found to be free of unexpected trauma. The bronchoscopy was terminated at that time. ^[4]

A double lumen endotracheal tube was placed, per anesthesia. The position was confirmed by bronchoscopy. The patient was placed in the decubitus position with the left side up. The chest was prepped in standard fashion with Betadine, sterile towels, sheets, and drapes. A small incision is made along the upper boarder of the fourth rib just below the intercostal space and a standard port placement was utilized to gain access to the thoracic cavity. An endoscope was inserted into the chest cavity. Initially we had excellent exposure with good isolation of the lung. ^[5] We identified a large bleb at the apex of the lower lobe of the left lung, which was likely to be the source of the chronic air leak. We removed the area of the large bleb at the apex with a wedge resection using thoracoscopic green load for therapeutic correction of the patient's pneumothorax. ^[6] The wounds were closed in layers. Chest tubes were placed. The patient tolerated the procedure well and was taken to the recovery room.

^[1] Report the post-operative diagnosis and verify from the operative note.

^[2] Statement of two procedures performed, must be verified in the body of the operative note.

^[3] Traumatic pneumothorax.

^[4] Diagnostic bronchoscopy.

^[5] Thoracoscope was used.

^[6] Wedge resection.

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 32666-LT, 31622-51

ICD-10-CM codes: S27.0XXA, V03.90XA

Rationale:

CPT® codes: There are two procedure codes to report for this case, because two distinct surgical approaches were used as were two different scopes. The first procedure to report is the surgical thoracoscopy (VATS), removing a wedge of the left lung through an endoscope. In the CPT® Index, look for Thoracoscopy/Surgical/with Therapeutic Wedge Resection of Lung, which guides you to codes 32666 and 32667. Code 32667 is an add-on code for additional resections. Because only one resection was documented, 32666 is the most appropriate code. The second procedure code to report is a diagnostic bronchoscopy, which was performed to examine the bronchus due to concern for trauma in that area. In the CPT® Index, look for Bronchoscopy/Exploration, which guides you to code 31622, 31634, 31647, 31651. There is no mention of any surgical interventions, making 31622 the correct code. Append modifier 51 to code 31622 to indicate an additional procedure during the same surgical session by the same physician was performed.

ICD-10-CM codes: The patient had a pneumothorax (air trapped in the space between the outside of the lung and the inside of the chest wall). Further indication in the operative note states that this was due to trauma resulting from a pedestrian and a motor vehicle involving a car. In the ICD-10-CM Alphabetic Index look for Pneumothorax NOS/traumatic guiding you to

code S27.0-. In the Tabular List, a 7th character is required. The complete code is S27.0XXA. Documentation in the Preoperative Diagnosis and Postoperative Diagnosis headings of the note indicate this was a pedestrian in a motor vehicle accident (MVA) involving a car. In the ICD-10-CM External Cause of Injuries Index look for Accident/transport/pedestrian/on foot/collision (with)/car, guides you to V03.90-. In the Tabular List, report 7th character A to complete code V03.90XA.

Case 10

Preoperative Diagnosis:

1. Chronic hyperplastic rhinosinusitis
2. Allergies
3. Status post-prior polypectomy and sinus surgery

Postoperative Diagnosis:

1. **Intranasal and sinus polyps** ^[1]
2. **Chronic hyperplastic rhinosinusitis** ^[1]

Operative Procedure:

Left sinusotomy (three or more sinuses) including:

- Nasal and sinus endoscopy
- Endoscopic intranasal polypectomy
- Endoscopic total sinus ethmoidectomy
- Endoscopic sphenoidotomy
- Endoscopic nasal antral windows, middle meatus, and inferior meatus
- Endoscopic removal of left maxillary sinus contents

Right sinusotomy (three or more sinuses) including:

- Nasal and sinus endoscopy
- **Endoscopic** ^[2] intranasal polypectomy
- Endoscopic total sinus ethmoidectomy
- Endoscopic sphenoidotomy
- Endoscopic nasal antral windows, middle meatus, and inferior meatus
- Endoscopic removal of right maxillary sinus contents

Specimens sent to pathology:

1. Left ethmoid and sphenoid contents for routine and fungal cultures
2. Right maxillary contents for routine and fungal cultures
3. Left intranasal ethmoid, sphenoid, and maxillary specimens for pathology
4. Right ethmoid, sphenoid, maxillary, and right intranasal contents for pathology

Findings: Complete **nasal obstruction by polyps** ^[3] obscuring of all of the normal landmarks. The right middle turbinate was found and preserved. The residual body of the left middle turbinate was found and preserved. There was thickened hyperplastic mucosa throughout the sinuses **with some polyps in the sinuses**, ^[4] and the majority of the sinus cavities were filled with glue-like mucopurulent debris. At the end of the case there were no visible polyps, the airway was clear, and the debris had been removed.

Procedure: The patient was taken to the operating room, placed in the supine position, and general endotracheal anesthesia was obtained adequately. A pharyngeal pack was placed. The nose was infiltrated with Xylocaine with epinephrine and cottonoids soaked in 4% cocaine were placed. The procedure was performed in a similar manner bilaterally. The cottonoids were removed.

The 30-degree, wide-angle sinus telescope with Endo-scrub and the Stryker Hummer device were used to remove the polyps starting anteriorly and working posteriorly. ^[5] This led to visualization of the middle turbinates.

The middle meati disease was removed. The area of the uncinate process and infundibulum was shaved away and forceps were used to remove portions of bone particle. Using blunt dissection, the agger nasi cells, **ethmoid and sphenoid sinuses were**

entered and the contents removed with forceps and suction. ^[6] The inferior turbinates were infRACTURED; a mosquito clamp was placed through the lateral nasal wall into the maxillary sinuses through the inferior meatus. That opening was opened with forward and backward biting forceps, ^[7] sinus endoscopy was performed, and inspissated mucus and debris cleaned out of the sinuses. ^[8]

In a similar manner the sinuses were opened from the middle meatus and the sinuses cleaned. ^[9] Like before, the ethmoid, sphenoid, and maxillary sinuses were cleaned of debris, and inspissated mucus was suctioned from the frontal recesses.

The patient was then suctioned free of secretions, with adequate hemostasis noted. Gelfilm was soaked, rolled, and placed in the middle meati. Telfa gauze was infused with Bacitracin, folded and placed in the nose. Vaseline gauze was placed between the folds of Telfa. The pharyngeal pack was removed. He was suctioned free of secretions, with adequate hemostasis noted, and the procedure terminated. He tolerated it well and left the operating room in satisfactory condition.

^[1] Report these diagnoses if no further positive findings are found in the operative note.

^[2] Indication the surgery will be performed through an endoscope.

^[3] Report this diagnosis for the intranasal polyps.

^[4] Documentation supports the presence of sinus polyps.

^[5] Endoscope was used for the surgical excision of nasal polyps obstructing normal anatomical landmarks. A total excision was performed with the operative note indicating the removal was performed anteriorly and posteriorly (front to back).

^[6] Diseased tissue removed in the ethmoid and sphenoid sinuses.

^[7] Maxillary antrostomy.

^[8] Diseased tissue removed in the maxillary sinus.

^[9] Indication this is a bilateral procedure.

What are the CPT® and ICD-10-CM codes to report?

CPT® codes: 31259-50, 31267-50-51

ICD-10-CM codes: J33.0, J33.8, J32.9

Rationale:

CPT® codes: For this case, the patient is having removal of diseased tissue (including polyps) from three different sinus cavities through an endoscope. There will be two procedure codes reported for this case. The first code to report is the ethmoidectomy. In the CPT® Index, look for Endoscopy/Nose/Surgical 31237-31241, 31253-31257, 31259, 31267, 31276, 31287, 31288, 31290-31298. Code 31259 is the correct code to report since the operative note documents anterior and posterior, and tissue was removed from the sphenoid sinus.

In the CPT® Index, look for Sinus/Maxillary/Antrostomy, which guides you to codes 31256–31267. Antrostomy is the making of a surgical opening into the nasal cavity. Code 31267 is the correct code to report because tissue and debris were removed.

Modifier 50 is appended to both codes because bilateral procedures were performed. Append modifier 51 to code 31267 to indicate an additional procedure was performed at the same surgical session by the same physician.

ICD-10-CM codes: Documentation in the operative notes states polyps are in the nose and sinuses. In the ICD-10-CM Alphabetic Index, look for Polyp, polypus/nasal (mucous)/cavity which guides you to code J33.0. Next, look for Polyp, polypus/sinus, which guides you to code J33.8 for polyps in all the sinus cavities (ethmoid, sphenoid, maxillary and frontal). Hyperplastic rhinosinusitis is when a patient has chronic sinus inflammation, which may include polyp formation in the nose and sinuses. In the Alphabetic Index look for Sinusitis (accessory) (chronic) (hyperplastic) (nasal) (nonpurulent) (purulent) guides you to code J32.9. Verify code selection in the Tabular List.



Case 1

Preoperative Diagnosis: Sinus of Valsalva aneurysm on the left coronary sinus. ^[1]

Postoperative Diagnosis: Same.

Operation: Repair sinus of Valsalva aneurysm with pericardial patch. ^[2]

Procedure: The patient was taken to the operating room and placed supine on the table. After general endotracheal anesthesia was induced, rectal temperature probe, a Foley catheter and TEE probe were placed. The extremities were padded in the appropriate fashion. Her neck, chest, abdomen, and legs were prepared and draped in standard surgical fashion.

The chest was opened through a standard median sternotomy. ^[3] The patient was fully heparinized and placed on cardiopulmonary bypass. ^[4] At this point, we started to open the pericardium. We were met with a large amount of dense adhesions and some fluid that was blood-tinged, salmon colored, and it was cultured. Tonsil clamps were placed on the inferior portion of the pericardial sac and we used Bovie cautery and Metzenbaum scissors to take down all the adhesions laterally, exposing the right atrium first and then the aorta. There were some lighter adhesions over the left ventricle, which were broken with finger dissection. There was a moderate amount of fluid in different pockets that were suctioned free. There was no evidence of frank blood. ^[5]

After dissecting out the right atrium, we dissected out the aorta circumferentially using Bovie cautery and Metzenbaum scissors. We then freed up the entire LV and the apex, as well as the inferior and lateral borders of the heart. After this, we then checked the activated clotting time (ACT), which was greater than 550. The ascending aorta was cannulated without difficulty. A dual stage venous cannula was placed in the right atrium. Retrograde cardioplegia was placed in the right atrium through the coronary sinus, and antegrade cardioplegia was placed in the ascending aorta. ^[5]

After the patient was on bypass, we completed dissection. We looked through the superior pulmonary vein. It appeared to be densely adhered, so we opted to vent through the apex of the LV. We proceeded to flush our lines, cooled to 32 degrees. Once we had a nice arrest we opened the aorta. An aortotomy was created in standard fashion, the area was tacked back, and we were able to identify the aneurysm in question. ^[6] There was a large amount of thrombus and it was removed. There was also some mural thrombus which was laminar and stuck to the aneurysm, and I elected not to debride this area.

This defect apparently took up the entire left of the sinus of Valsalva. ^[7] The coronary was probed and there was approximately 2–3 mm rim of tissue beneath the coronary to sew to, and the valve was intact. The aortic valve was intact, and there was a rim of tissue just lateral to the annulus for us to sew to. After debriding and irrigating, we sized a bovine pericardial patch and sutured it in place with 4-0 Prolene suture. ^[8] This was done in a running fashion, working from the annulus up towards the coronary artery underneath the coronary, and then around laterally and superiorly, sewing through the aortic tissue.

We now successfully excluded the aneurysm and packed the entire sinus. ^[9] We gave cardioplegia in a retrograde fashion, with nice flow back from the left main. We inspected the repair and it was competent. We irrigated one more time and closed the aorta, de-aired the heart with standard maneuvers, and removed the cross-clamp. We then weaned the patient off of bypass and re-warmed the patient. There was no aortic insufficiency, good function of the aortic valve, and no flow into the aneurysm anymore, with a nice patch repair. We closed the chest with stainless steel wires, the fascia was closed with Vicryl sutures, and subcutaneous tissue and skin were closed in similar fashion. ^[10]

^[1] This is the working diagnosis unless the report gives a different diagnosis or more defining information.

^[2] This is the procedure performed, but coders must confirm the procedure was performed in the body of the notes.

^[3] This describes the approach.

^[4] The patient was placed on cardiopulmonary bypass.

- ⁵ This is part of the dissection and findings. This describes how the bypass was performed, it is not important to the procedure itself. It is very important from a legal perspective.
- ⁶ This is the documentation of the aneurysm.
- ⁷ This tells you exactly where the aneurysm is located.
- ⁸ This documentation describes the patch procedure.
- ⁹ This documents that the entire aneurysm was repaired.
- ¹⁰ The rest of the note explains that the patient was removed from the bypass machinery and closure. Note there is no indication of chest tube placement. Any time you open the chest the negative pressure required for respiration is lost and a chest tube is placed to re-establish this negative pressure. This is never a separately coded item because it is an integral part of the surgery.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® Code: 33720

ICD-10-CM Code: Q25.49

Rationale:

CPT® Code: Looking in the CPT® Index for Repair/Sinus of Valsalva directs you to 33702–33722. Code 33720 is the correct code to report for the repair with cardiopulmonary bypass.

ICD-10-CM Code: Look in the ICD-10-CM Alphabetic Index for Aneurysm/sinus of Valsalva, directs you to Q25.49. In the Tabular List, Aneurysm of sinus of Valsalva (ruptured) is listed under this code as an inclusion term. Note this can be a congenital problem or an acquired condition. The code is correct because the ICD-10-CM Alphabetic Index directs you to Q25.49. The documentation provided does not distinguish the etiology of the problem.

Case 2

Preoperative Diagnosis: Acute renal failure. ¹

Postoperative Diagnosis: Same.

Indication: Patient is a 23-year-old critically ill woman who went to the operating room for a lung transplant. A Vas-Cath ² was indicated to proceed with CVVHD upon arrival in the ICU.

Procedure: Left subclavian Vas-Cath placement (insertion). ³

The left chest was draped and prepped in the usual sterile fashion, and the patient was placed in the Trendelenburg position. The subclavian vein was readily located with a needle, ⁴ and the Seldinger technique was used to place a Vas-Cath for dialysis.

⁵ Excellent flow was returned through both lumens. The catheter was secured in place and a sterile dressing was applied. The patient is to be transported to the ICU where a post-procedural X-ray will be taken.

¹ This is the diagnosis.

² Catheter.

³ This is the working description of the procedure.

⁴ Entry directly into the subclavian vein indicates a non-tunneled catheter.

⁵ This is the description of the placement.

What are the CPT® and ICD-10-CM codes reported?**CPT® Code:** 36556**ICD-10-CM Code:** N17.9**Rationale:**

CPT® Code: Looking in the CPT® Index under Placement, there is not an entry for venous. Insertion is a term for placement, and under Insertion/Catheter/Venous we see a long list of ranges. The procedure described is a central line, because the catheter is placed in the subclavian vein. Check the notes under Central Venous Access Procedures and you see the subclavian vein is a central vein. Looking in the Index for Central Venous Catheter Placement/Insertion/Central/non-tunneled, you are directed to 36555, 36566. Upon reading through the selections given, code 36556 describes catheter placement in the subclavian vein for a 23-year-old patient.

ICD-10-CM Code: Look in the ICD-10-CM Alphabetic Index for Failure, failed/renal/acute, and you are directed to code N17.9. Verify your code selection in the Tabular List.

Case 3

Preoperative Diagnosis: 6.7 cm descending thoracic aortic aneurysm. Type B aortic dissection, chronic. ^[1]

Postoperative Diagnosis: Same.

Operation: Left thoracotomy. ^[2] Repair of a descending thoracic aortic aneurysm with a 34 mm Gelweave graft. ^[3]

Bypass Time: 1 hour, 15 minutes. ^[4]

Procedure: The patient was brought to the operating room, placed on the table in the supine position. A blocker was placed on the left main stem bronchus, and we isolated the left lung. We proceeded to place the patient in the right lateral decubitus position. He was padded and secured with all pressure points relieved, and at this point, we prepared and draped the patient in the usual sterile fashion.

We performed a left posterolateral thoracotomy; ^[5] dividing the muscles, the fourth intercostal space was entered. The lung was completely deflated. At the same time, we exposed the left common femoral vein as well as the left common femoral artery, and heparinized the patient. These vessels were isolated and prepared for cannulation.

A venous line was placed into the right atrium through the common femoral vein, and this was secured. The patient was placed on partial bypass maintaining a blood pressure in the lower extremities of around 50 mm Hg. We continued at this point with our dissection. The esophagus was plastered against the aorta. It was peeled off. Intercostals were controlled and divided. We placed an aortic cross-clamp proximally and distally, and we entered the aneurysm. ^[6] We identified two lumens and these were resected, and proximally we identified the true lumen and resected the false lumen after obtaining control of the subclavian artery. Distally we fenestrated the wall between the true and false lumen to prevent any malperfusion.

At this point, we sized the aorta to a 34 mm aortic graft; ^[7] and we fashioned the proximal anastomosis using 3-0 Prolene with a large needle in a running fashion. We nerve hooked this suture line and tied this down. The posterior suture line of the proximal anastomosis was reinforced with 4-0 Prolene pledged stitches. At this point, we removed the cross-clamp and pressurized the anastomoses. Areas of leak were controlled with 4-0 Prolene. The graft was cut to length and after examining our distal aorta and making sure an appropriate fenestration had been performed we fashioned an anastomosis again using 3-0 Prolene with a large needle. Before removing the proximal cross-clamp we de-aired the graft with a 25 gauge needle. We very slowly removed the proximal cross-clamp as well as the distal cross-clamp, and flow was reinstated down the aorta. We weaned the patient off bypass and examined our distal and proximal anastomoses. All incisions were closed and the patient tolerated the procedure well.

^[1] This is the working diagnosis, until report is reviewed.

^[2] This is the surgical approach.

^[3] This is the surgical procedure.

- ^[4] Our first indication that cardiopulmonary bypass was used.
- ^[5] This is our approach to this surgery.
- ^[6] Here, we note the aneurysm.
- ^[7] This is the description of the graft used for the repair.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® Code: 33875

ICD-10-CM Code: I71.2, I71.01

Rationale:

CPT® Code: Looking in the CPT® Index under Graft/Aorta, you are directed to ranges 33840–33851, and 33860–33877. Reading through the codes, 33875 describes the descending thoracic aortic graft, with or without bypass. Partial bypass was used in this procedure; however, it's included in 33875.

ICD-10-CM Code: Look in the ICD-10-CM Alphabetic Index for Aneurysm/aorta, aortic/descending/thoracic codes to I71.2. Look in the Alphabetic Index for Dissection/aorta/thoracic, and you are directed to I71.01. It will be very important to verify your code selection in the Tabular List and make certain you choose the correct code based on whether the aneurysm is ruptured or not.

Case 4

Preoperative Diagnosis: Cardiac tamponade secondary to malignant effusion due to the pericardial metastasis from the lung. ^[1]

Postoperative Diagnosis: Same.

Procedure: Pericardial window via subxiphoid approach. ^[2]

Details: The patient was positioned supine on the table and prepped and draped. A low midline incision approximately 5 cm in length was made over the sternum and xiphoid. ^[3] This was carried down to the linea alba, which was opened. The xiphoid was divided. We then found the pericardium and opened the pericardium again with electrocautery. We enlarged the site so it was easily 1 cm across. ^[4] At this time, there was a gush of fluid under pressure. It was serosanguinous fluid. It was not turbid, nor was there any odor. We suctioned this fluid for approximately 500 ml in the suction container. There was probably an additional 100 ml of spill on the drapes. Approximately 100 ml was also sent for cytology and culture. ^[5]

After we felt we had fully drained the pericardium and had a significant hemodynamic improvement, we then made a small transverse incision to the right of her lower sternal incision; and through this and across the fascia, we passed a #20-French Blake drain. ^[6] This was placed on the diaphragmatic surface of the heart and was tied in place using 2-0 Ethibond sutures. We then closed the fascia with 0 Vicryl and the subcutaneous tissue with 0 Vicryl. These were all interrupted, and the skin was stapled. At the end of the procedure the patient's condition remained stable.

- ^[1] This is the diagnosis as the pre and post-operative diagnoses are the same.
- ^[2] This is the working procedure description, but it must be verified in the report.
- ^[3] This is the approach used to gain access to the pericardium.
- ^[4] The pericardium is cut open for drainage.
- ^[5] A sample of body fluids retrieved during the procedure is sent to the lab for pathological workup.
- ^[6] A tube is placed and left in the chest to allow for continued drainage.
-

What are the CPT® and ICD-10-CM codes reported?**CPT® Code:** 33025**ICD-10-CM Codes:** C79.89, C34.90, I31.4**Rationale:**

CPT® Code: The removal of the fluid from the pericardium was performed by an open approach via a median sternotomy to create an opening (or window) to allow pericardial fluid to drain. A drainage tube is placed to allow continuous drainage. In the CPT® Index, look for Pericardial Window/Creation/for Drainage, which directs you to codes 32659, 33025. Code 33025 is reported for an open procedure. Code 33015 is not reported because it is not for an open procedure. CPT® code 33015 is used when the pericardial fluid is aspirated by a needle and an indwelling catheter is then placed for drainage, usually under fluoroscopic or ultrasound guidance.

ICD-10-CM Codes: Look in the ICD-10-CM Alphabetic Index for Tamponade, heart directing you to I31.4. Verification in the Tabular List for I31.4 instructs you to code first the underlying cause. You are given malignant effusion due to the pericardial metastasis from the lung in the diagnostic statement. Use ICD-10-CM guideline I.C.2.f, Admission/Encounter to determine the extent of malignancy: “When the reason for the admission/encounter is to determine the extent of the malignancy, or for a procedure such as paracentesis or thoracentesis, the primary malignancy or appropriate metastatic site is designated as the principal or first-listed diagnosis.”

Look in the Alphabetic Index for Metastasis, metastatic/cancer/from specified site referring you to — see Neoplasm, malignant, by site. Go to the Table of Neoplasms and look for Neoplasm/heart/Malignant Secondary column referring you to C79.89 and Neoplasm/lung/Malignant Primary column referring you to C34.9-. Verify the codes in the Tabular List. Add the 5th character 0 for unspecified lung C34.90. Report C79.89, C34.90 followed by I31.4. The effusion is a symptom of secondary metastasis of the pericardium; therefore, it is not reported.

Case 5**Preoperative Diagnosis:** Prosthetic valve endocarditis. ^[1]**Postoperative Diagnosis:** Same.**Operation:** Re-replacement of a 10-year-old tricuspid valve using a 31 mm Carpentier-Edwards pericardial bioprosthesis. ^[2]**Procedure:** The patient was brought to the operating room, and after having the appropriate monitoring devices placed, he was intubated and general endotracheal anesthesia was achieved. The patient was prepared and draped in the usual sterile fashion.

The chest was entered via a median sternotomy incision. ^[3] Simultaneous to this, the right common femoral vein was dissected. The pericardium was opened, the patient was given systemic heparin, and the ascending aorta and superior vena cava were cannulated. Similarly, the right common femoral vein was cannulated. The patient was started on bypass. ^[4]

Caval snares were placed, and the right atrium was opened. An intra-atrial thrombus excised and cultured. The prosthetic valve was excised, the annulus was debrided and irrigated. The valve was sized and a 31 mm valve was selected. ^[5]

Pledged 2-0 Ethibond sutures were passed circumferentially around the annulus in a ventriculoatrial fashion. These sutures were tied and the valve was inspected. The valve was found to be well-seated, ^[6] and the atrium was closed with running 4-0 Prolene sutures.

The patient was rewarmed, de-aired, and then weaned from bypass with low-dose inotropic support. Temporary drains were placed and the mediastinum was policed for hemostasis and the sternum re-approximated with stainless steel wire. The femoral vein and groin wounds were closed with layered Vicryl sutures. The patient was taken back to the Cardiac Surgical Unit in stable condition after tolerating the procedure well.

^[1] This is the working diagnosis, coming into the surgery.

^[2] This is the planned procedure statement, replacement of the tricuspid valve.

- ^[3] This is the approach used.
- ^[4] This documents the use of cardiopulmonary bypass.
- ^[5] This was the removal of the old valve and the placement of the new one. Note just the leaflets were removed and the annulus stayed.
- ^[6] This documents that the valve is in the correct place and fits well.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® Codes: 33465, 33530

ICD-10-CM Code: T82.6XXA, I07.9

Rationale:

CPT® Codes: Looking in the CPT® Index under Replacement/Tricuspid valve, we are lead to 33465. This is our code. The documentation states this is a re-replacement indicating a re-operation. CPT® 33530 is an add-on code found in the CPT® Index under Reoperation/Coronary Artery Bypass/Valve Procedure.

ICD-10-CM Codes: Look in the ICD-10-CM Alphabetic Index for Endocarditis/due to prosthetic cardiac valve T82.6. Verification in the Tabular List indicates this code requires a 7th character. The X placeholder is needed for the 5th and 6th characters. The 7th character A is reported for the initial encounter. The complete code is T82.6XXA. The notes in the Tabular List indicate to use an additional code to identify the infection. The infection is not listed. We also have the disease of the valve to code (that is the complication) as the secondary code. In the Alphabetic Index, look for Endocarditis/tricuspid, directs you to I07.9. Verify code selection in the Tabular List. Under category code I07 there is an Includes note that indicates the codes are reported for rheumatic tricuspid valve diseases as rheumatic or unspecified. Documentation needs to specify non-rheumatic to report a code from category code I36.

Case 6

Preoperative Diagnosis: Multiple varicose veins with severe leg pain. ^[1]

Postoperative Diagnosis: Same.

Procedure: Removal of multiple varicose veins, right lower leg, involving both the greater and lesser saphenous systems. ^[2]

Anesthesia: General.

Procedure: With the patient prepped and draped in the usual sterile manner, multiple small incisions were made over the patient's varicose veins in the right leg. Through these incisions, multiple clusters and branches from the greater saphenous vein and lesser saphenous veins were removed. ^[3] Starting at the saphenofemoral junction, dilated tortuous segments of the greater saphenous vein and lesser saphenous vein were also removed. Most of the greater saphenous vein was removed to well below the knee. Meticulous hemostasis was achieved. All perforators associated with these clusters were ligated with 3-0 Vicryl suture. The patient's leg was wrapped in sterile Webril and Ace wrap. There were no complications.

^[1] This is the diagnosis as the pre-operative and postoperative diagnoses are the same.

^[2] This is the planned procedure.

^[3] This is the documentation for the removal of varicose vein clusters and branches from the lesser and greater saphenous veins.

What are the CPT® and ICD-10-CM codes reported?

CPT® Codes: 37722-RT, 37718-51-RT

ICD-10-CM Code: I83.811

Rationale:

CPT® Codes: Looking in the CPT® Index under Removal/Vein/Saphenous, you are directed to a range, 37718–37735, and 37780. There is also an entry for Varicose, 37765–37766. Looking at the Varicose vein entries, you see these are stab phlebectomies of the extremities. When you read the entries for the saphenous veins, you see that 37718 is the short saphenous vein, and 37722 is the long (greater) saphenous vein. There is a parenthetical note under 37122 (*For ligation and stripping of the short saphenous vein, use 37718*). Codes 37722 and 37718 are appended with modifier RT to designate the right side. Modifier 51 denotes multiple procedures during the same operative session.

ICD-10-CM Code: Look in the ICD-10-CM Alphabetic Index for Varicose/Vein — see Varix. Look in the Alphabetic Index for Varix/leg (asymptomatic)/right/with/pain, and you are directed to I83.811. The procedure report indicates that the right leg was worked on. Verify your code selection in the Tabular List.

Case 7

Preoperative Diagnosis: Coronary artery disease. ^[1] Hypercholesterolemia. ^[2]

Postoperative Diagnosis: Same.

Operation: Coronary artery bypass graft x 4. ^[3] Left internal mammary artery to obtuse marginal artery, ^[4] right internal mammary artery to the left anterior descending artery, ^[5] reverse saphenous vein to the first diagonal artery ^[6] and reverse saphenous vein graft to the right posterior descending artery. ^[7]

Indications: The patient is a 39-year-old gentleman with a history of hypercholesterolemia and hypertension, who presents with a positive stress test. Catheterization revealed left main, circumflex disease, as well as total right coronary artery disease. ^[8]

Procedure: The patient was brought to the operating room and placed supine on the operating table. After the induction of general endotracheal anesthesia, the patient was prepared and draped in the usual sterile fashion. We proceeded to harvest a saphenous vein endoscopically from the left lower extremity. ^[9] At the same time, the LIMA and then RIMA ^[10] were harvested by open technique.

The pericardium was opened and tacked up to form a cradle. The patient was heparinized. The conduits were prepared for bypass. We opened the cardiac cradle, cannulated the ascending aorta and right atrium. Antegrade and retrograde cardioplegia catheters were placed. At this time, we placed the patient on cardiopulmonary bypass. ^[11] The targets were examined, and they seemed to be graftable. At this point, we placed a cross-clamp on the ascending aorta and arrested the heart with antegrade and retrograde cardioplegia, topical ice, and the patient was cooled down to 32 °C.

At this point, we exposed the territory of the RPDA. It was found to be a modest target. A reverse saphenous vein ^[12] graft to right posterior descending artery was fashioned using 7-0 Prolene. ^[13] Flow was measured at 50 ml/min. Next, we directed our attention to the first diagonal artery. It was also a modest target. It was opened. The anastomosis was fashioned using the reverse saphenous vein graft with 7-0 Prolene. ^[14] Flow was measured at 60 ml/min. At this point, we exposed the territory of the obtuse marginal. The left internal mammary was prepared. The LIMA to obtuse marginal graft was performed ^[15] with 7-0 Prolene. There was excellent hemostasis. We tacked down the wings of the mammary. The bull-dog was placed on the mammary.

At this point, we performed two proximal aortotomies with the 4.0 mm aortic punch. Two proximal anastomoses were fashioned after the veins were cut to length with 6-0 Prolene. Bull-dogs were placed on each of these veins.

We rewarmed the patient. The territory of the left anterior descending artery was exposed. The RIMA was prepared. The RIMA to left anterior descending coronary artery (LAD) anastomoses was fashioned using ^[16] the 7-0 Prolene. Once this was completed, the wings of the mammary were tacked.

At this point, warm cardioplegia was given in retrograde fashion. The bull-dogs were removed from both the LIMA and the RIMA. We resumed perfusion of the heart. We de-aired the root of the aorta and removed the cross-clamp. The patient resumed a normal sinus rhythm. The sites were oversewn; the vein grafts were de-aired in the usual fashion.

We examined the proximal and distal anastomoses, and there was excellent hemostasis. Three Blake drains were placed, two into the mediastinum and one into the right pleura, as we did not enter the left pleural space. The patient was weaned off cardiopulmonary

bypass without any difficulty. The sternum was reapproximated with heavy stainless steel wire in a mattress fashion. The pectoralis fascia and subcutaneous tissue were approximated with 1-Vicryl skin with 4-0 Vicryl, as well as Dermabond. The lower extremities were closed in similar fashion. The instrument counts were correct. The patient was transferred to the SICU in stable condition.

-
- ^[1] Primary diagnosis code.
 - ^[2] Secondary diagnosis code.
 - ^[3] CABG performed; four vessels.
 - ^[4] Bypass first arterial graft.
 - ^[5] Bypass second arterial graft.
 - ^[6] Bypass first vein.
 - ^[7] Bypass second vein.
 - ^[8] Primary diagnosis: why the bypass is necessary.
 - ^[9] Endoscopic harvest of the lower extremity vein.
 - ^[10] Harvest Left Internal Mammary Artery (LIMA) and Right Internal Mammary Artery (RIMA).
 - ^[11] The procedure was done with cardiopulmonary bypass and cardioplegia.
 - ^[12] Reverse saphenous vein grafts are a method of seating the vein in the reverse direction of how it is normally found in the body. There are valves in the veins to help push blood from the lower extremities up to the heart. These would hinder blood flow in the graft if the graft is seated in the same orientation as it is encountered in the leg. The reverse saphenous vein graft is done to facilitate good blood flow without clearing all the valves from the vein before it's used.
 - ^[13] This describes the first venous graft.
 - ^[14] This describes the second venous graft.
 - ^[15] This is the first arterial graft (LIMA).
 - ^[16] This was the second arterial graft (RIMA).
-

What are the CPT® and ICD-10-CM codes reported?

CPT® Codes: 33534, 33518, 33508

ICD-10-CM Codes: I25.10, E78.00

Rationale:

CPT® Codes: Look in the CPT® Index for CABG because this was the main procedure. CPT® directs you to *see* Coronary Artery Bypass Graft (CABG). Coronary Artery Bypass Graft (CABG)/Arterial Bypass directs you 33533-33536. Reading through the range, 33534 is listed as an arterial graft, two coronary grafts. The right and left internal mammary arteries are the arterial grafts.

Look in the Index for Coronary Artery Bypass (CABG)/Arterial-Venous Bypass, which directs you to Arterial-Venous codes, 33517–33519, 33521-33523. When the descriptors are read, 33518 is the add-on code for two venous grafts noted above and listed separately in addition to the arterial grafts. Modifier 51 is not reported with add-on codes.

The procedure being performed requires three codes. Harvesting of the saphenous vein also must be coded. This is performed in a different area of the body and the notes describe an endoscopic approach. Look in the CPT® Index for Bypass Graft/Harvest/Endoscopic, code 33508. Procedures in which arteries and veins are used for the grafts require a code for each of the veins and each of the arteries.

ICD-10-CM Codes: The postoperative diagnosis indicates CAD and hypocholesteremia, which are the main reasons and are pertinent to the surgery performed.

For the primary diagnosis, look in the ICD-10-CM Alphabetic Index for Disease, diseased/coronary (artery). You are directed to *see* Disease, heart, ischemic, atherosclerotic. This refers you to I25.10. For the secondary diagnosis, look in the Alphabetic Index for Hypercholesterolemia, which directs you to E78.00. Verify your code selection in the Tabular List.

Case 8

Preoperative Diagnosis: Ischemic cardiomyopathy. Intraventricular block delay. Congestive heart failure. ^[1] The patient has a dual-system pacemaker in place.

Postoperative Diagnosis: Same.

Operation: Insertion of left ventricular epicardial pacemaker lead with generator change. ^[2]

Indications: Ischemic cardiomyopathy with intraventricular conduction delay in a patient experiencing congestive heart failure; status post failed attempt at placement of transvenous coronary sinus lead. ^[3]

Procedure: The patient was brought to the operating room and, after having the appropriate monitoring devices placed, was intubated and general endotracheal anesthesia was achieved. The patient was prepared and draped in the usual sterile fashion.

The chest was entered via a small left posterior thoracotomy. ^[4] The left anterior chest generator pocket was opened, and the generator explanted. ^[5] The left lung was collapsed. The pericardium was opened, and two unipolar epicardial leads were placed in the posterolateral left ventricle. ^[6] Thresholds were checked and found to be adequate. The leads were tunneled subcutaneously to the generator pocket.

A new St. Jude biventricular pacemaker generator was then reconnected to the transvenous atrial and ventricular leads as well as to the epicardial lead. ^[7] The generator was again interrogated, and the thresholds and impedances of all leads were found to be adequate. The generator was replaced in the pocket. ^[8] The pocket was irrigated with antibiotic saline and closed in layers with Vicryl suture.

A single left pleural drain was placed, and a single pericostal suture was utilized to re-approximate the ribs. The fascia and subcutaneous tissue were closed with layered Vicryl suture, and the skin was closed with a subcuticular stitch.

The patient was transferred to the coronary care unit in stable condition, having tolerated the procedure well.

^[1] This is the working diagnoses. Unless the report lists these as anything else, or more information, these will be the diagnoses to establish medical necessity.

^[2] This is the completed procedure. This is a short description, but NEVER code from this: Read the entire report and note, and highlight as needed.

^[3] More documentation of the diagnoses.

^[4] This is the approach used to access the heart.

^[5] This is the generator portion of the procedure.

^[6] This describes open placement of leads for the pacemaker and where they were implanted.

^[7] This describes the new generator and placement.

^[8] This describes the generator being replaced in the original pocket; no new pocket had to be created.

What are the CPT® and ICD-10-CM codes reported?

CPT® Codes: 33202, 33224-51

ICD-10-CM Codes: I25.5, I45.4, I50.9

Rationale:

CPT® Codes: For this case, the provider opened the chest (thoracotomy), placed two epicardial leads on surface of the ventricle. The *Indications for Surgery* cite a failed transvenous approach to placing the third lead in the left ventricle. Look in the CPT® Index for Insertion/Electrode/Heart, and you are directed to a list of codes. Code 33202 represents insertion of epicardial electrode(s) by thoracotomy. See the subsection guidelines in CPT® for the subheading *Pacemaker or Implantable Defibrillator*, look in second paragraph and jump to the last sentence. The last sentence directs the coder to use CPT® codes 33202 and 33203 for epicardial placement of a left ventricular lead.

The second procedure performed is replacement of the pacemaker pulse generator. You must also code for the insertion of the pacing electrode for the left ventricular pacing at the time of the upgrade of the dual pacemaker to a multi-system pacemaker. See notes in second paragraph of CPT® for Pacemaker or Implantable Defibrillator. Look in the CPT® Index for Insertion/Electrode/Heart directs you to a long list of codes. Report 33224, which includes insertion of the pacing electrode for left ventricular pacing, with attachment to a previously placed pacemaker or implantable defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator). Check the notes under 33224 and you will see it is reported in conjunction with 33202. 33224 includes the replacement of the pulse generator, so it is not reported separately. The correct order of the codes is 33202, 33224-51. Modifier 51 is needed to show an additional procedure performed during the same session.

ICD-10-CM Codes: Look in the ICD-10-CM Alphabetic Index for Cardiomyopathy/ischemic, and you are directed to I25.5. For the conduction diagnosis, look in the Alphabetic Index for Block/intraventricular (nonspecific), and you are referred to I45.4. For the last diagnosis, look in the Alphabetic Index for Failure, failed/heart/congestive, which directs you to I50.9. Verify your code selection in the Tabular List.

Case 9

Preoperative Diagnoses: Critical aortic valve stenosis, coronary artery disease, hypertension, diabetes mellitus. ^[1]

Postoperative Diagnoses: Same.

Operation: Aortic valve replacement with a 19 mm St. Jude bioprosthesis. ^[2] Coronary artery bypass graft x 2 ^[3] — reverse saphenous vein graft to left anterior descending artery and reverse saphenous vein graft to obtuse marginal artery. ^[4]

Anesthesia: General.

Indications: This is an 80-year-old female with a history of hypertension, diabetes mellitus, and coronary artery disease. ^[5] who presented to the emergency department with a syncopal episode. ^[6] An echo revealed severe to critical aortic valve stenosis. ^[7] Cath confirmed this diagnosis as well as two-vessel coronary artery disease ^[8] with a tight proximal left anterior descending artery lesion, a tight circumflex lesion, and a 40% right coronary artery lesion.

Procedure: The patient was brought to the operating room and placed supine on the table. After induction of general anesthesia, the patient was prepped and draped in the usual sterile fashion.

We harvested the saphenous vein endoscopically ^[9] from the left lower extremity. Once we were ready to divide the conduit, the patient was heparinized. The conduit was divided and prepared for bypass. A median sternotomy was performed; there was a pericardial cradle.

We cannulated the ascending aorta. Antegrade and retrograde cardioplegia catheters were placed. The patient was placed on cardiopulmonary bypass ^[10] with an ACT greater than 400. We examined the targets, and they were deemed to be graftable.

At this point, the pulmonary artery was dissected off the aorta. We placed a vent through the right superior pulmonary vein, and then we cross-clamped the ascending aorta and gave cardioplegia in antegrade and retrograde fashion, as well as topical ice. We cooled the patient to 32 °C.

With an excellent arrest, we exposed the territory of the obtuse marginal. It was opened, found to be a graftable vessel. A reverse saphenous vein graft ^[11] to the obtuse marginal was fashioned using 7-0 Prolene. ^[12] The flow was measured at 90 ml/min.

At this point, the territory of the LAD was exposed. It was opened, and a reverse saphenous vein graft to left anterior descending artery anastomosis was fashioned using 7-0 Prolene.^[13] Flow was measured at 110 ml/min. Cardioplegia was given down these grafts as well as in a retrograde fashion throughout the case, every 20 minutes.

We performed a hockey-stick incision of the aorta approximately 1.5 cm above the right coronary artery. We used silk sutures to expose the aortic valve. It was a severely calcified, trileaflet aortic valve. The leaflets were cut out.^[14] The annulus was debrided. We irrigated the ventricle, then we proceeded to size the valve to a 19 mm valve. Sutures of 2-0 Ethibond were placed in ventriculo-aortic fashion circumferentially. They were then passed through the valve. The valve was seated and tied down^[15] without difficulty. The right and left coronary ostia appeared to be intact and free of obstruction. There appeared to be no evidence of weakness around the annulus.

We rewarmed the patient. The aorta was closed using two layers of 4-0 Prolene with two felt strips. We proceeded to perform two proximal aortotomies once the veins were cut to length. The veins had bull-dogs on them. At this point, we removed the cross-clamp, and normal sinus rhythm was reinstated.

Ventricular pacing wires were placed, and after de-airing maneuvers, the vent was removed. We placed Blake drains into the mediastinum x 2.

^[1] These are tertiary diagnoses that will affect her post-operative treatment.

^[2] Aortic valve replacement.

^[3] Two coronary arteries bypassed with two arterial grafts.

^[4] Both grafts accomplished with saphenous vein grafts.

^[5] Here are three diagnoses.

^[6] This is not considered a diagnosis because it's considered a symptom. There are several definitive diagnoses to support the need for surgery and the syncope could be related to any of them. It is not coded.

^[7] This is the fourth diagnosis.

^[8] This is further documentation of the coronary artery disease.

^[9] Endoscopic vein harvest.

^[10] Here we know cardiopulmonary bypass was used.

^[11] Reverse saphenous vein grafting is a method of putting the vein in reverse of the arterial blood flow to maintain good blood flow without clearing all the valves from the vein before it's used.

^[12] This is the first vein graft.

^[13] This is the second vein graft.

^[14] This is the reason for the aortic valve replacement.

^[15] This is the replacement of the aortic valve.

What are the CPT® and ICD-10-CM codes reported?

CPT® Codes: 33405, 33511-51, 33508

ICD-10-CM Codes: I35.0, I25.10, I10, E11.9

Rationale:

CPT® Codes: Modifier 51 is used because multiple procedures are performed in two distinct areas of the heart in the same operative session. Neither procedure is related to the other.

The aortic valve replacement can be located in the CPT® Index under Replacement/Aortic Valve, which directs you to 33361-33365, 33367-33369, 33405, 33406, 33410-33413. Code 33405 describes a prosthetic aortic replacement with the use of cardiopulmonary bypass. This was not a homograft, and there was no stent.

The coronary artery bypass performed here involved two coronary arteries grafted with two veins. In the CPT® Index, Coronary Artery Bypass Graft (CABG)/Venous Bypass directs you to 33510–33516. Codes 33510–33516 are for venous grafting only. Code 33511 describes two venous grafts.

The harvesting of the saphenous vein also must be coded. This is performed in a different area of the body, and we have the notes to describe the endoscopic method used. Look in the CPT® Index, for Bypass Graft/Harvest/Endoscopic directs you to 33508.

ICD-10-CM Codes: Each of the ICD-10-CM codes allow for the procedure's medical necessity. The aortic valve is replaced because of the aortic valve stenosis due to calcification described in the notes. Look in the ICD-10-CM Alphabetic Index for Stenosis/stenotic/aortic (valve)/specified cause NEC, reporting I35.0. For the second diagnosis, look in the Alphabetic Index for Disease, diseased/coronary. You are directed to *see* Disease, heart, ischemic, atherosclerotic. This directs you to code I25.10. Next, look in the Alphabetic Index for Hypertension, hypertensive, and you are directed to I10. For the final diagnosis, look for Diabetes, diabetic and you are directed to E11.9. Verify your code selection in the Tabular List. Remember, when looking for a code in the ICD-10-CM Alphabetic Index, the code listed next to the main term is referred to as the default code. In this case, the type of Diabetes is not specified and as such the default code E11.9 is used.

Case 10

Preoperative Diagnosis: Severe two-vessel coronary artery disease and moderate valve aortic stenosis. ^[1]

Postoperative Diagnosis: Same.

Operation: Triple-vessel coronary artery bypass grafting: ^[2] Left internal mammary artery to the left anterior descending coronary artery, reverse saphenous vein to the first diagonal branch, and a ramus intermedius. Aortic valve replacement with a 23 mm bovine pericardial bioprosthesis.

Anesthesia: General.

Indications: This is a 66-year-old white male who presented with unstable angina pectoris. ^[3] He underwent coronary angiography. And had a 70 percent occlusion in the distal left main, an 80 percent occlusion in the proximal left anterior descending coronary artery (LAD), a 95 percent occlusion of the proximal ramus intermedius, and a 70 percent occlusion in the proximal diagonal branch. ^[4] The right coronary artery had no significant lesions. His aortic valve gradient was 40 mm Hg by catheter and echocardiogram. He presented with a new onset of angina pectoris and significant coronary artery disease. ^[5] surgery was warranted.

Procedure: While monitoring the intra-arterial blood pressure and EKG, the patient was anesthetized without incident. The entire chest, abdomen, and both legs were prepared and draped into the usual sterile field. A median sternotomy was performed. The left internal mammary artery was dissected off the chest wall. ^[6] Simultaneously, the greater saphenous vein was endoscopically harvested from the left leg and the layers were closed with Vicryl and Dermabond. ^[8] A sterile compressive dressing was applied.

The pericardium was opened and tacked up to form a cradle. After heparinization, the ascending aorta and the right atrial appendage were cannulated and connected to cardiopulmonary bypass ^[9] using a membrane oxygenator with an initial flow of 4.9 liters/min. Antegrade and retrograde cardioplegia catheters were inserted. On bypass, a left ventricular vent was placed through the right superior pulmonary vein. The coronaries were dissected out and found to be suitable for grafting, although the circumflex branches were less than 1 mm in diameter. The ramus intermedius was identified as well as the diagonal branch, which was small. ^[10] The heart was then arrested with cold enriched blood cardioplegia, given antegrade after cross-clamping the ascending aorta. Once diastolic arrest was obtained, the heart was cooled with cold blood cardioplegia, given initially antegrade and subsequently retrograde. Additional doses were given retrograde as well as down the vein graft. At the end, a hot shot was given. Systemic temperature was lowered to 32 degrees. Myocardial temperature was maintained around 20 degrees.

The ramus intermedius was opened first. This was found to be a 1.5-2.0 mm vessel. An **end-to-end anastomosis using a segment of reverse saphenous vein was then performed with** ^[11] running 7-0 Prolene suture technique. This was felt to be a good graft with flow of 90 ml/min.

Next, the first diagonal branch was grafted in a similar manner with a **second segment of reverse saphenous vein with a resultant** ^[12] flow of 50 ml/min.

The **left internal mammary artery was anastomosed to the left anterior descending coronary artery in an end-to-end fashion using the in situ left mammary** ^[13] with running 8-0 Prolene suture technique. The diagonal branch was a 1.5 mm vessel and the LAD was a 1.5–2.0 mm vessel.

Next, the aorta was opened in an oblique transverse fashion and a moderately **calcified trileaflet aortic valve** was examined ^[14]. The left ventricle was irrigated with saline. The **annulus sized to a 23 mm pericardial tissue valve (Model #3000, Serial # 5555555).** **The valve was sutured;** ^[15] in a supra-annular fashion with interrupted 2-0 Ethibond valve sutures placed in the pledgets on the left ventricular out-flow tract side. The valve was seated and tied down securely. The aortotomy was then closed in two layers with running 4-0 Prolene reinforced within the corners pledgets.

During the same cross-clamp time, the proximal vein grafts were then anastomosed to the ascending aorta to two separate circular openings using 6-0 Prolene suture technique. After filling the heart with blood and evacuating the air from the apex of the left ventricle with an 18-gauge needle, the cross-clamp was removed and the vein graft de-aired. Rewarming had begun while constructing the proximal anastomoses. While rewarming continued, two temporary atrial, temporary ventricular, and temporary ground pacing wires were placed, as well as two Blake drains for mediastinal drainage.

Once the patient reached a rectal temperature of 36 degrees, he was weaned off cardiopulmonary bypass without any inotropic support and without any difficulties. The venous cannula was removed, the heparin was reversed with protamine, and the aortic cannula was removed. The mediastinum was irrigated with copious amounts of saline and Bacitracin solution, using the pulse lavage irrigator.

The sternum was reapproximated with the surgical Pioneer Sternal Cable System using four figure-of-eight cables. After pulse irrigating and pulse lavaging the fascia and subcutaneous tissue, the incision was closed in layers with Vicryl and the skin reapproximated with a subcuticular closure and Telfa sterile dressing was applied. There were no difficulties and the patient was taken to the ICU in stable condition.

^[1] There are two separate diagnoses, the coronary atherosclerosis and aortic valve stenosis.

^[2] Three vessels were grafted: two veins and an artery. The note goes on to describe the performed procedures.

^[3] Additional information regarding the coronary atherosclerosis.

^[4] Occluded coronary arteries with a high degree or percent of blockage, can cause ischemia.

^[5] Refers back to the blockages.

^[6] This describes the harvesting of the mammary artery.

^[7] This mentions the endoscopic approach vs. an open approach.

^[8] This describes the harvesting of the saphenous vein.

^[9] This indicates that coronary bypass was used to complete this procedure.

^[10] This indicates the coronary vessels to be grafted and the number in question. The term native refers to the patient's own vessel versus a synthetic graft.

^[11] This describes the first vein graft.

^[12] This describes the second vein graft.

- 13] This is the third graft, which is the left internal mammary artery (LIMA) graft.
- 14] This describes that the aorta was opened, providing access to the aortic valve. Aortic stenosis, due calcification of the aortic valve.
- 15] This describes the type of valve replacement procedure and includes the serial number for the prosthesis in the event there is a problem postoperatively the surgeon will be able to identify the specific unit used. This also describes the method of attachment for the prosthetic valve.

What are the CPT® and ICD-10-CM codes reported?

CPT® Codes: 33405, 33533-51, 33518, 33508

ICD-10-CM Codes: I35.0, I25.110

Rationale:

CPT® Codes: The aortic valve replacement is the most work-intensive procedure, and it's located in the CPT® Index under Replacement/Aortic Valve, which directs you to a range of codes. Code 33405 describes a prosthetic aortic replacement with the use of cardiopulmonary bypass. This was not a homograft, and there was no stent.

Next, look for CABG in the CPT® Index and the code book instructs you to *see* Coronary Artery Bypass Graft (CABG). There is a long list of codes under coronary bypass graft (CABG). This surgery included both arterial and venous grafts. Look first for Arterial grafts 33533 -33536 and then for Arterial – Venous bypass grafts. Reading through the range, code 33533 is the best code to describe the LIMA. CPT® add-on code 33518, is the code for 2 saphenous vein grafts.

Coders should note the sub-section guidelines just above CPT® code 33517, under the subheading *Combined Arterial – Venous Grafting for Coronary Bypass*. Here you will find specific instructions for coding a surgery where both arterial and venous grafts are used to complete the CABG. The add-on codes 33517- 33523 are the only appropriate venous by-pass codes for CABG when venous and arterial grafts are performed together. CPT® codes 33510- 33516 should never be coded in the same surgery with 33533-33536. These codes are only reported when the sole source of the grafts for CABG are veins.

Harvesting the saphenous vein must also be coded. This is performed in a different area of the body and we have evidence in the notes describing an endoscopic method was used. Look in the CPT® Index, for Bypass Graft/Harvest/Endoscopic directs you to 33508. Procedures in which artery and veins are used for the grafts require a code for each of the veins and each of the arteries.

ICD-10-CM Codes: Each of the ICD-10-CM codes provides medical necessity for the procedures. The aortic valve is replaced because of aortic stenosis, due calcification of the aortic valve indicated within the operative note. In the ICD-10-CM Alphabetic Index, look for Stenosis, stenotic/aortic (valve)/specified cause NEC I35.0. If you look for Calcification/heart/valve, you are directed to *see* Endocarditis. Endocarditis/aortic (heart) (nonrheumatic) (valve) directs you to I35.8 which is not specific. The patient also has coronary atherosclerosis with unstable angina pectoris. Look in the Alphabetic Index for Atherosclerosis (see also Arteriosclerosis). Look for Arteriosclerosis, arteriosclerotic/coronary (artery)/native vessel/with/angina pectoris/unstable. This directs you to I25.110. Verify code in the Tabular List.



Case 1

Preoperative Diagnosis: Right-sided colonic polyps.

Postoperative Diagnosis: Right-sided colonic polyps.

Procedure: Laparoscopic right hemicolectomy with ileocolic anastomosis.

Description of Procedure: After induction of adequate general endotracheal anesthesia,^[1] the patient was carefully positioned in the supine, modified-lithotomy position and Allen stirrups. Great care was taken to carefully pad and protect all areas of potential bodily injury. The abdomen was prepped and draped in the usual sterile manner.^[2]

Using a supra-umbilical vertical incision, a Hasson technique^[3] was employed to carefully place a 10 mm cannula. Carbon dioxide pneumoperitoneum of 15 mm Hg was achieved, after which a 30-degree telescope was carefully introduced. Under direct vision, two left-sided ports were placed: one in the left lower quadrant, one in the left upper quadrant, each lateral to the epigastric vessels through horizontal stab wounds.^[4] With a combination of head up, head down, and right side up, the entire right colon was mobilized from the duodenum, pancreas, and right ureter, using 10 mm diameter Babcock grasping forceps and 5 mm diameter harmonic scalpel.^[5]

After complete mobilization and copious irrigation and verification of meticulous hemostasis, the supraumbilical port was lengthened to 4 cm, through which an Alexis wound protector was placed. The entire right colon was withdrawn.^[6] High ligation of the ileocolic arcade and the right branch of the middle colic^[7] were undertaken using 10 mm diameter LigaSure Atlas.^[8] The Atlas was used for the remaining mesentery. The bowel was circumferentially cleared of fat proximally and distally, and each end was divided with a GIA 100 mm stapler with a blue cartridge. The field was draped with blue towels, and the antimesenteric border of each staple line was excised along with the terminal ileum. A side-to-side, functional end-to-end anastomosis was fashioned between the remaining ileum and colon with a GIA 100 mm stapling device with a blue cartridge.^[9] The staple line was verified for hemostasis, after which the afferent limb was secured to the efferent limb with 3-0 PDS II seromuscular Lembert-type sutures. After verification of anastomotic hemostasis, the apical enterotomy was also secured with a GIA 100 mm stapling device with a blue cartridge. The anastomosis was healthy, pink, widely patent, circumferentially intact, and easily returned into the peritoneal cavity.^[10]

After copious irrigation and verification of meticulous hemostasis, the fascia was closed with interrupted No. 1 Vicryl plus figure-of-eight sutures. The subcutaneous layers were irrigated and meticulous hemostasis was verified. Port sites were closed in a similar manner. The skin was closed and covered by dry dressings,^[11] and the patient was discharged to the recovery room in stable condition, without having suffered any apparent operative complications.

^[1] General anesthesia.

^[2] Positioning and draping the patient is standard of care — not billable.

^[3] Type of laparoscopic approach. The Hasson technique employs an open type of port insertion site for laparoscopic procedures.

^[4] Placement of the trocars for visualization into the abdominal cavity.

^[5] The colon is freed away from its attachments to other structures. The Babcock grasper holds the colon in place while the harmonic scalpel cuts away the connections.

^[6] Pulled to outside the cavity through the extended incision.

^[7] The division of the colon.

^[8] Device used to seal or divide the circulation to that portion of the bowel slated for removal.

- ^{9]} Reattachment of the two ends of the colon: ileocolostomy.
- ^{10]} The externalized colon is reinserted into the abdominal cavity after it is checked for hemostasis and perfusion.
- ^{11]} After the trocars are removed, the stab sites are sutured closed.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 44205

ICD-10-CM code: K63.5

Rationale:

CPT® code: The surgeon removes a portion of the colon laparoscopically and performs ileocolostomy (surgical anastomosis that brings the end of the ileum to the colon). In the CPT® Index, look for Colectomy/Partial/with Ileocolostomy Laparoscopic 44205.

ICD-10-CM code: Indication for the surgery is colonic polyps. In the ICD-10-CM Alphabetic Index, look for Polyp, polypus/colon K63.5. Verify code selection in the Tabular List.

Case 2

Procedure: Uvulopalatopharyngoplasty.^[1]

Indication: A 63-year-old with obstructive sleep apnea. He is intolerant of CPAP.

Description of Procedure: I identified the patient and he was brought to the operating room. General endotracheal anesthesia was induced without complication. Tonsillar pillars and palate were injected with 0.25% Marcaine. The right tonsil was grasped with an Allis forceps and dissected from the tonsillar fossa ^[2] with a combination of blunt and cautery dissection. The posterior pillar remained intact as I proceeded to do similar mobilization of the left tonsil. ^[3] I then made a mucosa incision across the base of the palate approximately 0.5 cm from the base of the uvula, connecting the anterior tonsillar incisions. The muscular portion of the uvula and edge of the soft palate was then opened. Posterior pillar was opened inferiorly on the right tonsil fossa, and extended through the palate to include the uvula, and then extended inferiorly on the left side. The uvula, edge of the soft palate, and both tonsils were removed in total. Hemostasis was achieved with electrocautery. The mucosal incision was then closed with interrupted Vicryl sutures. The oral cavity was irrigated with clindamycin solution.

The patient was awakened, extubated, and brought safely to the recovery room.

^[1] The procedure is to repair the uvula and tonsils.

^[2] Right tonsillectomy. It's not billable because it's included in the primary procedure.

^[3] Left tonsillectomy. It's not billable because it's included in the primary procedure — cannot be unbundled.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 42145

ICD-10-CM code: G47.33

Rationale:

CPT® code: This is a surgical procedure in which the airway at the back of the throat is widened by the removal of excess soft tissue (including the uvula, tonsils, and part of the soft palate), for treatment of obstructive sleep apnea. In the CPT®

Index, look for Uvula/Excision, which guides you to 42140–42145. The operative note heading indicates a uvulopalatopharyngoplasty was performed and the narrative portion of the note confirms this. The operative note documents that the uvula, edge of the soft palate, and both tonsils were removed, which are all included in CPT® code 42145.

ICD-10-CM code: Indication for the surgery was for obstructive sleep apnea. In the ICD-10-CM Alphabetic Index, look for Apnea, apneic/sleep/obstructive (adult) (pediatric) G47.33. Verify code selection in the Tabular List.

Case 3

Extent of Examination: Upper gastrointestinal endoscopy.

Reason(s) for Examination: Gastroesophageal Reflux Disease (GERD). ^[1]

Description of Procedure: Informed consent was obtained with the benefits, risks, including the risk of perforation and alternatives to upper GI endoscopy were explained. The patient agreed to proceed. No contraindications were noted on physical exam. Anesthesia was administered by the ICU staff. (See anesthesiologist report) Monitored anesthesia care (MAC) was administered by the anesthesia team. The procedure was performed with the patient in the left lateral decubitus position. The instrument was inserted through the mouth to the second part of the duodenum. The patient tolerated the procedure well. There were no complications. The heart rate was normal. The oxygen saturation and skin color were normal. Upon discharge from the endoscopy area, the patient will be recovered per established procedures and protocols.

Findings: The esophagus was examined and no abnormalities were seen. The gastroesophageal junction (upper level of gastric folds) was located 40 cm from the incisors. The stomach was examined and no abnormalities were seen. The small bowel was examined and no abnormalities were seen. ^[2]

^[1] This shows medical necessity for the procedure.

^[2] An upper gastrointestinal endoscopy to the duodenum was performed.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 43235

ICD-10-CM code: K21.9

Rationale:

CPT® code: An endoscope enters through the patient’s mouth into the esophagus. The esophagus, stomach, duodenum, and sometimes the jejunum are viewed to determine if bleeding, ulcers, tumors, or other abnormalities are present (diagnostic endoscopy). This is indexed under Endoscopy/Gastrointestinal/Upper/Exploration 43235, 43252. Code 43235 is the correct code for this case because optical endomicroscopy was not employed.

ICD-10-CM code: The indication for this procedure is gastroesophageal reflux disease (GERD). In the ICD-10-CM Alphabetic Index, look for GERD K21.9. Verify code selection in the Tabular List.

Case 4

Extent of Examination: Proximal sigmoid colon.

Reason(s) for Examination: Proctitis.

Postoperative Assessment: Proctitis.

Description of Procedure: Informed consent was obtained with the benefits, risks, including the risk of perforation and alternatives to sigmoidoscopy explained. The patient agreed to proceed. No contraindications were noted on physical exam. Patient was re-examined and no interval changes were noted from the preoperative history and physical. After being placed on the table, patient identification was verified prior to the procedure. Immediately prior to sedation for endoscopy the patient’s ASA

classification was Class 2: **Mild systemic disease. Monitored anesthesia care (MAC) was administered by the anesthesia team.**^[1] The quality of the prep was adequate. Prior to the exam, a digital exam was performed and it was unremarkable.

The procedure was performed with the patient in the left lateral decubitus position. The sigmoidoscope **was inserted to the proximal sigmoid colon.**^[2] In the rectum, a retroflex was performed. The withdrawal time from the proximal sigmoid colon was 8 minutes. The patient tolerated the procedure well.

There were no complications. The heart rate was normal. The oxygen saturation and skin color were normal. IV moderate sedation was administered under direct supervision of the physician. Upon discharge from the endoscopy area, the patient will be recovered per established procedures and protocols.

Findings: In the rectum, **mild segmental inflammation with erythema**^[3] was seen. There was no mucosal bleeding.

^[1] This is important for the anesthesiologist.

^[2] This is pertinent as the correct code is selected by the level of exam in the colon.

^[3] These are the symptoms of proctitis — only use symptoms in the absence of a definitive diagnosis.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 45330

ICD-10-CM code: K62.89

Rationale:

CPT® code: A sigmoidoscope is inserted into the anus and advanced into the sigmoid colon. The sigmoid colon and rectum are visualized. In the CPT® Index, look for Sigmoidoscopy/Exploration 45330, 45335. Code 45330 is correct for this case.

ICD-10-CM code: The indication for the procedure is proctitis. Look in the ICD-10-CM Alphabetic Index for Proctitis K62.89.

Case 5

Preoperative Diagnosis: History of rectal carcinoma.

Postoperative Diagnosis: History of rectal carcinoma.

Procedure Performed: Closure of loop ileostomy with small bowel resection and enteroenterostomy with intraoperative flexible sigmoidoscopy.

Description of Procedure: **After induction of adequate general endotracheal anesthesia,**^[1] the patient was carefully positioned in the **supine modified lithotomy position in Allen stirrups.**^[2] Great care was taken to pad and protect all areas of potential bodily injury. Digital rectal examination revealed a widely patent circumferentially intact pouch anal anastomosis within 1 cm of the dentate line. Flexible sigmoidoscopy was performed revealing healthy pink mucosa. The abdomen was prepped and draped in the usual sterile manner, and a **parastomal incision**^[3] was made and carried down sharply into the peritoneal cavity. Meticulous hemostasis was obtained with electrocautery. A 360 degree subfascial mobilization was undertaken until approximately 40 cm of each the afferent and efferent limb reached above the skin in a tension-free manner. **Betadine was insufflated down each limb to verify that no enterotomies or seromyotomies were made.**^[4] The mesentery was scored and vessels were divided with a 10 mm LigaSure Impact. The bowel was circumferentially cleared of fat proximally and distally, and each end was divided with a GIA 100 mm stapling device with blue cartridge. The field was protected with blue towels and the antimesenteric border of each staple line was excised. **A side-to-side functional end- to-end anastomosis was fashioned with a GIA 100 mm stapling device.**^[5] The staple line was reinforced for hemostasis with 3-0 PDS 2 suture where necessary and the afferent limb was secured to the efferent limb

with 3-0 PDS 2 seromuscular Lembert type sutures. After verification of the meticulous hemostasis, the apical enterotomy was secured with a GIA 100 mm stapling device. The anastomosis was healthy pink and widely patent and circumferentially intact and easily returned into the peritoneal cavity, after copious irrigation and verification of meticulous hemostasis.

-
- ^[1] General anesthesia.
 - ^[2] Lying on back with legs in stirrups.
 - ^[3] Cutting around the ostomy opening to release it from the abdominal wall and surrounding area.
 - ^[4] Verification that the colon is without injury or puncture from the dissection.
 - ^[5] Reattachment of the two ends of the colon in a side-by-side fashion.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 44625

ICD-10-CM codes: Z43.2, Z85.048

Rationale:

CPT® code: The operative note heading helps us to understand this patient had a surgical operation in which there is an attachment of the ileum to the abdominal wall as an ileostomy stoma, thereby diverting waste to a colostomy bag. The stoma is closed. A portion of the small intestines is removed (resection). The severed ends of the remaining intestine are joined to form a continuous channel (anastomosis) in the bowel. In the CPT® Index, look for Enterostomy/closure. This guides you to 44227, 44620, 44625, and 44626. Code 44626 includes colorectal anastomosis (reconnection of the colon and rectum). This note supports only the bowel reconnection, as reported using 44625. An enteroenterostomy is an anastomosis of one end of the small bowel to another part of the small bowel.

ICD-10-CM codes: The indication for the surgery is closure of a loop ileostomy. In the ICD-10-CM Alphabetic Index, look for Attention (to)/ileostomy Z43.2. The second code describes history of rectal carcinoma. In the Alphabetic Index, look for History/personal (of)/malignant neoplasm (of)/rectum NEC Z85.048. Verify code selection in the Tabular List.

Case 6

Preoperative Diagnosis: Morbid obesity. BMI 40.

Postoperative Diagnosis: Morbid obesity. BMI 40.

Procedure Performed: Laparoscopic sleeve gastrectomy. ^[1] Intraoperative esophagogastroduodenoscopy. Intraoperative endoscopy.

Anesthesia: General endotracheal anesthesia.

Operative Procedure: The patient was brought to the operating room and placed on the OR table in supine position. Once general endotracheal anesthesia was achieved and pre-op antibiotics were given, the abdomen was prepped and draped in the standard surgical fashion. Access to the abdominal cavity was through a 1 cm supraumbilical incision with an Optiview trocar. ^[2] CO₂ was insufflated to achieve an intraabdominal ^[3] pressure of approximately 15 mm Hg. Accessory trocars were placed in the subxiphoid, right, mid, and left upper quadrants of the abdomen, as well as in the right and left lower quadrants of the abdomen. All this was done under appropriate videoscopic observation.

The pyloric channel was then identified and approximately 4 cm proximal to it, the short gastric vessels of the greater curvature are taken down all the way up to the GE junction with the harmonic scalpel. A 38 French bougie is passed into the stomach into the

pyloric channel and with the help of the linear cutter, the stomach is transected in a vertical fashion creating a gastric tube which is approximately 100 mm in diameter. The staple line is then over sewn with a running 2-0 Vicryl suture. Good hemostasis was achieved.

Then I performed **intraoperative esophagogastroduodenoscopy**.^[4] The scope was advanced through the oropharynx, and under direct vision it was taken down through the esophagus and into the sleeve. There was no evidence of leak, bleeding, or any other abnormalities. A patent sleeve was seen all the way down to the pylorus. The scope was then retrieved carefully.

A placement of a drain through the subhepatic space and extraction of the specimen through a right lower quadrant incision was done. All trocars were removed under appropriate videoscopic observation. There was no evidence of bleeding from any of the trocar sites. **All the trocar sites were sutured closed and injected with local anesthesia**.^[5] The patient tolerated the procedure well. He was extubated on the table and transferred to the recovery room in stable condition. There were no complications.

^[1] Laparoscopic Sleeve Gastrectomy.

^[2] Laparoscopic procedure.

^[3] Gas is used to extend the abdomen to improve the visual field.

^[4] This is done to verify patency, hemostasis and integrity. It is not reported separately.

^[5] The small incisions are closed. The anesthetic helps with pain control post operatively.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 43775

ICD-10-CM codes: E66.01, Z68.41

Rationale:

CPT® code: A laparoscopic gastric restrictive procedure (sleeve gastrectomy) is performed to treat morbid obesity. In the CPT® Index, look for Gastrectomy/Sleeve, which directs you to 43775. The operative note clearly indicates this was done via laparoscope. Note there is not an open equivalent for this procedure and as such laparoscopic is the only coding option. This is listed under Bariatric Surgery and it is done for weight loss reasons. The intraoperative esophagogastroduodenoscopy is performed to make sure there is no post-op bleeding or leakage in the upper gastrointestinal tract and it's included in the primary procedure.

ICD-10-CM codes: The indication for the surgery is morbid obesity. In the ICD-10-CM Alphabetic Index, look for Obesity/morbid E66.01. The next code is for the body mass index (BMI) of the patient. An instructional note with subcategory code E66 indicates to *Use additional code to identify body mass index (BMI), if known (Z68.-)*. Code Z68.41 is for a BMI of 40. This can be located in the Alphabetic Index looking for Body, bodies/mass index/adult/40.0-44.9. Verify code selection in the Tabular List.

Case 7

Preoperative Diagnosis: Cholelithiasis, chronic cholecystitis, and acute pancreatitis.

Postoperative Diagnosis: Cholelithiasis, chronic cholecystitis and, acute pancreatitis, pathology pending.

Procedure Performed: Laparoscopic cholecystectomy, with intra-operative fluoroscopic cholangiography.

Anesthesia: General anesthesia and 0.5% Marcaine (10 cc/s).

Estimated Blood Loss: Minimal.

Drains: None.

Specimen: Gallbladder.

Operative Indications: This is a 49-year-old female with the above diagnosis who presents for elective laparoscopy, cholecystectomy, and intra-operative cholangiography.

Operative Procedure: The patient was brought to the OR suite with **PAS stocking** ^[1] in place. She was transferred to the operative table, given a general anesthetic, positioned supine on the table, and the operative field was sterilely prepped and draped.

A vertical incision was made in the base of the umbilicus and deepened through the fascia. Stay sutures of 0-Prolene were placed, and the abdomen was entered under direct vision. **A Hassan cannula** ^[2] was anchored in place with the stay sutures and the abdomen was insufflated to 15 mm Hg with CO₂ gas.

A 10 mm, 30-degree scope was assembled, focused, weight-balanced, and placed into the abdomen. cursory evaluation revealed no other obvious pathology with the exception of the gallbladder. Under direct vision, 3-5 mm ports were placed in the epigastrium, right upper quadrant, and right lower quadrant. The patient was placed in **reverse Trendelenburg position**, ^[3] with the right side up.

The fundus of the gallbladder was grasped and retracted over the dome of the liver. Adhesions to the gallbladder were taken down with sharp and blunt dissection while carefully maintaining hemostasis with electrocautery. The ampulla of the gallbladder was grasped with a second instrument and retracted downward and laterally, displaying the angle of Calot distracted from the portal structures. The cystic duct and artery were dissected circumferentially. A single clip was placed on the distal cystic duct and an opening created just proximal to it. The cholangiogram apparatus was introduced into the abdomen via the 5 mm RUQ port and the 5-French whistle-tip ureteral catheter was threaded into the common bile duct through the opening in the cystic duct. **The cholangiogram was performed under fluoroscopy and was normal, demonstrating filling of the duct with defects and prompt flow into the duodenum.** ^[4] The cholangiogram apparatus was withdrawn from the abdomen, and the cystic duct was clipped twice proximally and divided. The cystic artery was clipped once distally, twice proximally, and divided. The cystic duct and artery were dissected circumferentially, clipped once distally, twice proximally, and divided. Care was taken not to encroach upon the common bile duct or portal structures.

The gallbladder was taken down from the liver using the hook-dissector and cautery carefully maintaining hemostasis during the process. The right upper quadrant was irrigated with saline and suctioned dry. Hemostasis was confirmed. There was no bile drainage from the gallbladder bed in the liver. A 5 mm, 30-degree scope was assembled, focused, white-balanced, and placed into the epigastric port. The gallbladder was removed under direct vision through the umbilical port. The other ports were removed under direct vision, and hemostasis was achieved.

The abdomen was de-insufflated. ^[5] The fascia in the umbilical incision was closed with a figure-of-eight suture of 0 Vicryl. The wounds were infiltrated with a total of 10 cc of 0.5% Marcaine. The skin incisions were closed with subcuticular sutures of 4.0 Vicryl. Steri-strips and sterile dressings were applied. After a correct sponge, instrument, and needle count, the patient was awakened, extubated, and taken to the recovery room in good condition.

^[1] Pneumatic antiembolism stockings — these are compression stockings to help prevent blood clots during and after surgery.

^[2] Brand of laparoscopic instrument.

^[3] Reverse Trendelenburg refers to the patient in the supine position with the head of the bed elevated twenty degrees to help increase the amount of operative work space during upper abdominal surgery.

^[4] This is a fluoroscopic look at the bile ducts, which shows that the bile duct is unobstructed, because contrast was able to reach the duodenum. This is not an interpretation of the cholangiogram.

^[5] Gas is released from the abdomen.

What are the CPT® and ICD-10-CM codes reported?**CPT® code:** 47563**ICD-10-CM codes:** K80.10, K85.90**Rationale:**

CPT® code: The gallbladder is removed laparoscopically. An X-ray examination, including injection of a contrast dye into the bile ducts to visualize its course (cholangiography), is performed. In the CPT® Index, look for Cholecystectomy/Any Method/with Cholangiography. This refers you to 47563, 47605, and 47620. Code 47563 is correct because the surgery was performed laparoscopically. CPT® code 47563 includes cholecystectomy and the cholangiogram. Radiology code 74300 is not reported because you need to see a separate report or addendum for the interpretation of the cholangiogram and identify who interpreted it.

ICD-10-CM codes: The documented indication for the surgery is cholelithiasis, chronic cholecystitis, and acute pancreatitis. In the ICD-10-CM Alphabetic Index, look for Cholelithiasis which directs you to *see* Calculus, gallbladder. Look for Calculus/gallbladder/with/cholecystitis/chronic K80.10. Next, look in the Alphabetic Index for Pancreatitis/acute K85.90. Verify code selection in the Tabular List.

Case 8**Extent of Examination:** Terminal ileum.**Reason(s) for Examination:** Anemia, Fe Deficiency.

Description of Procedure: Informed consent was obtained and I explained about the benefits, risks, including the risk of perforation and alternatives to colonoscopy. The patient agreed to proceed. No contraindications were noted on physical exam. **Monitored anesthesia care (MAC)** ^[1] was administered by the anesthesia team. The bowel was prepared with GoLYTELY prep. The quality of the prep is based on the Ottawa bowel preparation quality scale. Total score: Right: 1 + Middle: 1 + Left: 1 + Fluid: 0 = 3/14. Prior to the exam, a digital exam was performed; hemorrhoids were noted.

The procedure was performed with the patient in the left **lateral decubitus position**. ^[2] The **instrument was inserted in the Anus and advanced to the terminal ileum**. ^[3] The cecum was identified by the following: the ileocecal valve and the appendiceal orifice. In the rectum, a retroflex was performed. The patient tolerated the procedure well. There were no complications.

Findings: In the rectum, a few medium-size uncomplicated internal hemorrhoids were seen. The internal hemorrhoids were not bleeding. There was no evidence of inflammation, friability, granularity, or bleeding. **Biopsy** ^[4] was taken. In the ascending colon and cecum there was mild granularity and red spots that were nonspecific and possibly due to air insufflation. No friability, ulcerations or bleeding. Biopsy was taken. The remainder of the colon was normal. The terminal ileum was normal.

^[1] MAC is IV anesthesia with multiple drugs — not general anesthesia.

^[2] Patient was lying on his left side — semi-fetal position.

^[3] Scope was inserted in rectal area to ileum.

^[4] Biopsy was taken from two locations, the ascending colon and cecum.

What are the CPT® and ICD-10-CM codes reported?**CPT® code:** 45380**ICD-10-CM codes:** D50.9, K64.8**Rationale:**

CPT® code: A colonoscope is performed for an internal examination of the colon and rectum, with tissue samples (biopsy). In

the CPT® Index, look for Colonoscopy/Flexible/Biopsy, which refers you to 45380, 45392. CPT® code 45380 is correct in this case.

ICD-10-CM codes: The indication for this procedure is for iron [Fe] deficiency anemia. Look in the ICD-10-CM Alphabetic Index for Anemia/deficiency/iron D50.9.

The operative note documents that internal hemorrhoids were seen in the examination. Look in the Alphabetic Index for Hemorrhoids/internal referring K64.8. Verify code selection in the Tabular List.

Case 9

Extent of Examination: Terminal ileum.

Reason(s) for Examination: Hx of rectal cancer s/p Low Anterior Resection (LAR) and colonic J pouch for closure of loop ileostomy.^[1]

Description of Procedure: Informed consent was obtained with the benefits, risks, including the risk of perforation and alternatives to colonoscopy explained. The patient agreed to proceed. No contraindications were noted on physical exam. Monitored anesthesia care (MAC)^[2] was administered. The bowel was prepared with Fleets enemas. The quality of the prep was fair. Prior to the endoscopic exam, a digital rectal exam was performed and it was unremarkable. The procedure was performed with the patient in the left lateral decubitus position.^[3] The cecum was identified by the ileocecal valve. The withdrawal time from the cecum was 7 minutes. The patient tolerated the procedure well. There were no complications. The exam was limited by poor preparation.

Findings: At the splenic flexure, moderate inflammation with erythema, granularity, friability, and hypervascularity was seen. There was no mucosal bleeding. In the proximal descending colon, there was moderate segmental inflammation with erythema, granularity, friability, and hypervascularity. In the rectum, an abnormality was noted.

Anastomosis is patent and normal.^[4] No evidence of polyp. Just proximal to prior anastomosis — significant diffuse colitis was noted.^[5]

^[1] Patient has had a previous surgical procedure — this is a “look-see” for any further problems.

^[2] IV anesthesia with medications — not general anesthesia.

^[3] The patient is lying on left side in semi-fetal position.

^[4] Refers to the area where prior surgery occurred verified the area where the colon was anastomosed is normal.

^[5] Some inflammation.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 45378

ICD-10-CM codes: K52.9, Z85.048

Rationale:

CPT® code: Diagnostic colonoscopy is performed for a look-see on a previous surgery (closure loop ileostomy) to make sure there are no problems. A colonoscope is inserted in the anus, and the scope advances through the colon past the splenic flexure to examine the lumen of the rectum and colon. The operative note documents the colon was examined to the splenic flexure and into the proximal descending colon; no surgical procedures were performed during the diagnostic colonoscopy. In the CPT® Index, look for Endoscopy/Colon/Exploration 44388, 45378. Code 45378 is correct for this case.

ICD-10-CM codes: The operative report documents that diffuse colitis was found proximal to the anastomosis. Look in the ICD-10-CM Alphabetic Index for Colitis K52.9. The second code is for the history of rectal cancer. Look in the Alphabetic Index for History/personal (of)/malignant neoplasm (of)/rectum Z85.048.

Case 10

Preoperative Diagnosis: Severe obesity. Hypertension. BMI 53. ^[1]

Postoperative Diagnosis: Severe obesity. Hypertension. BMI 53.

Procedure Performed: Laparoscopic antecolic Roux-en-Y gastric bypass with 150 alimentary limb, and a 40 cm biliopancreatic limb.

Anesthesia: General endotracheal anesthesia.

Operative Procedure: The patient was brought to the operating room and placed on the OR table in supine position. Once endotracheal anesthesia was achieved and pre-op antibiotics were given, the abdomen was prepped and draped in the standard surgical fashion. Access to the abdominal cavity was through a 1 cm supraumbilical incision with an Optiview trocar. CO₂ was insufflated to achieve an intraabdominal pressure of approximately 15 mm Hg. Accessory trocars were placed in the subxiphoid, right, mid and left upper quadrants of the abdomen, as well as in the right and left lower quadrants of the abdomen. All of this was done under appropriate videoscopic observation. ^[2]

The procedure begins with identification of the gastroesophageal junction ^[3] and dissection of the angle of His. ^[4] On the lesser curvature of the stomach, a window is dissected into the lesser sac. A linear stapler is passed, and the stomach is transected. Reinforcement of the staple line was done with a continuous absorbable seromuscular suture, creating a pouch approximately 50 cc in diameter. An Ewald tube ^[5] is used to calibrate the pouch. At this point, the ligament of Treitz ^[6] is identified and 40 cm from the ligament of Treitz, the small bowel was transected. The distal limb of the small bowel is then brought to the upper abdomen, and a side-to-side gastrojejunostomy between the pouch and the alimentary limb is performed with a linear stapler. The gastrojejunostomy site is then closed with a double layer of running 2-0 Vicryl sutures. The anastomosis was observed for leakage with air and Methylene blue. ^[7] There was no evidence of leakage.

I then proceeded 150 cm distal from the gastrojejunostomy. ^[8] A side-to-side jejunojejunostomy was created between the biliopancreatic limb and alimentary limb. This was performed using two applications of the linear stapler. The jejunojejunostomy site was closed with several applications of the linear stapler. Hemoclips were applied to the suture line for hemostasis. Good hemostasis was evident. A 19-French Blake drain was placed over the gastrojejunal anastomosis. All trocars were removed under appropriate videoscopic observation. There was no evidence of bleeding from any of the trocar sites. The trocar sites were suture closed and injected with local anesthesia. The patient tolerated the procedure well. She was extubated on the OR table and transferred to the recovery room in stable condition. There were no complications.

^[1] This demonstrates medical necessity.

^[2] This is a laparoscopic procedure.

^[3] This is where the stomach connects to the esophagus.

^[4] The angle of His is the acute angle created between the cardia at the entrance of the stomach and the esophagus. It forms a valve, preventing reflux of duodenal bile, enzymes, and stomach acid from entering the esophagus where it can cause inflammation.

^[5] This is the gastrointestinal tube used for analysis and emptying the stomach, named after the man who designed it.

^[6] This is a useful landmark for finding the beginning of the jejunum.

^[7] A blue dye is sent through the connected limbs to look for leakage.

^[8] This is significant because the code is different for over 150 cm.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 43644

ICD-10-CM codes: E66.01, I10, Z68.43

Rationale:

CPT® code: Laparoscopic gastric bypass is performed by partitioning the stomach using linear staplers to create a small 20-30 cc gastric pouch just past the gastroesophageal junction. Then a small bowel division of the jejunum 30-50 cm past the ligament of Treitz was performed. The jejunum is then attached to the proximal pouch. The remaining stomach, duodenum and jejunum are reattached to the gastrointestinal tract approximately 75-150 cm from where the pouch is attached to the jejunum. (Roux-en-Y gastroenterostomy). In the CPT® Index, look for Laparoscopy/Gastric Restrictive Procedures. This refers you to 43644–43645; 43770–43775. Code 43644 is the correct.

ICD-10-CM codes: The indication for this surgery is for severe obesity, hypertension, and BMI of 53. Look in the ICD-10-CM Alphabetic Index for Obesity/severe E66.01. The second code is found by looking for Hypertension: I10. In the Tabular List, category E66 indicates to report an additional code for the BMI. Look in the Alphabetic Index, for Body, bodies/mass index (BMI)/adult/50.0-59.9 Z68.43 for a BMI of 53. Verify code selection in the Tabular List.



Case 1

Operative Note

Preoperative Diagnosis: Desire for circumcision.

Postoperative Diagnosis: Desire for circumcision. ^[1]

Procedure: Circumcision.

Anesthesia: General.

Indications: The patient is a 19 year-old white male, sexually active for two years. He requests circumcision. He understands the risks and benefits of circumcision.

Procedure Description: The patient is a 19-year-old, ^[2] white male, sexually active for two years. He requests circumcision. He understands the risks and benefits of circumcision.

Procedure description: The patient was brought to the operating room and placed on the operating room table in the supine position. After adequate LMA anesthesia was accomplished, he was given a dorsal penile block and a modified ring block with 0.25% Marcaine plain. ^[3]

Two circumferential incisions ^[4] were made around the patient's penis to allow for the maximal aesthetic result. Adequate hemostasis was then achieved with the Bovie, and the skin edges were re-approximated using 4-0 chromic simple interrupted sutures with a U-stitch at the frenulum.

The patient was extubated and taken to the recovery room in good condition.

Disposition: The patient was taken to the post anesthesia care unit and then discharged home.

^[1] This is the diagnosis to report for this surgery if there are no further findings in the operative note.

^[2] The age of the patient.

^[3] This is the type of penile nerve block provided for the circumcision.

^[4] Surgical incision is made, as using a clamp or device is usually reserved for infants.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 54161

ICD-10-CM code: Z41.2

Rationale:

CPT® code: Circumcision is another very straight forward procedure. In a surgical setting, you only have to decide the age of the patient and surgical technique to determine the appropriate CPT® code. In the CPT® Index, look for Circumcision/ Surgical Excision (54161). This is the correct code due to the patient's stated age of 19. Clearly, he is not a newborn (less than 28 days old). Penile block would not be reported because this is inclusive in the global surgical package.

ICD-10-CM code: In the ICD-10-CM Alphabetic Index, look for Circumcision (in the absence of medical indication) (ritual) (routine) Z41.2. Verify code selection in the Tabular List.

Case 2

Operative Report

Preoperative Diagnosis: Prostate cancer.

Postoperative Diagnosis: Prostate cancer.^[1]

Procedure: Radical retropubic prostatectomy with bilateral pelvic lymph node dissection.

Statement of Medical Necessity: The patient is a very pleasant 58-year-old gentleman with Gleason 7 prostate cancer. He understood the risks and benefits of radical retropubic prostatectomy including failure to cure, recurrence of cancer, need for future procedures, impotence, and incontinence. He understood these risks, and he elected to proceed.

Statement of Operation: The patient was brought to the operating room and placed on the operating table in the supine position. After adequate general endotracheal anesthesia was accomplished, he was put in the dorsal lithotomy position and was prepped and draped in the usual sterile fashion. A 20 French Foley catheter was introduced in the patient's urethra, and the balloon was inflated with 20 ml of sterile water.

Made a mid-line infraumbilical incision and dissected down to the rectus fascia. Then transected the rectus fascia between the bellies of the rectus muscle and dissected into the retropubic space.^[2] Placed a Bookwalter retractor to aid in visualization and to protect the surrounding structures. Performed a bilateral pelvic lymph node dissection,^[3] taking care to avoid the hypogastric and obturator nerves bilaterally. The node packets were sent off the field for permanent section and frozen section. Then dissected the prostate free from its lateral side wall and dorsal attachments superficially and placed a right-angle clamp behind the dorsal venous complex and tied off the dorsal venous complex with two free ties of #1 Vicryl. Sewed some back bleeding sutures over the prostate and placed a right angle again behind the dorsal venous complex and then transected it with a long handled blade. Carefully inspected the dorsal venous complex for any bleeding and no bleeding was noted. Then placed a right-angle clamp behind the urethra and transected the anterior aspect of the urethra, exposing the Foley catheter. Grasped this with a tonsil and then cut off the Foley catheter at the urethral meatus and pulled the Foley catheter into the urethral incision that had been made. Transected the posterior urethra, freeing the prostate from its apical attachment. This allowed us to apply upward retraction to the prostate and dissect it free from the rectal anterior wall. Clipped and cut the lateral pedicles to free the prostate up to the level of the bladder neck. Transected Denonvilliers' fascia and identified the bilateral vas deferens, which were clipped and cut accordingly. Also, dissected the seminal vesicles leaving the tips of the seminal vesicles in place in the hopes of improving his incontinence.^[4]

Once this was complete, dissected the prostate free from the bladder neck using electrocautery.^[4] Opened the anterior aspect of the bladder, able to identify the bilateral ureteral orifices effluxing indigo carmine that had been administered about 10 minutes earlier by the anesthesiologist. Once the prostate was sent off the field for permanent section, attention was turned to recapitulating the bladder neck. Everted the bladder mucosa with 4-0 Monocryl and then closed the bladder neck in a tennis racquet closure using 2-0 Vicryl. Then placed a Roth sound in the patient's urethra after ensuring adequate hemostasis in the pelvis and placed five anastomotic sutures of 2-0 Monocryl surrounding the urethra. Placed them in the corresponding location in the bladder neck after a Foley catheter, 20 French in size, had been placed through the urethra and into the bladder, and the balloon was inflated with 20 ml of sterile water. Cinched down these anastomotic sutures and tied them off. Irrigated the Foley catheter and ensured that there was no bladder leak. We then placed a JP drain in the patient's left lateral quadrant, taking care to avoid the epigastric vessels. Stitched the drain in place with a 2-0 silk. Closed the fascia with #1 Vicryl in a running fashion and closed the subcutaneous tissues with 3-0 Vicryl. The skin was stapled closed, and a sterile dressing was applied. His catheter was again irrigated with return of blue urine. No clots.

The patient was extubated, and taken to the recovery room in good condition.

^[1] This is the diagnosis to report for the surgery. The pre and post-operative diagnoses match and are supported in the statement of medical necessity.

^[2] This indicates the surgery is performed by an open approach into the retropubic area.

^[3] Bilateral pelvic lymphadenectomy.

^[4] Radically removing the entire prostate.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 55845

ICD-10-CM code: C61

Rationale:

CPT® code: The operative note documents that a radical prostatectomy was performed via an incision in the retropubic space. In the CPT® Index, look for Prostatectomy/Retropubic/Radical, Code 55845 is correct because there was a local bilateral lymphadenectomy performed with the radical prostatectomy. A bilateral lymphadenectomy includes the lymph nodes of the internal, external, and common iliac nodes. The internal iliac is also known as the hypogastric artery and its branches are the obturators.

ICD-10-CM code: In the ICD-10-CM Alphabetic Index, look for Cancer - *see also* Neoplasm, by site, malignant. In the Table of Neoplasms, look for Neoplasm, neoplastic/prostate (gland)/Malignant Primary (column) C61. Verify code selection in the Tabular List.

Case 3

Operative Note

Preoperative Diagnosis: Prostate cancer.

Postoperative Diagnosis: Prostate cancer. ^[1]

Procedure: Ultrasound guidance placement of gold fiducial markers.

Description of Procedure: The patient is a 62-year-old male with prostate cancer. He is to undergo external beam radiation therapy, and radiation oncology asked me to place the fiducial gold markers. Informed consent was obtained. The patient was brought to the procedure room. He received oral sedation prior to the procedure. Ultrasound was performed, and utilizing 20 ml of lidocaine, the prostate was numbed with lidocaine. Next, position markers were placed at the right and left bases, as well as the left apex of the prostate gland without difficulty. ^[2] He had an excellent appearance and ultrasound. The patient did not suffer any pain or other problems during the procedure. The hospital ultrasound department assisted me in imaging. ^[3]

^[1] This is the diagnosis to report. The pre and post-operative diagnoses are the same and are supported in the operative note.

^[2] This is the placement of markers for radiation therapy.

^[3] Indication not to code for the radiology service.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 55876

ICD-10-CM code: C61

Rationale:

CPT® code: The CPT® Index does not list the terms fiducial or marker as a main term to identify this code; however, CPT® does list Placement. Look for Placement/Fiducial Markers/Prostate, which directs you to code 55876. When reviewing the description of CPT® 55876, you find this is the code needed to report this procedure.

There was documentation that the hospital ultrasound department assisted in the ultrasound imaging. The radiology department can report 76942, with modifier TC appended. The documentation here does show the ultrasound department assisting with imaging, indicating that the facility will report 76942 without any modifier appended to show that they performed the full procedure.

ICD-10-CM code: The diagnosis is stated several times as prostate cancer. Look in the ICD-10-CM Alphabetic Index for Cancer - *see also* Neoplasm, by site, malignant. Go to the Table of Neoplasms and look for Neoplasm, neoplastic/prostate (gland)/Malignant Primary (column) C61. Verify code selection in the Tabular List.

Case 4

Operative Report

Preoperative Diagnosis: RT ureteral stones.

Postoperative Diagnosis: RT ureteral stones. ¹

Operation: Open right ureterolithotomy.

Intraoperative Findings: The patient had marked inflammatory reaction around the proximal ureter, just below the renal pelvis. Multiple stone fragments were embedded in the edematous ureteral lining.

Procedure: The patient was placed on the operating room table in the supine position. General anesthesia was induced. He was then placed in a right flank up position. An incision was made off the tip of the 12th rib, and dissection was carried down through skin, fat, and fascia to open the lumbodorsal fascia entering the retroperitoneal space. ² The peritoneum was swept anteriorly.

Careful dissection was then carried down in the retroperitoneal space to first identify the vena cava and then to identify the renal vein. Once these structures were localized, the ureter was identified.

Careful dissection was done to mobilize the ureter and to identify the area of the stone impaction by palpation.

The ureter was then opened longitudinally and the ureteral stent was identified. The multiple embedded stone fragments were then removed from the ureteral lumen. ³ The ureteral lumen was then irrigated copiously, and no other stone fragments were identifiable.

The ureterotomy was then re-approximated with interrupted sutures of 5-0 chromic.

Inspection showed good hemostasis.

Sponge and needle counts were correct, and closure was begun after placement of a Blake drain through separate inferior stab wound. Marcaine 0.5% with no epinephrine was used to infiltrate the intercostal nerves. The wound was then closed in layers with muscle and fascial approximation with #1 Vicryl. The skin was closed with staples. Sterile dressings were applied.

The patient returned to the recovery area in satisfactory condition.

¹ This is the diagnosis to report as the pre and post-operative diagnoses match and the diagnosis is supported in the operative report.

² This indicates the surgery was performed by open approach.

³ Surgical removal of the stones from the ureter.

What are the CPT® and ICD-10-CM codes reported for this procedure?

CPT® code: 50610-RT

ICD-10-CM code: N20.1

Rationale:

CPT® code: In the CPT® Index, look for Ureterolithotomy. You are referred to codes 50610–50630; Laparoscopy-50945; Transvesical-51060. For this operative report, the surgeon makes an open incision through the skin and into the ureter to remove stones from the ureter. This guides you to codes 50610–50630. The descriptions of these codes are specific to the upper (proximal) one-third (50610), middle one-third (50620), and lower (distal) one-third (50630) of the ureter. You’ll notice in the “Intraoperative Findings” that the surgeon states the proximal ureter is the area of concern; therefore, it is most appropriate to code this procedure using 50610. There are no other reportable procedures identified in this report.

ICD-10-CM code: In the ICD-10-CM Alphabetic Index, look for Calculus, calculi, calculous/ureter N20. 1. Verify code selection in the Tabular List.

Case 5

Operative Note

Preoperative Diagnosis: Left renal calculus.

Postoperative Diagnosis: Left renal calculus.^[1]

Procedure: ESWL 2300 shocks at 22kV.

Description of Procedure: The KUB was reviewed revealing a lower caliceal calculi on the left. The patient was anesthetized and positioned on the lithotripsy table. The stone was targeted and treated with 60 shocks for 2 minutes, and then a 2-minute pause was carried out. We then resumed at 60 slowly working up to 120, for a total of 1800 shocks on the lower pole, which completely disappeared.^[2] We then shocked the tip of the stent with 500 shocks as calcification was seen there on the prior KUB, but it was unclear on today’s KUB with fluoro whether that was still present. The patient appeared to tolerate the procedure well, and he was brought to the recovery room in stable condition. He will follow up in 1 week for possible stent removal as KUB prior to the procedure.

^[1] This is the diagnosis to report if there are no further positive findings are found in the operative note.

^[2] Lithotripsy.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 50590-LT

ICD-10-CM code: N20. 0

Rationale:

CPT® code: Shock waves are used to pulverize the kidney stone. In the CPT® Index, look for Shock Wave Lithotripsy or you can look for Lithotripsy/Kidney. The amount of shocks used or time spent has no bearing on the description of the procedure. Modifier LT is reported to indicate the procedure was performed on the left kidney.

ICD-10-CM code: In the ICD-10-CM Alphabetic Index, look for Calculus/kidney N20. 0. Verify code selection in the Tabular List.

Case 6

Operative Note

Preoperative Diagnosis: Ta grade 3 transitional cell carcinoma (TCC)^[1] bladder CA in January 2010.

Postoperative Diagnosis: Ta grade 3 transitional cell carcinoma (TCC) bladder CA in January 2010; now 2 new bladder lesions.^[2]

Operation: Cystoscopy.

Anesthesia: Local.

Findings: There were 2 tiny papillary lesions in the posterior wall of the bladder; otherwise, the cystoscopy was negative.

Procedure Description: A flexible cystoscope was introduced into the patient's urethra. A thorough **cystoscopic examination**^[3] was done. Bilateral ureteral orifices were visualized effluxing clear yellow urine. All sides of the bladder were inspected, and retroflexion was performed. Cytology was sent.

Plan: We will **schedule the patient for a bladder biopsy**^[4] at the next available date.

^[1] TCC = transitional cell carcinoma.

^[2] This is the stated diagnosis and is documented in the body of the operative report.

^[3] Indication of a diagnostic cystoscopy.

^[4] Indication that a surgical endoscopy was planned for later.

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 52000

ICD-10-CM codes: N32. 9, Z85. 51

Rationale:

CPT® codes: This procedure note is very straight forward. A diagnostic cystoscopy (only examining the urethra, bladder, and ureteric openings in the bladder) was performed. In the CPT® Index, look for Bladder/Endoscopy (52000).

ICD-10-CM codes: Because there were findings of new bladder lesions, report the bladder lesion as your diagnosis. In the ICD-10-CM Alphabetic Index, look for Lesion/bladder N32. 9. This is an unspecified code, but because the note clearly states "lesion," report N32. 9. Do not report a bladder cancer code because that diagnosis was not established. The patient had bladder cancer in January. In the Alphabetic Index, look for History/personal (of)/malignant neoplasm (of)/bladder Z85. 51.

Case 7

Operative Note

Preoperative Diagnosis:

1. Intrinsic sphincter deficiency.
2. Stress incontinence.

Postoperative Diagnosis:

1. **Intrinsic sphincter deficiency.**^[1]
2. **Stress incontinence.**

Procedure: Cystoscopy with Durasphere injection.

Estimated Blood Loss: Less than 5 cc.

Complications: None.

Counts: Correct.

Indications: This is a very pleasant female with intrinsic sphincter deficiency causing urinary incontinence. She understood the risks and benefits of the procedure, and she elected to proceed.

Procedure Description: The patient was brought to the operating room and placed on the operating room table in the supine position. After adequate LMA anesthesia was accomplished, she was prepped and draped in the usual sterile fashion.

A 21-French cystoscope^[2] was introduced in the patient's urethra. Her urethra was fairly pale, not well approximated, and was patulous. We injected 2½ syringes of Durasphere material into the urethra^[3] but were unable to get any more than that amount into the tissue. There was moderate approximation of the urethral mucosa.

The bladder was emptied and lidocaine jelly instilled. She was extubated and taken to the recovery room in good condition.

Disposition: The patient was taken to the post anesthesia care unit and then discharged home.

^[1] This is the diagnosis to report as there are no further positive findings in the operative note.

^[2] Indication that the procedure will be performed through a scope entering the urethra.

^[3] Injection of the synthetic material into the urethra and bladder neck, helping to prevent urinary incontinence.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 51715

ICD-10-CM codes: N36.42, N39.3

Rationale:

CPT® code: For this procedure, there is an endoscopic injection of synthetic material in the urethra and bladder neck to prevent urinary incontinence. In the index, look for Urethra/Endoscopy/Injection of Implant Material. This guides you to 51715. The cystoscopy (52000) would not be reported separately because this code is a separate procedure. Codes with the “separate procedure” designation are normally not reported when another related procedure is performed at the same time. Durasphere is a bulking agent used to relieve the symptoms of incontinence when injected into the tissues of the urethra. The Durasphere is not reported by the physician as the facility supplies it.

ICD-10-CM codes: In the ICD-10-CM Alphabetic Index, look for Deficiency, deficient/intrinsic/sphincter N36.42. There is a note under subcategory N36.4 to use additional code to identify associated urinary stress incontinence (N39.3). This can be found in the Alphabetic Index by looking for Incontinence/urine (urinary)/stress (female) (male) N39.3. Verify code selection in the Tabular List.

Case 8

Operative Note

Preoperative Diagnosis: Gross hematuria.

Postoperative Diagnosis: Bladder/Prostate tumor.^[1]

Operation: Transurethral resection bladder tumor (TURBT) large (5.3 cm).

Anesthesia: General.

Findings: The patient had extensive involvement of the bladder with solid and edematous-appearing hemorrhagic tumor completely replacing the trigone and extending into the bladder neck and prostatic tissue. The ureteral orifices were not identifiable.

Digital rectal examination revealed nodular, firm mass per rectum.

Procedure Description: The patient was placed on the operating room table in the supine position, and general anesthesia was induced. He was then placed in the lithotomy position and prepped and draped appropriately.

Cystoscopy ^[2] was done which showed evidence of the urethral trauma due to the traumatic removal of the Foley catheter (patient stepped on the tubing and the catheter was pulled out). The bladder itself showed extensive clot retention. There was papillary and necrotic-appearing nodular tissue mass extensively involving the trigone and the bladder neck and the prostate area. The ureteral orifices were not identified.

After consulting with the patient's wife and obtaining an adjustment to the surgical consent, the **tumor was resected from the trigone, bladder neck, and prostate. Obvious edematous and hemorrhagic tissue was removed.** ^[3] Extensive electrocauterization was done for bleeding vessels. Several areas of necrotic-appearing tissue were evacuated. Care was taken to avoid extending resection into the area of the external sphincter.

Digital rectal examination revealed the firm, nodular mass in the anterior rectum. No impacted stool was identified.

At the end of the procedure, hemostasis appeared good. Tissue chips were evacuated from the bladder. Foley catheter was inserted.

Patient was taken to the recovery room in satisfactory condition.

Addendum: The patient had a previous partial prostatectomy and had been found to have T2b N0 MX prostate cancer. On the physical examination today and on the endoscopic exam, it was unclear as to whether the tumor mass was related to the bladder or recurrent prostate cancer.

Pathology revealed bladder carcinoma in the trigone and bladder neck, and recurrent prostate cancer. ^[4]

^[1] This is the diagnosis if no other positive findings are found in the operative note. In this case, the post-operative diagnosis is different from the pre-operative and has incorporated findings from the operative session and ultimately the pathology report.

^[2] Here is the indication that the surgical procedure will be performed through a cystoscope.

^[3] Transurethral resection of the bladder tumor.

^[4] Pathology report indicates carcinoma of both the bladder and the prostate.

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 52240

ICD-10-CM codes: C67.0, C67.5, C61

Rationale:

CPT® codes: The patient had a large bladder tumor, measuring 5.3 cm, removed by excision through a cystoscope. In the CPT® Index, look for Bladder/Endoscopy/Excision/Tumor.

Transurethral resection procedures of bladder tumors are reported according to the size of the tumor resected. If there is no documentation of the size of the tumor, the coder must use code 52224; however, this note clearly states that the tumor resected was 5.3 cm, which is reported using 52240.

Catheter insertion is not a reportable procedure within cystoscopy procedures, unless otherwise stated.

ICD-10-CM codes: The post-operative heading in the operative report has the diagnosis as Bladder/Prostate tumor. In the operative note, the pathology report confirmed cancer. The pathology report is found at the bottom of the operative narrative and it verifies the presence of malignant cells in the bladder trigone, bladder neck and recurrent cancer in the prostate. Look in the ICD-10-CM Alphabetic Index for Carcinoma - *see also* Neoplasm, by site, malignant. In the ICD-10-CM Table of Neoplasms, look for Neoplasm, neoplastic/bladder (urinary)/trigone/Malignant Primary (column) C67.0. Next, look for Neoplasm, neoplastic/bladder/neck/Malignant Primary (column) C67.5; and, finally, Neoplasm, neoplastic/prostate (gland)/Malignant Primary (column) C61. The sites are reported as primary because there is no indication that these sites are secondary or metastasized from a primary site. Verify the code selection in the Tabular List.

Case 9

Operative Report

Preoperative Diagnosis: Transitional cell carcinoma in the bladder.

Postoperative Diagnosis: Transitional cell carcinoma in the bladder. ^[1]

Procedure:

Cystoscopy; Excision bladder tumor — 1 cm.
Bilateral retrograde pyelogram.
Cytology of bladder.

Anesthesia: General. ^[2]

Estimated Blood Loss: 10 cc.

Complications: None.

Counts: Correct.

Indications: The patient is a 58 year-old male status post partial cystectomy for transitional cell carcinoma of the bladder. He understood the risks and benefits of today's procedure, and elected to proceed.

Procedure Description: The patient was brought to the operating room, placed on the operating room table, and placed in the supine position. After adequate LMA anesthesia was accomplished he was put in the dorsal lithotomy position and prepped and draped in the usual sterile fashion.

A 21-French rigid cystoscope was introduced through the urethra and a thorough cystourethroscopy ^[3] was performed. A 1 cm tumor was noted on the posterior bladder wall. ^[4] The tumor was resected without complications.

We obtained bladder cytology and performed a retrograde pyelogram, which showed no filling defects or irregularities.

The bladder was emptied, and lidocaine jelly was instilled in the urethra. He was extubated and taken to the recovery room in good condition.

Disposition: The patient was taken to the post anesthesia care unit and then discharged home.

Bilateral Retrograde Pyelogram Interpretation

A bilateral retrograde pyelogram was performed, which showed no filling defects or irregularities. ^[5]

^[1] This is the diagnosis to report, since the pre and post-operative diagnoses are the same. The operative note is consistent with a tumor on the posterior bladder wall. Pathology is not back yet, but the stated diagnosis is transitional cell carcinoma in the bladder. In the US, 90% of all bladder cancers are transitional cell in origin. This is sometimes referred to as urothelial carcinoma.

^[2] Anesthesia, local or general, is usually not reported by the physician performing the procedure. This information is for documentation quality purposes only.

^[3] The surgery will be performed through a cystourethroscopy.

^[4] This is the location of the tumor to report as the definitive diagnosis.

^[5] Retrograde radiological imaging (supervision and interpretation) of the kidneys and ureters. Retrograde refers to going against the normal flow. Urine flows down to the bladder and the dye is injected to travel back up towards the kidney.

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 52234, 74420-26

ICD-10-CM code: C67. 4

Rationale:

CPT® codes: A cystoscopy, excision of a 1 cm bladder tumor, bilateral retrograde pyelogram and cytology were performed. In the CPT® Index, look for Tumor/Bladder. Code 52234 is correct; it reports resection of small bladder tumors .5 up to 2.0 cm. This tumor is reported as 1 cm.

Retrograde pyelogram also was performed. In the CPT® Index, see Pyelogram (see Urography). Go to Urography/Retrograde, which directs you to 74420. The radiographic imaging was performed in a facility. Modifier 26 is appended to the radiology supervision and interpretation CPT® code to account for the professional portion only. When appending modifier 26 (supervision and interpretation) of the retrograde pyelogram, there must be documentation within the record of the findings.

Within this note, the surgeon states the retrograde pyelogram showed no filling defects or irregularities. This statement is found under a subheading in the body of the operative report titled; Bilateral Retrograde Pyelogram Interpretation.

ICD-10-CM code: In the ICD-10-CM Alphabetic Index, look for Carcinoma; there is no listing for transitional cell. Next to the main term Carcinoma it instructs you to – *see also* Neoplasm, by site, malignant. The operative note indicates there is a 1 cm tumor noted on the posterior bladder wall. Go to the Table of Neoplasms and look for Neoplasm, neoplastic/bladder (urinary)/wall/posterior/Malignant Primary (column) C67.4. Verify code selection in the Tabular List.

Case 10

Operative Note

Preoperative Diagnosis:

1. Large right inguinal hernia.
2. Bilateral undescended testes.

Postoperative Diagnosis:

1. Bilateral inguinal hernias. ^[1]
2. Undescended testes. ^[1]

Procedure Performed: Bilateral orchiopexy and bilateral inguinal hernia repairs as well as circumcision on a 10 year-old patient.

Estimated Blood Loss: Less than 5 ml.

Complications: None.

Description of Procedure: After informed consent had been obtained previously and reviewed again in the preoperative area, the patient was brought back to the OR, placed supine, and general anesthesia was induced without problems. It was somewhat difficult to find an IV site, because of the patient's body habitus. However, there were no complications with anesthesia. The patient was then appropriately padded and prepped and draped in sterile fashion. 0.25% Marcaine plain was used for bilateral inguinal ^[2] blocks as well as injected in the sub-q in the inguinal crease. I began on the right-hand side, where he had an intermittent right inguinal bulge for several months. A scalpel was used to make a skin incision ^[3] following the creases, and this was extended down through very generous subcutaneous fat and Scarpa's fascia to expose the external oblique aponeurosis. The external ring was identified as was the ilioinguinal ligament. The ring was opened for a short distance. The testis was high in the scrotum and was brought through. The gubernaculum was then divided. A very large hernia sac was carefully opened and very carefully dissected down to the level of the internal ring. ^[4] There did not appear to be abdominal contents within the hernia sac. It was then twisted and suture ligated at the base. ^[5] The hernia sac was then sent to pathology. The testis was pink and viable. A dartos pouch was created and the testis brought through it. The neck of the pouch was tightened with a few interrupted sutures of 3-0 Vicryl. Care was taken to make sure it did not twist the testicle that the testis lay in a normal anatomical position. The scrotal incision was then closed with 5-0 plain gut. The external ring was recreated by approximating the aponeurosis of the external oblique. The underlying ilioinguinal nerve was identified and spared. Scarpa's was approximated with 3-0 Vicryl and the skin closed with 5-0 Monocryl in a running subcuticular stitch. Steri-Strips and dressing were placed over this.

On the left-hand side ^[6] initially his testis was felt to be almost nonpalpable but on exam under anesthesia it again was within the high scrotum. With gentle pressure, I could make this essentially disappear into his abdomen suggesting a large communicating

hydrocele. I made the decision to proceed with inguinal hernia repair^[7] and exploration. Again, he had a Marcaine inguinal block and the skin was also anesthetized with 0.25% Marcaine. A matching incision was made with a scalpel following the skin creases. This was extended down through subcutaneous tissues and Scarpa's to expose the external oblique and the external ring. It was then twisted and suture ligated at the base with 3-0 Vicryl. The hernia sac was also sent to pathology. At this point, there was sufficient length to easily bring the testis into the scrotum.^[8] A dartos pouch was created and the testis was brought into it with care taken to make sure we did not twist the cord structures. The neck of the pouch was tightened with 3-0 Vicryl and then the scrotal incision closed with 5-0 plain gut in an identical fashion. The external oblique was approximated with a few interrupted sutures of 3-0 Vicryl to recreate the ring. Again, care was taken to preserve the underlying ilioinguinal nerve. Scarpa's was approximated 3-0 Vicryl, as well, and the skin was closed with Monocryl. Steri-Strips and dressing were placed over this, as well.

0.25% Marcaine plain was then used for a penile block. A circumcising incision was made approximately 3 mm below the coronal margin and the penis partially degloved.^[9] Meticulous hemostasis was obtained with Bovie cautery. The excess prepuce was trimmed. It was then discarded. The skin edges were approximated with 5-0 plain gut in a running fashion x 2. Hemostasis was excellent. The glans head appeared normal. A dressing of conform and Vaseline gauze was applied. The patient was then extubated and sent to the recovery in stable condition. No complications.

[1] The pre and post-operative diagnoses match but the operative note supports repair to bilateral inguinal hernias.

[2] This is the anatomical area that will be cut into for choosing the CPT® code.

[3] Indication the surgical procedure will be performed by an open approach.

[4] Fixation of the right undescended testicle.

[5] Hernia repair.

[6] This shows the surgeon moved to perform procedure(s) on the left, making it a bilateral procedure.

[7] Left hernia repair.

[8] Left fixation of the left undescended testicle.

[9] Surgical circumcision is performed.

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 49505-50, 54640-50-51, 54161-51

ICD-10-CM codes: K40.20, Q53.23, Z41.2

Rationale:

CPT® codes: Three procedures were performed: Bilateral orchiopexy, bilateral hernia repair, and circumcision. In the CPT® Index look for Hernia Repair/Inguinal/Initial, Child 5 years or older. CPT® Code 49505 is reported. In the CPT® Index, look for Orchiopexy. The codes are listed by the type of anatomical incision made. CPT® 54640 is the appropriate code for an inguinal approach. You also will note that the code descriptor states with or without hernia repair. Looking further into the parenthetical information, you are instructed to report inguinal hernia repair in addition to the orchiopexy codes. Therefore, when reporting the bilateral orchiopexy and bilateral hernia repair, you would report codes 49505 and 54640 with modifier 50 appended to both codes.

Look at the CPT® Index for Circumcision/Surgical Excision referring you to 54161. By reading the descriptions of the circumcision procedures in the numeric section, you would disregard code 54150 because the circumcision was not performed using a clamp; you would disregard code 54160 because of the patient's age. Report 54161, because the operative note indicates the excess prepuce was trimmed and discarded.

Modifier 51 is appended to 54640 and 54161 to indicate additional procedures performed in the same surgical session by the same surgeon.

ICD-10-CM codes: In the ICD-10-CM Alphabetic Index, look for Hernia, hernia/inguinal/bilateral K40. 20. The operative note indicates the testes were high in the scrotum. Look for High/scrotal testis, testes/bilateral referring you to Q53.23. Next, look for Circumcision Z41. 2. Verify code selection in the Tabular List.



Case 1

Diagnoses: Stage III cystocele, stage II uterine prolapse. ^[1]

Procedure: Pessary fitting.

Indications: A 75-year-old, gravida 4, para 4, ^[2] female with pelvic organ prolapse. She had atrophic vaginitis so we had her use Premarin vaginal cream twice a week for six weeks. She is back for a pessary fitting today.

Findings: She has a third-degree cystocele, and after examination we've determined she actually has a third-degree uterine prolapse. ^[3] Her vaginal tissues are improved, although still atrophic, but much less thin than prior appointment.

Description of procedure: After her exam, I started with a #4 ring pessary with support. This was clearly not large enough and the cystocele was coming around it. I then went to a #5 ring pessary with support with the same problem. I went to the #6 ring pessary with support. ^[4] It did not lodge behind her pubic bone very well, but it definitely reduced all of her prolapse. She mentioned earlier in the appointment that she could not void when she came in today. She has not tried reducing it. I am hopeful that the pessary may help with that. The #6 was comfortable for her. I stood her up and put her through some maneuvers and it stayed nicely in place. Then she went walking with the pessary in place for 10 or 15 minutes and went up and down the stairs. She was able to void more easily with it in. It was comfortable and she did not really notice it was in.

On recheck it still seemed like she had a little more room in the pelvis. I removed the #6 and went up to a #7 size. This seemed to reduce the prolapse a bit better, but was a little uncomfortable for her. We went back to the #6 ring pessary with support. She was able to remove it and place it with instruction in our clinic today.

Disposition: We have ordered the #6 ring pessary ^[5] with support and it will be sent to her. After she gets the pessary, she will remove it once a week and leave it out overnight. She will continue to use the Premarin vaginal cream twice a week. She will return to clinic after she has used the pessary for 2 or 3 weeks, so we can check her tissues. She is to report if she has vaginal discharge or bleeding, as she is at risk for getting ulceration from the pessary.

I answered all of her questions about her condition of pelvic organ prolapse and treatment with estrogen and pessary. She will call if she has any bleeding.

^[1] Do not code the cystocele separately as it is included in the diagnosis code for the uterine prolapse.

^[2] This information indicates that the patient has had four pregnancies with four term births and the last two babies were quite large.

^[3] The diagnosis is cystocele with uterine prolapse. Stage III uterine prolapse is considered a complete prolapsed.

^[4] The provider indicates the size of the pessary that he is fitting.

^[5] If the provider supplied the pessary, a HCPCS Level II code would be reported.

What are the CPT® and ICD-10-CM codes reported?

CPT® Code: 57160

ICD-10-CM Code: N81.3

Rationale:

CPT® Code: The procedure performed is a pessary fitting. In the CPT® Index, look for Pessary/insertion. You are referred to 57160. A review of the code description verifies 57160 is for fitting and insertion of pessary which is the correct code.

ICD-10-CM Code: The patient is diagnosed with a cystocele and uterine prolapse. In the diagnosis, it is referred to as stage 2; however, in the findings it is stage 3 prolapse. In the ICD-10-CM Alphabetic Index, look for Cystocele/female/with prolapse of uterus - see Prolapse, uterus. Prolapse, prolapsed/uterus/third degree guides you to N81.3. Verify the code selection in the Tabular List.

Case 2

Indications: 21-year-old, G3, P1-0-2-1,^[1] found to have an abnormal cervical Pap test^[2] with possible LGSIL.^[3] She presents for follow up Pap and colposcopy.

Exam: Pubic hair is shaved. Negative inguinal adenopathy. The urethra, the introitus, and anus are grossly normal. Vagina is long, and an extra-long Pederson speculum is needed. Cervix is posterior, parous. Uterus anteverted, normal size. Some tenderness of the adnexa to deep palpation. No cervical motion tenderness. Normal discharge. Pap test was performed.^[4]

Colposcopic Procedure: Speculum was inserted for the colposcopy. An extra-long, narrow Pederson speculum was required and the cervix was visualized. 3% acetic acid was placed and the T-zone is large and bleeds to touch. The 3% acetic acid was placed, and several aceto-white lesions were noted, particularly at the 12 and 11 o'clock positions. Lugol solution was placed, and there was no uptake at the 6 and 11 o'clock portions of the cervix. 4% topical lidocaine was placed without epinephrine, followed by 1 cc of 1% lidocaine also without epinephrine. A LEEP^[5] biopsy was taken of the cervix without difficulty and this also cauterized the bleeding.

Instructions given to the patient that she must refrain from intercourse for at least 1 week. She is aware to call if any severe pain, bleeding that does not stop, foul odor, or fever. She is aware the results will take approximately 1–2 weeks and she will receive direct notification.

^[1] Patient has been pregnant three times, has given birth to a term infant one time, has had two abortions/miscarriages and has one living child.

^[2] Abnormal cervical Pap smear is the diagnosis.

^[3] Low-Grade Squamous Intraepithelial Lesion is documented as possible so it is coded.

^[4] Pap test is performed.

^[5] Loop Electrocautery Excision Procedure biopsy.

What are the CPT® and ICD-10-CM codes?

CPT® Code: 57460

ICD-10-CM Code: R87.619

Rationale:

CPT® Code: The provider performs a Loop Electrosurgical Excision Procedure (LEEP) biopsy and Pap smear test. In the CPT® Index, look for Colposcopy/Biopsy/Cervix/Loop Electrode Biopsy. You are referred to 57460. Review the code description to verify the code accuracy. The LEEP biopsy was performed during a colposcopy and is the correct code. The Pap smear is not reported separately.

ICD-10-CM Code: The indication for the procedure is an abnormal Pap smear. The provider documents possible LGSIL which is not coded because it has not been confirmed. Look in the ICD-10-CM Alphabetic Index for Abnormal/Papanicolaou (smear)/cervix referring you to R87.619. Verify code selection in the Tabular List.

Case 3

Anesthesia: General with LMA.

Preoperative Diagnosis: Patient requesting sterilization.

Postoperative Diagnosis: Sterilization. ^[1]

Procedure Performed: ^[2] **Procedure Performed:** Tubal ligation with bilateral Falope- ring application. ^[2]

Counts: Needle, sponge and instrument counts were correct.

Intraoperative Medications: 0.25% Marcaine with epinephrine.

Operative Findings: The left ovary was mildly adhered to the side of the uterus. The right ovary appeared normal. Both tubes appeared normal. The upper abdomen appeared normal. There was a small subserosal fibroid approximately 1 to 1.5 cm on the left upper aspect of the uterus.

Description of Procedure: After informed consent, Ms. Mathews was taken to operating suite #4 and a general anesthetic was administered. She was placed in the dorsal lithotomy position. She was sterilely prepped and draped in the usual manner. A sponge stick was placed vaginally. An infraumbilical incision ^[3] was made and a non-bladed trocar and sheath were placed. Proper placement was confirmed and insufflation was performed. A suprapubic incision was then made and the suprapubic trocar and sheath were placed under direct visualization. ^[4] Findings were made as noted above and the right tube was ligated with the Falope-ring, and then the left. ^[5] Pictures were taken to document proper placement.

All instruments were removed and gas was allowed to escape. The sheaths were removed. Marcaine with epinephrine were placed again at the incision sites and they were closed with Monocryl in a subcuticular manner.

The patient was allowed to emerge from the anesthetic and was transferred to the Postanesthesia Care Unit in stable condition.

^[1] Select a code from the postoperative diagnosis.

^[2] Indicates the tubal ligation by Falope ring. This method of sterilization uses a small silastic ring shaped band placed around a loop of each fallopian tube.

^[3] The incision is made below the navel.

^[4] Indication the procedure is performed laparoscopically.

^[5] The procedure is performed on the right and left side.

What are the CPT® and ICD-10-CM codes?

CPT® Code: 58671

ICD-10-CM Code: Z30.2

Rationale:

CPT® Code: The method of the tubal ligation is placement of Falope-ring on the right and left tubes. This placement blocks or occludes the fallopian tubes. The method dictates the proper code selection. In the CPT® Index, look for Fallopian Tube/Occlusion/Endoscopic. You are referred to 58671. On finding this code in the numeric section, you will see this is a laparoscopic occlusion of the oviducts with device and there is a parenthetical note (e.g. band, clip or Falope-ring).

ICD-10-CM Code: The indication for the procedure is sterilization. Look in the ICD-10-CM Alphabetic Index for Encounter (with health service) (for)/sterilization. You are referred to Z30.2. Verify code selection in the Tabular List.

Case 4

Preoperative Diagnosis: Severe cervical dysplasia.

Postoperative Diagnosis: Severe cervical dysplasia.

Procedure Performed: Cold knife conization.^[1]

Anesthesia: General.

Complications: None.

Estimated Blood Loss: 25 cc.

Fluids: 500 cc crystalloid.

Drains: Straight catheter x 1.

Indications: All risks, benefits, and alternatives of this procedure were discussed with the patient and informed consent was obtained.

Description of Procedure: The patient was taken to the operating room where general anesthesia was obtained without difficulty. She was prepped and draped in the normal sterile fashion after being placed in the dorsal lithotomy position.

Attention was turned to the patient's pelvis where a weighted speculum was placed inside the patient's vagina.^[2] The anterior lip of the cervix was grasped with a single-tooth tenaculum and a paracervical block was performed using 10 units of Pitressin and 20 cc of normal saline. A #2-0 Vicryl stitch was used at the 3 o'clock and 9 o'clock positions on the cervix to ligate the cervical branch of the uterine artery.

Procedure (continued): A #11 blade was then used to incise in a circumferential fashion. This incision was carried down to the cervix using a cone shape. The cervical biopsy was removed^[3] and marked at the 12 o'clock position using a silk suture.

The cervical bed was cauterized using the Bovie cautery with good hemostasis noted. The FloSeal was placed into the cervical bed and the cervical stitches were tied together in the midline. Good hemostasis was noted.

All instruments were removed from the patient's vagina. All sponge, needle and instrument counts were correct x 2.

The patient was taken out of the dorsal lithotomy position and taken to the recovery room awake and in stable condition.

^[1] A cold knife conization is a biopsy performed to sample abnormal tissue from the cervix.

^[2] A vaginal approach is performed.

^[3] The cervical biopsy is performed.

What are the CPT® and ICD-10-CM codes reported?

CPT® Code: 57520

ICD-10-CM Code: D06.9

Rationale:

CPT® Code: The procedure performed is a conization of the cervix using a cold knife. In the CPT® Index, look for Conization/Cervix. You are referred to 57461, 57520, 57522. The approach and method will determine the proper code. The method is a cold knife which is reported with 57520.

ICD-10-CM Code: The indication for the procedure is severe cervical dysplasia. Look in the ICD-10-CM Alphabetic Index for Dysplasia/cervix (uteri)/severe. You are referred to D06.9. Verify code selection in the Tabular List. Look at the INCLUDES notes for category code D06 to confirm we have the correct code. The INCLUDES note lists *severe dysplasia cervix uteri*, and the 4th character 9 is used because the notes did not specify whether the dysplasia was in the endocervix, exocervix or other specific parts of the cervix.

Case 5

Diagnosis: Intrauterine pregnancy at 18 weeks with multiple fetal anomalies.

Procedure: D&E ^[1]

Anesthesia: Moderate sedation.

Indications: The patient is a 29-year-old gravida 1 ^[2] at 18 weeks ^[3] with multiple fetal anomalies, who desires a termination of pregnancy. ^[3]

Description of Procedure: The patient was brought to the operating room, and moderate sedation was administered by the anesthesia team. ^[4] The patient then placed in the dorsal lithotomy ^[5] position and was prepped and draped in usual sterile fashion.

The laminaria and prostaglandin suppositories ^[6] were removed. The patient's cervix was dilated to 5–6 cm. ^[6] There was a bulging bag that ruptured during vaginal prep. A speculum was attempted to be placed, but the fetus was already delivering into the vagina. The umbilical cord was severed at this time, and no fetal heart beat was noted on ultrasound. Ultrasound guidance was used for the entire procedure. ^[7] Gentle traction was applied and the fetus delivered intact. There was no respiratory or cardiac effort noted. Bierer forceps were then used to remove the placenta intact. There was a small amount of bleeding noted from the lower uterine segment; 20 units of Pitocin was added to the patient's IV fluids and pressure was held against lower uterine segment for 5 minutes. At this time, hemostasis was noted to be excellent. The speculum was then removed, and the patient was taken out of the dorsal lithotomy position after her perineum was cleansed.

The patient's anesthesia was discontinued and she was brought to the recovery room in stable condition. There were no complications during the procedure. The patient tolerated the procedure well.

Specimen(s): The products of conception were sent to pathology for cytogenetics and pathologic evaluation.

Plan: The patient will follow up in the outpatient clinic.

^[1] Dilation and evacuation.

^[2] Gravida represents number of pregnancies the woman has had. Thus, gravida 1 means this is her first pregnancy.

^[3] The number of weeks of the pregnancy and the desire to terminate the pregnancy.

^[4] The anesthesia was handled by an anesthesiologist, who will bill separately for their services.

^[5] This position is common in female reproductive procedures. The patient is lying supine with legs bent at the knees and elevated in stirrups.

^[6] Vaginal suppositories and cervical dilation were performed.

^[7] In order to bill for ultrasound guidance a permanent image must be retained in the medical record. There must also be a description of the images requiring the ultrasound guidance. Although this physician did keep an image there is no description of anything visualized through the ultrasound other than the fetal heartbeat. Without this description, the service is not separately billable.

What are the CPT® and ICD-10-CM codes?**CPT® Code:** 59855**ICD-10-CM Codes:** Z33.2, O35.9XX0**Rationale:**

CPT® Code: The procedure performed is an induced abortion with dilation and evacuation for the management of the mother due to fetal abnormalities. From the CPT® Index, look for Abortion/Induced/by Vaginal Suppositories referring you to 59855, 59856. The correct code is 59855, because dilation and curettage were not performed to evacuate the fetus. The fetus was delivered.

ICD-10-CM Codes: In the ICD-10-CM Alphabetic Index, look for Termination/pregnancy, elective referring you to Z33.2. Code Z33.2 is listed in ICD-10-CM guideline I.C.21.c.16 stating it may only be reported as principal diagnosis. The encounter is for an induced legal abortion due to fetal abnormalities (termination of the pregnancy). Look in the ICD-10-CM Alphabetic Index for Pregnancy/complicated/by/fetal abnormality or damage O35.9-. In the Tabular List, 7th character 0 indicates single gestation. Two placeholders (X) are used to keep the 7th character in the seventh position for a complete code of O35.9XX0. According to ICD-10-CM guideline I.C.21.11, Z3A codes should not be assigned for pregnancies with abortive outcomes.

Case 6**OB Delivery Note**

Indications: 31 y/o **G3P1**^[1] at 39 and 4/7 weeks admitted in labor. **She has been followed in the OB clinic with 12 normal antenatal visits.**^[2]

Stage I: Patient was admitted with a cervical exam of 3/c/-1. She slowly progressed to 5 cm dilation. She had **SROM**^[3] at 0330 which showed light meconium. She continued to labor and reached the end of stage I at 1000, a period of 10 hours. **FHTs showed some periods of reactivity but responded to stimulation.**^[4]

Stage II: Duration of Stage II (from pushing to delivery) was approximately 3 hours. A pediatric team was present. There was slight **meconium staining present at delivery.**^[5] **Presentation was OP with right shoulder anterior shoulder. There was no nuchal cord.**^[6] The cord was clamped x2 and cut and the baby was handed to the pediatric team.

Gender: Male**Weight:** 3772 grams. **Apgars 8 /9**^[7]

Stage III: Placenta delivered spontaneously with gentle traction and fundal massage and was intact. Vagina and cervix examined for lacerations. Inspection revealed a small **second degree perineal laceration which was repaired**^[8] with 3.0 Polysorb in the usual sterile fashion in layers. Another small lateral cutaneous tear was repaired with 3.0 polysorb and a figure-of-eight stitch. Good hemostasis was noted.

Patient will return to clinic for follow up in 6 weeks.^[9]

^[1] This is a woman who has been pregnant three times and has one term delivery.

^[2] Routine antepartum care.

^[3] Spontaneous rupture of membranes.

^[4] Monitoring fetal heart tones (FHT) is standard for hospital-based deliveries and is included in the global delivery code.

^[5] This is an additional diagnosis.

- ^[6] This is an occipital posterior (OP) presentation and the cord was not around the baby's neck. A nuchal cord is a life threatening problem when the umbilical cord is wrapped around the baby's neck.
- ^[7] This is a measure of the health of the baby at birth. An APGAR of 10 is perfect. The first number is the rating at one minute and the second number is the rating after 5 minutes following delivery. This is a healthy infant.
- ^[8] Repair after delivery of either tear or an episiotomy is included in the delivery and cannot be billed separately by the delivering physician. A second degree laceration makes this delivery complicated and code O80 cannot be used.
- ^[9] This represents the physician will be providing the postpartum care as well.

What are the CPT® and ICD-10-CM codes?

CPT® Code: 59400

ICD-10-CM Codes: O70.1, O77.0, Z37.0, Z3A.39

Rationale:

CPT® Code: The stages indicate the patient is in labor and delivers vaginally. The note indicates a vertex occiput posterior presentation and vaginal lacerations. There is no mention of an incision made for a Cesarean delivery. To locate the code in CPT® Index, look for Vaginal Delivery/routine care. Code 59400 represents routine obstetric care including antepartum care, vaginal delivery and postpartum.

ICD-10-CM Codes: This is a pregnancy complicated by the second degree perineum laceration and the meconium in the amniotic fluid. In the ICD-10-CM Alphabetic Index, look for Delivery/complicated/by/laceration/perineum, perineal/second degree referring you to O70.1. Also documented is meconium in the amniotic fluid. Look in the Alphabetic Index for Delivery/complicated/by/meconium in amniotic fluid referring you to O77.0. According to ICD-10-CM guidelines I.C.15.b.5, a code from category Z37 should be included on every maternal record when a delivery has occurred. In the Alphabetic Index, look for Outcome of delivery/single NEC/liveborn. A single live birth is Z37.0. In the Tabular List, at the beginning of Chapter 15 for Pregnancy, Childbirth and the Puerperium, there is a note indicating to report an additional code from category Z3A. Look in the Alphabetic Index for Pregnancy/weeks of gestation/39 weeks referring you to Z3A.39. Verify code selection in the Tabular List.

Case 7

Procedure performed: Amniocentesis.

Indications: The patient is a 28-year-old G4 P2103 ^[1] at 36 weeks, here in the office today ^[2] for amniocentesis for FLM ^[3] secondary to Rh isoimmunization to D antigen. ^[4] Following informed consent she elected to proceed with the amniocentesis.

Procedure: An ultrasound was carried out that revealed a single intrauterine gestation of 36+2 weeks in vertex presentation. A site for amniocentesis was identified in the left upper uterine segment, which did not transgress the placenta and an image was retained for the record. The amniocentesis site was sterilely prepped and draped with a sterile towel and an alcohol based solution. Following this using direct ultrasound guidance ^[5] a 22-gauge amniocentesis needle was sharply inserted in the amniotic fluid cavity. ^[6] This returned clear amniotic fluid. 20 cc was easily aspirated and 10 cc sent for FLM and 10 cc held for possible OD450 if needed. The patient tolerated the procedure very well and normal fetal cardiac activity was seen following the procedure. The patient will be sent for a follow up NST. Rhogam is not indicated as the patient is already sensitized.

^[1] This patient has been pregnant four times (counting her current pregnancy), she has had a term birth two times. One of the deliveries produced twins the other was a single birth thus she currently has three living children.

^[2] Procedure performed in the office.

^[3] Fetal lung maturity, an important measure for patients who may need to deliver early.

- ^[4] Although the diagnosis is not clearly specified in the note we can pull the diagnosis and medical necessity from the indications. If this information was not present, the service could not be billed before querying the provider and instigating a documentation amendment.
- ^[5] Ultrasound guidance can be billed with this procedure as the guidance requirements (retained image and description of the localization) are met.
- ^[6] This is the description that supports the code. This is a diagnostic amniocentesis.

What are the CPT® and ICD-10-CM codes?

CPT® Codes: 59000, 76946

ICD-10-CM Codes: O36.0130, Z3A.36

Rationale:

CPT® Codes: The amniocentesis is performed to determine fetal lung maturity in case there is a need for early delivery. The provider performs amniocentesis with ultrasound guidance in the office. To locate the code, look in the CPT® Index for Amniocentesis/Diagnostic. You are referred to 59000. There is a parenthetical statement under code 59000, which instructs you to report code 76946 for radiological S&I. This procedure was performed in the provider's office and can be reported as a global service. Modifier 26 is not reported on the radiologic guidance code.

ICD-10-CM Codes: The indication for the amniocentesis is pregnancy complicated by Rh immunization, in which the mother's blood can be Rh-negative type and fetus or newborn can have Rh-positive blood. Rh isoimmunization can cause multiple problems in the fetus. In the ICD-10-CM Alphabetic Index, look for Pregnancy/complicated by/Rh immunization, incompatibility or sensitization NEC/anti-D antibody referring you to O36.01-. In the Tabular List, additional characters are required. The 6th character indicates what trimester the patient is in. The patient is 36 weeks pregnant, placing her in the third trimester (O36.013-). The code requires a 7th character to indicate which fetus is affected. A 0 is reported for single gestation making the complete code O36.0130.

In the Tabular List, at the beginning of Chapter 15 for Pregnancy, Childbirth, and the Puerperium, there is a note that indicates to report a code from category Z3A to identify the weeks of gestation. Look in the Alphabetic Index for Pregnancy/weeks of gestation/36 weeks Z3A.36. Verify code selection in the Tabular List.

Case 8

ABC Hospital

Indication: A 30-year-old **G0P0Ab0** ^[1] with irregular periods. **She is infertile and requires hysterosalpingogram for evaluation to see if there is a cause for the infertility.** ^[2]

Procedure Note: The patient was brought to the outpatient surgical suite. After written consent was obtained and written final verification, the cervix was visualized with a Pedersen speculum, anesthetized with Cetacaine spray and swabbed with three swabs of Betadine scrub and an endocervical prep.

A single-tooth tenaculum was placed on the anterior lip of the cervix without problems. An HSG catheter was introduced through the cervix. At this point the balloon was insufflated with 1 ml of normal saline within the cervix, speculum was then removed. **Ethiodol contrast, approximately 8 ml, was instilled under fluoroscopic guidance.** ^[3]

Under fluoroscopic guidance, the uterus shape was found to be normal. **The tubes filled and spilled on the left. The right tube filled normally but no spill could be documented due to exuberant spill from the left.** ^[4] The patient was instructed to roll completely for two revolutions. An additional film was taken which showed normal dispersion.

Plan: Follow up as scheduled.

^[1] The patient has never been pregnant.

^[2] Reason for the procedure.

^[3] This describes the hysterosalpingogram and injection procedure which allows for examination of the uterus and fallopian tubes for any abnormalities or blockages.

^[4] This documentation reports the findings of the HSG.

What are the CPT® and ICD-10-CM codes?

CPT® Codes: 58340, 74740-26

ICD-10-CM Code: N97.9

Rationale:

CPT® Codes: The procedure performed is a hysterosalpingogram. To locate the code, look in the CPT® Index for Hysterosalpingography/Injection Procedure which refers you to 58340. When you review the code description there is a parenthetical statement which informs us to use code 74740 for the radiological supervision and interpretation of a hysterosalpingography. The procedure was performed in the outpatient hospital setting. Modifier 26 is appended to 74740 to report the professional component.

ICD-10-CM Codes: Look in the ICD-10-CM Alphabetic Index for Infertility/female N97.9. Verify code selection in the Tabular List.

Case 9

Chief Complaint: Contraceptive placement of IUD ^[1]

Indications: Ms. Barrett is coming into the office for placement of an IUD. She is a 29-year-old, gravida 1, para 1-0-0-1 ^[2] who is status post a normal spontaneous vaginal delivery of a male infant weighing 4,086 grams. She has not had intercourse since delivery. She is interested in a Mirena IUD at this time.

Procedure: After obtaining consent, the patient is placed in the dorsal lithotomy position. A speculum was placed in the vagina to visualize the cervix. The cervix was cleaned three times with Betadine. Following this, a single-tooth tenaculum was placed on the anterior lip of the cervix. The uterus was sounded to approximately 6.5 cm. The Skyla IUD 13.5 mg was then placed in the usual fashion ^[3] and the strings cut to 2.5 cm. The lot number is TU003SL. The patient tolerated the procedure well, and hemostasis was achieved at the tenaculum site after removal.

The patient tolerated the procedure well and was provided instructions to return, if she should have any difficulties.

^[1] This is the reason for the visit.

^[2] This patient has been pregnant once having recently given birth to her first child who is currently alive.

^[3] This is the insertion of an intrauterine birth control device.

What are the CPT® and ICD-10-CM codes?

CPT® Code: 58300, J7301

ICD-10-CM Code: Z30.430

Rationale:

CPT® Code: The provider inserts an IUD. To locate the code in the CPT® Index, look for Insertion/Intrauterine Device (IUD). Review of the code description verifies that 58300 is the correct code. Because the Skyla IUD is inserted in an office setting, the physician can report a HCPCS code for the product/supply. In the HCPCS code book go to the Table of Drugs and Biologicals and look for Skyla, 13.5 mg referring you to code J7301.

ICD-10-CM Code: To locate the code, look in the ICD-10-CM Alphabetic Index for Intrauterine contraceptive device/insertion Z30.430. Verify code selection in the Tabular List.

Case 10**Diagnoses:**

1. Complete procidentia ^[1]
2. Recurrent urinary tract infections ^[2]
3. Postmenopausal vaginal bleeding ^[3]

Procedures:

1. Vaginal hysterectomy
2. Anterior and posterior colporrhaphy
3. Cystoscopy
4. Vaginal vault suspension

Specimens: Uterus and cervix.

Findings: A thick hypertrophic ulcerated cervix was noted. The adnexa were small and atrophic. Complete procidentia with cystocele and rectocele. ^[4] Cystoscopy done after indigo carmine was administered ^[5] at the end of the case, revealed bilateral strong ureteral jets.

Indications: Pt. with history of postmenopausal vaginal bleeding, anemia and recurrent urinary tract infections, although she denied any urinary incontinence. Her cervix was found to be ulcerated, erythematous and hypertrophic. Cervical biopsy was negative for neoplasia. She desires surgical management of these problems.

Operation: The patient was taken to the operating room and placed in lithotomy position while awake. The patient has a history of bilateral knee replacements and cannot bend her legs. We put her in lithotomy position using Yellofin stirrups keeping her legs without any bend and positioning her while she was awake in a comfortable way. ^[6] The patient was then placed under general anesthesia. An exam under anesthesia ^[7] was done with findings of a complete procidentia with ulcerations posteriorly. The vagina and perineum was prepped in the usual sterile fashion. A tenaculum was then placed on the right and left lateral cervix. A circumferential incision was made at the cervicovaginal junction using Bovie cautery. The vesicovaginal fascia was then dissected anteriorly using a combination of sharp dissection with Metzenbaum scissors and blunt dissection.

Attention was then turned posteriorly. The posterior peritoneum was grasped with a half curve, identified a then incised using Mayo scissors. A weighted speculum was then placed in the posterior cul-de-sac. The uterosacral ligaments were identified and clamped bilaterally with Heaney clamps, and a transection suture using 0 Vicryl suture was placed at the tip of the clamp system in both the right and left side. The uterocervical ligaments were then tagged and held for use during the vaginal vault suspension.

Attention was then turned to the anterior peritoneum. A finger was placed in the posterior cul-de-sac up around the uterine fundus distending the anterior vaginal epithelium and allowing the anterior peritoneum to be entered safely using Mayo scissors. The cardinal ligaments were clamped and cut bilaterally. The utero-ovarian ligaments were identified, cut, suture-ligated, and then free tied bilaterally. The uterus was then removed from the vagina ^[8] and sent to pathology. All pedicles were then inspected and were found to be hemostatic. We could not visualize the ovaries ^[9] but were palpated and felt to be atrophic.

At this point, we began the vaginal vault suspension. ^[10] There was some oozing from the patient's left side near the vaginal cuff area. This was controlled with a figure-of-eight suture of 0 Polysorb. ^[11] Other small areas along the cuff were touched with the Bovie, and hemostasis was very good at this point. The uterosacral ligament remnant was put under pressure to palpate the ligament through its course to near the ischial spine. The bladder was drained with a Foley. A long Allis clamp was placed on the uterosacral near the ischial spine by tugging gently on the remnant that was stretched out and using the more inferior fibers. A

suture of 0 Polysorb was placed through the ligament with care to drive the needle from superior to inferior, to avoid the ureter. A second suture was placed slightly more distal with 0 Maxon and then more distal again a 0 Polysorb. These were all held while a similar procedure was repeated on the left side with palpation of the ligament and the ischial spine and taking the inferior fibers.

All of the sutures were held while the anterior and posterior repairs were made. The anterior vagina was then inspected and the cystocele identified. The vaginal wall was trimmed anteriorly. The posterior vagina was also inspected and excessive tissue was excised. At this point the vaginal cuff appeared hemostatic and was closed by first taking the 0 Polysorb, which is the distal uterosacral stitch and making an angle stitch to close the vagina. The anterior and posterior vaginal walls were closed as well as the pubocervical fascia anteriorly ^[12] and the rectovaginal fascia posteriorly ^[13] to get fascia-to-fascia closure. Once each of the angle stitches had been placed, they were held and not tied down yet. The 0 Maxon were then placed in a similar fashion through the anterior vaginal fascia and mucosa and the posterior fascia and mucosa. Lastly the 0 Prolene, which were the most superior stitches, were placed through the anterior posterior vaginal cuff, but these were taken slightly away from the cut edge so that the knots could be buried but again taking fascia and vaginal mucosa. Then a 0 Polysorb figure-of-eight suture was placed across the midline and vaginal mucosa so that we could completely bury the Prolene sutures at the end of the case. At this point, all of the sutures were tied except the Polysorb to close the mucosa in the midline. There appeared to be excellent vaginal support at this point. ^[10]

The Foley catheter was removed. The 17-French cystoscope ^[14] sheath was placed through the urethra. The 70-degree lens was used with sterile water infusing to inspect the bladder. There was moderate trabeculation of the bladder. ^[15] There were no mucosal lesions to explain her infections. There were no stones, stitches or other lesions. A quarter of an ampule of indigo carmine had been given about 10 minutes earlier IV. Strong ureteral jets were observed from both sides, although the right side concentrated the dye faster than the left side by about 5 minutes. The bladder was drained and the urethra was inspected with the 0-degree lens and there were no urethral lesions. The bladder was drained and the Foley catheter replaced.

The last midline 0 Polysorb suture was closed over the midline to bury the Prolene. All the sutures were cut and the cuff was irrigated with the cystoscopy fluid. A rectal exam was done, which did not yield any sutures. The vagina was then irrigated and was found to be hemostatic. A vaginal pack was then placed. The patient was awakened from general anesthesia and brought to the PACU in stable condition.

^[1] The stated diagnosis is *Complete Procidentia*, and this is well supported in the body of the operative note. A review of several medical dictionaries shows the definition of Procidentia, as prolapse of an organ or part.

^[2] A history of postmenopausal vaginal bleeding, anemia and recurrent urinary tract infection (UTI).

^[3] Select codes for the definitive diagnoses.

^[4] These problems are addressed in the body of the note below.

^[5] Indigo carmine is a dye injected during urogynecologic procedures for better visualization of structures/fluids, etc., by turning the urine red.

^[6] Lithotomy position is typically supine with the knees bent and legs elevated in stirrups. Use of this unusual set of Yellofin stirrups does not impact the coding.

^[7] An exam cannot be billed separately if a therapeutic procedure is performed during the same encounter.

^[8] This is the completion of the vaginal hysterectomy. Note that the uterus was not weighed, which will limit the code to be chosen.

^[9] Note that the tubes and ovaries were not removed, only examined. The final code choice includes this information.

^[10] Colpopexy using uterosacral ligaments by vaginal approach.

^[11] Control of normal intraoperative bleeding is included in surgical procedures and is not billed separately.

^[12] Anterior colporrhaphy.

- 13] Posterior colporrhaphy.
- 14] Cystoscopy performed only to verify that there was no damage to the bladder and ureters, which run parallel to the uterine artery near the cervix. Great care is usually taken not to sever the ureter when transecting the uterine artery in a vaginal hysterectomy. Injection of Indigo Carmine allows the surgeon to confirm the patency in the ureter as the red urine enters the bladder. The operative note indicates “strong uterine jets,” which confirm ureteral patency.
- 15] This is a thickening of the bladder muscle.
-

What are the CPT® and ICD-10-CM codes?

CPT® Code: 57260, 58260-51, 57283-59

ICD-10-CM Code: N81.3, N95.0, N32.89

Rationale:

CPT® Codes: To code the anteroposterior colporrhaphy, look in the CPT® Index for Colporrhaphy/Anteroposterior referring you to 57260-57265. The combined anteroposterior colporrhaphy repairs the vaginal wall reporting code 57260. In the CPT® Index, look for Hysterectomy/Vaginal. This leads you to several CPT® codes. Because the weight of the uterus is unknown, select the appropriate code for surgical technique with the lowest uterine weight. Upon reviewing the codes in the numeric section, the correct code for the vaginal hysterectomy is 58260. Cystoscopy procedure is bundled into the other procedures because it is performed only to verify that there is no damage to the bladder and ureters. Next look for Colpopexy/Vaginal. The colpopexy (57283) is bundled in 58260, but in this case, it is reported because the work for the colpopexy is separately documented from the anterior-posterior colporrhaphy. Modifier 59 is reported on code 57283 to indicate this. Modifier 51 is appended to 58260 to show the procedure was performed as a second procedure of lesser value during the same surgical session as the colporrhaphy.

ICD-10-CM Codes: The patient is diagnosed with a cystocele and the uterine prolapse. In the ICD-10-CM Alphabetic Index, look for Cystocele/female/with uterine prolapse - *see* Prolapse, uterus; Prolapse, prolapsed/uterus/complete N81.3. Next, look in the Alphabetic Index for Bleeding/postmenopausal which is reported with N95.0. The cystoscopy showed trabeculation of the bladder. Look in the Alphabetic Index for Trabeculation, bladder referring you to N32.89. Verify code selections in the Tabular List.



Case 1

Preoperative Diagnosis: Right thyroid follicular lesion.

Postoperative Diagnosis: Right thyroid follicular lesion. ^[1]

Operative Procedure: Right thyroid lobectomy. ^[2]

Findings: A large thyroid mass in the inferior aspect of the right thyroid. ^[3] The right recurrent laryngeal nerve was identified intact and there were bilateral movements of vocal cords post procedure.

Description of operative procedure:

The patient was identified and taken to the operating room. She was placed in a supine reverse Trendelenburg position on the operating table. Once adequate sedation was given, the patient was intubated. The neck was prepped and draped in a standard surgical fashion. Using a #15 blade, a linear incision was made approximately 2.0 cm above the sternal notch. This incision was carried through subcutaneous tissues and through the platysma until the anterior jugular veins were identified. Superior and inferior flaps were then created using electrocautery. A midline incision was then made separating the strap muscles. Once the thyroid was encountered, the right thyroid lobe was dissected free from the surrounding tissues. Using the harmonic scalpel, the superior, medial, and inferior vessels were divided. Using the harmonic scalpel, the isthmus was then divided free from the right thyroid lobe. The recurrent laryngeal nerve on the right side was identified and not touched during the case. The right thyroid lobe was explored revealing a single nodule. The right thyroid was then completely removed ^[4] from the trachea and the surrounding tissues. It was marked and sent off the table as a specimen. The cavity was then irrigated with saline and hemostasis was achieved using electrocautery. The fascia and the strap muscles were then approximated using 3-0 Vicryl suture and a drain was placed into the cavity, exiting the left aspect of the incision. The platysma was then reapproximated using 3-0 Vicryl suture. The skin was then reapproximated using 4-0 Monocryl suture in running subcuticular closure and covered with Dermabond. By the end of the procedure, the sponge, needle, and instrument counts were correct. The patient was extubated observing bilateral movement of the vocal cords.

^[1] Diagnosis to report if no further detail is found in the note.

^[2] Planned procedure. Review the operative report to verify this is the procedure performed.

^[3] The findings confirm the diagnosis.

^[4] This confirms the right thyroid lobectomy.

What are the CPT® and ICD-10-CM codes reported?

CPT® Code: 60220

ICD-10-CM Code: E04.1

Rationale: CPT® Code: In the CPT® Index, look for Lobectomy/Thyroid Gland/Total and you are directed to 60220–60225. Verify codes in the numeric section. The code selection depends on whether a contralateral subtotal lobectomy was performed. In this case, a contralateral subtotal lobectomy is not performed, making 60220 the correct code. The code description states with or without isthmusectomy.

ICD-10-CM Code: In the thyroid, a mass is considered a nodule. Look in the ICD-10-CM Alphabetic Index for Nodule(s), nodular/thyroid, and you are directed to E04.1. Verify code selection in the Tabular List.

Case 2

Preoperative Diagnosis: Papillary thyroid cancer.

Postoperative Diagnosis: Papillary thyroid cancer. ^[1]

Operative Procedure: Near total thyroidectomy. ^[2]

Anesthesia: General endotracheal.

Findings: Nodular right thyroid with parathyroids visualized.

Estimated Blood Loss: Approximately 100 cc.

Description of Operative Procedure: The patient was identified and taken to the operating room. She was placed in the supine position on the operating table. Once adequate sedation was given, the patient was intubated. A towel was placed behind the patient's shoulder blades and the neck slightly extended. The neck was prepped and draped in the standard surgical fashion. Using a #15 blade, the patient's old incision was excised. The incision was carried down through subcutaneous tissue. The superior and inferior flaps were created and using electrocautery, a midline incision was made. Once the strap muscles were identified, using blunt dissection, a plane was developed in between the strap muscle and the right thyroid. The right thyroid appeared nodular. Using blunt dissection and electrocautery, the right thyroid lobe was freed from surrounding tissues and removed. ^[3] Using the harmonic scalpel, two-thirds of the left thyroid lobe and the isthmus were removed, sparing the parathyroids and staying clear of the recurrent laryngeal nerve. ^[4] Once this was completed, hemostasis was achieved using electrocautery and Surgicel. Due to some bleeding around the parathyroid glands, Gelfoam and thrombin were placed over this area and the bleeding subsided. A round JP drain was then placed around the remaining thyroid tissue. The strap muscles were reapproximated using interrupted 3-0 Vicryl suture, the platysma was reapproximated using interrupted 3-0 Vicryl suture, and the skin was reapproximated using 4-0 Monocryl suture in an interrupted fashion and covered with Dermabond. By the end of the procedure, the sponge, needle, and instrument counts were correct. The patient was then transferred to the recovery room in stable condition.

^[1] Diagnosis to report if no further positive findings are found in the note.

^[2] Procedure planned. Review the body of the operative report to verify this is the procedure performed.

^[3] The patient's right thyroid lobe was removed.

^[4] Two-thirds of the patient's left thyroid lobe and isthmus were removed.

What are the CPT® and ICD-10-CM codes reported for the primary surgeon?

CPT® Code: 60225

ICD-10-CM Code: C73

Rationale: CPT® Code: Look in the CPT® Index for Thyroid Gland/Excision/for Malignancy. You have an option between a limited neck dissection and a radical neck dissection. A radical neck dissection includes removal of all of the lymph nodes on one side of the neck. A limited neck dissection includes removal of a limited number of lymph nodes. There is no mention of lymph node removal. Thyroidectomy/Partial directs you to codes 60210–60225. Verify codes in the numeric section. The right lobe was removed with part of the left lobe. This is best described with code 60225 for a total thyroid lobectomy, unilateral (right); with contralateral subtotal lobectomy (left), including isthmusectomy.

ICD-10-CM Code: The patient has papillary thyroid cancer. Look in the ICD-10-CM Alphabetic Index for Cancer - *see also* Neoplasm, by site, malignant. Look in the Table of Neoplasms for Neoplasm, neoplastic/thyroid (gland). The code in the Malignant Primary column is C73. Verify code selection in the Tabular List.

Case 3

Operative Report

Preoperative Diagnosis: Papillary carcinoma of the thyroid

Postoperative Diagnosis:

Papillary carcinoma of the left thyroid ^[1]

Lymph nodes exhibiting metastasis ^[2]

Procedure: Approximately 85% thyroidectomy (subtotal) ^[3]

Indications: The patient is a 43-year-old white female patient who was referred with a history of having been diagnosed in the fall of 20XX with a papillary carcinoma of the thyroid. ^[4] Thyroidectomy had been recommended to her; however, because she had no insurance, it became quite obvious that she was going to have a difficult time being cared for in another state where she was at the time. She returned to this area and came to the office. We completed her workup including PET scan, sestamibi scan for metastatic disease, etc. I recommended to her that we proceed with a subtotal thyroidectomy, and resect 85% of the thyroid. However, if we could isolate any parathyroids and preserve them, then we would do a total thyroidectomy. She appears to understand and is amenable to this and is willing to proceed.

Procedure: The patient was placed on the operating room table in the supine position, neck slightly hyperextended, and the table tilted in reverse Trendelenburg. The neck and anterior chest were prepped and draped in the usual sterile fashion. The incision was to be made two fingerbreadths above the sternal notch. Actually, there was a fold in her skin at this level and we simply followed this natural fold from the anterior border of the left sternocleidomastoid around to the anterior border on the right. This was deepened down through the subcutaneous tissue and the platysma muscle. Flaps were then created both superior and inferior to the incision, inferiorly to the sternal notch and superiorly well over and above the thyroid cartilage. At this point, it was quite apparent that the left lobe of the thyroid was rock hard, an entirely different feel from that of the right lobe.

We began on the left side with mobilization of the inferior pole. Vessels were serially clamped, cut, and ligated on the left lobe side of the thyroid. Sutures were placed for traction at the point of clamping, staying inside these vessels. The vessels were closed with a suture ligature of 3-0 silk. As the thyroid was mobilized, the recurrent laryngeal nerve was identified and avoided throughout the course of the dissection. There was a small lymph node attached to the side of the gland ^[5] which appeared to be metastatic disease. This was obviously included with the specimen sent to pathology for confirmation. We also removed several enlarged lymph nodes. ^[6] The inferior pole was entirely mobilized, and then the middle thyroid vessels were dealt with as well, staying well away from the recurrent laryngeal nerve. Then the superior pole vessels were likewise clamped, cut, and ligated. This allowed us to divide the isthmus on the right lobe side of the midline and then remove the left lobe ^[7] without difficulty. There was one small bleeding vessel on or immediately adjacent to the recurrent laryngeal nerve; therefore, a Surgicel packing was applied to this area and bleeding was controlled.

Then dissection began on the right side where we encountered a lesion toward the trachea which was half the size of a yellow pencil eraser and could have passed for a parathyroid. Biopsies of this were taken; however, they returned simply fatty tissues. ^[8] We mobilized the right lobe of the thyroid and left approximately 10% of the right lobe of the thyroid intact ^[9] at the superior end of the right thyroid lobe. When the portion of the lobe was amputated, we controlled the bleeding from the raw edge of the thyroid with multiple suture ligatures of 3-0 silk. Once hemostasis was secure, the procedure was terminated.

Hemostasis was secure throughout the wound. A 10 mm Jackson-Pratt drain was placed through a separate stab wound and left to lay in the midline or slightly to the left of the midline in the thyroid cavity. Strap muscles were closed in the midline with multiple interrupted figure-of-eight sutures of 2-0 Vicryl. The platysma muscle was closed with 2-0 Vicryl and the skin closed with a continuous running subcuticular closure of 3-0 Monocryl. Dermabond was applied to the wound, and the drain secured with an 0 silk and a small gauze dressing.

Prior to leaving the operating room, the patient was extubated and with the help of the anesthesia personnel, the glide scope was inserted into the hypopharynx and the larynx and vocal cords visualized, showing symmetric movement of the cords. This was confirmed by multiple observers. The procedure was terminated. The patient tolerated the procedure well and she was taken to the recovery area in stable condition. Estimated blood loss was 80 cc. Sponge and needle counts were correct times two.

-
- ^[1] Diagnosis to report if no further positive findings are found in the note.
 - ^[2] This is a working diagnosis. The lymph node exhibited signs of metastasis and was sent for pathologic testing. There is otherwise no confirmation of this status in the record.
 - ^[3] This is the procedure planned. Read the body of the operative report to verify this is the procedure performed.
 - ^[4] Confirmation of the diagnosis is reflected in the body of the report.
 - ^[5] The lymph node attached to the gland was removed.
 - ^[6] Several large lymph nodes were removed.
 - ^[7] The left lobe was removed.
 - ^[8] Lesion biopsy was negative for cancer.
 - ^[9] Part of the right lobe was removed.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® Code: 60252

ICD-10-CM Code: C73

Rationale: CPT® Code: Look in the CPT® Index for Thyroid Gland/Excision/for Malignancy. You have an option between a limited neck dissection and a radical neck dissection. A radical neck dissection includes removal of all of the lymph nodes on one side of the neck. A limited neck dissection includes removal of a limited number of lymph nodes. This procedure included a limited number of lymph nodes, making 60252 the correct code. Verify code selection in the numeric section.

ICD-10-CM Code: The patient has papillary thyroid cancer. Look in the ICD-10-CM Alphabetic Index for Cancer - *see also* Neoplasm, by site, malignant. Look in the Table of Neoplasms for Neoplasm, neoplastic/thyroid (gland). The code in the Malignant Primary column is C73. Verify code selection in the Tabular List. If the lymph nodes appearing metastatic are confirmed by pathology before coding, this would be coded as a secondary malignancy in addition to the thyroid cancer.

Case 4

Preoperative Diagnosis: Post-hemorrhagic hydrocephalus.

Postoperative Diagnosis: Post-hemorrhagic hydrocephalus. ^[1]

Operation:

1. Insertion of left frontal ventriculoperitoneal shunt. ^[2]
2. Removal of right frontal external ventricular drain. ^[2]

Primary surgeon and assistant surgeon used.

Anesthesia: General endotracheal.

Operative Indication: Patient is an 8-year-old boy who suffered a significant head trauma with intraventricular hemorrhage. He previously had an external ventricular drain placed. He failed clamp trial. ^[3] Plan was made for permanent shunt implantation. ^[4] The risks and benefits of surgery were discussed in detail with the patient and family. Risks include bleeding, infection, stroke, paralysis, seizure, coma, and death. All questions were answered in detail. I believe the patient and family understand the risks and benefits of surgery and wish to proceed.

Operative Account: Patient was brought in the operating room and placed under general endotracheal anesthesia. His head was turned to the right, and a shoulder roll was placed. He was then clipped, prepped, and draped in the usual sterile fashion. Using

the micropoint electrocautery, a half-moon incision was carried out over the patient's left coronal suture at the mid-pupillary line. The galea was divided and the scalp flap retracted. A second incision was created above and behind the pinna of the ear.

Attention was turned to the abdomen where a 2 cm incision was carried out just to the left and superior to the umbilicus. Using the micropoint electrocautery, subcutaneous dissection was carried down to the superficial rectus fascia. The fascia was secured with hemostats, elevated, and opened sharply in a vertical fashion. This allowed dissection of the underlying muscular fibers. We then secured the deep rectus fascia with hemostats, elevated this, and opened this sharply. The underlying peritoneum was visible. This was secured and opened, allowing easy passage of a #4 Penfield into the peritoneal cavity.^[5]

A subcutaneous tunneler was then used to bring a Medtronic BioGlide catheter from the abdominal to the retro-auricular incisions. This was then brought to the anterior incision. It was secured to the distal end of the Medtronic Delta valve, performance level 1, with 3-0 silk tie. The Midas perforator was then used to create a burr hole.^[6] The brain needle was then placed to the dura and electrocautery applied, creating a small durotomy, through which the brain needle was advanced. This was advanced into the ventricle^[7] with excellent return of cerebrospinal fluid under elevated pressure. We observed slightly stiff ependymal walls at the time of passage.

The brain needles were removed and a new Medtronic BioGlide ventricular catheter was advanced down this track with excellent return of cerebrospinal fluid. This catheter was trimmed and secured to the proximal end of the valve with 3-0 silk suture.^[8] Spontaneous flow of cerebrospinal fluid was observed at the distal end of the peritoneal catheter prior to placement within the peritoneum. All wounds were then thoroughly irrigated with vancomycin-containing saline, and 1 ml of vancomycin-containing saline was injected into the bulb of the shunt.

At the two cranial incisions, the galea was reapproximated with inverted 3-0 Vicryl suture. Skin edges were approximated with a running 5-0 Monocryl stitch. At the abdominal incision, the peritoneum and deep rectus fascia were closed with a 3-0 Vicryl pursestring. Superficial rectus fascia was closed with interrupted 3-0 Vicryl suture. Subcutaneous tissue was reapproximated with interrupted and inverted 3-0 Vicryl suture. Skin edges were reapproximated with a running 5-0 Monocryl stitch. That wound was washed and dried, and a sterile dressing was applied. At the cranial wound, the patient's hair was shampooed and bacitracin ointment applied to the wounds. The patient was awakened, extubated, and taken to the recovery room in stable condition.

^[1] Diagnosis to report if no further positive findings are found in the note.

^[2] These are the procedures planned; however, there is no documentation to support the removal.

^[3] What the initial surgery was and the reason for the procedure being performed.

^[4] Even though this was a planned procedure following the patient's failed clamp trial, the initial procedure has no global days.

^[5] Peritoneal access for the ventriculoperitoneal shunt.

^[6] A burr hole was created, but it is included in placement of the shunt.

^[7] Ventricular access for the ventriculoperitoneal shunt.

^[8] Insertion of the ventricular portion of the ventriculoperitoneal shunt.

What are the CPT® and ICD-10-CM codes reported for the primary surgeon?

CPT® Code: 62223

ICD-10-CM Code: G91.3

Rationale: CPT® Code: In the CPT® Index, look for Shunt/Brain/Creation and you are directed to 62180–62223. Review codes in the numeric section. Creation of a ventricular shunt is reported from the code range 62220–62223. Catheters were run from the peritoneal cavity to the ventricle, creating a ventriculoperitoneal shunt, which is reported with 62223. There is no documentation in the operative account to support the removal of the right frontal external ventricular drain. The initial surgery of the insertion of the ventricular catheter is code 61107 and there are no global days for this procedure. This means modifier 58 should not be used because there is no post-operative period.

ICD-10-CM Code: The diagnosis is post-hemorrhagic hydrocephalus due to head trauma. In the ICD-10-CM Alphabetic Index, look for Hydrocephalus/post-traumatic NEC G91.3. Verify code selection in the Tabular List.

Case 5

Operation Performed: Right-sided decompressive hemicraniectomy with duraplasty.^[1]

Complications: None.

Anesthesia: General endotracheal.

Estimated Blood Loss: Approximately 400 ml

Indications: The patient is a 56 year-old male with significant past medical history who came in this evening with an ischemic infarct^[2] to his right MCA^[3] territory which converted to hemorrhagic^[4] transformation. The significant shift was following commands on the right side and hemiplegia on the left side. After a thorough discussion with the family, we explained to them that this would be a life-saving procedure and we could not ensure that there would be any further neurological improvement from the state that he was in. They understood these risks and wanted to proceed ahead.

Operation performed: After informed consent was obtained, the patient was taken to the operating room and induced under general endotracheal anesthesia without incident. TEE monitor was placed due to the patient's significant cardiac history. At this point, a roll was placed underneath the right shoulder and the head was placed in a horseshoe reverse question mark. This area was sterilely prepped and draped in usual fashion. A #10 blade was used to make an incision sharply. Raney clips were applied to the skin edges. The temporalis fascia and muscle were then resected with the cutaneous flap anteriorly. This was done until the keyhole could be identified. The musculocutaneous flap was then retracted with towel hooks, rubber bands, and Allis clamps. The perforator was then used to make several burr holes (approximately six) and a footplate was then applied to perform the hemicraniectomy.^[5] We ensured that we were off midline to make certain that we did not get into the sagittal sinus or any draining veins associated with this. Once the bone was removed, hemostasis was obtained, the dura was opened in the C-shaped fashion and a large piece of Durepair was placed underneath this. There was a small subdural clot which was also evacuated and the large piece of Durepair was then used to create a duraplasty.^[6] This was stitched in several points with 4.0 nylon. Hemovac was then tunneled through, as well.

At this point, the galea and the temporalis fascia were then reapproximated with 0 Vicryl in interrupted fashion, and the overlying galea was reapproximated with 0 Vicryl in interrupted fashion. The overlying skin was closed with staples and the Hemovac drain was secured with 2-0 nylon. At the end of the case, all counts of the needles and sponges were correct.

^[1] This is the planned operation. Review the operative report to confirm it is the procedure performed.

^[2] Ischemic infarct is the initial diagnosis.

^[3] MCA is the middle cerebral artery.

^[4] The infarct converted to a hemorrhage.

^[5] Documentation supports performance of the hemicraniectomy.

^[6] The performance of the duraplasty is described.

What are the CPT® and ICD-10-CM codes reported?

CPT® Code: 61322

ICD-10-CM Code: I61.9

Rationale: CPT® Code: The surgeon is performing a decompressive hemicraniectomy with duraplasty. Burr holes, the placement of which are included in the procedure, are used to facilitate the decompressive hemicraniectomy. A dural opening is made to remove the subdural clot. Then, a reconstructive operation on the dura mater (duraplasty) is performed using the Durepair for closure. This procedure is indexed under Craniectomy. In the CPT® Index, look for Craniectomy/Decompression and you are directed to codes 61322-61323, 61340, and 61343. Confirm code 61322 in the numeric section as the correct code choice.

ICD-10-CM Code: The diagnosis is ischemic infarct to the middle cerebral artery territory. However, this converted to a hemorrhage. Look in the ICD-10-CM Alphabetic Index for Hemorrhage, hemorrhagic/artery/brain and you are directed to see Hemorrhage, intracranial, intracerebral. Look for Hemorrhage, hemorrhagic/intracranial/intracerebral (nontraumatic) (in) I61.9. Verify code selection in the Tabular List.

Case 6

Preoperative Diagnosis: Dorsal column stimulator generator malfunction.

Postoperative Diagnosis: Dorsal column stimulator generator malfunction. ^[1]

Procedure Performed: Replacement of dorsal column stimulator generator. ^[2]

Attending: John Smith, MD

Anesthesia: Monitored anesthetic coverage with local.

Estimated Blood Loss: Less than 5 ml

Specimens: None.

Drains: None.

Complications: None.

Implants: Medtronic prime advanced nonreconstructable generator.

Indications: This woman has a dorsal column stimulator in place and has benefited from the therapy. Her current device has a complication in which it began malfunctioning approximately a month prior to this procedure and she has gradually noticed declining effectiveness. The device was interrogated approximately a week prior to this procedure and telemetry was obtained, indicating a breakdown of the battery. ^[3] On this basis, revision of the device was offered and accepted.

Procedure in brief: After extensive preoperative counseling, informed consent was obtained. The patient was brought to the operating room and positioned on the table in the left lateral decubitus position. Sedation was induced and a dose of IV antibiotics was administered. A wide area of the right lateral flank region surrounding her existing scar was prepped and draped in standard fashion and infiltrated with 0.5% Marcaine with 1:200,000 epinephrine. The skin was incised. The pouch housing the existing generator was entered. This was explanted and a new prime advanced generator was prepared. ^[4] The leads were disconnected from the old generator and connected to the new generator in the same orientation. ^[5] An impedance test was performed, which yielded acceptable results. The generator was implanted and secured to the fascia using 0 Ethibond suture. The wound was irrigated copiously and closed in layers using interrupted 0 and 3-0 Vicryl sutures followed by Mastisol and Steri-Strips to reapproximate the skin. Sterile dressing was applied. The patient was aroused from sedation and taken to the recovery area in good condition. All final needle and sponge counts were correct. There were no apparent complications.

^[1] The postoperative diagnosis is used for coding unless further detail is found in the body of the operative report.

^[2] Battery.

^[3] Documentation reveals that battery malfunction in the device is the reason for the surgery.

^[4] The old generator with battery is taken out and replaced with a new one.

^[5] The same leads were used.

What are the CPT® and ICD-10-CM codes reported?

CPT® Code: 63685

ICD-10-CM Code: T85.113A

Rationale: CPT® Code: A dorsal column stimulator is a spinal cord stimulator. Look in the CPT® Index for Replacement/Neurostimulator/Pulse Generator/Receiver/Spinal and you are directed to code 63685. Verify this as the correct code in the numeric section. The removal of the original pulse generator is included and should not be reported separately.

ICD-10-CM Code: There was a battery malfunction (breakdown) involving the column stimulator. Look in the ICD-10-CM Alphabetic Index for Complication(s)/nervous system/electronic stimulator (electrode(s)) - see Complications, electronic stimulator device. Look for Complications/electronic stimulator device/generator/breakdown and you are directed to T85.113. Turn to the Tabular List to complete the code for the type of encounter. A 7th character of A is selected for the initial encounter. The complete code is T85.113A.

Case 7

Preoperative Diagnosis: Acute epidural hematoma ^[1]

Postoperative Diagnosis: As above

Anesthetic Agent: General Endotracheal

Operation: Left craniotomy for evacuation of epidural hematoma (emergent) ^[2]

Indications: : The patient presented with a history of a motor vehicle accident. ^[3] He presented to the emergency department neurologically intact. An urgent CT scan revealed a large epidural hematoma and the patient was taken emergently to the operating room for evacuation.

Procedure/Techniques/Description of Findings/Condition of Patient: The patient was brought to the operating room and after induction of adequate general anesthesia, was prepped and draped in the usual sterile fashion for a left frontotemporal parietal craniotomy. ^[4] A curvilinear incision was made beginning just anterior to the left ear, curving posteriorly, then upward and anteriorly, to and at the hair line just off the midline. The resulting musculocutaneous flap was then reflected anteriorly. Multiple burr holes ^[5] were then placed and connected using the high-speed drill to create a large free bone flap. This was removed from the immediate operative field. Directly beneath the bone flap was a large well-formed clot which delivered itself from the epidural space. A bleeding point was found in the region of the middle meningeal artery. This was carefully and thoroughly coagulated using bipolar cauterization. A small opening was then made in the dura to ensure that there was not an underlying blood clot. There was not. This opening was primarily closed using 4-0 Nurolon. Additional meticulous hemostasis was then obtained. The bone flap was then replaced and held in place using multiple K LS fixation devices. Skin was then reapproximated using 2-0 Vicryl for the subcutaneous tissues and 5-0 Monocryl for the skin. The patient was then awakened from anesthesia at which time his vital signs were stable and he was neurologically improved from preoperatively.

Estimated Blood Loss: 100 cc

Specimens: None

Labs Ordered: None

Diagnostic Procedures Ordered: None

Complications: None

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- ^[1] Postoperative diagnosis is indicated as same as pre-operative diagnosis.
 - ^[2] This is the procedure that is planned. Review the operative report to confirm the procedure. The location of the hematoma found here will assist in CPT® code selection.
 - ^[3] The patient is in the acute phase of treatment for injuries caused by the motor vehicle accident, requiring an external cause code.
 - ^[4] A parietal craniotomy is performed and will assist in code selection.
 - ^[5] Burr holes were created but are included in the primary procedure.
-

What are the CPT® and ICD-10-CM codes?

CPT® Code: 61312

ICD-10-CM Codes: S06.4X0A, V89.2XXA

Rationale: CPT® Code: Look in the CPT® Index for Hematoma/Brain/Evacuation via Craniotomy and you are directed to code range 61312–61315. Review codes in the numeric section. First, the code selection is narrowed by knowing if the craniotomy is supratentorial or infratentorial. The tentorium lies in between the occipital lobes and the cerebellum. Supratentorial is above the tentorium and infratentorial is below the tentorium. This is a parietal craniotomy, indicating it is supratentorial (or above the tentorium). Then the code selection is based on where the hemotoma is located. In this case, it is epidural, making 61312 the correct code.

ICD-10-CM Codes: In the ICD-10-CM Alphabetic Index, look for Hematoma/epidural (traumatic) – see Injury, intracranial, epidural hemorrhage. Look for Injury/intracranial (traumatic)/epidural hemorrhage (traumatic) and you are directed to S06.4X-. Turn to the Tabular List to complete the code. The 6th character identifies whether there was loss of consciousness and, if so, for how long; the 7th character is for the type of encounter. With no loss of consciousness, 6th character 0 is reported (S06.4X0-). The 7th character is A for an initial encounter. The complete code is S06.4X0A.

The patient was brought in after a motor vehicle accident, requiring an external cause code. In the ICD-10-CM External Cause of Injuries Index, look for Accident/motor vehicle NOS and the default code is V89.2- (the documentation does not state what type of traffic accident). Turn to the Tabular List to complete the code. A 7th character is required, necessitating two placeholder Xs for the 5th and 6th characters. The 7th character of A is chosen to denote the initial encounter. Code V89.2XXA is correct.

Case 8

Preoperative Diagnoses:

1. Low back pain.
2. Degenerative lumbar disc.

Postoperative Diagnoses:

1. Low back pain. ^[1]
2. Degenerative lumbar disc. ^[1]

Procedure Performed: Bilateral paravertebral facet joint injection of steroid at the L3–L4 and L4–L5 with fluoroscopic guidance. ^[2]

Description of Procedure: The patient was transferred to the operative suite and placed in the prone position with a pillow under the abdomen. A smooth IV sedation was given with midazolam and fentanyl. The patient's back was prepped with Betadine in a sterile fashion, and we used lidocaine, 1% plain as a local anesthetic at the injection site. With the use of fluoroscopic assistance, ^[3] first to the right and then to the left 20 degrees, the scotty-dog view was identified, and we were able to place the spinal 22-gauge

needle, first to the **right L3–L4, then to the right L4–L5, then to the left L3–L4, and then to the left L4–L5.** ^[4] We used a lateral X-ray to assess the proper placement of the needle. We proceeded to inject a mixture of 4 ml of 0.25% Marcaine plain plus 80 mg of methylprednisolone divided between the four joints. The needles were removed. The patient's back was cleaned, and a Band-Aid was applied. The patient was transferred to the recovery area with no apparent procedural complications.

^[1] Diagnosis to report if no further positive findings are found in the note.

^[2] This is the working procedure. Read the body of the operative report to confirm it is the procedure performed.

^[3] Fluoroscopic guidance was used.

^[4] Four injection points are specified.

What are the CPT® and ICD-10-CM codes?

CPT® Codes: 64493-50, 64494-50

ICD-10-CM Code: M51.36

Rationale: CPT® Codes: In the CPT® Index, look for Injection/Paravertebral Facet Joint/Nerve/with Image Guidance and you are directed to code range 64490–64495. In the numeric section, code selection is dependent on the location of the injection and how many levels are injected. Code range 64493–64495 is for the lumbar or sacral region. 64493 is reported for the first level (L3–L4). Code 64494 is reported for the second level (L4–L5). Modifier 50 is appended since both levels were bilateral. Fluoroscopy is included and not reported separately.

ICD-10-CM Codes: The diagnoses listed are low back pain and degenerative lumbar disc. Low back pain is a symptom of degenerative lumbar disc and is not coded separately. Look in the ICD-10-CM Alphabetic Index for Degeneration, degenerative/disc disease and you are directed to *see* Degeneration, intervertebral disc NEC. Look in the Alphabetic Index for Degeneration, degenerative/intervertebral disc/lumbar region M51.36. Verify code selection in the Tabular List.

Case 9

Preoperative Diagnosis: Spinal stenosis at L4–L5

Postoperative Diagnosis: Spinal stenosis at L4–L5

Operation Performed: **L4–L5 laminotomy, right foraminotomy, bilateral decompression of the lateral recess** ^[1]

Operative Anesthesia: General endotracheal tube anesthesia.

Estimated Blood Loss: Minimal.

Operative Complications: None apparent.

Operative Findings: **Tight stenosis at L4–L5 from ligament hypertrophy and facet arthropathy.** ^[2]

Operative Indications: The patient is a 51 year-old gentleman. He has had ongoing **lower extremity pain with numbness and tingling on the right side more so than the left side.** ^[3] He has had paresthesias. He has had progressive loss of strength. He has had very little back pain, however. The patient is brought to the operating room for operative decompression following an MRI scan that showed tight spinal stenosis at L4–L5, having failed conservative measures to date.

Description of procedure: The patient was given 1 gm of Kefzol preoperatively. He was taken to the operating room where he underwent general endotracheal tube anesthesia without complications. All appropriate anesthetic monitors and lines were placed. He was placed prone onto a Wilson frame which was padded in the usual fashion. All pressure points were checked and padded appropriately. The patient's back was then outlined with a marking pen through the L4–L5 level in a vertical direction. He was then prepped using Prevail solution and allowed to dry. He was draped using sterile technique. Marcaine 0.25% with

1:200,000 units of epinephrine was instilled in the proposed incision for a total of 10 cc of injection. Using a #10 blade scalpel, a vertical midline incision was made. The soft tissues were dissected down to the thoracolumbar fascia using Bovie coagulation. The fascia was incised on the right hand side and the paraspinal muscles were stripped off the lamina and spinous processes of L4 and L5 on the right. A self-retaining Taylor retractor was placed into the wound and **intraoperative fluoroscopy**^[4] revealed the L4–L5 level. The soft tissue in the interlaminar space was then resected with a rongeur. The ligamentum flavum was resected with Kerrison punches and cervical curets. **The laminotomy was performed on the superior aspect of L5 and the undersurface of L4. The laminotomy was taken out to the medial edge of the right pedicle.**^[5] **A foraminotomy was performed with a #3 Kerrison punch for the exiting right L5 nerve root. The lateral recess was now decompressed.**^[6] The disc was inspected and found not to be ruptured. **We then performed a similar procedure on the left and the laminotomy was taken to the medial edge of the left pedicle.**^[7] **We then decompressed the patient’s left side by slightly depressing the thecal sac with cottonoids and under-cutting the interspinous ligament with Kerrison punches so that the left lateral recess was also decompressed from overgrowth of the ligamentum flavum.**^[8] The wound was copiously irrigated using warm bacitracin solution. Depo-Medrol 40 mg in 1 cc was placed epidurally. A piece of Gelfoam was placed over the laminotomy defect to try to preserve the epidural space, and the wound was ready for closure. During all areas of closure, bacitracin irrigation was used in copious amounts. The fascia was closed with #0 Vicryl in an interrupted fashion. The subcutaneous tissue was closed with #30 Vicryl in an interrupted fashion. The skin was closed with #40 Vicryl in an interrupted fashion to the subcuticular space. Steri-Strips were placed on the wound. A sterile dressing was placed. The patient was taken to the recovery room in stable condition with sponge and needle counts correct times three.

^[1] This is the procedure planned. Read the body of the operative report to confirm.

^[2] Confirmation of postoperative diagnosis.

^[3] These symptoms are consistent with neurogenic claudication.

^[4] Intraoperative fluoroscopy was used.

^[5] The laminotomy is described to the right pedicle.

^[6] This describes right-sided foraminotomy.

^[7] Decompression was performed on the right side.

^[7] The laminotomy to the left pedicle is described.

^[8] Decompression of the left side was also performed.

What are the CPT® and ICD-10-CM codes?

CPT® Code: 63030-50 or 63030-RT, 63030-LT

ICD-10-CM Code: M48.061

Rationale: CPT® Code: The main procedure performed is the laminotomy between L4–L5. A laminotomy is partial removal of the lamina, also referred to as a hemilaminectomy. In the CPT® Index, look for Hemilaminectomy and you are directed to codes 63020–63044. In the numeric section, the code selection is based on the location and whether it is a re-exploration. This was not a re-exploration and was performed on the lumbar spine, making 63030 the correct code choice. This code also includes the decompression and the foraminotomy. The procedure was performed on both sides, so modifier 50 is reported or modifiers RT and LT are both applied to code 63030.

ICD-10-CM Code: For spinal stenosis, look in the ICD-10-CM Alphabetic Index for Stenosis, stenotic/spinal/lumbar region M48.061. Verify code selection in the Tabular List.

Case 10

Preoperative Diagnosis: Left L5 radiculopathy; left L5–S1 neural foraminal stenosis.

Postoperative Diagnosis: Left L5 radiculopathy; left L5–S1 neural foraminal stenosis. ^[1]

Procedure Performed: L5-S1 hemilaminectomy with left foraminotomy; microsurgical technique. ^[2]

Anesthesia: General endotracheal.

Estimated Blood Loss: 25 ml.

Specimens: None.

Drains: None.

Complications: None.

Indications: This woman has a history of left lower extremity L5 radicular pain. She has had previous surgery in the lumbar region for a herniated disc.^[3] Her preoperative exam was remarkable for subjective complaints in an L5 pattern on the left. Her MRI scan showed high-grade neural foraminal narrowing on the left due to facet arthropathy. Based on these findings, treatment options were discussed including ongoing conservative therapy and surgical intervention. After contemplating alternatives, the patient elected to proceed with surgery.

Description of Procedure: After extensive preoperative counseling, informed consent was obtained. The patient was brought to the operating room, intubated, placed under general anesthesia, and positioned in the prone position. A wide area of the lumbar region was prepped and draped in standard fashion. A midline incision was marked overlying the L5–S1 spinous processes and infiltrated with 0.5% Marcaine with 1:200,000 epinephrine. A standard surgical timeout was performed wherein the patient was identified and the surgical site and procedure were confirmed. Preoperative dose of antibiotics was administered IV. The skin was incised and subcutaneous bleeding points were controlled. The subcutaneous fat was transgressed to the lumbodorsal fascia, which was incised in the midline from the top of the spinous process of L5 through the bottom of the spinous process of S1. Paraspinal musculature was elevated subperiosteally and reflected laterally towards the patient's left. A high speed osteotome was used to create a trailing edge laminotomy of L5 and a leading edge laminotomy of S1, encompassing the medial third of the facet complex.^[4] Microscope was then employed for magnification and illumination.^[5] A variety of curettes and rongeurs were then used to complete the laminotomy. The bone resection was carried laterally until the medial edge of the pedicle was encountered. As the bone resection and ligamentous resection was conducted, a large fragment of synovium type material with admixed scar tissue was extracted, resulting in marked decompression of the thecal sac and root sleeve.^[6] A probe could then be admitted through the neural foramen. For this aspect of the procedure, the microscope was utilized for magnification and illumination.^[7] A confirmatory X-ray was obtained with the probe inserted through the L5–S1 foramen; both the L5 and S1 root sleeves were directly visualized and were completely without impingement.^[8] Hemostasis was achieved with bipolar coagulation. A bulging of the disc was appreciated, but the decision was made to forego a discectomy. A pledget of fat was harvested from the subcutaneous tissue and tucked in the laminotomy defect. A layered closure was then conducted using interrupted 0 Vicryl sutures. The lumbodorsal fascia was closed using interrupted 0 Vicryl sutures in watertight fashion. The skin was closed using interrupted buried subcuticular 3-0 Vicryl sutures followed by Mastisol and Steri-Strips. Sterile dressing was applied. The patient was aroused from anesthesia and extubated without difficulty. All final needle and sponge counts were correct. There were no perioperative complications.

^[1] The postoperative diagnosis is used for coding and is reported if no different or more specific findings are found in the body of the operative report.

^[2] This is the working procedure until the report is read.

^[3] Due to her previous lumbar herniated disc surgery, her current procedure is considered a re-exploration.

^[4] The laminotomy is described.

^[5] Use of a surgical microscope qualifies the procedure as microsurgery.

- 6] Decompression was performed.
 - 7] The surgical microscope was used again.
 - 8] Confirmation of foraminotomy is present in the body of the report.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® Code: 63042-LT

ICD-10-CM Codes: M54.16, M48.07

Rationale: CPT® Code: The main procedure performed is the laminotomy between L5-S1. A laminotomy is partial removal of the lamina, also referred to as a hemilaminectomy. In the CPT® Index, look for Hemilaminectomy and you are directed to codes 63020–63044. In the numeric section, code range 63040–63044 is for reexplorations. The code selection is further defined by location. Code 63042 is the correct code. The use of the microscope is included in this procedure and should not be reported separately. Although code 63042 does not appear in the list of procedure codes considered be inclusive of microsurgery (code 69990). Add a note in your code book next to 69990 that codes 63001–63066 are bundled according to NCCI.

ICD-10-CM Codes: Look in the ICD-10-CM Alphabetic Index for Radiculopathy/lumbar region M54.16. Spinal stenosis is narrowing of the spine. Look in the Alphabetic Index for Stenosis/spinal/lumbosacral region M48.07. Verify both code selections in the Tabular List.



Case 1

Anesthesia: Laryngeal mask anesthesia.

Preoperative Diagnosis: Retinal detachment, right eye.

Postoperative Diagnosis: Retinal detachment, right eye. ^[1]

Procedure: Scleral buckle, cryoretinopexy, drainage of subretinal fluid, C3F8 gas in the right eye.

Procedure: After the patient had received adequate laryngeal mask anesthesia, he was prepped and draped in usual sterile fashion. A wire lid speculum was placed in the right eye.

A limbal peritomy was done for 360 degrees using 0.12 forceps and Westcott scissors. Each of the intramuscular quadrants was dissected using Aebli scissors. The muscles were isolated using a Gass muscle hook with an 0 silk suture attached to it. The patient had an inspection of the intramuscular quadrants and there was no evidence of any anomalous vortex veins or thin sclera. **The patient had an examination of the retina using an indirect ophthalmoscope and he was noted to have 3 tears in the temporal and inferotemporal quadrant and 2 tears in the superior temporal quadrant.** ^[2] These were treated with **cryoretinopexy.** ^[3] Most posterior edge of each of the tears was marked with a scleral marker followed by a surgical marking pen. The patient had 5-0 nylon sutures placed in each of the 4 intramuscular quadrants. The 2 temporal sutures were placed with the anterior bite at about the muscle insertion, the posterior bite 9 mm posterior to this. In the nasal quadrants, the anterior bite was 3 mm posterior to the muscle insertion and the posterior bite was 3 mm posterior to this. A 240 band was placed 360 degrees around the eye and a 277 element from approximately the 5-1 o'clock position. The patient had another examination of the retina and was noted to have a moderate amount of subretinal fluid, so a **drainage sclerotomy site was created at approximately the 9:30 o'clock position incising the sclera until the choroid was visible.** ^[4] The choroid was then punctured with a #30-gauge needle. A moderate amount of subretinal fluid was drained from the subretinal space. The eye became relatively soft and 0.35 ml of C3FS gas was injected into the vitreous cavity 3.5 mm posterior to the limbus. The superior temporal and inferior temporal and superior nasal sutures were tied down over the scleral buckle. **The 240 band was tightened up and excessive scleral buckling material was removed from the eye.** ^[5] The inferior nasal suture was tied down over the scleral buckle and all knots were rotated posteriorly. The eye was reexamined. The optic nerve was noted to be nicely perfused. The tears were supported on the scleral buckle. There was a small amount of residual subretinal fluid. The patient received posterior sub-Tenon Marcaine for postoperative pain control. The 0 silk sutures were removed from the eye. The conjunctiva was closed with #6-0 plain gut suture. The patient received subconjunctival Ancef and dexamethasone. The patient was patched with atropine and Maxitrol ointment.

The patient tolerated the procedure well and returned to the postoperative recovery room.

^[1] The postoperative diagnosis is used for coding.

^[2] Exam reveals the location of the tears.

^[3] Cryoretinopexy is the use of intense cold to close the tear in the retina.

^[4] A sclerotomy is performed to drain subretinal fluid.

^[5] Sclera buckling is performed.

What are the CPT® and ICD-10-CM codes?**CPT® code:** 67107-RT**ICD-10-CM code:** H33.021**Rationale:**

CPT® code: Multiple procedures are performed to repair the retinal detachment. In the CPT® Index, look for Retina/Repair/Detachment/by Scleral Buckling. Review the code descriptions that are referred to in the index. All components of the procedure are described with code 67107. Documentation indicates that gas was injected into the vitreous cavity. This documentation does not support reporting code 67110. To report code 67110, the gas is injected through the sclera to flatten the retina against the choroid, followed by a laser or cryotherapy to seal the retinal tear.

ICD-10-CM code: The indication for the surgery is retinal detachment. The physician documents retinal tears when the retina is examined. To determine the ICD-10-CM code, look in ICD-10-CM Alphabetic Index for Detachment/retina/with retinal/break/multiple H33.02-. In the Tabular List the 6th character 1 is reported for the right eye for a complete code, H33.021.

Case 2**Preoperative Diagnosis:** Dacryostenosis, both eyes.**Postoperative Diagnosis:** Dacryostenosis, both eyes.**Procedure Performed:** Nasolacrimal duct probing, both eyes.**Anesthesia:** General.**Condition:** To recovery, satisfactory.**Counts:** Needle count correct.**Estimated Blood Loss:** Less than 1 mL.**Informed Consent:** The procedure, risks, benefits, and alternatives were thoroughly explained to the patient's parent who understands and wants the procedure done.

Procedure: The patient was prepped and draped in the usual sterile manner under **general anesthesia**.^[1] Starting on the **right eye**^[2] the upper punctum was dilated with double-ended punctal dilator, and starting with a 4-0 probe, increasing up to a 2-0 probe, the **nasolacrimal duct was dilated until probed patent**.^[3] Then, using a curved 23-gauge punctal irrigator, 0.125 ml of sterile fluorescein stained saline was easily irrigated down the nasolacrimal duct into the nostril where it was carefully collected with a clear #8 catheter. The instruments were removed and an **identical procedure was done on the opposite eye nasolacrimal duct**.^[4] TobraDex eye drops were placed in each lower cul-de-sac. The eyelids were closed. The patient left the operating room for recovery in satisfactory condition.

^[1] General anesthesia is used for this procedure.

^[2] This indicates the procedure is performed on the right eye.

^[3] This indicates the nasolacrimal duct is probed.

^[4] The same procedure is performed on the left eye.

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 68811-50 or 68811-RT, 68811-LT

ICD-10-CM code: H04.553

Rationale:

CPT® codes: In the CPT® Index, look for Nasolacrimal Duct/Exploration/with Anesthesia. When this procedure is performed using general anesthesia, the code selection is 68811. During this encounter, the provider probes the nasolacrimal duct of the right and left eyes. There is a parenthetical note to append modifier 50 if the procedure is performed bilaterally. Some payers may require you to use modifier LT and RT instead of modifier 50. If that is the case, submit 68811-RT and 68811-LT. Payer policy will dictate how the procedures are reported. For certification exams purposes, follow the coding guidelines in CPT® and append modifier 50 to the procedure code.

ICD-10-CM Code: The patient is diagnosed with dacryostenosis. In the ICD-10-CM Alphabetic Index, look for Dacryostenosis, which refers you to - *see also* Stenosis, lacrimal. There is no indication the condition is congenital. Look for Stenosis/lacrimal/duct H04.55-. In the Tabular List, 6th character 3 is reported for both eyes, making the complete code H04.553.

Case 3

Preoperative Diagnosis: Bilateral protruding ears.

Postoperative Diagnosis: Bilateral protruding ears.

Procedure: Bilateral otoplasty.

Anesthesia: General.

Estimated Blood Loss: Minimal.

Complications: None.

Procedure is as Follows: The patient was placed supine then prepped and draped in the usual sterile fashion. Measurements were taken from the helix to the mastoid at the superior, mid, and inferior portions and they were within 1 to 2 mm of the same bilaterally and were approximately 17 mm superior, 24 mm middle, and 25 mm inferior. The right ear was begun first.^[1] A curved incision was made just anterior to the sulcus^[2] of the posterior ear. This was done with a 15-blade scalpel. Electrocautery was used for hemostasis and further dissection. An iris scissors was used to dissect the soft tissues off of the mastoid region and the posterior ear. The concha was shut back and sutured in place with clear 4-0 nylon suture and in a horizontal mattress pattern.^[3] Three tacking sutures were used. This brought the ear back approximately 2 to 3 mm. However, greater correction was needed and Mustarde' sutures were placed.^[4]

The mid and superior portions of the antihelical fold were placed.^[5] These were spaced widely on either side of the helical fold. They were then sutured in place, tacking the fold more acutely to a point that was deemed acceptable and held in that position. Next, a margin of skin was excised along the posterior ear and closure of the wound was performed with 5-0 chromic suture. Prior to closure, full hemostasis had been obtained with electrocautery. Both ears were done in the exact same fashion; therefore, only one is dictated in detail.^[6]

The patient was then checked very carefully for symmetry. Postoperative measurements were approximately 14 mm superior, 15 mm mid, and 16 mm lower.

^[1] Procedure is performed on the right ear.

^[2] An incision is made.

^[3] The concha, which is the external part of the ear, is sutured in place.

- ^[4] This is a suturing technique used to perform otoplasty.
 - ^[5] There are a total of three portions of the external ear that are repaired during this otoplasty.
 - ^[6] This indicates that a bilateral procedure is performed.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 69300-50

ICD-10-CM code: Q17.5

Rationale:

CPT® code: An otoplasty is performed, which is a surgical fixation of the external ear. The patient has protruding ears that are being corrected. In the CPT® Index, look for Otoplasty, which refers the coder to 69300. The code description matches the procedure performed. There is a parenthetical note that states if performed bilaterally to append modifier 50. If 69300 was performed under Moderate (Conscious) Sedation, an additional code from code range 99151-99157, would be reported with the appropriate documentation, but because general anesthesia is used no additional code is warranted.

ICD-10-CM code: To determine the diagnosis code, look in the ICD-10-CM Alphabetic Index for Prominence, prominent/auricle (congenital) (ear) Q17.5. The cause of protruding ears develops at birth and the appearance of the protrusion can be seen later in life. Verify code selection in the Tabular List.

Case 4

Operative Report

Preoperative Diagnosis: Foreign body, right external ear canal.

Anesthetic: General. Time began: 10:15 a.m. Time ended: 10:35 a.m.

Postoperative Diagnosis: Foreign body, right external ear canal. ^[1]

Pathology Specimen: None.

Operation: Removal of foreign body using the microscope.

Date of Procedure: 05/12/xx Time began: 10:21 a.m. Time ended: 10:22 a.m.

Description of Operation: Under general anesthesia ^[2] with the microscope in place, a pearly white plastic ball was seen virtually obstructing the entire ear canal. Gently with a curette, this was teased out of the ear canal atraumatically. ^[3] The ear canal and eardrum were perfectly intact.

The patient tolerated the procedure well and was returned to the recovery room in satisfactory condition.

^[1] The postoperative diagnosis is used for coding.

^[2] General anesthesia is used.

^[3] The foreign body is removed.

What are the CPT® and ICD-10-CM codes reported?**CPT® code:** 69205-RT**ICD-10-CM code:** T16.1XXA**Rationale:****CPT® code:** Look in the CPT® Index for Removal/Foreign Body/Auditory Canal, External/with Anesthesia, 69205. Modifier RT is appended to report the procedure was performed on the right ear.**ICD-10-CM code:** To locate the diagnosis code, look in the ICD-10-CM Alphabetic Index for Foreign body/entering through orifice/ear (external) T16.-. In the Tabular List, a 7th character of A is reported for the initial visit. Two placeholder Xs are reported to keep the 7th character in the seventh position. Placeholder X is used with certain codes to allow for future expansion.**Case 5****Preoperative Diagnosis:** Cataract, right eye.**Postoperative Diagnosis:** Cataract, right eye. ^[1]**Procedure:**

1. Complex phacoemulsification with manual stretch of the iris, right eye.
2. Peripheral iridectomy, right eye.

Anesthesia: Topical. ^[2]**Indications:** The patient was seen in the Ophthalmology office with a complaint of decreased vision in the right eye and was diagnosed with a cataract in the right eye. The patient was symptomatic and therefore, given the option of cataract surgery for improved vision or observation. The details of the procedure were discussed at length as well as the potential risks, which include, but are not limited to, permanent decrease of vision from infection, inflammation, bleeding, retinal detachment and need for reoperation. The patient understood the above and desired to proceed with cataract surgery.**Description of Procedure:** The patient received dilating drops and anesthesia in the preoperative area and was later brought into the operating room. The patient was sedated by the anesthesia staff. The patient was then prepped and draped in the usual sterile manner. The microscope was focused onto the right eye and the speculum was inserted to separate the eyelids. ^[3] The tip of the 2.8 mm keratome blade was used at the 6:00 o'clock position to create the paracentesis that after which Amvisc plus was injected into the anterior chamber to create a deep anterior chamber. The same blade was used at 1:00 o'clock to create the main clear corneal wound into the anterior chamber. ^[4] A two hand technique using iris expansion devices was used to expand the size of the pupil. ^[5] The instruments were used at the sites directly opposite of one another to stretch the iris. They were then rotated 180 degrees to stretch the iris in that new meridian. The cystotome needle on the balanced salt solution syringe was used to initially create the capsulorrhexis flap and the capsulorrhexis forceps were used to create the continuous capsulorrhexis tear. ^[6] A flat tip hydrodissection cannula on the balanced salt solution syringe was used to hydrodissect and hydrodelineate the lens. The phacoemulsification unit was used to remove the nucleus and irrigation and aspiration was used to remove the residual cortex. ^[7] The bag was inflated with Amvisc plus and a lens of 27.5 diopter model SI40MB was injected into the bag ^[8] and then dialed into place. The Amvisc plus was removed with irrigation and aspiration mode. The anterior chamber was then inflated to the appropriate firmness using balanced salt solution. After the globe was inflated to the appropriate firmness, 0.1 cc of Vancomycin was injected into the anterior chamber. The wounds were checked for leakage and none was found. The globe was checked for appropriate firmness and found to be desirable. The speculum was disinserted and the patient was brought into the postoperative area where postoperative instructions for surgical eye care were given, including the use of topical eye drops and the need for subsequent follow up.^[1] The postoperative diagnosis is used for coding.^[2] Topical anesthesia is used.

- ^[3] The procedure begins in the right eye.
- ^[4] This describes the approach.
- ^[5] Manual iris expansion.
- ^[6] A capsulorrhexis tear is created.
- ^[7] Phacoemulsification is used to break up the lens so it can be removed.
- ^[8] An intraocular lens is inserted.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 66982-RT

ICD-10-CM code: H26.9

Rationale:

CPT® code: This case is coded as an extracapsular cataract removal because phacoemulsification is performed. The physician also uses devices to expand the iris and a capsulorrhexis tear is created making this a complex procedure. In the CPT® Index, look for Cataract/Extraction/Removal/Extracapsular and you are referred to 66982, 66984. Code 66984 includes the insertion of intraocular lens prosthesis, which was not performed. The procedures are reported with 66982. An iridectomy is included in code 66982 and would not be billed separately. Modifier RT is appended to report the procedure was performed on the right eye.

ICD-10-CM code: The patient is diagnosed with a cataract in the right eye. In the ICD-10-CM Alphabetic Index, look for Cataract H26.9. There is no additional information provided to select a more specific diagnosis code. Verify code selection in the Tabular List.

Case 6

IV Sedation and Local ^[1]

Preoperative Diagnosis: Cataract of the left eye

Postoperative Diagnosis: Cataract of the left eye ^[2]

Procedure Performed: Cataract extraction, foldable posterior chamber intraocular lens of the left eye ^[3]

Procedure: The patient was brought to the operating room and placed supine on the operating table. An intravenous line was started in the patient's left arm. After appropriate sedation, a left O'Brien and left retrobulbar block were administered, ^[4] which consisted of a 50/60 mixture of 0.75% Bupivacaine and 2% lidocaine. The Honan balloon was then placed over the operative eye. While the surgeon scrubbed for 5 minutes the patient was prepped and draped in the usual sterile fashion including instillation of 5% Betadine solution to the left cornea and cul-de-sac, ^[5] which was irrigated with balanced salt solution and the use an eyelid drape. A limbal incision ^[6] was performed with the super sharp blade. Provisc was injected into the anterior chamber. A capsulotomy was performed with a cystitome and Utrata forceps ^[7] such that it was 6 mm and oval in shape. Hydrodissection was performed with balanced salt solution. The nucleus was removed using the phacoemulsification ^[8] mode of the Alcon 20,000 Legacy Series System by divide and conquer technique under Viscoat control. The cortex was removed using the irrigation aspiration mode. The anterior chamber was then filled with Proviso and the AcrySof foldable posterior chamber intraocular lens was then inserted ^[9] into the capsular bag and rotated into position such that the optic was well centered. The Proviso was removed using the irrigation and aspiration mode. Miochol was injected to constrict the pupil. The wound was checked and deemed to be watertight. A collagen shield soaked in Ciloxan and Pred Forte was applied. The standard postoperative patch and shield were placed and the patient was transferred to the Recovery Room in stable condition.

-
- ^[1] IV Sedation and local anesthesia is used.
 - ^[2] The postoperative diagnosis is used for coding.
 - ^[3] Indicates the type of intraocular lens (IOL).
 - ^[4] The surgeon performs a block and sedation which is included in the surgical package.
 - ^[5] The left eye is prepped for the surgery.
 - ^[6] An incision is made.
 - ^[7] The physician performs a capsulotomy.
 - ^[8] Phacoemulsification is performed.
 - ^[9] The intraocular lens is inserted in the capsular bag.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 66984-LT

ICD-10-CM code: H26.9

Rationale:

CPT® code: This is an extracapsular cataract removal. Phacoemulsification is performed to remove the cataract. The IOL is inserted into the capsular bag. In the CPT® Index, look for Cataract/Extraction/Removal/Extracapsular and you are referred to 66982, 66984. The procedures performed are reported with 66984 which includes insertion of intraocular lens prosthesis. Modifier LT is appended to report the procedure is performed on the left eye.

ICD-10-CM code: The indication of the surgery is cataract. In the ICD-10-CM Alphabetic Index, look for Cataract H26.9. There is no additional information provided to select a more specific diagnosis code. Verify code selection in the Tabular List.

Case 7

Preoperative Diagnosis: Tympanic membrane perforation, conductive hearing loss in the right ear.

Postoperative Diagnosis: Tympanic membrane perforation, conductive hearing loss in the right ear. ^[1]

Name of Procedure: Right tympanoplasty via the postauricular approach.

Anesthesia: General.

Estimated Blood Loss: Less than 20 ml.

Complications: None.

Specimens: None.

Indications: This is a 9 year-old white female with the above diagnoses and now presents for surgical intervention.

Intraoperative Findings: Intraoperative findings revealed tympanosclerosis posteriorly with a central eardrum perforation ^[2] of approximately 30% of the surface of the eardrum. There was no cholesteatoma. The ossicular chain is intact.

Description of Operative Procedure: Under satisfactory general anesthesia the patient was given preoperative intravenous antibiotic. The right ear was prepared and draped in the usual sterile fashion. A **postauricular incision was made and the temporalis fascia graft was harvested.** ^[3] The posterior ear canal skin was elevated and tympanomeatal flap was developed. The Rosen needle was used to freshen the edge of the perforation. Gelfoam was placed in the middle ear space. **The graft was cut into the appropriate size and laid medial to the remnant of the tympanic membrane anteriorly, posteriorly, inferiorly and superiorly.** ^[4] Antibiotic ointment and Gelfoam were placed in the ear canal. Closure of the wound was done in layers with 4-0 Vicryl for the subcutaneous tissue and 4-0 Prolene for skin. Pressure dressing was placed around the right ear. The patient tolerated the procedure well.

^[1] Code the postoperative diagnosis. Two codes are required to fully describe the patient's conditions.

^[2] The findings include additional diagnosis information.

^[3] This is the approach. Postauricular incision is made behind the auricle of the ear. A graft is harvested from the temporalis fascia to repair the perforated tympanic membrane.

^[4] The graft is cut to size and placed.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 69620-RT

ICD-10-CM code: H72.01, H90.11, H74.01

Rationale:

CPT® code: In this case, the patient has a perforated tympanic membrane which requires repair. The physician uses a graft which is obtained from the temporalis fascia. The surgery is performed on the tympanic membrane only. The physician does not perform a procedure on the middle ear or a mastoidectomy. In the CPT® Index, look for Tympanoplasty. All the code references include other surgical procedures. There is an instruction to see Myringoplasty. Myring/o means tympanic membrane and plasty means surgical fixation. Myringoplasty refers to 69620. The description includes “confined to drum head and donor area,” which describes the procedure. Code 69610 is not correct because a patch (which is made of paper) was not placed, a graft was placed. All other tympanoplasty codes include additional surgical procedures which is not appropriate in this case. Modifier RT is appended to identify the procedure was performed on the right ear.

ICD-10-CM code: The indication for the surgery is tympanic membrane perforation and conductive hearing loss. In the Intraoperative Findings section, the physician documents the perforation is central and the patient also has tympanosclerosis. In the ICD-10-CM Alphabetic Index, look for Perforation, perforated/tympanum, tympanic/central H72.0-. In the Tabular List, a 5th character of 1 is reported for the right ear.

For the next diagnosis code, look for Loss (of)/hearing/conductive/unilateral/unrestricted hearing on the contralateral side H90.1-. There is no mention of restricted hearing on the contralateral side. In the Tabular List, a 5th character of 1 is reported for the right ear. A perforated tympanic membrane can heal on its own. Not all tympanic membrane perforations need to be repaired, so the hearing loss shows why the surgery is being performed.

For the last diagnosis, look in the Alphabetic Index for Tympanosclerosis and you are directed to see subcategory H74.0. In the Tabular List, a 5th character of 1 is reported for the right ear.

Case 8

Preoperative Diagnosis: Right otosclerosis.

Postoperative Diagnosis: Right otosclerosis.

Type of Procedure: Right stapedectomy.

Anesthesia: General endotracheal.

Findings: There was otosclerosis on the **anterior footplate of the stapes** ^[1] with preoperative conductive hearing loss in the right ear.

Description of Procedure: The patient was taken to the operating room and placed supine on the operating table. Following induction of general endotracheal anesthesia, the head was turned to the left and the right ear was prepped and draped in the usual fashion. Then 1% Xylocaine with 1:100,000 epinephrine was infiltrated in the skin along the posterior ear canal wall and the skin over the tragus.

After a short waiting time, an incision was made over the tragus and **a piece of posterior tragal perichondrium was harvested for a graft and set aside to dry.** ^[2] A speculum was then placed in the canal. The canal was quite large. An incision was made along the posterior canal wall, and a tympanomeatal flap was elevated and laid forward to include the fibrous annulus without perforation. The middle ear was inspected. The ossicular chain was palpated and otosclerosis appeared to be fixing the stapes. The chorda tympani nerve was very carefully preserved and not manipulated and was kept moist throughout the procedure. No curetting of bone was necessary in order to access the footplate. A control hole was made in the footplate with a straight pick. The incudostapedial joint was separated with an IS joint knife. **The stapedius tendon was severed, and the superstructure of the stapes was fractured over the promontory and removed.** ^[3] The footplate was then picked out with a 45-degree pick, completely removing all fragments. Great care was taken not to suction in the vestibule. The distance between the incus and the oval window was then measured. The **tragal perichondrial graft was then taken and laid over the oval window with complete coverage.** ^[4] A **3.75 Shea platinum Teflon cup piston** ^[5] was then chosen. The platinum wires were opened and the shaft was placed down against the graft and into the oval window niche. The cup was placed under the long process of the incus by gently lifting the incus, and the platinum wires were snugly crimped around the long process of the incus. **An excellent round window reflex was achieved upon palpation of the ossicular chain at this point.** ^[6]

Small, dry, pressed Gelfoam pledgets were then placed around the shaft of the prosthesis and over the graft. The tympanomeatal flap was replaced. The lateral surface of the drum was covered with Gelfoam, and the canal was filled with antibiotic ointment. The incision over the tragus was closed with running, interlocking 5-0 plain, fast-absorbing gut. A cotton ball was placed in the canal, and the patient was awakened, extubated, and returned to recovery in satisfactory condition. He will be discharged when fully awake and will return to my office in two weeks. He will avoid strenuous activity, keep the ear dry, keep a clean cotton ball in the ear, apply antibiotic ointment to the tragal incision, avoid driving while dizzy, and he was given prescriptions for Lorcet Plus, Keflex, and Xanax.

^[1] Location of otosclerosis.

^[2] A graft of ear cartilage is obtained for the procedure.

^[3] The stapes is removed.

^[4] The graft is placed.

^[5] A prosthesis is used.

^[6] Ossicular continuity is achieved.

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 69660-RT, 21235-51-RT

ICD-10-CM codes: H80.81

Rationale:

CPT® codes: In this case, the stapes is removed and replaced with a prosthesis. A cartilage graft is also placed. In the CPT® Index, look for Stapedectomy/without Foreign Material. The footplate was picked out, but drill out was not necessary. Sometimes, the footplate bone is too thick for a laser or pick to be effective. When the footplate bone is too thick, a drill is required (footplate drill out). There is no mention of foreign material. Code 69660 is the correct code. Modifier RT is appended to the procedure codes to report they were performed on the right ear. To report the harvesting of the cartilage

graft, look in the CPT® Index for Harvesting/Cartilage Graft/Ear 21235. Modifier 51 is appended to the lesser value RVU code when multiple procedures are performed.

ICD-10-CM codes: The indication for the surgery is otosclerosis. In the ICD-10-CM Alphabetic Index, look for Otosclerosis. The documentation identifies otosclerosis located on the anterior footplate of the stapes, which is not listed as an option under otosclerosis, so the specified type (specified NEC) is reported H80.8-. In the Tabular List, a 5th character of 1 is reported for the right ear. Conductive hearing loss is a sign/symptom of otosclerosis and is not reported. Verify code selection in the Tabular List.

Case 9

Preoperative Diagnosis: Adenoidal hypertrophy and serous otitis media with effusion.

Postoperative Diagnosis: Adenoidal hypertrophy and serous otitis media with effusion. ^[1]

Name of Procedure: Bilateral ventilation tube placement, Donaldson-Activevent type, Adenoidectomy.

Anesthesia: General ^[2]

Estimated Blood Loss: Less than 5 mL.

Findings: The patient is an 18 month-old ^[3] white male with a history of the above noted diagnosis. Operative findings included bilateral thickened drums. He had a right and left serous effusion. The left was aerated for the most part. He had an intact palate and a 3-4 + adenoid pad.

Technique: Patient was brought into the operative suite and comfortably positioned on the table. General mask anesthesia was induced. Appropriate drapes were placed. Attention was turned to the right ear. ^[4] The external canal was cleaned of cerumen and irrigated with alcohol. A radial incision was made in the right tympanic membrane. ^[5] Middle ear was evacuated of effusion and Donaldson-Activevent tube was followed by Ciprodex otic ^[6] drops. The same procedure was performed on the contralateral side. ^[7] The bed was turned 30° in clockwise fashion. The Crowe-Davis mouth gag was inserted and suspended. The palate was palpated and felt to be intact. The soft palate was elevated and under direct nasopharyngoscopy. The adenoid was removed with powered adenoidectomy blade taking care to avoid injury to the Eustachian tube orifice. ^[8] The base was cauterized with Bovie suction cauterium and a pack was placed. After several minutes, the packs were removed. The nasopharynx and oral cavity was irrigated and suctioned free of debris. The stomach was evacuated with orogastric tube. Re-evaluation showed no further active bleeding. Further drapes and instruments were removed. The patient was returned to the care of Anesthesia, allowed to awaken, extubated and transported in stable condition to the recovery room having tolerated the procedure well.

^[1] Two diagnoses to report.

^[2] General anesthesia is used.

^[3] Age of the patient.

^[4] Indication of which ear the tube will be placed.

^[5] Tympanostomy.

^[6] Placement of the ventilating tube.

^[7] Placement of tube performed on the left side.

^[8] Adenoidectomy.

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 42830, 69436-51-50

ICD-10-CM codes: J35.2, H65.93

Rationale:

CPT® codes: Two procedures were performed for this case. The first procedure reported is for the removal of the adenoids. In the CPT® Index, look for Adenoids/Excision, referring you to codes 42830-42836. Code 42830 is the correct code to report due to the age of the patient. A secondary adenoidectomy was not performed because documentation does not indicate that adenoid tissue had grown back since an initial adenoidectomy.

The second procedure reported is the insertion of the ventilating tubes. An incision is made in the tympanum to insert the tubes. In the CPT® Index, look for Tympanostomy/General Anesthesia, 69436. The procedure is performed on both the left and right ear which requires appending modifier 50. Some payers may prefer modifier LT and RT instead of modifier 50. In that case, the codes are 69436-RT and 69436-LT. For exam purposes, follow CPT® guidelines and append modifier 50. Modifier 51 is appended to indicate more than one procedure was performed.

ICD-10-CM codes: Two diagnosis codes are reported which identify the medical necessity for the adenoidectomy and the tympanostomy. In the ICD-10-CM Alphabetic Index, look for Hypertrophy, hypertrophic/adenoids (infective) J35.2. Verify code selection in the Tabular List.

The patient also had serous otitis media. The findings of the operative note indicate the serous otitis media has effusion. This means the patient has fluid in the middle ear that cannot drain. This is supported in the documentation in which the note states, “Middle ear was evacuated of effusion.”

In the Alphabetic Index, look for Otitis/with effusion which instructs you to *see also* Otitis, media, nonsuppurative; Otitis/media/nonsuppurative H65.9-. Turn to the Tabular List to complete the code. The complete code is H65.93 to indicate the right and left ear had this condition. Note, serous otitis media is listed as a condition in the inclusion terms for this code.

Case 10

Preoperative Diagnosis: Left lower eyelid basal cell carcinoma

Postoperative Diagnosis: Left lower eyelid basal cell carcinoma ^[1]

Operation: Excision of left lower eyelid basal cell carcinoma with flaps and full thickness skin graft and tarsorrhaphy. ^[2]

Indication for Surgery: The patient is a very pleasant female who complains of a one-year history of a left lower eyelid lesion. This was recently biopsied and found to be basal cell carcinoma. She was advised that she would benefit from a complete excision of the left lower eyelid lesion. She is aware of the risks of residual tumor, infection, bleeding, scarring and possible need for further surgery. All questions have been answered prior to the day of surgery. She consents to the surgery.

Operative Procedure: The patient was placed supine on the operating table and an intravenous line was established by hospital staff prior to sedation and analgesia. Throughout the entire case, the patient received monitored anesthesia care. ^[3] The patient's entire face was prepped and draped in the usual sterile fashion with a Betadine solution and topical tetracaine, and corneal protective shields were placed over both corneas. A surgical marking pen was used to mark the tumor. Markings that were 3 mm were obtained around the tumor. ^[4] The tumor was noted to encompass approximately 1/3 of the left lower eyelid. ^[5] A wedge resection was performed and this was marked and 2% Xylocaine with 1:100,000 epinephrine, 0.5% Marcaine with 1:100,000 epinephrine was infiltrated around the lesion. This was excised with a #15 blade. This was sent for intraoperative fresh frozen sections. Intraoperative fresh frozen sections revealed persistent basal cell carcinoma at the medial margin. Another 2 mm of margin ^[6] was discarded and a revised left lower eyelid medial margin was sent for permanent sections. The area could not be closed primarily, thus a tarsconjunctival advancement flap was advanced from the left upper eyelid to fill the defect. ^[7] This was sutured in place with multiple 5-0 Vicryl sutures. The anterior lamella defect of skin was closed by harvesting a full-thickness skin graft from the left upper eyelid and placing it in the left lower eyelid defect. ^[8] This was sutured in place with multiple interrupted 5-0 chromic gut sutures. The eyelids were sutured shut both on the medial aspect of the Hughes flap as well as the lateral aspect of the Hughes flap with a 4-0 silk suture. ^[9] A pressure dressing and TobraDex ointment were applied. The patient tolerated the procedure well and was transported back to the recovery area in excellent condition.

-
- ¹¹ The postoperative diagnosis is used for coding.
 - ¹² Listed procedure.
 - ¹³ MAC anesthesia used.
 - ¹⁴ A margin of 3 mm is excised in addition to the lesion.
 - ¹⁵ The size of the lesion is 1/3 of the left lower eyelid.
 - ¹⁶ An additional 2 mm is excised.
 - ¹⁷ A flap is used to close the defect.
 - ¹⁸ A FTSK from the upper eyelid is used to repair the defect of the lower eyelid.
 - ¹⁹ A tarsorrhaphy is performed.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 15260-E2, 67966-51-E2, 67971-51-E2, 67875-51-E1-E2

ICD-10-CM code: C44.1192

Rationale:

CPT® codes: In this case, an excision of a basal cell carcinoma is performed. More than 1/3 of the lower eyelid is excised. A full thickness graft as well as a flap (adjacent tissue transfer) is required for the closures. A full-thickness skin graft from the left upper eyelid which was placed on the left lower eyelid defect. Skin grafts are always reported according to the recipient site. Look in the CPT® Index for Skin Graft and Flap/Free Skin Graft/Full Thickness 15200-15261. The size is not reported, so 15260 is assigned.

In the CPT® Index, look for Excision/Lesion/Eyelid. Refer to the codes referenced in the index. Under code 67840, there is a parenthetical note which states, “For excision and repair of eyelid by reconstructive surgery, see 67961, 67966.” Code 67961 is for an excision and repair of the eyelid including preparation for skin graft or flap with adjacent tissue transfer or rearrangement involving up to one-fourth of the lid margin. Code 67966 reports the excision and reconstruction with a flap or an excision over one-fourth of the lid margin which is one of the correct code for this case. This can also be found by looking in the CPT® Index for Repair/Eyelid/Excisional.

For the reconstructive procedure, look for Reconstruction/Eyelid/Tarsconjunctival Flap Transfer 67971 in the CPT® Index. Code 67971 indicates it is for a full thickness reconstruction of the eyelid with a flap from the opposing eyelid of up to two-thirds of the eyelid.

A tarsorrhaphy (eyelids sewn shut) is performed. Look in the CPT® Index for Tarsorrhaphy, which refers to 67875. Review the code description for accuracy. When multiple procedures are performed, they are sequenced in order from the most labor intensive (highest RVUs) to the lowest. In this case, the proper sequence is 15260, 67966, 67971, 67875. The procedure codes 15260, 67966, and 67971 are performed on the left lower eyelid, which is reported with HCPCS modifier E2. Code 67875 is reported with HCPCS modifiers E1 and E2 because both eyelids were closed shut. When multiple procedures are performed, modifier 51 is appended to the procedure codes that are listed after the first listed CPT® code.

ICD-10-CM code: To determine the ICD-10-CM code, look in the ICD-10-CM Alphabetic Index for Carcinoma/basal cell. There is guidance to - see also Neoplasm, skin, malignant. In the Table of Neoplasms, look for Neoplasm, neoplastic/skin NOS/eyelid/basal cell carcinoma and report the code from the Malignant Primary column C44.11-. In the Tabular List, a 6th character 9 and 7th character 2 is reported for the lower left eyelid.



Case 1

Anesthesiologist personally performed ^[1]

Anesthesia Time: 7:12 to 10:08 ^[2]

Physical Status 2 ^[3]

Preoperative Diagnosis: Suspected Prostate Cancer

Postoperative Diagnosis: Prostate Carcinoma ^[4]

Procedure: Radical Retropubic Prostatectomy ^[5]

Anesthesia: General ^[6]

^[1] Personally performed by anesthesiologist—use AA modifier.

^[2] Time is 176 minutes.

^[3] Physical status 2, use P2 modifier.

^[4] Post-operative diagnosis.

^[5] Procedure performed. Make note the procedure is “radical.”

^[6] General anesthesia.

What are the CPT® and ICD-10-CM Codes reported for the Anesthesiologist?

CPT® Code: 00865-AA-P2

ICD-10-CM Code: C61

What is the time reported for this service?

176 minutes

Rationale: CPT® Code: The procedure performed is a radical retropubic prostatectomy. The prostate is considered extraperitoneal in the lower abdomen. Look in the CPT® Index for Anesthesia/Prostatectomy/Radical which refers you to CPT® 00865. P2 is used to report the physical status level 2. AA is used to report the anesthesiologist personally performed the anesthesia.

ICD-10-CM Code: In the ICD-10-CM Alphabetic Index, look for Carcinoma. You are directed to *see also* Neoplasm, by site, malignant. In the ICD-10-CM Table of Neoplasms, look for Neoplasm, neoplastic/prostate and report the code from the Malignant Primary column C61. Verify code selection in the Tabular List.

Time: The start time is 7:12. The end time is 10:08. This calculates to 2 hours and 56 minutes, or 176 minutes.

Case 2

Anesthesia Start: 14:07 ^[1] **Anesthesia End:** 17:33 ^[1]

Physical Status 3 ^[2]

Anesthesiologist: Michael D, MD ^[2]

Operative Report

Preoperative Diagnosis: Lumbar spinal stenosis

Postoperative Diagnosis: L4–L5 spinal stenosis ^[3]

Procedure: L4–L5 laminectomy, removal of synovial cyst, bilateral medial facetectomy and posterolateral fusion L4–L5 with vertebral autograft, bone morphogenetic protein, chip allograft, all with intraoperative somatosensory evoked potentials, electromyographies and loupe magnification. ^[4]

Anesthesia: General endotracheal anesthesia. ^[5]

Description of Procedure: The patient was taken to the operating room and underwent intravenous anesthetic and orotracheal intubation. Her head was placed in the three-pin Mayfield headrest. She was turned into the prone position on a four-poster frame. All pressure points were carefully padded. The fluoroscope was brought in and sterily draped to help localize the incision.

A midline incision was made between L4 and L5 through skin and subcutaneous tissue and the paraspinal muscles were dissected free of the spinous process, lamina, facets and L4, L5 transverse processes. Self-retainers were placed more deeply. We proceeded to use the double-action rongeur to remove the L4–L5 spinous process lamina. 3 and 4 millimeter Kerrison punches were used to complete the laminectomy including removing the hypertrophied ligamentum flavum. We made sure that we decompressed from the top of the L4 pedicle to the bottom of the L5 pedicle, which was confirmed with intraoperative fluoroscopy. The medial facets were drilled and then we undercut over the nerve roots with a 3 millimeter Kerrison punch. Hemostasis was achieved with powdered Gelfoam. We irrigated the wound. We decorticated the L4 and L5 transverse processes. We placed our vertebral autograft, bone morphogenetic protein and chip allograft in the posterolateral gutters. Hemovac drain was placed. We closed the muscle with 0 Vicryl. Fascia was closed with 0 Vicryl. Subcutaneous tissue was closed with 2-0 Vicryl and the skin was closed with staples.

^[1] Total anesthesia time 3 hours 26 minutes, or 206 minutes.

^[2] Physical status 3, use modifier P3.
Personally performed by the anesthesiologist, use modifier AA.

^[3] Post-operative diagnosis of lumbar (L4-L5) stenosis.

^[4] The following procedures were performed: L4-5 laminectomy, removal of synovial cyst, bilateral medial facetectomy and posterolateral fusion L4-L5 with vertebral autograft, bone morphogenetic protein, chip allograft, all with intraoperative somatosensory evoked potentials, electromyographies and loupe magnification. The Laminectomy is more complex and carries a higher base value.

^[5] Type of anesthesia is general.

What are the CPT® and ICD-10-CM Codes reported for the Anesthesiologist?

CPT® Code: 00630-AA-P3

ICD-10-CM Code: M48.061

What is the time reported for this service?

206 minutes.

Rationale: CPT® Code: The following procedures were performed: L4–L5 laminectomy, removal of synovial cyst, bilateral medial facetectomy and posterolateral fusion L4–L5 with vertebral autograft, bone morphogenic protein, chip allograft, all with intraoperative somatosensory evoked potentials, electromyographies and loupe magnification. Look in the CPT® Index, Anesthesia/Spine and Spinal Cord/Lumbar refers you to codes 00630–00635, 00640, 00670. The most complex procedure performed is the laminectomy which is reported with 00630. Modifier AA is used to indicate the anesthesia service was personally performed by the Anesthesiologist. Modifier P3 is used to indicate a level 3 Physical Status. Anesthesia modifiers always precede physical status modifiers.

ICD-10-CM Code: The postoperative diagnosis is L4–L5 Spinal Stenosis. L4–L5 is in the lumbar region. To locate the ICD-10-CM code, look in the Alphabetic Index for Stenosis, stenotic/spinal/lumbar region. You are referred to M48.061. Verify code selection in the Tabular List.

Time: The start time is 14:07 (2:07 pm) and the end time is 17:33 (5:33 pm). This time calculates to 3 hours and 26 minutes, or 206 minutes.

Case 3

Anesthesiologist personally performed case ^[1]

Anesthesia Time: 13:04 to 13:41 ^[2]

Physical status 3 ^[3]

Preoperative Diagnosis: RLL Lung Cavity, possible CA of lung

Postoperative Diagnosis: Right Lower Lobe Lung Carcinoma ^[4]

Procedure: Bronchoscopy ^[5]

Anesthesia: Monitored anesthesia care ^[6]

Procedure Description: With the patient under satisfactory anesthesia, a flexible fiberoptic bronchoscope was introduced via oral cavity and advanced past the larynx for visualization of the bronchus. Cell washings were obtained and sent to pathology. The bronchoscope was then removed. Patient tolerated procedure well.

Cell washings obtained from the right lower lobe were confirmed by pathology as malignant carcinoma.

^[1] Use modifier AA to indicate the Anesthesiologist personally performed the case.

^[2] Anesthesia time is 37 minutes.

^[3] Physical status 3 – use P3 modifier.

^[4] Post-operative diagnosis confirms RLL CA.

^[5] Procedure performed.

^[6] Use modifier QS to indicate monitored anesthesia care was used.

What are the CPT® and ICD-10-CM Codes reported for the Anesthesiologist?

CPT® Code: 00520-AA-QS-P3

ICD-10-CM Code: C34.31

What is the time reported for this service?

37 minutes.

Rationale: CPT® Code: Look in the CPT® Index under Anesthesia/Bronchoscopy and you are directed to code 00520. Modifier AA is used to indicate the anesthesia service was personally performed by the anesthesiologist. Modifier QS is used to indicate MAC was used. Modifier P3 is used to indicate the patient is physical status 3. Anesthesia modifiers are always listed first, followed by the MAC modifier QS. Physical status modifiers are listed last.

ICD-10-CM Code: The diagnosis is confirmed as RLL CA. Look in the ICD-10-CM Alphabetic Index for Cancer - *see also* Neoplasm, by site, malignant. Look in the Table of Neoplasms for Neoplasm, neoplastic/lung/lower lobe and select the code from the Malignant Primary column C34.3-. In the Tabular List, 5th character 1 is reported for the right lung.

Time: The start time is 13:04. The end time is 13:41. The time calculates to 37 minutes.

Case 4

Anesthesia services personally provided by Anesthesiologist ^[1]

Physical Status 2 ^[2]

Anesthesia Start: 10:03 ^[3] Anesthesia Stop: 11:06 ^[3]

Preoperative Diagnosis: Sternal wound hematoma.

Postoperative Diagnosis: Complicated upper abdominal wall wound. ^[4]

Name of Procedure: Sternal wound exploration and wound vac placement. ^[5]

Anesthesia: Monitored Anesthesia Care ^[6]

Brief History: He is a 52-year-old patient who is two weeks out from re-do sternotomy and aortic valve replacement for critical aortic stenosis in the setting of heart failure. He had a postoperative coagulopathy and required sternal re-exploration with open packing. ^[7] He was closed the next day. He had serous discharge prior to going home but this was culture negative and the wound looked very good. He continued to have serous discharge in the clinic and it was felt he had a retained hematoma. He was scheduled for evaluation of the hematoma and wound vac placement. This was done without incident. He did not have any evidence of infection. There was no evidence of any sternal instability.

Description of Operative Procedure: Following delivery of the patient to the operating room, the patient was placed on the operating table, prepared and draped in the usual sterile manner. His upper abdominal wound was explored. There was hematoma at the base of the wound which was very carefully evacuated ^[8] and the wound was irrigated with antibacterial solution. A wound vac was then placed with the assistance of the wound care nurse. ^[9] The patient was returned to the PCU in stable condition.

^[1] Use modifier AA to indicate the anesthesia was personally performed by the anesthesiologist.

^[2] Physical status 2, use modifier P2.

^[3] Anesthesia time is 1 hour and 3 minutes, or 63 minutes.

^[4] Postoperative diagnosis used for coding if no other indication is found in the operative note.

^[5] Procedure performed.

^[6] Use modifier QS to indicate MAC is used.

^[7] The wound is a post-operative complication.

^[8] Confirms a postoperative hematoma.

^[9] Wound vac placed by a wound care nurse.

What are the CPT® and ICD-10-CM Codes reported for the Anesthesiologist?

CPT® Code: 00700-AA-QS-P2

ICD-10-CM Code: L76.32

What is the time reported for this service?

63 minutes.

Rationale: CPT® Code: In the CPT® Index, look for Anesthesia/Abdomen/Abdominal Wall and you are directed to a range of codes. This is an upper abdominal wound from a sternal (anterior) procedure. 00700 is the correct code. Anesthesia modifier AA indicates that the anesthesiologist personally performed the anesthesia care. Anesthesia modifiers are always placed first. The QS modifier indicates MAC, and the physical status P2 is listed last.

ICD-10-CM Code: The diagnosis is listed as a complicated abdominal wound; however, the body of the note indicates it is a retained hematoma from the procedures two weeks prior. Look in the ICD-10-CM Alphabetic Index for Hematoma/postoperative - see Complication, postprocedural, hematoma; Complication/postprocedural/hematoma (of)/skin and subcutaneous tissue/following a procedure on other organ directs you to L76.32. Verify code selection in the Tabular List.

Time: The start time is 10:03. The end time is 11:06. This calculates to 1 hour and 3 minutes, or 63 minutes.

Case 5

Anesthesia Start: 12:18 ^[1] **Anesthesia End:** 13:31 ^[1]

CRNA: John Sleep, CRNA (Non-Medically Directed) ^[2]

ASA Physical status-III ^[3]

Operative Report

Preoperative Diagnosis: Stricture of the left ureter, postoperative

Postoperative Diagnosis: SAME ^[4]

Procedure:

1. Cystoscopy of ileal conduit.
2. Exchange of left nephroureteral catheter.

Anesthesia: Monitored anesthesia care. ^[5]

Description of Procedure: The patient is identified in the holding area, marked, taken to the operating room. Subsequently, she was given monitored anesthesia care. She was prepped and draped in the usual sterile fashion in the supine position. Next, using a flexible cystoscope, the ileal conduit was entered. Cystoscopy was performed, which showed the ureteroileal anastomosis on the left with a stent protruding from it. There were no calcifications seen on the stent. Thus, the cystoscope was removed from the ileal conduit and then a super stiff wire was advanced through the nephroureteral catheter, up into the kidney. Once it was up there, then the catheter was taken off of the wire and then a new 8-French x 28-centimeter, nephroureteral ureteral catheter was advanced fluoroscopically into the level of the kidney. Once this was done and its position was confirmed fluoroscopically, the wire was pulled. A good curl was there fluoroscopically in the kidney, as the wire was pulled. A good curl was seen in the bladder and then the distal end was protruding out from the ileal conduit. This was placed in the ostomy bag and the patient was taken in stable condition to the recovery room.

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- ^[1] Time reported is 1 hour 13 minutes, or 73 minutes.
 - ^[2] Modifier QZ used to indicate services are performed by a CRNA with no medical direction.
 - ^[3] Physical status 3—use modifier P3.
 - ^[4] Postoperative diagnosis is the same as preoperative which is stricture of the left ureter, postoperative.
 - ^[5] Modifier QS is used to indicate MAC.
-

What are the CPT® and ICD-10-CM Codes reported for the CRNA?

CPT® Code: 00860-QZ-QS-P3

ICD-10-CM Code: N13.5

What is the time reported for this service?

73 minutes.

Rationale: CPT® Code: Both a cystoscopy and exchange of ureteral stent via ilealoconduit were performed. The ureteral stent was more complex and carries a higher base value. The ureter is part of the urinary system. Look in the CPT® Index for Anesthesia/Urinary Tract, and you are directed to 00860. Anesthesia modifier QZ indicates the CRNA was without medical direction. Modifier QS is reported to show MAC. The physical status was 3.

ICD-10-CM Code: The diagnosis is a stricture of the left ureter, postoperative. Look in the ICD-10-CM Alphabetic Index for Stricture/ureter (postoperative) and you are directed to N13.5. Verification in the Tabular List confirms code selection.

Time: The start time is 12:18. The end time is 13:31. This calculates to 73 minutes.

Case 6

CRNA performed anesthesia ^[1]

Anesthesiologist medically directing ^[1] **two cases** ^[2]

Anesthesia Time: 9:30 to 10:06

Physical Status 3 ^[3]

Preoperative Diagnosis: Cyst on knee

Postoperative Diagnosis: **Baker's Cyst** ^[4]

Procedure: **Excision of Baker's Cyst, knee** ^[5]

Anesthesia: **Monitored Anesthesia Care** ^[6]

-
- ^[1] Use Modifier QX to indicate CRNA services with medical direction by a physician.
 - ^[2] Use modifier QK to indicate medical direction of two cases.
 - ^[3] Physical status 3—use P3 modifier.
 - ^[4] Use post-operative diagnosis.

^[5] Excision is an open procedure and is performed on the knee.

^[6] MAC services require QS modifier.

What are the CPT® and ICD-10-CM Codes reported for the Anesthesiologist?

CPT® Codes: 01400-QK-QS-P3

ICD-10-CM Code: M71.20

What are the CPT® and ICD-10-CM Codes reported for the CRNA?

CPT® Code: 01400-QX-QS-P3

ICD-10-CM Code: M71.20

What is the time reported for this service?

36 minutes

Rationale: CPT® Codes: Look in the CPT® Index for Anesthesia/Knee. You are referred to a large selection of codes. Other than 00400 (used for Integumentary), the codes directed fall within the range 01320–01444 (Knee and Popliteal Area). An excision is an open procedure, so you would find the code specific to open procedures on the knee. There is not a specific anesthesia code for excision of a Baker’s cyst, so CPT® 01400 is reported. The physical status is reported as level 3 (P3). QK is used to indicate the anesthesiologist is directing 2–4 concurrent cases. QX is used to indicate the services reported by the CRNA. QS reports Monitored Anesthesia Care (MAC) services.

ICD-10-CM Code: The post-operative diagnosis is Baker’s Cyst. In the ICD-10-CM Alphabetic Index, look for Cyst/Baker’s, M71.2-. In the Tabular List, 5th character 0 is reported for unspecified knee.

Time: The anesthesia time is noted as 9:30–10:06, which is 36 minutes.

Case 7

CRNA performed anesthesia under medical direction of anesthesiologist ^[1]

Anesthesiologist medically directing one case ^[2]

CRNA placed arterial line ^[3]

Anesthesia Time: 10:43 to 12:50 ^[4]

Physical Status 3 ^[5]

Preoperative Diagnosis: Left Renal Mass

Postoperative Diagnosis: Same ^[6]

Procedure: Left Partial Nephrectomy, Laparoscopic ^[7]

Anesthesia: General ^[8]

Procedure Description: Abdominal wall insufflated. The laparoscope was placed through the umbilical port and additional trocars were placed into the abdominal cavity. Using the fiberoptic camera, the renal mass was identified and the diseased kidney tissue was removed using electrocautery. Minimal bleeding is noted. Instruments were removed and the abdominal incisions were closed by suture. Patient tolerated surgery well and was transferred to the Post Anesthesia Care Unit in satisfactory condition.

-
- ^[1] QX (CRNA with medical direction by a physician).
 - ^[2] QY (medical direction of one CRNA by an anesthesiologist).
 - ^[3] 36620 - Arterial line placed by CRNA.
 - ^[4] Time reported is 2 hours 7 minutes or 127 minutes.
 - ^[5] Use physical status modifier P3.
 - ^[6] Postoperative diagnosis is the same as the preoperative diagnosis—Left Renal Mass.
 - ^[7] Procedure performed.
 - ^[8] General anesthesia.
-

What are the CPT® and ICD-10-CM Codes reported for the Anesthesiologist?

CPT® Code: 00862-QY-P3

ICD-10-CM Code: N28.89

What are the CPT® and ICD-10-CM Codes reported for the CRNA?

CPT® Codes: 00862-QX-P3, 36620

ICD-10-CM Code: N28.89

What is the time reported for this service?

2 hours and 7 minutes, or 127 minutes

Rationale: CPT® Codes: Look in the CPT® Index for Anesthesia/Nephrectomy and you are guided to 00862. Verification of the code confirms this code is for anesthesia for renal procedures. The anesthesiologist was medically directing one CRNA; therefore, QY is appended to 00862. The medically directed CRNA service is reported with modifier QX. The anesthesia modifiers always precede the physical status modifier. The CRNA also inserted an A-Line (arterial line) which is coded separately with 36620.

ICD-10-CM Code: The post-operative diagnosis is Kidney Mass (Do not code mass as neoplasm—coding instructions indicate to see disease of specified organ when not listed under mass). Look in the ICD-10-CM Alphabetic Index for Mass/kidney and you are directed to N28.89. Verify code selection in the Tabular List.

Time: The start time is listed as 10:43. The end time is listed as 12:50. This calculates to 2 hours and 7 minutes or 127 minutes.

Case 8

CRNA performed anesthesia under medical direction of anesthesiologist ^[1]

Anesthesiologist medically directing three cases ^[2]

Anesthesia Time: 8:52 to 9:34 ^[3]

Physical status 1 ^[4]

Preoperative Diagnosis: Phimosis, congenital

Postoperative Diagnosis: Phimosis, congenital ^[5]

Procedure: Circumcision on six-month-old boy ^[6]

Anesthesia: Monitored anesthesia care ^[7]

-
- ^[1] QX (CRNA service with medical direction by a physician).
 - ^[2] QK (Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individual).
 - ^[3] Anesthesia time is 42 minutes.
 - ^[4] Physical status 1, use modifier P1.
 - ^[5] Postoperative diagnosis is used for coding.
 - ^[6] Circumcision (6 month-old child, don't forget about age Qualifying Circumstances).
 - ^[7] Monitored Anesthesia Care (Requires QS modifier.).
-

What are the CPT® and ICD-10-CM Codes reported for the Anesthesiologist?

CPT® Codes: 00920-QK-QS-P1, 99100

ICD-10-CM Code: N47.1

What are the CPT® and ICD-10-CM Codes reported for the CRNA?

CPT® Code: 00920-QX-QS-P1

ICD-10-CM Code: N47.1

What is the time reported for this service?

42 Minutes

Rationale: CPT® Codes: The procedure is circumcision. Look in the CPT® Index under Anesthesia for Genitalia/Male and you are directed to code range 00920–00938. There is not a code specific to circumcision, so 00920 is used. The patient is 6-months-old so you would add the qualifying circumstance for extreme age (99100). The qualifying circumstance is only reported for the physician. The physical status is stated as 1, so modifier P1 is appended. Modifier QS is appended to indicate Monitored Anesthesia Care (MAC). Modifier QK is appended to the anesthesiologist's code to indicate medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals. Modifier QX is appended to the CRNA's services to indicate the CRNA is performing under the medical direction of an anesthesiologist. The anesthesia modifier is placed first, followed by QS, with the physical status modifier placed last.

ICD-10-CM Code: The diagnosis is phimosis. Look in the ICD-10-CM Alphabetic Index for Phimosis (congenital) (due to infection) and you are directed to code N47.1. Verification of this code in the Tabular List confirms code selection.

Time: The anesthesia time is noted as 8:52–9:34, which is 42 minutes.

Case 9

Non-medically directed CRNA ^[1] performed anesthesia and documented intra-operative placement of continuous femoral nerve catheter for post operative pain. ^[2]

Anesthesia Time: 7:18 to 9:10 ^[3]

Physical Status 3 ^[4]**Preoperative Diagnosis:** Left Knee Osteoarthritis**Postoperative Diagnosis:** Left Knee Osteoarthritis, localized primary, ^[5] Acute post-operative pain ^[6]**Procedure:** Total knee arthroplasty ^[7]**Anesthesia:** General anesthesia ^[8] provided for surgery, Surgeon requested post-operative pain management via continuous femoral catheter

^[1] CRNA services without medical direction require modifier QZ.

^[2] Anesthesia and intra-operative placement of continuous femoral nerve catheter.

^[3] Time calculates to 1 hour 52 minutes, or 112 minutes.

^[4] Physical status 3 requires P3 modifier.

^[5] Primary diagnosis is specified as Left Knee Osteoarthritis, localized, primary.

^[6] Diagnosis of Acute post-operative pain gives medical necessity for the intra-operative placement of continuous femoral nerve catheter.

^[7] The procedure is total knee arthroplasty NOT Arthroscopy, which carries a lower base value.

^[8] Anesthesia provided is general.

What are the CPT® and ICD-10-CM Codes reported for the CRNA?**CPT® Codes:** 01402-QZ-P3, 64448-59**ICD-10-CM Codes:** M17.12, G89.18**What is the time reported for this service?**

112 minutes

Rationale: CPT® Codes: Look in the CPT® Index for Anesthesia/Arthroplasty/Knee and you are directed to CPT® 01402. P3 indicates a physical status level 3. Modifier QZ is used to indicate the services were performed by a CRNA without medical direction.

The intra-operative placement of continuous femoral nerve catheter is separate from the general anesthesia used for the surgery; therefore, it is reported separately. The catheter is placed for management of the post-operative pain via continuous femoral catheter. To find the CPT® code to report this, look in the index under Femoral Nerve/Injection/Anesthetic, this directs you to 64447–64448. CPT® code 64448 is for the continuous infusion by catheter and includes the catheter placement, so a separate code for the placement would not be reported. Modifier 59 is appended to indicate it is a separate procedure from the general anesthesia used for the surgery.

ICD-10-CM Codes: The diagnosis for the general anesthesia is left knee osteoarthritis, localized, primary. Look in the ICD-10-CM Alphabetic Index for Osteoarthritis/primary/knee to find M17.1-. In the Tabular List, 5th character 2 is reported for the left knee. To report the acute postoperative pain, look in the Alphabetic Index for Pain(s)/postoperative NOS. You are referred to G89.18. Verify code selection in the Tabular List.**Time:** The start time is 7:18, the end time is 9:10. This calculates to 1 hour 52 minutes, or 112 minutes.

Case 10

CRNA directly supervised by anesthesiologist ^[1] who is directing two other cases. ^[1]

CRNA inserted a separate CVP, ^[2] Swan-Ganz catheter, ^[2] and an A-line ^[2]

Patient has a severe systemic disease that is a constant threat to life ^[3]

Anesthesia Time: 11:43 to 15:26 ^[4]

Preoperative Diagnosis: Multivessel coronary artery disease.

Postoperative Diagnosis: Coronary artery disease, native artery ^[5]

Name of Procedure: Coronary artery bypass graft x 3, left internal mammary artery to the LAD, saphenous vein graft to the obtuse marginal, saphenous vein graft to the diagonal.

Anesthesia: General ^[6]

Brief History: This 77-year-old patient who was found to have a huge aneurysm. Preoperative cardiac clearance revealed a markedly positive stress test and cardiac catheterization showed critical left-sided disease. Coronary revascularization was recommended. The patient has multiple medical illnesses including chronic obstructive pulmonary disease with emphysema and chronic renal insufficiency. I discussed with the patient and the family, the risks of operation including the risk of bleeding, infection, stroke, blood transfusion, renal failure, and death. At operation, we harvested a vein from the left leg using an endoscopic technique that turned out to be a very good conduit. Her obtuse marginal vessel was a 1.5 mm diffusely diseased vessel that was bypassed distally as it ran in the left ventricular muscle. The diagonal was a surprisingly good vessel at 1.5 mm in size. The LAD was bypassed in the mid aspect of the LAD and there was distal disease though a 1.5 mm probe passed quite easily. Good flow was measured in the graft. The patient came off bypass very nicely. Note should be made that her ascending aorta was calcified and we used a single clamp technique.

Description of Operative Procedure: Following delivery of the patient to the operating room, the patient was placed under general anesthetic, was prepped and draped in the usual sterile manner. Arterial line through the skin, Right Pulmonary Artery Catheter and a Left Subclavian central lines were placed by the Anesthesia Department. ^[7] A median sternotomy was made and the left internal mammary artery was harvested from the left chest wall, the saphenous vein was harvested from the left leg. The patient was heparinized and cannulated and placed on cardiopulmonary bypass ^[8] with an aortic cannula on the undersurface of the aortic arch and a venous cannula through the right atrial sidewall. Note should be made that the upper aorta was very heavily calcified, but the area that we cannulated was felt to be disease free. The aorta was cross clamped and the heart was stopped with antegrade and retrograde cardioplegic solution. The heart was retracted out of the pericardial sac and then displaced into the right chest which afforded good access to the lone marginal vessel which was bypassed with a reversed saphenous vein graft using a running 7-0 Prolene suture. Cold cardioplegic solution was then instilled down this graft. Note should be made that during the mammary artery harvest, the left lung was completely adherent to the left chest wall, most likely from old episodes of pneumonia. Next, a second saphenous vein segment was placed to the diagonal vessel and then the left internal mammary artery was placed to the mid LAD. As noted, there was diffuse calcification distally in this artery just beyond the anastomosis, but the 1.5 mm probe passed very nicely and we felt that it was not necessary to double jump this LAD. With the cross clamp in place, two proximal aortotomies were made and the two proximal anastomoses were formed using 6-0 Prolene in a running fashion. Just prior to completion of the second anastomosis, appropriate de-airing maneuvers were performed and then the suture lines were tied as the cross clamp was removed. The patient was allowed to rewarm completely and was weaned from bypass. The cannulas were removed and the cannulation sites were secured with pursestring sutures. Once hemostasis was secured, chest tubes were placed and the wound was closed. Final needle, instrument, and sponge counts were reported as correct. The patient tolerated the procedure well and returned to the recovery room in stable condition.

^[1] CRNA directly supervised by the Anesthesiologist supports modifier QX.
Anesthesiologist was directing two cases this supports the use of modifier QK.

^[2] Swan-Ganz is reported separately by the CRNA.
CVP is reported separately by the CRNA.
A-line (Arterial line) is reported separately by the CRNA.

- 3 Supports modifier P4 for physical status 4.
- 4 Time calculates to 3 hours 43 minutes or 223 minutes.
- 5 Post-operative diagnosis should be used for diagnosis reporting.
- 6 Anesthesia is general.
- 7 Verifies line placement by the Anesthesiology department.
- 8 A bypass machine was used indicating the “pump oxygenator.”

What are the CPT® and ICD-10-CM Codes reported for the Anesthesiologist?

CPT® Code: 00567-QK-P4, 99100

ICD-10-CM Code: I25.10

What are the CPT® and ICD-10-CM Codes reported for the CRNA?

CPT® Codes: 00567-QX-P4, 36556-59, 93503, 36620

ICD-10-CM Code: I25.10

What is the time reported for this service?

223 minutes

Rationale: CPT® Codes: The procedure performed was a CABG (Coronary Artery Bypass Graft). To locate the service in the CPT® Index, look under Anesthesia/Heart/Coronary Artery Bypass Grafting and you are directed to 00566, 00567. Selecting between the two codes depends on the use of a pump oxygenator. The documentation states “. . .the patient was placed on a cardiopulmonary bypass. . .” indicating with pump oxygenator. 00567 is the correct anesthesia code. The patient is identified as having severe systemic disease that is a constant threat to life, supporting a P4 modifier.

For the CRNA, modifier QX is used to report the CRNA service with medical direction. Anesthesia modifiers precede physical status modifiers. The CRNA placed a central venous catheter in the left subclavian. Look in the CPT® Index for Central Venous Catheter Placement/Insertion/Central Non-tunneled. Code 36556 is reported because the patient’s age is 77 years-old. Next, a Swan-Ganz catheter is in the right pulmonary artery. Look in the Index for Swan-Ganz Catheter/Insertion referring you to 93503. A central line (36556) is bundled with code 93503. A Swan-Ganz catheter is a central line with multiple lumens which is flow-directed into the pulmonary artery. Modifier 59 is required with 36556 to indicate that this central line is in another site and totally separate from 93503. The CRNA also inserted an A-Line (arterial line) which is coded separately. Look in the Index for Arterial Catheterization referring you to *See Cannulation, Arterial*. Look for Cannulation/Arterial. Code 36620 is the correct code for insertion through the skin. Anesthesia modifiers are not used on surgical procedure codes.

For the anesthesiologist, modifier QK indicates the medical direction of 2–4 concurrent cases. The anesthesia modifiers precede physical status modifiers. Code 99100 is also reported due to the patient being 77-years-old.

ICD-10-CM Code: The diagnosis is stated as Coronary Artery Disease, Native Artery. To find the ICD-10-CM code, look in the Alphabetic Index for Disease, diseased/artery/coronary and you are directed to I25.10. Verify code selection in the Tabular List.

Time: The anesthesia time is stated as 11:43 to 15:26 (3:26 pm), which calculates to 3 hours 43 minutes, or 223 minutes.



Case 1

Location: Imaging center, radiologist employed. ^[1]

Study: Femur AP and Lateral ^[2]

Reason: Left leg pain

Left Femur:

Comparison: There are no prior studies for comparison.

Findings: There is no fracture or dislocation of the left femur. The femoral head is concentrically seated within the acetabulum without deformity of the femoral head.

Impression: Normal ^[3] views of the left femur.

^[1] Radiologist is employed by the imaging center; the imaging center should report the global component.

^[2] 2 views taken.

^[3] Findings are normal, the reason for the study is used for the diagnosis.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 73552-LT

ICD-10-CM code: M79.605

Rationale:

CPT® Code: In the CPT® Index look for X-ray/Femur and you are directed to 73551, 73552. 73552 is supported by the AP (anterior-posterior) and lateral views in the report. The X-ray was taken at an imaging center, which employs the radiologists. The global procedure is reported with no modifiers (26 or TC). Append modifier LT to indicate the left femur was X-rayed.

ICD-10-CM Code: Look in the ICD-10-CM Alphabetic Index for Pain(s)/leg - see Pain, limb, lower. Look for Pain/limb/lower referring you to M79.60-. In the Tabular List, 6th character 5 is reported for the left leg. Verify code selection in the Tabular List.

Case 2

Location: Regional Hospital ^[1]

MRI of the lumbar spine

History: Low back pain. ^[2]

Technique: On a 1.5 Tesla magnet multiple sagittal and axial ^[3] images were performed through the lumbar spine ^[4] using variable pulse sequences.

Findings: There is normal lumbar alignment. The conus is in normal position at the thoracolumbar junction. No suspect bone marrow lesions are present. There is mild anterior wedging of the L3 vertebral body. I am uncertain whether this is an acute or chronic finding.

At the T12–L1 level, there is a small posterior disc bulge. There is no central canal stenosis. There is no neural foraminal stenosis.

At the L1–L2 level, there is no disc bulge or protrusion. There is no central canal or neural foraminal stenosis.

At the L2–L3 level, there is moderate loss of disc height. There is 106s of T2 signal. There is a focal area of increased T1 signal involving the L2–L3 disc. This could be related to disc calcification or possibly blood product. There is a small posterior disc bulge. There is no central canal stenosis. There is no neural foraminal stenosis.

At the L3–L4 level, there is a minimal posterior disc bulge. There is no central canal stenosis. There is no neural foraminal stenosis.

At the L4–L5 level, there is mild loss of disc height and loss of T2 disc signal. There is a moderate size right paracentral disc protrusion impinging the anterior aspect of the thecal sac. There is no central canal stenosis. There is no neural foraminal stenosis.

At the L5–S1 level, there is no disc bulge or disc protrusion. There is no central or neural foraminal stenosis.

Impression: Mild anterior **wedging of the L3 vertebral body.**^[5] It is uncertain whether this is acute or chronic finding. There is increased T1 signal involving the L2–L3 disc which could be related to calcification or possible hemorrhage although this is felt to be less likely.

Moderate size right **paracentral disc protrusion at L4–L5.**^[6] **Multilevel degenerative disc disease.**^[7]

^[1] The hospital will report the technical component. Only the professional component should be reported.

^[2] Reason for the MRI, also known as Lumbago.

^[3] Sagittal and axial images were taken.

^[4] Location—lumbar spine.

^[5] Wedging of vertebrae is considered Osteoporosis.

^[6] Disc protrusion is coded as intervertebral disc displacement and is in the lumbar region.

^[7] Degenerative Disc Disease covers more than one level in the lumbar spine.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 72148-26

ICD-10-CM codes: M48.56XA, M51.26, M51.36

Rationale:

CPT® Code: MRIs can be performed with or without contrast. This record shows no indication of contrast material being used. To find the code, look in the CPT® Index under Magnetic Resonance Imaging (MRI)/Diagnostic/Spine/Lumbar and you are directed to code range 72148–72158. The code is determined based on whether or not contrast is used. 72148 is an MRI of the lumbar spinal canal and contents, without contrast material. Modifier 26 is used to report the professional component only. The technical component is reported by the hospital.

ICD-10-CM codes: In the ICD-10-CM Alphabetic Index look for Wedge-shaped or wedging vertebra which directs you to – see Collapse, vertebra NEC. Look for Collapse/vertebra/lumbar region referring you to M48.56-. Turn to the Tabular List to complete the code. The complete code is M48.56XA. Next, look for Protrusion/intervertebral disc - see Displacement/intervertebral disc. Look for Displacement/intervertebral disc NEC/lumbar region referring you to M51.26; because the disc protrusion is at L4–L5. Degenerative disc is found under Degeneration, degenerative/ intervertebral disc NOS/lumbar region referring you to M51.36. Verify code selection in the Tabular List.

Case 3

Location: Imaging center; radiologist employed. ^[1]

Study: Mammogram bilateral screening, ^[2] all views, producing direct digital image.

Reason: Screen

Bilateral digital mammography with computer-aided detection (CAD). ^[3]

No previous mammograms are available for comparison.

Clinical History: The patient has a positive family history of breast cancer. ^[4]

Mammogram was read with the assistance of GE iCAD (computerized diagnostic) system.

Findings: Residual fibroglandular breast parenchymal tissue is identified bilaterally. No dominant spiculated mass or suspicious area of clustered pleomorphic microcalcifications are apparent. Skin and nipples are seen to be normal. The axilla is unremarkable.

Impression: BIRADS 1—Negative ^[5]

^[1] Radiologist is employed by the imaging center; the imaging center should report the global component.

^[2] Screening bilateral mammogram.

^[3] Use of CAD.

^[4] Family history of breast CA.

^[5] Negative screening.

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 77067

ICD-10-CM codes: Z12.31, Z80.3

Rationale:

CPT® codes: Look in the CPT® Index for Mammography/Screening. Report code 77067. Because the services are performed by an imaging center, and the radiologists are employed, the global service is reported (no modifiers 26 or TC).

ICD-10-CM codes: This is a screening mammogram. Look in the ICD-10-CM Alphabetic Index for Mammogram (examination)/routine referring you to Z12.31. A secondary diagnosis of family history of breast cancer is also reported. Look in the Alphabetic Index for History/family (of)/malignant neoplasm (of)/breast referring you to Z80.3. Verify code selection in the Tabular List.

Case 4

Location: Independent Diagnostic Testing Facility, radiologist employed by the facility. ^[1]

CT brain/head w/wo contrast exam: CT head, without and with contrast August 5, 20XX

Comparison: None available.

History: Non-small-cell lung cancer. ^[2]

Technique: Axial images of the calvarium without and with ^[3] 125 cc Omnipaque-300 intravenous contrast. ^[4]

Findings: The calvarium is intact. Imaged upper portions of the maxillary antra show minimal mucosal thickening. The sphenoid ethmoid and frontal sinuses are clear bilaterally. No hydrocephalus, mass effect, brain shift, abnormal extra-axial fluid collection or mass. Calcification left basal ganglia without mass effect, nonspecific, likely benign. Abnormal but nonspecific decreased density in the periventricular and subcortical white matter of the cerebral hemispheres bilaterally without mass effect or enhancement, most consistent with remote microvascular ischemic change present to mild degree. Bilateral intracavernous carotid and vertebral arteriosclerotic calcification. Probable anterior communicating artery aneurysm 6 x 5 mm. Recommend intracranial CT angiography to further characterize.

Conclusion: 1. No finding suggestive of metastatic disease. 2. Probable ^[5] 6 x 5 mm anterior communicating artery aneurysm. Recommend intracranial CT angiography to further characterize. 3. Cerebrovascular arteriosclerosis. ^[6] 4. Nonspecific cerebral white matter lesions ^[7] most consistent with remote microvascular ischemic change. 5. Calcification left basal ganglia, ^[8] likely benign; however, recommend continued imaging follow up.

^[1] Radiologist is employed by the facility, the IDTF will bill for global component.

^[2] Patient has non-small-cell lung cancer, not specified to location in lung.

^[3] CT performed without and with contrast.

^[4] Contrast was intravenous.

^[5] Aneurysm is probable and would not be coded.

^[6] Additional diagnosis of cerebrovascular arteriosclerosis.

^[7] Additional diagnosis of cerebral lesions.

^[8] Additional diagnosis of calcification left basal ganglia.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 70470

ICD-10-CM codes: C34.90, I67.2, G93.9, G23.8

Rationale:

CPT® code: In the CPT® Index, look for CT Scan/without and with Contrast/Brain referring you to 70470 and 70496. 70496 reports a CTA (Computed Tomography Angiography). This service is reported with 70470.

ICD-10-CM codes: ICD-10-CM coding guidelines IV.L indicates: For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

In the ICD-10-CM Alphabetic Index, look for Cancer-*see also* Neoplasm, by site, malignant. In the Table of Neoplasms look for, Neoplasm, neoplastic/lung/Malignant Primary column which directs you to subcategory code C34.9-. Turn to the Tabular List to complete the code. The complete code is C34.90. Further location within the lung is unknown. For the cerebrovascular arteriosclerosis, look in the Alphabetic Index for Arteriosclerosis/cerebrovascular referring you to I67.2. Cerebral lesions are found by looking for Lesion(s)/brain referring you to G93.9. Basal ganglia are located in the cerebral cortex. Next, look for Calcification/basal ganglia referring you to G23.8. Verify codes in the Tabular List.

Case 5

Location: Regional hospital. ^[1]

Study: Ultrasound Urinary Tract

Indications: Status ureteral reimplantation ^[2] to evaluate for continued vesicoureteral reflux.

Left Kidney: ^[3] Length: 7.0 cm
 Prior length: 7.4 cm
 Parenchyma: Cortical scarring.
 Pelvic dilatation: Normal
 Calyceal dilatation: Normal
 Hydronephrosis grade: Normal

Right Kidney: Length: 6.6 cm,
 Prior length: 6.4 cm,
 Parenchyma: Cortical scarring.
 Pelvic dilatation: Normal
 Calyceal dilatation: Normal
 Hydronephrosis grade: Normal
 Interval hydronephrosis change: None

Ureters: ^[4] Normal.

Bladder: ^[5] Almost empty and difficult to evaluate.

Impression:

1. Interval right renal enlargement without hydronephrosis. ^[6]
2. Stable asymmetric small left renal size ^[7] likely to represent diffuse cortical scarring.

^[1] Provided at the hospital, the radiologist will report the professional component.

^[2] The surgical procedure has been performed. The ultrasound is being performed after a surgical procedure for evaluation of continued reflux.

^[3] Kidney evaluated.

^[4] Ureters evaluated.

^[5] Bladder evaluated.

^[6] Diagnosis—right renal growth.

^[7] Secondary diagnosis—small left renal size.

What are the CPT® and ICD-10-CM codes reported for this service?**CPT® code:** 76770-26**ICD-10-CM codes:** Z48.816, N13.70, N28.81, N27.0**Rationale:**

CPT® code: In the CPT® Index, look for Ultrasound/Bladder 51798. Look for Ultrasound/Kidney which directs you to the code range 76770–76776. 51798 is for measurement of post-voiding residual urine which is not appropriate. 76770–76775 are for ultrasound, retroperitoneal, complete or limited. The examination of the complete urinary tract (kidney, ureters, and urinary bladder) indicate a complete retroperitoneal ultrasound exam and is reported with 76770. Modifier 26 is used to report the professional component only because this was performed at a hospital. The hospital will report the technical component.

ICD-10-CM codes: The patient had a surgical ureteral implantation for vesicoureteral reflux. According to the ICD-10-CM guidelines I.C.21.c.7, Aftercare visit codes cover situations when the initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. To find the diagnosis code, look in the ICD-10-CM Alphabetic Index for Aftercare/following surgery (for) (on)/genitourinary system referring you to Z48.816. Aftercare codes are listed as the first-listed diagnosis. The secondary diagnosis is vesicoureteral reflux. Look for Reflux/vesicoureteral N13.70. For the next diagnosis, right renal enlargement, look for Enlargement – *see also* Hypertrophy. Look for hypertrophy, hypertrophic/kidney (compensatory) referring you to N28.81. Look for Small/kidney (unknown cause)/unilateral referring you to code N27.0. Verify code selection in the Tabular List.

Case 6**Location:** Regional Hospital ^[1]

Fluoro Hysterosalpingogram

Examination: Hysterosalpingogram ^[2] (procedure performed by radiologist) ^[3]**Indication:** Infertility ^[4] for 15 years. Patient had one child 15 years ago. Last menstrual period was 1/13/20XX.

No history of pelvic infection or surgery.

Comparison: None

Procedure: The examination and anticipated discomfort was discussed with the patient. A plastic vaginal speculum was introduced with the patient's legs in the stirrups following preliminary vaginal examination and lubrication. The posterior vaginal fornix and outer cervical os were prepped with a cleansing solution. A 5-F hysterosalpingogram catheter ^[5] was used. The catheter balloon was inflated in the lower uterine segment. Fluoroscopic and radiographic assessments were done. ^[6]

The patient tolerated the procedure well.

Findings: Contrast ^[7] was administered through the catheter and multiple images were taken. There is a possible abnormal contour to the right cornua with patchy contrast opacification which may represent intramural contrast with intravasation.

No definite spillage of contrast from either fallopian tube was identified

Impression:

1. Possible right cornual contour abnormality manifested by focal extravasation and minimal intravasation of undetermined etiology. Recommend endovaginal ultrasound for further evaluation.
2. No contrast filling of either tubes and no spill into pelvic peritoneal space.

^[1] The location is the hospital, so the radiologist will report the professional component only.

^[2] Hysterosalpingogram is procedure performed.

^[3] The procedure was performed by the radiologist.

^[4] Reason for test is infertility.

^[5] Catheter inserted.

^[6] Fluoroscopy and X-rays were utilized.

^[7] Contrast used.

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 58340, 74740-26

ICD-10-CM code: N97.9

Rationale:

CPT® codes: In the CPT® Index look for Hysterosalpingography. You are given the radiology code 74740, and for the catheterization, you are directed to 58345. There is also a code listed for Injection Procedure 58340. 58340 reports the catheterization and injection of contrast material for a hysterosalpingography. In reading the parenthetical instructions, you are instructed to use 74740 for the supervision and interpretation of the hysterosalpingography. A Modifier 26 is used to report the professional component only. Do not report 58345 because the catheter was not placed in the fallopian tubes.

ICD-10-CM code: The procedure was performed for infertility. In the ICD-10-CM Alphabetic Index look for Infertility/female and referring you to N97.9. On exam, the radiologist found extravasation and minimal intravasation of undetermined etiology, but it is not noted this is the cause of infertility; therefore, not reported. Verify code selection in the Tabular List.

Case 7

Location: Regional Hospital ^[1]

CT thorax w/contrast, CT abdomen w/contrast, CT pelvis w/contrast, low osmolar contrast ^[2]

Exam: CT chest with contrast; CT abdomen with contrast; CT pelvis with contrast August 5, 20XX.

Comparison: CT chest Regional Hospital 7/8/20XX.

History: Non-small-cell lung cancer. ^[3]

Technique: Axial images of the chest, abdomen pelvis with oral and 125 cc Omnipaque-300 intravenous contrast. ^[4]

Findings: Chest CT ^[5] shows left upper ^[6] lobe and pulmonary mass which appear centrally necrotic abutting the posterior pleural surface and mediastinum without definitive invasion, 83 x 64 mm, prior 76 x 56 mm, image 15. Stable lingular and left basilar, right middle lobe and right lower lobe superior segment pleural-parenchymal opacity suggesting scarring. New mild subsegmental infiltrate left upper lobe. No pneumothorax or pleural fluid. No thoracic adenopathy. Heart size normal, no pericardial effusion. Left coronary arteriosclerotic calcification present. No osseous neoplasm. Abdomen CT ^[7] shows normal liver, gallbladder, biliary ducts, pancreas, spleen, adrenal glands and kidneys. Stomach and duodenum within normal limits. Aortoiliac arterial sclerosis without aneurysm. No retroperitoneal adenopathy. Pelvis ^[8] CT shows no mass, adenopathy or ascites. No bowel obstruction. No hernia. No osseous neoplasm. Lumbar spine degenerative change present. Left-sided muscle atrophy and brace noted.

Conclusion:

1. Increasing size left upper lobe pulmonary mass ^[9] with central cavitation suggested.
2. No thoracic adenopathy or distant metastatic disease demonstrated.
3. Coronary arteriosclerosis. ^[10]

-
- Ⓜ Performed at the hospital, the radiologist will only code for the professional component.
 - Ⓜ Three separate CT scan performed:
 - Thorax (chest)
 - Abdomen
 - Pelvis
 - Ⓜ Pt has non-small cell lung CA.
 - Ⓜ Contrast used.
 - Ⓜ Chest CT findings.
 - Ⓜ Mass is in the left upper lobe.
 - Ⓜ Abdomen CT findings.
 - Ⓜ Pelvis CT findings.
 - Ⓜ The mass is part of the lung CA.
 - Ⓜ Secondary diagnosis of coronary arteriosclerosis.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 74177-26, 71260-26

ICD-10-CM codes: C34.12, I25.10

Rationale:

CPT® Codes: In the CPT® Index, look in the for CT Scan/with Contrast/Thorax (71260), Abdomen (74160), and Pelvis (72193). When you look at the codes for CT abdomen and CT pelvis, there are parenthetical instructions referring you to combination codes. Modifier 26 is appended to show the professional component only; the hospital will report the technical component.

ICD-10-CM codes: The patient has non-small cell lung cancer. The mass/tumor is specified in the report as being in the left upper lobe. In the ICD-10-CM Alphabetic Index, look for Cancer - *see also* Neoplasm, by site, malignant. In the Table of Neoplasms, look for Neoplasm, neoplastic/lung/upper lobe/Malignant Primary referring you to subcategory C34.1-. In the Tabular List, 5th character 2 is reported for the left lung. The radiologist also notes a secondary diagnosis of coronary arteriosclerosis. Look in the Alphabetic Index for Arteriosclerosis/coronary (artery) or Disease, diseased/artery/coronary referring you to I25.10. Verify code selection in the Tabular List.

Case 8

Location: Regional Hospital

Exam:

Renal and bladder ultrasound dated 10/01/20XX

Renal artery Ⓜ Doppler evaluation dated 10/01/20XX

Comparison: Renal MRA dated 04/01/20XX

History: 80-year-old with renal artery stenosis. Diagnostic ultrasound of the kidneys was ordered to see if there was kidney damage due to the renal stenosis or other kidney issues. This was followed after review with a renal Doppler study.

Findings: Multiple grayscale sonographic and color Doppler images of the kidneys and renal vasculature were submitted for interpretation. ^[2]

The right kidney measures 10.1 cm without evidence of pelvic caliectasis. ^[3]

There is a small 8 mm cyst noted within the lower pole of the right kidney. There is relatively normal internal architecture and echogenicity. The left kidney measures 10.4 cm with no evidence of pelvicaliectasis. There are at least 3 renal cysts identified, the largest measuring 2 cm in diameter. There is normal internal architecture and echogenicity. The bladder is distended with urine and appears within normal limits. ^[3]

The aorta demonstrates peak systolic velocity of 1.07 m/sec.

The right renal artery origin demonstrates peak systolic velocity of 3.0 m/sec with a resistive index of 0.92. The midportion of the right renal artery demonstrates a peak systolic velocity of 1.1 m/sec with resistive index of 0.8. The right renal hilum has a peak systolic velocity of 0.64 m/sec with resistive index of 0.85. The inferior pole has a systolic velocity of 0.16 m/sec with resistive index of 0.54. The midpole has a systolic velocity of 0.18 m/sec and resistive index of 0.70. ^[4]

The superior pole has a velocity peak of 0.22 m/sec with a resistive index of 0.77.

The left renal artery origin demonstrates a peak systolic velocity of 2.0 m/sec with a resistive index of 0.87. The mid portion of the left renal artery demonstrates a peak velocity at 0.42 m/sec and a resistive index of 0.80. The left renal hilum has a peak systolic velocity of 0.47 m/sec and a resistive index of 0.82. The inferior pole has a systolic velocity of 0.16 m/sec and a resistive index of 0.67. The midpole has a systolic velocity of 0.17 m/sec and a resistive index of 0.63. ^[5]

The superior pole has a velocity peak of 0.13 m/sec with a resistive index of 0.69. ^[6]

Impression: Renal artery Doppler study:

1. Moderate stenosis of the right renal artery origin. ^[6]
2. Mild to moderate left renal artery origin stenosis.

Renal and bladder ultrasound:

1. Bilateral probable ^[7] renal cysts.
2. Normal appearing bladder

^[1] Renal artery is a “visceral artery.”

^[2] Indicates this provider only provided an interpretation supporting the use of modifier 26.

^[3] Right and left renal and bladder ultrasound.

^[4] Right renal artery Doppler evaluation.

^[5] Left renal artery Doppler evaluation.

^[6] Stenosis of the right and left renal artery will be used as the diagnosis.

^[7] Probable diagnosis should not be coded.

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 93976-26, 76770-26-59

ICD-10-CM code: I70.1

Rationale:

CPT® codes: The radiologist interpreted a renal artery Doppler study. The renal artery is considered a visceral (pertaining to an internal organ of the body) artery. Look in the CPT® Index for Duplex Scan/Arterial Studies/Visceral and you are directed to code range 93975-93979. 93976 is the correct code because the venous outflow was not studied.

Next code for the ultrasound. In the CPT® Index, look for Ultrasound/Bladder directs you to 51798. Look for Ultrasound/Kidney which directs you to the code range 76770–76776. 51798 is for measurement of post-voiding residual urine which is not appropriate. 76770–76775 are for ultrasound, retroperitoneal, complete or limited. The examination of the complete urinary tract (kidney, ureters, and urinary bladder) indicates a complete retroperitoneal ultrasound exam and is reported with 76770. Modifier 26 is used to report the professional component only. According to NCCI edits code 76770 is bundled in code 93976. Diagnostic ultrasound is included in 93976; however, there are two separate reports for two separate studies to be read by the radiologist. The radiologist must append modifier 59 to 76770 to show the studies were separate. The physician's documentation should indicate the medical necessity for the renal ultrasound.

ICD-10-CM code: The history indicates renal artery stenosis. The impression indicates stenosis of both renal arteries. Look in the ICD-10-CM Alphabetic Index for Stenosis/artery NEC/renal artery and you are directed to I70.1. The “probable” renal cysts indicated on the renal and bladder ultrasound should not be coded because it is a probable and not definitive diagnosis (ICD-10-CM guideline IV.H.). Verify code selection in the Tabular List.

Case 9

Location: Regional Hospital ^[1]

Examination:

1. CT enteroclysis (fluoro enteroclysis with CT abdomen ^[2]—neutral enteral with iv contrast—2D reformats)
2. CT enteroclysis (fluoro enteroclysis with CT pelvis ^[3]—neutral enteral with IV contrast—2D reformats)

Clinical Indication: Unexplained abdominal pain and diarrhea, as well as weight loss. ^[4]

Normal colonoscopy.

Comparison: None.

Procedure: In accordance with policy and procedure standard medication reconciliation was performed by the radiologic technologist prior to IV contrast administration. ^[5] No contraindication was identified.

The examination was performed in accordance with the standard protocol on a 43 year-old male. ^[6]

Following preprocedure assessment, informed consent was obtained. **Conscious sedation:** Independent observation performed by Amy Smith, RN. Total Time of Sedation: 60 minutes ^[6]. Vital signs, pre- and post-procedure monitoring were done by nurse in attendance with me performing the conscious sedation ^[6]. A transnasal intubation was done following a nasal drop of a local anesthetic.

Under fluoroscopic guidance, ^[7] using guidewire and positional maneuvers, the enteroclysis catheter was advanced and the tip anchored at the distal horizontal duodenum. ^[8]

Neutral enteral contrast was infused and monitored to a total of approximately 3.5 L. 0.6 mg Glucagon was administered IV prior to IV contrast administration. CT acquisition was done during continued infusion of enteral contrast following a 45 to 50 seconds delay. Intravenous administration of 100 ml Isovue 370 at 4 ml/second infusion rate. CT parameters used were 40 x 0.625 mm collimation reconstructed at 2 mm section thickness reconstructed at 1 mm intervals. The source images were transferred to

an independent workstation (EBW) and cross referenced multiplanar interactive 2D interpretation was done by the radiologist. Images were reviewed using soft tissue window settings.

Following completion of the infusion, the catheter was withdrawn into the stomach and refluxed contrast removed prior to catheter removal.

No acute adverse events occurred.

Findings: There is no evidence of transmural inflammatory disease changes involving the small bowel or the colorectum. There is, however, mild prominence of the vasa recta in the right lower abdomen, mild increased attenuation of the cecum and ascending colon and adjacent distal small bowel. Suggest biopsy *at* the ascending colon to exclude microscopic colitis. If the patient has a history of blood in the stools, air double-contrast enteroclysis would be of value to exclude aphthous ileitis. CT enteroclysis may not be able to assess for early Crohn's until transmural involvement is seen. The rest of the colon also appears normal.

There are no fold changes to suggest adult celiac disease.

There is no evidence of a small bowel mass. The mesentery appears normal.

Solid abdominal organs are grossly unremarkable.

Impression:

1. No evidence of transmural inflammatory disease changes involving the small bowel or colorectum. No fold abnormalities to suggest sprue.
2. Prominence of vasa recta of cecum and ascending colon and distal ileum with **question of mild increased attenuation.** **Consider microscopic colitis.** ^[9] See discussion and recommendation above.

If there is strong clinical suspicion of Crohn's disease, consider air DC barium enteroclysis to exclude or confirm early aphthoid changes.

3. Reproduction of **abdominal pain** ^[10] during contrast infusion, thus, correlated for visceral hypersensitivity.
4. Solid abdominal organs grossly unremarkable.

^[1] Procedure performed at a hospital, only the professional component will be reported by the physician.

^[2] CT Abdomen with contrast.

^[3] CT Pelvis with contrast.

^[4] Reason for exam to be used if no definitive diagnosis is made.

^[5] The contrast is administered via IV.

^[6] Conscious sedation was used. The presence of an independent trained observer to assist in the monitoring, the total time and performed by the physician.

^[7] Fluoroscopic guidance used.

^[8] A tube placed through the nasal opening to the duodenum would be considered a long gastrointestinal tube.

^[9] No definitive diagnosis—questionable diagnosis are not coded.

^[10] Abdominal pain should be coded.

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 74177-26, 74340-26, 44500, 99152, 99153x3

ICD-10-CM codes: R10.9, R19.7, R63.4

Rationale:

CPT® codes: To find the code for tube placement, look in the CPT® Index for Placement/Nasogastric Tube and you are directed to 43752; however, when you look at the parenthetical instructions under 43752, you are directed to CPT® codes 44500 and 74340 for enteric (pertaining to the small intestines) tube placement. Placement of a long gastrointestinal tube is reported with 44500. In looking at the parenthetical instructions, the supervision and interpretation of the tube placement is reported with 74340. To report the CT scans, look in the CPT® Index for CT Scan/with contrast/Abdomen (74160, 74177) and Pelvis (72193, 74177). When you verify the CT codes, there are parenthetical instructions indicating a combination code is used when a CT of the abdomen and a CT of the pelvis are performed reported with code 74177. Modifier 26 is used on the radiological codes to report the professional component only. Moderate sedation was given. Look in the CPT® Index for Sedation/Moderate. Report code 99152 for a patient 5 years-old and older for the first 15 minutes. Report add-on code three times for the remaining 45 minutes of conscious sedation.

ICD-10-CM codes: There is no definitive diagnosis in the impression; therefore, the reason for the study is used. In this case, code unexplained abdominal pain. In the ICD-10-CM Alphabetic Index, look for Pain(s)/abdominal referring you to R10.9. Look in the Alphabetic Index for Diarrhea referring you to R19.7 and look for Weight loss referring you to R63.4. Verify code selection in the Tabular List.

Case 10

Location: Regional Hospital ^[1]

Type of Procedure:

1. Abdominal aortic angiogram
2. Mesenteric artery angiogram

History: Mesenteric ischemia. ^[2]

Informed Consent: The procedure was discussed with the patient and his wife. The risks, including bleeding, infection, and vascular injuries such as dissection, perforation, thrombus, and embolus were outlined. Informed consent was obtained.

Contrast: 123 mL Ultravist 370.

Description of Procedure: The patient's right groin was sterilely prepped and draped. The skin and subcutaneous tissues were anesthetized with 2% lidocaine. The right common femoral artery was then percutaneously accessed and a wire advanced into the abdominal aorta ^[3] under fluoroscopic visualization. A 5-French vascular sheath was placed into the right groin. An Omni Flush catheter was advanced to the upper abdominal aorta. Digital subtraction angiography of the abdominal aorta was performed. It demonstrates mild tortuosity of the aorta. The caliber is normal. A single renal artery is seen bilaterally without stenosis. The common iliac vessels are patent.

The Omni Flush catheter was then exchanged for a Cobra 2 catheter. The superior mesenteric artery was then selectively catheterized. ^[4] Digital subtraction angiography was performed in multiple obliquities. The origin is patent. No focal stenosis or branch occlusions are identified. Next, the celiac artery was selectively catheterized. Digital subtraction angiography was performed in 2 obliquities. The origin is normal. No focal stenosis or branch occlusions are present.

Next, attempts were made to catheter the inferior mesenteric artery with the Cobra 2 catheter. This was unsuccessful. Selective catheterization of the inferior mesenteric artery ^[5] was achieved with a Simmons 2 catheter. Digital subtraction angiography was then performed in 2 obliquities. The origin is patent. No stenosis or branch occlusions are present. The Simmons 2 catheter was removed as was the right groin sheath over a wire. Hemostasis in the right groin was then achieved using an Angio-Seal closure device.

Impression: **Normal** ^[6] abdominal aortic angiogram and mesenteric angiogram of selective catheterization of the celiac, superior mesenteric and inferior mesenteric arteries.

-
- [1] The hospital will report the technical component. Only the professional component should be reported.
 - [2] Reason for the angiogram.
 - [3] The abdominal aorta is commonly accessed through the common femoral artery.
 - [4] Selective catheterization of the SMA (Superior Mesenteric Artery). From the aorta, this is a first order.
 - [5] Selective catheterization of the IMA (Inferior Mesenteric Artery). From the aorta, this is a first order.
 - [6] The findings were normal, the reason for the angiogram will be used for the diagnosis.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 36245, 36245-59, 36245-59, 75726-26, 75726-26-59, 75726-26-59

OR

36245, 36245-59 x 2, 75726-26, 75726-26-59 x 2

ICD-10-CM code: K55.9

Rationale:

CPT® codes: Catheter placement into the aorta is coded with CPT® code 36200; however, because the physician went on to selective catheterization, the selective catheterizations are coded and 36200 is inclusive (not billed separately). Selective catheterization from the aorta of the superior mesenteric artery is first order. The selective catheterization from the aorta of the celiac and inferior mesenteric arteries are also first order (refer to appendix L in your CPT® code book). 36245 is coded for each first order (SMA, celiac & IMA). This is found in the CPT® Index by looking for Selective Catheterization/Arterial/First Order/Abdominal. The mesenteric arteries are considered visceral arteries. The imaging supervision and interpretation (S&I) code reported is 75726 is found in the CPT® Index under Angiography/Abdomen for the first mesenteric artery. The aortography 75625-26 is bundled with the visceral angiography. Do not report 75774, *Angiography, selective, each additional vessel studied after basic examination*. Each vessel was examined; therefore, 75726 is reported x3 for the superior mesenteric, the celiac, and the inferior mesenteric. The Angio-Seal device placement is included in the selective catheterization procedures. Code 75774 would be used if, for example, selective catheterization was performed in the celiac artery (36245) and angiography (75726-26) was performed. Next the catheter was advanced passed the common hepatic artery (36246) into the left hepatic artery, third order (36247), and angiography was performed (75774-26). The first order (36245) is now dropped and replaced with the highest order (36247). Only report 75774 when after the basic examination of a visceral artery (75726), the artery is further investigated. In this case there was no further examination of the three arteries. Modifier 26 should be used to show only the professional component.

ICD-10-CM code: The angiogram is ordered for mesenteric ischemia. The findings were normal, so mesenteric ischemia will remain the diagnosis. Mesenteric ischemia is a type of intestinal ischemia. To find in the ICD-10-CM Alphabetic Index look for Ischemia. Mesenteric ischemia can be acute or chronic. There is no indication in the record of either acute or chronic. There is an entry under Ischemia, ischemic/intestine referring you to K55.9 which is for unspecified. There is also a subterm under Ischemia/intestine for due to mesentery artery insufficiency, but there is no indication in this record to suggest the insufficiency. If mesentery insufficiency were documented, it would be coded as chronic intestinal ischemia K55.1.



Case 1

R/O MRSA—Central line catheter

Clinical Indications: ^[1] Patient with fever not responsive to antibiotics

Collected: 03/30/XX 17:45

Accession Num: TXXXXX

Status: Authenticated

Method: Single nucleic acid sequence ^[2]

Culture: Methicillin resistant Staphylococcus aureus (MRSA) isolated ^[3]

^[1] Clinical indications provide medical necessity when there are no other findings.

^[2] Note the method used to identify the infectious agent and/or resistance.

^[3] Select the diagnosis code based on the findings.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 87641

ICD-10-CM code: A49.02

Rationale:

CPT® code: The test is performed to detect if the patient has MRSA. The method used is nucleic acid sequence. In the CPT® Index, look for Infectious Agent/Agent Detection/Nucleic acid Probe/Staphylococcus Aureus. You are referred to 87640–87641. The findings confirm it is Methicillin resistant report 87641.

ICD-10-CM code: The diagnosis is MRSA. In the ICD-10-CM Alphabetic Index, look for MRSA (Methicillin resistant staphylococcus aureus)/infection or Infection/methicillin/resistant staphylococcus aureus (MRSA). You are referred to A49.02. Verify code selection in the Tabular List.

Case 2

Requesting Provider: CI, MD

Surgical Pathology Report: Collected: Received: 3/4/20XX, the pathologist providing the service is an employee of the lab.

Materials Received for Consultation: Three referred specimens described as left base of tongue, left tonsil and right tonsil ^[1]

Clinical Data: Slides are prepared and reviewed in conjunction with the patient being seen for Radiation Oncology consultation for carcinoma of base of tongue ^[2]

Final Diagnosis:

Eight slides prepared and reviewed A–H. ^[3]

Left base of tongue (part A) and right tonsil, biopsies (parts B, C, G): Squamous mucosa and tonsillar tissue; no carcinoma identified. ^[3]

Left tonsil, biopsies (parts D, E, F, H): Tonsillar tissue with no carcinoma identified. ^[3]

^[1] There are three specimens.

^[2] Use this diagnosis as consultation on referred materials is negative.

^[3] A total of eight slides are prepared and reviewed.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 88323

ICD-10-CM code: C01

Rationale:

CPT® code: A consultation and slide preparation is performed. In the CPT® Index, look for Consultation/Surgical Pathology. This is reported with 88323. Consultation and report on referred material requiring preparation of slides is reported per surgical case, not by the number of specimens. Only one unit is reported.

ICD-10-CM code: Cancer is not found in the tonsillar tissue but the patient is diagnosed with cancer in the base of the tongue. In the ICD-10-CM Alphabetic Index, look for Cancer - *see also* Neoplasm, by site, malignant. In the Table of Neoplasms, look for Neoplasm, neoplastic/tongue/base (dorsal surface)/Malignant Primary column C01. Verify code selection in the Tabular List. There is an instructional note to use an additional code for alcohol abuse/dependency or tobacco abuse/dependency. The case note does not give that information so it will not be coded.

Case 3

Requested by P Norris, MD

Surgical Pathology Report

Materials Received: Referred slides of inguinal lymph node ^[1]

Clinical Data: History of Merkel cell carcinoma.

Final Diagnosis: Lymph node, left inguinal, excision:

1. High grade neuroendocrine carcinoma ^[2] involving one of four lymph nodes (1/4); see Comment.
2. No extranodal extension identified.

Comment: The neoplasm consists of sheets of small round blue cells with powdery chromatin, scant cytoplasm, and indistinct cell borders. Numerous mitotic figures and areas of single cell necrosis are seen. The morphologic findings are consistent with a high grade neuroendocrine carcinoma and the differential diagnoses include metastatic Merkel cell carcinoma or small cell carcinoma. ^[3] Given the patient's reported history (slides not reviewed at UMMM), the features are consistent with metastatic Merkel cell carcinoma. Correlation with clinical findings is advised.

^[1] Consultation on referred slides.

^[2] This is the only definitive diagnosis reported.

^[3] Even though these diagnoses are given in the differential diagnoses, the final diagnosis indicates a specific malignant carcinoma so this is coded.

What are the CPT® and ICD-10-CM codes?

CPT® code: 88321

ICD-10-CM code: C7A.1

Rationale:

CPT® Code: In the CPT® Index, look for Pathology/Surgical/Consultation 88321–88325. A consultation with review of slides prepared elsewhere is reported with 88321. Only one specimen is reviewed so the code is only reported once.

ICD-10-CM code: The differential diagnoses are not reported until they are confirmed. The only definitive diagnosis documented is metastatic high grade neuroendocrine carcinoma. In the ICD-10-CM Alphabetic Index, look for Carcinoma/neuroendocrine/high grade, any site referring you to C7A.1. Note, neuroendocrine carcinoma is listed under final diagnosis. Verify code selection in the Tabular List.

Case 4

Surgical Pathology

Ordering Physician: Karen Smith, MD

Procedures: Surgical pathology procedure performed by a pathologist.

Clinical Indications: Patient presents to her gynecologist for follow-up of an **abnormal Papanicolaou (Pap) smear**.^[1] The physician refers patient for repeat Pap smear. The specimen is sent for interpretation and report by the pathologist providing consultative services.

Specimens: Pap smear, cervix.

Methodology: **Morphometric analysis Fluorescent In Situ Hybridization (FISH) using computer-assisted technology, professional component.**^[2]

Results: The pathologist reviews images from the slides. The pathologist does not identify any copies of the **3q26**^[3] and **5p15**^[4] genes in the stained slide images. This report is consistent with the patient's HPV results and the patient is not at presently at risk to develop severe dysplasia.

A 41 year-old female presents to her gynecologist to review her abnormal Pap results. The physician reviews her Pap results which indicates that this patient is at risk for cervical cancer. The gynecologist recommends the patient have a repeat Pap smear and FISH studies to evaluate the tissue for the 3q26 and 5p15 genes which are associated with increased risk to develop cervical dysplasia.

FISH studies may be ordered by gynecologist to evaluate the presence of copies of the 3q26 and 5p15 genes. The presence of these genes is associated with an increased risk to develop severe cervical dysplasia, and place the patient at a higher risk to develop invasive cervical cancer.

The patient decides to have these studies and the physician performs a Pap smear on the same day. The specimen is sent for both HPV testing and probe studies for the 3q26 and 5p15 genes.

Pathologist does the review and the interpretation and report of the FISH probes and reports that from the Pap smear probes 3q26 and 5p15 are not present in this patient's cervical Pap smear specimen.

Referring physician sends the patient's results of the FISH studies which include the pathologist's interpretation and report.

^[1] Diagnosis used for lab

^[2] Procedure performed

^[3] Initial stain

^[4] Additional stain

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 88367, 88373

ICD-10-CM code: R87.619

Rationale:

CPT® code: Look in the CPT® Index for Fluorescent In Situ Hybridization (FISH)/Probe/Morphometric Analysis Computer-Assisted referring you to 88367, 88373, and 88374. These codes are located in the Surgical Pathology code section. You will look in this subsection where you will find the morphometric analysis code 88367 to report the initial single stain procedure for probe 3q26 and add-on code 88373 to report additional single stain probe, 5p15.

ICD-10-CM code: Look in the ICD-10-CM Alphabetic Index for Abnormal, abnormality, abnormalities/Papanicolaou (smear)/cervix referring you to R87.619. Verify code selection in the Tabular List.

Case 5

Clinical Indications: The patient is a 28 year-old female for routine lab tests part of her yearly physical exam.

Collected: 04/14/XX 13:29

Patient number: xxxxxxxxxxxx

ID: verified

Site: right antecubital venipuncture

Disposition: outpatient, fasting

Tests: **metabolic** ^[1] & **CBC** ^[2]

Results:

Sodium Blood: 141 mEq/L (135–145)

Potassium Blood: 4.0 mEq/L (3.3–4.8)

Chloride Blood: 105 mEq/L (95–105)

Carbon Dioxide Blood: 24 mmol/L (23–30)

Urea Nitrogen Blood: 12 mg/dL (5–25)

Creatinine Blood: 0.86 mg/dL (0.70–1.50)

Glucose Blood: 93 mg/dL (70–110)

Calcium Blood (total): **9.3 mg/dL (8.5–10.5)** ^[3]

CBC: **(automated)** ^[4]

WBC: 6.9 thou/uL (3.9–10.3)

Hemoglobin Blood: 14.5 g/dL (11.8–16.0)

Platelet Count: 235 thou/uL (135–370)

Red Blood Cells: 5.02 mil/uL (4.00–5.50)

Impression: Normal labs

HCT: 40% (38–46%)

^[1] Metabolic Panel is a set of tests performed as a panel in CPT®. Review the two metabolic panels to see if one includes the tests performed.

^[2] CBC is not included in either metabolic panels and is reported separately.

^[3] The calcium is total instead of ionized.

^[4] CBC is automated with no differential.

What are the CPT® and ICD-10-CM codes for the pathologist?

CPT® codes: 80048, 85027

ICD-10-CM code: Z00.00

Rationale:

CPT® codes: All elements of a basic metabolic panel (80048) are performed. In the CPT® Index, look for Blood Tests/Panels/Metabolic/Basic. The calcium is indicated as total, not listed as ionized.

The CBC is Complete Blood Count. In the CPT® Index, look for Complete Blood Count (CBC)—*See* Blood Cell Count; Blood Cell Count/Complete (CBC) referring you to codes 85025–85027. Because there is not WBC differential, 85027 is the correct code.

ICD-10-CM code: The blood work performed is for routine lab tests. In the ICD-10-CM Alphabetic Index, look for Examination/laboratory (as part of a routine general medical examination Z00.00. Verify code selection in the Tabular List.

The results of the lab tests are normal.

Case 6

Requested by R Simon, MD

Cytology ^[1] Report: Collected: 1/26/20XX Received: 1/27/20XX, Pathologist performing the service is an employee of the lab.

Specimen Source: A. Peritoneal Fluid

Specimen Description: 100 mls yellow fluid

Cytopreparation: 2 ccf

Pertinent Clinical Data and Clinical Diagnosis: 26-year-old female with end-stage renal disease (ESRD) due to type 1 diabetes presents for elective kidney transplant. ^[2]

Cytologic Impression: Peritoneal dialysis drain fluid: No cytologically malignant cells are identified.

Comment: 100 mls yellow fluid is received from which two Papanicolaou stained cytocentrifuged ^[3] slides are made. Slides contain mesothelial cells with a spectrum of reactive changes and histiocytes. No malignant cells are identified. ^[4]

^[1] Report indicates type of procedure performed.

^[2] Use clinical diagnostic information to assign ICD-10-CM codes because the findings are negative.

^[3] A concentration technique is used on the smear.

^[4] Findings are negative.

What are the CPT® and ICD-10-CM codes?

CPT® code: 88108

ICD-10-CM codes: E10.22, N18.6, Z99.2

Rationale:

CPT® code: The test performed is cytopathology on the peritoneal fluid. The documentation indicates cytocentrifuged, meaning that the fluid was removed to concentrate the cells for the smears placed on the slides. In the CPT® Index, look for Cytopathology/Smears/Concentration Technique referring you to 88108. Review of the code description verifies 88108 is the correct code.

ICD-10-CM codes: The patient is diagnosed with type 1 diabetes and end-stage renal disease (ESRD). The patient presents for a kidney transplant but the procedure has not been performed yet. The ESRD is a manifestation of the diabetes. In the ICD-10-CM Alphabetic Index, look for Diabetes/type 1/with/chronic kidney disease referring you E10.22. In the Tabular List there is an instructional note for E10.22 to use additional code to identify stage of chronic kidney disease (N18.1-N18.6). The patient has end-stage renal disease (ESRD) N18.6. There is an instructional note for N18.6 to use additional code to identify dialysis status (Z99.2). Because the case note under Cytologic impression states, “Peritoneal dialysis drain fluid” it is appropriate to also report Z99.2.

Case 7

Requested by D Smith, MD. The pathologist providing the service is an employee of the lab.

Surgical Pathology Report

Clinical Data: Chronic infected skin ulcer status post amputation of first and third toes, current mid transmetatarsal amputation.

Gross and Microscopic Description: A) Received in formalin designated “right mid transmetatarsal amputation”^[1] is a distal right foot including second, fourth, and fifth toes, measuring 9.0 x 9.0 x 4.0 cm. Also in the container is a piece of tan bone measuring 2.4 x 1.3 x 1.3 cm.^[2] The skin and subcutaneous tissue recedes up to 4.0 cm from the smooth bony margins of resection. The skin is tan-white. The first and third toes are missing. The remaining toes are slightly flexed and with a thickened irregular nail of the second toe. There is a round, deep ulcer at the bottom of the foot^[3] proximal to the second toe, measuring 1.5 x 1.5 x 0.7 cm. No other lesions are identified. The piece of bone is submitted for decalcification.^[4] Representative sections are submitted in A1 and A2, including skin and soft tissue margins.

Final Diagnosis: A) Right foot, mid-transmetatarsal amputation:

1. Right foot with ulceration
2. Status post amputation of first and third toes.
3. Skin and soft tissue margins histologically viable.^[5]
4. Bone section pending decalcification, addendum report to follow.^[6]

Comment: Geographic fibrinoid necrosis associated with ulcer raises the possibility of a rheumatoid nodule.

Microscopic Description: Microscopic examination was performed.

Findings of decalcified^[7] specimen (A3).

Sections of the bone demonstrate chronic reactive changes. No evidence of active osteomyelitis is identified.

^[1] The specimen that is received.

^[2] Bone specimen is also sent for testing.

^[3] Diagnosis to report and specificity of where the ulcer is located.

^[4] Decalcification is reported separately.

- 5 Although there are no specific listings for amputations, the skin margins had to be examined for viability.
- 6 The bone fragments were examined for pathologic components and should be treated similar to pathologic fracture fragments.
- 7 Special treatment by decalcification is coded separately.

What are the CPT® and ICD-10-CM codes?

CPT® codes: 88307, 88311

ICD-10-CM codes: L97.511

Rationale:

CPT® codes: The operative note indicates Gross and Microscopic description (exam) performed on the specimens. In the CPT® Index, look for Pathology Laboratory/Surgical Pathology/Gross and Micro Exam. Levels II through VI are reported with 88302-88309. To determine which level to report, review the description for each code. 88307 is reported for extremity, amputation, non-traumatic; this is because the amputation was of the mid transmetatarsal (mid foot). Decalcification is a procedure where mineral or other calcified tissue so section can be cut histologic (microscopic) exam. Decalcification is reported separately. In the CPT® Index, look for Pathology and Laboratory/Surgical Pathology/Decalcification Procedure 88311. It is reported with 88311.

ICD-10-CM codes: The patient is diagnosed with an ulcer of the right foot. In the ICD-10-CM Alphabetic Index, look for Ulcer/foot - see Ulcer, lower limb. Look for Ulcer/lower limb/foot specified NEC/right/with skin breakdown only referring you L97.511. Verify code selection in the Tabular List.

Case 8

Requested by R Williams, MD

Surgical Pathology Report Collected: 2/1/20XX Received: 2/2/20XX. The pathologist is employed by the lab providing the service.

Clinical Data: 26 year-old with end-stage renal (ESRD) disease due to type 1 diabetes, status post kidney, pancreas transplant with subsequent pancreas allograft removal, now with disseminated intravascular coagulation and decreased urine output and kidney allograft showing no flow to the kidney.

Description:

- A) Received fresh designated “**ureteral stent-gross only**”^[1] is a 15 cm x 0.2 cm piece of plastic tubing with a 1.5 cm hairpin turn at either end. There are 0.05 cm holes at every 2 cm of the device.
- B) Received fresh in a container labeled “**removed kidney-gross and micro**”^[2] is a 138 gram, 11 x 7 x 3 cm kidney. The specimen has a smooth, glistening, pink capsule with lightly adherent fibrous tissue. There are multiple surgical clips within the hilum and perihilar fat. The specimen is bivalved to reveal a sharp but irregular demarcation at the cortex and the medullary interface. No masses, nodules or lesions are grossly appreciated. There is probable intravascular thrombus. **Representative sections are submitted as follows: B1—renal vein, renal artery and ureteral margins; B2–B5—representative sections of kidney parenchyma in relation to capsule.**^[3]

Final Diagnosis:

- A) Medical device, removal: Pigtail catheter (gross only).
- B) Kidney, allograft resection:
 1. **Widespread acute coagulative necrosis/infarct of renal parenchyma in the setting of multifocal microvascular thrombi (clinical history of disseminated intravascular coagulation).**^[4]
 2. **Focal renal arterial thrombosis.**^[4]
 3. No evidence of humoral or cellular rejection.

-
- ^[1] Specimen 1.
 - ^[2] Specimen 2.
 - ^[3] Although the specimen is split into several sections, it only represents one specimen so can only be billed once.
 - ^[4] Use this data to assign a diagnosis code.
-

What are the CPT® and ICD-10-CM codes?

CPT® codes: 88307, 88300

ICD-10-CM codes: T86.19, N28.0

Rationale:

CPT® codes: There are two specimens examined, the ureteral stent and the kidney. The ureteral stent was only examined grossly. In the CPT® Index, look for Pathology and Laboratory/Surgical Pathology/Gross Exam/Level I. This procedure is reported with 88300.

The kidney was examined both grossly and microscopically. In the CPT® Index, look for Pathology and Laboratory/Surgical Pathology/Gross and Micro Exam/Level V. The gross and microscopic exam of the kidney is reported with 88307.

ICD-10-CM codes: The patient is status post kidney transplant with a complication (thrombosis of the renal artery). In the ICD-10-CM Alphabetic Index, look for Complication(s) (from) (of)/transplant/kidney/specified type NEC referring you to T86.19. An additional code is selected to report the renal artery thrombosis. In the Alphabetic Index, look for Thrombosis/renal (artery) referring you to N28.0. Verify code selection in the Tabular List.

Case 9

Requested by D Freeman, MD

Surgical Pathology Report: Collected: 4/20/20XX Received: 4/20/20XX. The pathologist providing the service is an employee of the lab.

Clinical Data: Post-heart transplant, rule out rejection.

Gross Description: ^[1]

- A) Received in a scant amount of formalin labeled “right ventricle endomyocardium” ^[2] are seven tan-brown, irregular soft tissues averaging 0.1 cm in greatest dimension. The specimen is submitted in toto in cassette A1.
- B) Received in a vial of immunofluorescence fixative labeled “right ventricle endomyocardium” ^[3] are two tan, irregular soft tissues averaging 0.1 cm in greatest dimension. Specimen is entirely submitted for immunofluorescence.

Microscopic Description:

- A) Sections of the paraffin-embedded material show six fragments of myocardium which are adequate to evaluate. There are few mononuclear cells present within the tissue, but these are beneath the threshold required to diagnose biologically meaningful rejection.

No cell injury is seen and no inclusion bodies are noted.

- B) Sections of the frozen myocardium demonstrate two fragments of myocardium and one fresh blood clot. There is no inflammatory cell infiltrate.

Immunofluorescence Report: Tissue, received in transport media, is washed in buffer and snap frozen in liquid nitrogen-cooled isopentane. Acetone-fixed frozen sections of the snap-frozen tissue are incubated with fluorescein-conjugated polyclonal antibodies to IgG, IgM, IgA, C3, C1q, fibrinogen, and albumin. Localization is thus via direct immunofluorescence. ^[4] Indirect immunofluorescence staining of peritubular capillaries for C4d. ^[5]

Block (Original Label): B Population: Microvascular endothelium

Label	Marker For	Results	Special Pattern or Comments
C4d	C4d (Quidel Clone A213), immunofluorescence	2+	Venule staining with high interstitial background

Block (Original Label): B1 Population: Microvascular endothelium

Label	Marker For	Results	Special Pattern or Comments
IgG IF	IgG, immunofluorescence	Negative	Interstitial staining
IgA IF	IgA, immunofluorescence	Negative	
IgM IF	IgM, immunofluorescence	2+	Capillary and venule staining
C3 IF	C3, immunofluorescence	2+	Venule staining
C1q IF	C1q, immunofluorescence	2+	Venule staining
FIB IF	Fibrinogen, immunofluorescence	Negative	Diffuse interstitial staining
ALB IF	Albumin, immunofluorescence	Negative	Diffuse interstitial staining

Final Diagnosis: A, B) Right ventricular endomyocardial biopsy:

1. No significant cellular rejection.
2. Immunofluorescence studies positive for humoral/vascular rejection (IgM and complement present). Please see comment.

Comment: A, B) This is the fourth biopsy since transplant. Compared to his most recent biopsy, the current specimen shows no change in the degree of cellular rejection.

^[1] Two specimens are received, one for gross and microscopic and one for immunofluorescence.

^[2] Specimen 1

^[3] Specimen 2

^[4] Indicates direct immunofluorescence.

^[5] Note that indirect immunofluorescence is coded separately.

What are the CPT® and ICD-10-CM codes?

CPT® codes: 88307 x 2, 88346, 88350 x 7

ICD-10-CM code: T86.21

Rationale:

CPT® Codes: Two tissue specimens from the endomyocardium were separately identified and are sent for a gross and microscopic exam as well as a separate specimen for immunofluorescence. In the CPT® Index, look for Pathology/Surgical/Gross and Micro Exam. This lists the possible levels, Level II-VI. It is necessary to look at the lists with these different codes. Code 88307, Level V, lists “Myocardium, biopsy.” The gross and microscopic exam for this tissue is reported with 88307 x 2. In the CPT® Index, look for Immunofluorescence Microscopy/Antibody Stain Procedure. You are referred to 88346 and 88350. In this case, 8 antibodies are tested, so it is reported as 88346 for the initial stain, and 88350 x 7 for each additional stain. Notice, in the add-on code descriptor it says: each additional single antibody stain.

ICD-10-CM code: The patient is diagnosed with rejection of the heart transplant. In the ICD-10-CM Alphabetic Index, look for Rejection/transplant/ heart T86.21. Verify code selection in the Tabular List.

Case 10

Clinical Indications: Inpatient day 32 in ICU with fever, hematuria, generalized edema, pneumonia ^[1]

Urine ^[2] Fungal Culture: Urine

Special Requests: None

Culture: No fungus isolated in 30 days ^[3]

Lower Resp Fungal W/Dir. Exam: Sputum ^[4]

Special Requests: None

Stain for Fungus: No fungi seen ^[5]

Culture: One colony Candida albicans ^[6]

Blood Fungal Culture: ^[7] Blood Arm, Right

Special Requests: Aerobic bottle

Culture: No fungus isolated in 4 weeks

Blood Fungal Culture: Blood Right IJ Catheter SWAN ^[8]

Special Requests: Aerobic bottle

Culture: No fungus isolated in 4 weeks

^[1] Used for diagnoses coding.

^[2] Note the substance the specimen was collected from.

^[3] Since no fungus has been found in the analyte, the clinical indication must be used. Link this service to the hematuria diagnosis.

^[4] This specimen is from sputum. The information is needed to select the correct code.

^[5] Since no fungi have been identified assign the pneumonia code for this service.

^[6] This result is too limited to assign a diagnosis code.

^[7] Again, the source material is required to code the service and the clinical indications are used for the diagnosis since there are no findings.

^[8] The analysis using blood can be billed twice since there are two different source locations.

What are the CPT® and ICD-10-CM codes?

CPT® codes: 87102, 87102-59, 87103, 87103-59

ICD-10-CM codes: J18.9, R31.9, R60.1

Rationale:

CPT® codes: There are several specimens obtained (urine, sputum and blood) to perform cultures. In the CPT® Index, look for Culture/Fungus/Source Other than Blood for the sputum and urine. Code 87102 is reported twice (urine, sputum). Next, locate the code for the blood specimen. In the CPT® Index, look for Culture/Fungus/Blood. Code 87103 is reported twice because blood samples are taken from two different sites. According to CPT® subsection guidelines for Microbiology, *for multiple specimens/sites use modifier 59*. When the same test is performed on different specimen(s) that uses the same CPT® code modifier 59 is appropriate to use.

ICD-10-CM codes: The patient is stated as having fever, hematuria, generalized edema and pneumonia. Pneumonia indexes to J18.9 in the ICD-10-CM Alphabetic Index and is listed first. Fever (R50.9) is a symptom of the pneumonia and is not reported separately. Look in the Alphabetic Index for Hematuria R31.9 and Edema/generalized R60.1. Verify code selection in the Tabular List.



Case 1

Identification: The patient is a 37 year-old Caucasian lady.

Chief Complaint: The patient is here today for **follow-up**^[1] of **lower extremity swelling**.^[2]

History of Present Illness: A 37 year-old with a **history of dyslipidemia and chronic pain**.^[3] The patient is here for follow-up of **bilateral lower extremity**^[4] swelling. The patient tells me the **swelling responded to hydrochlorothiazide**.^[5]

Exam: Very pleasant, no acute distress (NAD). Vitals: P: 67, R: 18, Temp 98.6, BP: 130/85.

Data Review: **I did review her labs**,^[6] and **echocardiogram**.^[7] The patient does have moderate pulmonary hypertension.

Assessment:

1. Bilateral lower extremity swelling: This has resolved with diuretics; this **may be secondary to problem #2**.^[8]
2. Pulmonary hypertension: Etiology is not clear at this time, will do a work up and possible referral to a pulmonologist.

Plan: I think we will need to evaluate the etiology of the pulmonary hypertension. The patient will be scheduled for a sleep study.

^[1] Established patient & established problem.

^[2] Chief complaint.

^[3] Past medical history.

^[4] HPI: Location.

^[5] HPI: Modifying factor.

^[6] Lab reviewed.

^[7] Echocardiogram review.

^[8] Possibly due to pulmonary hypertension, but not certain, so code separately.

What are the CPT® and ICD-10-CM code(s) reported?

CPT® code: 99212

ICD-10-CM codes: M79.89, I27.20

Rationale:

CPT® code: Subcategory—office, established patient (requires 2 out of 3 key components)

History—Problem focused (2 HPI, 0 ROS, 1 PFSH)

Exam—Problem focused

Medical Decision Making—Moderate complexity (1 problem stable, 1 problem worsening, Lab & Echocardiogram reviewed, risk moderate (one or more chronic illness with exacerbation, progression))

ICD-10-CM codes: The bilateral lower extremity swelling is possibly due to the pulmonary hypertension, but it is not confirmed so it would be coded separately. In the ICD-10-CM Alphabetic Index, look for Swelling/leg/lower M79.89. For the pulmonary hypertension, look in the Alphabetic Index for Hypertension, hypertensive/pulmonary I27.20 Verification code selection in the Tabular List.

Case 2

The patient is a 32 year-old male here for the first time. ^[1]

Chief Complaint: Left knee area is bothersome, ^[2] painful moderate severity. ^[3] The patient also notes swelling ^[4] in the knee area, ^[5] limited ambulation, ^[6] and inability to perform physical activities such as sports or exercises. The patient first noticed symptoms approximately 4 months ago. ^[7] Problem occurred spontaneously. Problem is sporadic. ^[8] Patient has been prescribed hydrocodone and meloxicam. Patient has had temporary pain relief with the medications. The meloxicam has caused digestion problems so patient has avoided using it. ^[9]

Past Medical History: Patient denies any past medical problems. ^[10]

Surgeries: Patient has undergone surgery on the appendix. ^[10]

Hospitalizations: Patient denies any past hospitalizations that are noteworthy. ^[10]

Medications: Hydrocodone. ^[10]

Allergies: Patient denies having allergies. ^[10]

Family History: Mother: No serious medical problems; Father: No serious medical problems. ^[11]

Social History: Patient is married. Occupation: Patient is a chef. ^[12]

Review of Systems: ^[13]

Constitutional: Denies fevers. Denies chills. Denies rapid weight loss. ^[13]

Eyes: Denies vision problems. ^[13]

Ears, Nose, Throat: Denies any infection. Denies loss of hearing. Denies ringing in the ears. Denies dizziness. Denies a sore throat. Denies sinus problems. ^[13]

Cardiovascular: Denies chest pains. Denies an irregular heartbeat. ^[13]

Respiratory: Denies wheezing. Denies coughing. Denies shortness of breath. ^[13]

Gastrointestinal: Denies diarrhea. Denies constipation. Denies indigestion. Denies any blood in stool. ^[13]

Genitourinary: Denies any urine retention problems. Denies frequent urination. Denies blood in the urine. Denies painful urination. ^[13]

Integumentary: Denies any rashes. Denies having any insect bites. ^[13]

Neurological: Denies numbness. Denies tremors. Denies loss of consciousness. ^[13]

Hematologic/Lymphatic: Denies easy bruising. Denies blood clots. ^[13]

Psychiatric: Denies depression. Denies sleep disorders. Denies loss of appetite. ^[13]

Review of Previous Studies: Patient brings an MRI which is reviewed. Large knee effusion. No lateral meniscal tear. No ACL/PCL tear. No collateral fracture. Medial meniscus tear with grade I signal. ^[14]

Vitals: Height: 6'0", Weight: 160

Physical Examination: Patient is alert, appropriate, and comfortable. Patient holds a normal gaze. Pupils are round and reactive. ^[15] Gait is normal. ^[16] Skin is intact. No rashes, abrasions, contusions, or lacerations. ^[17] No venous stasis. No varicosities. ^[18] Reflexes are normal patellar. No clonus. ^[19]

Knee: Range of motion is approximately from 5 to 100 degrees. Pain with motion. No localized pain. Negative mechanical findings. There is an effusion. Patella is tracking well. No tenderness. Patient feels pain especially when taking stairs or squatting. ^[20]

Hip: Exam is unremarkable. Normal range of motion, flexion approximately 105 degrees, extension approximately 10 degrees, abduction approximately 25 degrees, adduction approximately 30 degrees, internal rotation approximately 30 degrees, external rotation approximately 30 degrees. ^[20]

Neck: Neck is supple. No JVD. ^[21]

Impression:

1. Infective synovitis of the left knee
2. Contracture of the left knee
3. Possible medial meniscal tear of right knee ^[22]

Assessment and Plan: A discussion is held with the patient regarding his condition and possible treatment options. Patient has GI upset. Patient is recommended to take Motrin 400 two to three times a day, discussion is held regarding proper use and precautions. Patient is given a prescription for physical therapy. ^[23] We will obtain an MRI ^[24] to rule out potential medial meniscus tear. Patient is instructed to follow up with PMD with labs. Patient is referred to Dr. XYZ. Patient may need arthroscopy if patient does have medial meniscus tear and repeat effusion.

^[1] New patient.

^[2] Chief complaint.

^[3] HPI: Severity.

^[4] HPI: Associated Signs & Symptoms.

^[5] HPI: Location.

^[6] HPI: Severity again (not counted twice).

^[7] HPI: Duration.

^[8] HPI: Timing.

^[9] HPI: Modifying factors and their effects.

^[10] PFSH: Past Medical History.

^[11] PFSH: Family History.

^[12] PFSH: Social History.

^[13] ROS: Complete.

^[14] Previous studies reviewed used in MDM.

^[15] Exam: Eyes.

^[16] Exam: Musculoskeletal.

^[17] Exam: Skin.

^[18] Exam: Cardiovascular.

^[19] Exam: Neuro.

^[20] Exam: Musculoskeletal.

^[21] Exam: Neck.

^[22] Uncertain diagnosis.

^[23] Physical therapy prescribed.

^[24] Additional test ordered.

What are the CPT® and ICD-10-CM code(s) reported?

CPT® code: 99203

ICD-10-CM codes: M65.162, M24.562

Rationale:

CPT® code: Subcategory—Office Visit, New Patient (3 of 3 key components required)

History—Comprehensive (HPI—extended, ROS—complete, PFSH—complete)

Exam—Detailed (5 organ systems—detailed knee and hip exam)

MDM—Moderate complexity— (New problem, add work up, previous MRI reviewed, ordered MRI) Risk is moderate (undiagnosed new problem with uncertain prognosis.)

ICD-10-CM codes: In the ICD-10-CM Alphabetic Index, look for Synovitis/infective NEC, and you are directed to *see also* tenosynovitis. Look for Tenosynovitis/infective NEC/lower leg M65.16-. In the Tabular List, 6th character 2 is reported for the left leg. Next, look for Contraction(s), contracture, contracted/joint/knee M24.56-. In the Tabular List, 6th character 2 is reported for the left knee. The medial meniscal tear is only a possible diagnosis, so it should not be coded.

Case 3

Susan is a 67-year-old female and is referred by Dr. R with a **suspicious neoplasm of her left arm.** ^[1] **She has had it for about a year but it has grown a lot this last few months.** ^[2] **I had the privilege of taking a skin cancer off her forearm in the past.** ^[3]

Past Medical History: Hypertension, arthritis.

Allergies: None.

Medications: Benicar and Vytorin.

Social History: Cigarettes: None.

Physical Examination: **On examination, she has a raised lesion. It is a little bit reddish and is on her left proximal arm. It has a little bumpiness on its surface.** ^[4]

Medical Decision Making: Suspicious neoplasm, left arm.

My **guess is this is a wart, but it may be a keratoacanthoma** ^[5] as Dr. R thinks it is. After obtaining consent, we infiltrated the area with 1 cc of 1% lidocaine with epinephrine, performed a **3 mm punch biopsy of the lesion, and then I shaved the rest of the lesion off and closed the wound with 3-0 Prolene.** ^[6] We will see her back next week to go over the results.

-
- [1] Chief complaint.
 - [2] Related to surgery.
 - [3] Established patient.
 - [4] Related to surgery.
 - [5] Possible diagnoses are not coded.
 - [6] Punch biopsy performed.
-

What are the CPT® and ICD-10-CM code(s) reported?

CPT® code: 11300

ICD-10-CM codes: D49.2, Z85.828

Rationale:

CPT® code: In the CPT® Index, look for Shaving/Skin Lesion and you are directed to code range 11300–11313. Or, in the CPT® Index, look for Skin/shaving and you are directed to the same code range. CPT® 11300 is correct for the shaving of a single lesion of the arm. According to CPT®, directions for biopsy during excision, destruction, or shave removals, “The obtaining of tissue for pathology during the course of these procedures is a routine component of such procedures;” therefore, the biopsy is not reported. The documentation does not support a separate evaluation and management service.

ICD-10-CM codes: The medical decision making has a suspicious lesion, left arm. There are possible diagnoses of a wart or keratoacanthoma, but neither is confirmed. For this case, the patient is coming in for a suspicious lesion on the skin of the left arm. There is no pathology report to indicate whether the lesion is malignant or benign. The diagnosis listed in the Medical Decision Making (MDM) identifies this is a suspicious neoplasm. In the ICD-10-CM Table of Neoplasms, look for Neoplasm/skin NOS/arm -see also Neoplasm, skin, limb NEC, upper; Neoplasm/skin/limb/upper/Unspecified Behavior (column) D49.2. It is documented that she had skin cancer in the past on the skin of her forearm. Reporting the history code, as an additional code is important information to further support the biopsy and shaving of the suspicious lesion as it indicates the potential for recurrence of skin cancer. Look for History/personal (of)/malignant neoplasm (of)/skin NEC Z85.828. Verify code selection in the Tabular List.

Case 4

Age: 33 year-old —Established patient

Vital Signs: TEMPERATURE: 98.9°F Tympanic, PULSE: 97 Right Radial, Regular, BP: 114/70 Right Arm Sitting, PULSE OXIMETRY: 98%, WEIGHT: 161 lbs.

Current Allergy List: Lortab

Current Medication List:

- Lunesta Oral Tablet 3 Mg, 1 Every Day at Bedtime, As Needed
- Prozac Oral Capsule Conventional 40 Mg, 1 Every Day
- Levothyroxine Sodium Oral Tablet 100 Mcg, 1 Every Day for Thyroid
- Meloxicam Oral Tablet 15 Mg, 1 Every Day for Joint Pain
- Imitrex Oral Tablet 100 Mg, 1 Tab Po as Directed, Can Repeat After 2 Hours for migraines, Max 2 Per Day
- Phenergan 25 Mg, 1 Every 4–6 Hours, As Needed for Nausea

Chief Complaint: Here for a comprehensive annual physical and pelvic examinations. ^[1]

History of Present Illness: Pt here for routine Pap and physical. Pt reports episode of syncope two weeks ago. Pt went to ER and had EKG, CXR and labs and says she was sent home and per her report everything was normal. She denies episodes since that time. She does occasionally have mild mid-epigastric discomfort but no breathing problems or light-headedness. Good compliance with her thyroid meds. ^[2]

Past Medical History: Depression.

Family History: No cancer or heart disease, mother has hypertension.

Social History: Tobacco Use: Currently smokes 1 1/2 PPD, has smoked for 15 to 20 years.

Review of Systems: Patient denies any symptoms in all systems except for HPI.

Physical Exam: ^[3]

Constitutional: Well developed, well-nourished individual in no acute distress.

Eyes: Conjunctivae appear normal. PERRLA

ENMT: Tympanic membranes shiny without retraction. Canals unremarkable. No abnormality of sinuses or nasal airways. Normal oropharynx.

Neck: There are no enlarged lymph nodes in the neck, no enlargement, tenderness, or mass in the thyroid noted.

Respiratory: Clear to auscultation and percussion. Normal respiratory effort. No fremitus.

Cardiovascular: Regular rate and rhythm. Normal femoral pulses bilaterally without bruits. Normal pedal pulses bilaterally. No edema.

Chest/Breast: Breasts normal to inspection with no deformity, no breast tenderness or masses. ^[4]

GI: Soft, non-tender, without masses, hernias or bruits. Bowel sounds are active in all four quadrants.

GU: External/Vaginal: Normal in appearance with good hair distribution. No vulvar irritation or discharge. Normal clitoris and labia. Mucosa clear without lesions. Pelvic support normal. ^[5]

Cervix: The cervix is clear, firm and closed. No visible lesions. No abnormal discharge. Specimens taken from the cervix for thin prep Pap smear. ^[5]

Uterus: Uterus non-tender and of normal size, shape and consistency. Position and mobility are normal. ^[6]

Adnexa/Parametria: No masses or tenderness noted.

Lymphatics: No lymphadenopathy in the neck, axillae, or groin.

Musculoskeletal exam: Gait intact. No kyphosis, lordosis, or tenderness. Full range of motion. Normal rotation. No instability.

Extremities: Bilateral Lower: No misalignment or tenderness. Full range of motion. Normal stability, strength and tone.

Skin: Warm, dry, no diaphoresis, no significant lesions, irritation, rashes or ulcers.

Neurologic: CNS II-XII grossly intact.

Psychiatric: Mood and affect appropriate.

Labs/Radiology/Tests: The following labs/radiology/tests results were discussed with the patient: Alb, Bili, Ca, Cl, Cr, Glu, Alk Phos, K, Na, SGOT, BUN, Lipid profile, CBC, TSH, Pap smear.

Assessment/Plan: Unspecified acquired hypothyroidism.

-
- ^[1] Patient is seen for a routine Pap smear and comprehensive physical exam. This will be a preventive visit.
 - ^[2] Discussion of meds for thyroid. This is not sufficient enough to bill a problem visit along with the preventive visit.
 - ^[3] Comprehensive physical exam.
 - ^[4] Breast exam.
 - ^[5] Thin prep Pap smear collection.
 - ^[6] Pelvic exam.
-

What are the CPT® and ICD-10-CM code(s) reported?

CPT® code: 99395—for some insurance carriers, also code G0101 for the pelvic and breast exam.

ICD-10-CM codes: Z00.00, Z01.419, E03.9

Rationale:

CPT® code: Subcategory—Preventive Medicine Services, established patient. In the CPT® Index, look for Preventive Medicine/Established Patient referring you to code range 99382-99397.

Age 33—code 99395

Some insurance carriers will also allow reporting of HCPCS Level II code G0101 for the pelvic and breast exam. The Pap smear results were discussed with the patient during the visit indicating the Pap analysis was performed in the office. If the documentation included a Pap report, we could also bill for the Pap smear.

ICD-10-CM codes: In the ICD-10-CM Alphabetic Index, look for Examination/annual (adult) (periodic) (physical) Z00.00. There is also a code for Examination/pelvic Z01.419. The provider also has documented unspecified acquired hypothyroidism. Since the provider confirmed her medication compliance, this can be listed as an additional code. In the Alphabetic Index, look for Hypothyroidism (acquired) E03.9. Verify codes in the Tabular List. Note: Some payers will require specific ICD-10-CM codes be reported with screening pelvic and breast exams. Check your payer policies.

Case 5

Mark is a 45 year-old male and is here as a new patient ^[1] to have several lipomas removed. ^[2] He has had these for many years. ^[3] He has had about 12 removed. ^[4] They get bigger slowly over time. ^[5] Some of them are tender to touch. ^[6] They get irritated when he is handling people as a firefighter. ^[7]

Past Medical History: None. ^[8]

Allergies: None. ^[8]

Medications: None. ^[8]

Past surgical History: Nasal surgery, knee surgery. ^[8]

Social history: Cigarettes: None. ^[9]

Family History: He does have a family history of melanoma in his paternal grandfather who died from it. ^[10]

Physical Examination: On examination, he has subcutaneous masses of his left forearm and two spots of his left posterior arm. That is the biggest of those three. It is about 1.3 cm. He has four on his right upper extremity, two on his lower forearm and two on his posterior arm. He has some on his belly. ^[11]

Medical Decision Making: The patient has **multiple lipomas**, ^[12] which are tender. He would like them removed. With his permission, I have drawn how we would incise the skin over these and about how long the scar would be. **There is really no alternative to treatment other than surgery. Some plastic surgeons will do this with liposuction, but I have found that personally the recurrence rate is quite high when I have tried to do it with liposuction, so I generally just excise them. Risks would include infection and bleeding.** ^[13] We do not know why people get these, so this is something that Mark must deal with forever. We will do that here in the office. We will do about three at a time. We are going to start with his left upper extremity. It will be a privilege to take care of Mark.

^[1] New patient

^[2] Chief complaint

^[3] HPI: Duration

^[4] ROS: Integumentary

^[5] HPI: Severity

^[6] HPI: Quality

^[7] HPI: Modifying factors

^[8] Past medical history

^[9] Social history

^[10] Family history

^[11] Organ: Skin

^[12] Diagnosis

^[13] Elective major surgery (removal of subcutaneous lipoma has a 90-day global); although provider documents risk of infection and bleeding, this is not above the normal risk associated with a surgery.

What are the CPT® and ICD-10-CM code(s) reported?

CPT® code: 99201

ICD-10-CM codes: D17.21, D17.22, D17.1

Rationale:

CPT® code: Subcategory, office visit, new patient (3 of 3 key components must be met)

History—Expanded problem focused (4 HPI, 1 ROS, Complete PFSH)

Exam—Problem focused (1 organ system)

Medical Decision Making—Moderate complexity (New problem, no additional work-up planned, Risk moderate—major surgery with no identified risk factors).

ICD-10-CM codes: Diagnosis is multiple lipomas on the skin of both the right and left arms. Look in the ICD-10-CM Alphabetic Index for Lipoma/site classification/arms (skin) (subcutaneous) D17.2-. In the Tabular List, there are codes for the right arm (D17.21) and the left arm (D17.22). Both codes are reported because the Physical Examination indicates the patient has lipomas on both arms. Lipomas of the belly were also seen, look for Lipoma/site classification/trunk (skin) (subcutaneous) D17.1.

Case 6

Hospital Progress Note

Subjective: Patient is without complaint. She states she feels much better. ^[1] No vomiting or diarrhea. She did have bowel movement yesterday. ^[2] No shortness of breath, no chest pain. ^[3]

The patient and daughter were questioned again about her cardiac history. She denies any cardiac history. She has no orthopnea, no dyspnea on exertion, no angina in the past and she has never had any heart problems in the past. ^[4]

Case discussed yesterday with Dr. Williams and I am waiting to find out on her surgery date.

Objective:

Vital signs: Shows a T-max of 99.6, T-current 98, pulse 72, respirations 18. Blood pressure 154/65, O2 sat 96% on room air. Accu-checks, 113, 132, 96, 98. ^[5]

General: No apparent distress, oriented x 3, pleasant Spanish-speaking female. ^[5]

Head, Ears, Eyes, Nose, Throat: Normocephalic, atraumatic. ^[6] Oropharynx pink and moist. ^[7] Left eye has sclera erythema. Pupils equal, round, and reactive to light accommodation (PERRLA). ^[8]

Laboratory Data: Shows C Diff toxin negative. Sodium 129, potassium 3.4, chloride 96, CO₂ 27, glucose 72, BUN 12, creatinine 0.6. Urine culture positive for E. coli, sensitive to Levaquin. ^[9]

Assessment:

1. Cholelithiasis
2. Cystitis
3. Conjunctivitis
4. Hyponatremia
5. Hypokalemia
6. Diabetes mellitus type 2
7. Hypertension

If the patient is not to go to surgery today, will feed the patient and likely discharge her if she tolerates regular diet. Will add Norvasc 5 mg p.o. daily. Also pleural effusion, small. Will repeat a chest X-ray PA and lateral this morning to evaluate that.

^[1] HPI: Quality

^[2] ROS: GI

^[3] ROS: Respiratory

^[4] ROS: Cardiovascular

^[5] Exam: Constitutional

^[6] Exam: Head, including face

^[7] Exam: ENMT

^[8] Exam: Eyes

^[9] Lab tests reviewed

What are the CPT® and ICD-10-CM code(s) reported?**CPT® code:** 99232**ICD-10-CM codes:** K80.20, N30.90, H10.9, E87.1, E87.6, E11.9, I10**Rationale:****CPT® code:** Subcategory: Subsequent Hospital Care (2 of 3 components)

History—Expanded problem focused (HPI—Brief, ROS—Extended, PFSH—none)

Exam—Expanded problem focused (3 organ systems—limited exams of all three)

MDM—Moderate Complexity (Extensive diagnosis, Review labs, Moderate Risk [Two or more stable chronic illnesses]).

ICD-10-CM codes:

1. Cholelithiasis—In the ICD-10-CM Alphabetic Index, look for Cholelithiasis – *see* Calculus, gallbladder; Calculus, calculi, calculous/gallbladder K80.20.
2. Cystitis—Look in the Alphabetic Index for Cystitis. There are no other descriptors, use N30.90. Physician needs to document the infectious agent to report it.
3. Conjunctivitis—Look in the Alphabetic Index for Conjunctivitis NOS H10.9.
4. Hyponatremia—Look in the Alphabetic Index for Hyponatremia E87.1.
5. Hypokalemia—Look in the Alphabetic Index for Hypokalemia E87.6.
6. Diabetes mellitus type 2—Look in the Alphabetic Index for Diabetes, diabetic/type 2 E11.9.
7. Hypertension— Look in the Alphabetic Index for Hypertension I10.

Verify code selections in the Tabular List.

Case 7**Discharge Summary** ^[1]

Hospital Course: The patient was hospitalized two days ago with nausea and vomiting. She had an uneventful hospital course. She was diagnosed with cholelithiasis. General surgery was consulted. Dr. Williams thought this was perhaps causing her upper GI symptoms. She was scheduled for surgery on Monday. She was tolerating a regular diet. Her nausea and vomiting resolved and she desired to be dismissed home. She was found to have a bladder infection. She was started on Levaquin and she also had left eye conjunctivitis and she was given Ciloxan eye ointment for that.

Discharge Diagnoses: ^[2]

1. Cholelithiasis
2. Cystitis
3. Conjunctivitis
4. Hyponatremia
5. Diabetes mellitus type 2
6. Hypertension

Discharge Medications:

1. Levaquin 500 mg p.o. daily x2 days
2. Ciloxan ointment, apply b.i.d. to left eye x 4 days/
3. Zofran 4 mg p.o. q. 4 hours p.r.n. nausea, vomiting #20
4. Benadryl 25 mg p.o. daily p.r.n. rash
5. Diovan 320 p.o. daily
6. Calcium 600 mg p.o. daily

7. Vitamin C 500 mg p.o. daily.
8. Metformin 1000 mg p.o. daily
9. Lipitor 20 mg p.o. at bedtime
10. Coreg CR 20 mg p.o. daily.

Discharge Diet: Cardiac

Activities: ad lib

Discharge instructions: Patient to be NPO after midnight Sunday.

Dismiss: Home ^[3]

Condition: Good

Follow-up: Follow up with me in 1 week. Follow up on Monday morning for cholecystectomy. NPO after midnight on Sunday. ^[4]

^[1] This indicates the provider is discharging the patient. Review the note to make sure discharge services were performed. Look for documented time in the note.

^[2] Select a diagnosis code for all discharge diagnoses.

^[3] This is confirmation the patient is being discharged to their home.

^[4] The patient is scheduled for surgery in one week.

What are the CPT® and ICD-10-CM code(s) reported?

CPT® code: 99238

ICD-10-CM codes: K80.20, N30.90, H10.9, E87.1, E11.9, Z79.84, I10

Rationale:

CPT® code: This is a discharge summary from a hospital. Subcategory--Hospital Discharge Services. In the CPT® Index, look for Discharge Services/hospital for code range 99238-99231. Discharge services are coded based on time. There is no time documented in the medical record, so the lowest time is selected. The CPT® code 99238 is the correct code. Remember, when reporting the discharge based on time, you would include all time spent by that physician on that date of service, whether it is continuous.

ICD-10-CM codes:

1. Cholelithiasis—In the ICD-10-CM Alphabetic Index, look for Cholelithiasis – *see* Calculus, gallbladder; Calculus, calculi, calculous/gallbladder K80.20.
2. Cystitis—Look in the Alphabetic Index for Cystitis. There are no other descriptors, use N30.90. Physician needs to document the infectious agent to report it.
3. Conjunctivitis—Look in the Alphabetic Index for Conjunctivitis NOS H10.9.
4. Hyponatremia—Look in the Alphabetic Index for Hyponatremia E87.1.
5. Diabetes mellitus type 2—Look in the Alphabetic Index for Diabetes, diabetic/type 2 E11.9.
6. The patient is on long-term metformin to control her blood sugar. Look in the Alphabetic Index for Long-term (current) (prophylactic) drug therapy (use of)/oral/hypoglycemia Z79.84.
7. Hypertension— Look in the Alphabetic Index for Hypertension I10.

Verify code selections in the Tabular List.

Case 8

XYZ Nursing Home

Subjective: The patient appears to be a little more altered than normal today. ^[1] He is in some obvious discomfort. ^[2] However, he is not able to communicate due to his mental status. ^[3] Patient does appear fairly anxious.

Physical Exam: Glucoses have been within normal limits. ^[4] Patient has had poor p.o. intake, ^[5] however, over the last 2–3 days. ^[6] Temperature is 97, pulse is 79, respirations 20, blood pressure 152/92, and oxygen saturation 97% on room air. Patient can be aroused. ^[7] Extraocular movements are intact. ^[8] Oral pharynx is clear. ^[9] Lungs are clear to auscultation bilaterally. ^[10] Heart has a regular rate and rhythm. ^[11] Abdomen is nontender and nondistended. ^[12] Patient is able to move all extremities. He does have some mild pain over the apex of his right shoulder and bruising over the anterior lateral rib cage on the right side over approximately T8 to T10. No crepitus is noted. ^[13] Patient indicates he hurts everywhere.

Ancillary Studies: A.M. labs—none new this morning. X-ray shows no evidence of fracture with definitive arthritis. ^[14] Patient has chronic distention of bowels. This is always atypical exam. Telemetry shows no significant new arrhythmias. ^[15]

Assessment & Plan:

1. Patient is an 84 year-old Caucasian male who presented after a fall with rib contusion, ^[16] right shoulder pain and uncontrolled pain since. ^[17] He has been on Tramadol. However, I believe this is making him more altered. Thus, we will back off on medications and see if he comes back more to himself. We may try a different medication at a low dose later today if patient's mental status improves significantly. We will have patient out of bed three times a day. Physical therapy is working with the patient for significant deconditioning.
2. Patient with elevated blood pressures ^[18] upon admission and still running a little bit high. Cardizem has been added to the medication regimen recently. We will follow this and see what it does for his blood pressure in the long run. He is in no immediate danger currently.
3. Very advanced dementia, ^[19] will follow, continue on home medications.
4. Coronary artery disease and congestive heart failure. ^[20] These appear stable at this time.
5. History of atrial fibrillation, ^[21] sounds to be in regular rhythm currently and appears to be doing well on telemetry monitor. Again, Cardizem has been added for better control and blood pressure control.
6. Type 2 diabetes mellitus. ^[22] Glycemic control has been good. However, patient has had poor p.o. intake over the last 2–3 days, which may be due to pain. Thus, we will hold glipizide for now to prevent hypoglycemia.
7. We will follow the patient closely and adjust medications as necessary.

^[1] HPI: quality.

^[2] HPI: Severity.

^[3] The physician is unable to obtain a history due to the patient's mental status.

^[4] ROS: Endocrine.

^[5] HPI: Quality again.

^[6] HPI: Duration.

^[7] Exam: Constitutional.

^[8] Exam: Eye.

^[9] Exam: Mouth and throat.

- [10] Exam: Respiratory.
- [11] Exam: Cardiovascular.
- [12] Exam: Abdomen.
- [13] Exam: Musculoskeletal.
- [14] Reviewed X-ray.
- [15] Reviewed telemetry.
- [16] Primary diagnosis.
- [17] Condition is not stable.
- [18] Additional diagnosis.
- [19] Additional diagnosis.
- [20] Additional diagnosis.
- [21] Additional diagnosis.
- [22] Additional diagnosis.

What are the CPT® and ICD-10-CM code(s) reported?

CPT® Code: 99309

ICD-10-CM codes: S20.211A, M25.511, R03.0, F03.90, I25.10, I50.9, I48.91, E11.9, Z79.84

Rationale:

CPT® code: Subcategory—Subsequent Nursing Facility Care (2 of 3 key components)

History: Expanded problem focused (3 HPI, 1 ROS)

Exam: Detailed (7 Organ systems with musculoskeletal detailed)

MDM: Moderate complexity (Extensive diagnosis, 2 items reviewed (X-ray & Telemetry), Moderate Risk (One or more stable chronic illnesses)).

ICD-10-CM codes:

1. Rib Contusion causing pain. In the ICD-10-CM Alphabetic Index, look for Contusion/chest (wall) – see Contusion, thorax. Look for Contusion/thorax (wall)/front S20.21-. Turn to the Tabular List to complete the code. Complete code is S20.211A. The Physical exam in the case documents that there is bruising over the lateral ribcage on the right side and this is the first time the patient is being seen for this injury reporting the letter A as the 7th character.
2. Shoulder pain. Look in the Alphabetic Index for Pain(s)/joint/shoulder or Pain(s)/shoulder M25.51-. Go to the Tabular List to complete the code. The Physical exam and the Assessment & Plan in the case documents that there is pain in the right shoulder. Complete code is M25.511.
3. The elevated blood pressure is not stated as hypertension. Because the patient had high blood pressure upon admission and it is still a little high, you will want to query the physician to see if this is elevated blood pressure, or hypertension. Look in the Alphabetic Index for Elevated, elevation/blood pressure/reading (incidental) (isolated) (nonspecific), no diagnosis of hypertension R03.0. It is coded because there was a medication change and the blood pressure will be monitored. Verify code selection in the Tabular List.

4. Dementia is coded because it is being followed and the home meds will be continued. Look in the Alphabetic Index for Dementia F03.90. Verify code selection in the Tabular List.
5. CAD is for coronary artery disease. Look in the Alphabetic Index for Disease, diseased/coronary - see Disease, heart, ischemic, atherosclerotic. Look for Disease, diseased/heart/ischemic/atherosclerotic I25.10. Verify code selection in the Tabular List.
6. CHF is for congestive heart failure. Look in the Alphabetic Index for Failure, failed/heart/congestive I50.9. Verify code selection in the Tabular List.
7. Patient has history of atrial fibrillation, currently controlled with telemetry monitor. Look in the Alphabetic Index for Fibrillation/atrial or auricular (established) I48.91. Verify code selection in the Tabular List.
8. Blood glucose is reviewed for type 2 DM. Look in the Alphabetic Index for Diabetes, diabetic/type 2 E11.9. Verify code selection in the Tabular List.
9. The patient is on long-term glipizide to control his blood sugar, although they are holding it temporarily. Look in the Alphabetic Index for Long-term (current) (prophylactic) drug therapy (use of)/oral/hypoglycemia Z79.84. Verify code selection in the Tabular List.

Case 9

Hospital Admission ^[1]

Chief Complaint: Nausea and vomiting, weakness ^[2]

HPI: The patient is a 78 year-old Hispanic female with a history of diabetes, hypertension, and osteoporosis who was just discharged after hospitalization for gastroenteritis three days ago. ^[3] She went home and was feeling fine, was tolerating regular diet ^[4] until yesterday when she vomited. ^[5] She stated she feels nauseated now, feels like she needs to throw up but cannot vomit. ^[6] Her last bowel movement was yesterday. She stated it was diarrhea ^[7] and states she has extreme ^[8] weakness. ^[9] No melena or hematochezia. ^[10] No shortness of breath, no chest pain. ^[11]

Medical History: Diabetes mellitus type 2. Hypertension. Osteoporosis. ^[12]

Surgical History: None. ^[12]

Medicines: Benadryl 25 mg daily, Diovan 320/25 one daily, calcium 600 daily, vitamin C 500 daily, multivitamin 1 tablet daily, Coreg CR 20 mg daily, Lipitor 20 mg at bedtime, metformin 1000 mg/day. ^[12]

Allergies: Morphine. ^[12]

Social History: No tobacco, alcohol or drugs. She is a widow. She lives in Marta. She is retired. ^[13]

Family History: Mother deceased after childbirth. Father deceased from asphyxia. ^[14]

ROS: Negative for fever, weight gain, weight loss. Positive for fatigue and malaise. ^[15]

Ears, Nose, Throat: Negative for rhinorrhea. Negative for congestion. ^[16]

Eyes: Negative for vision changes. ^[17]

Pulmonary: Negative for dyspnea. ^[18]

Cardiovascular: Negative for angina. ^[19]

Gastrointestinal: Positive for diarrhea, positive for constipation, intermittent changes between the two. Negative for melena or hematochezia. ^[20]

Neurologic: Negative for headaches. Negative for seizures. ^[21]

Psychiatric: Negative for anxiety. Negative for depression. ^[22]

Integumentary: Positive for rash for which she takes Benadryl. ^[23]

Genitourinary: Negative for dysfunctional bleeding. Negative for dysuria. ^[24]

Objective:

Vital Signs: Show a temperature max of 98.1, T-current 97.6, pulse 62, respirations 20, blood pressure 168/65. O₂ sat 95% on room air. Accu-Chek, 135. ^[25]

Generally: No apparent distress, oriented x 3, pleasant Spanish speaking female. ^[25]

Head, Ears, Eyes, Nose, Throat: Normocephalic, atraumatic. ^[26] Oropharynx is pink and moist. ^[27] No scleral icterus. ^[28]

Neck: Supple, full range of motion. ^[29]

Lungs: Clear to auscultation bilaterally. ^[30]

Cardiovascular: Regular rate and rhythm. No murmurs, gallops, rubs. ^[31]

Abdomen: Soft, nontender, nondistended. Normal bowel sounds. No hepatosplenomegaly. Negative Murphy's sign. ^[32]

Back: Costovertebral angle tenderness. ^[33]

Extremities: No clubbing, cyanosis or edema. ^[34]

Laboratory Studies

Shows a sodium 125, potassium 3.1, chloride 90, CO₂ 27, glucose 103, BUN 13, creatinine 0.7, white count 8.3, hemoglobin and hematocrit 12.6, 37.1, platelets 195, 000. Differential shows 76% neutrophils. Amylase 42, CK-MB 1.7, troponin 0.05, CPK 59. PTT 26.9. PT and INR 12.9 and 1.09. UA shows 500 leukocyte esterase, negative nitrite, 15 of ketones, 10 to 25 WBCs. ^[35]

Gallbladder sonogram shows a 1.24 x 1 cm echogenic focus in the gallbladder, possibly representing gallbladder polyp or gallbladder mass. CT abdomen and pelvis shows cholelithiasis, small left pleural effusion, small indeterminate nodules both lung masses, no acute bowel abnormality and sclerotic appearance of right greater trochanter, no free air. ^[36]

Assessment

1. Nausea, vomiting, diarrhea, likely gastroenteritis
2. Cystitis
3. Hypokalemia
4. Hyponatremia
5. Cholelithiasis
6. Diabetes mellitus type 2
7. Hypertension

Plan: Will admit patient for IV hydration, add Levaquin 500 mg IV q 24 hours. Will add 20 mg KCl per L to IV fluid. ^[37] Get a general surgery consult for cholelithiasis. Will check studies, fecal white blood cells, C. diff toxin and fecal stool culture and sensitivity. ^[38]

^[1] Choose from Initial Hospital Care Subcategory.

^[2] Chief complaint.

^[3] HPI: Timing.

^[4] HPI: Quality.

^[5] HPI: Timing.

- 16** HPI: Severity.
 - 17** ROS: GI.
 - 18** HPI: Severity.
 - 19** HPI: Associated Sign & Symptom.
 - 100** ROS: GI.
 - 111** ROS: Respiratory.
 - 122** PFSH: Personal History.
 - 133** PFSH: Social History.
 - 144** PFSH: Family History.
 - 155** ROS: Constitutional.
 - 166** ROS: ENT.
 - 177** ROS: Eyes.
 - 188** ROS: Respiratory.
 - 199** ROS: Cardiovascular.
 - 200** ROS: GI.
 - 211** ROS: Neurologic.
 - 222** ROS: Psychiatric.
 - 233** Integumentary.
 - 244** ROS: GU.
 - 255** Exam: Constitutional.
 - 266** Exam: Head, including face.
 - 277** Exam: Mouth (ENMT).
 - 288** Exam: Eye.
 - 299** Exam: Neck.
 - 300** Exam: Respiratory.
 - 311** Exam: Cardiovascular.
 - 322** Exam: Gastrointestinal.
 - 333** Exam: GU (CVA tenderness is check for signs of kidney infection).
 - 344** Exam: Cardiovascular.
 - 355** Labs reviewed.
 - 366** Ultrasound and CT reviewed.
 - 377** IV Hydration with additives.
 - 388** Ordered additional lab.
-

What are the CPT® and ICD-10-CM code(s) reported?**CPT® code:** 99222**ICD-10-CM codes:** R11.2, R19.7, N30.90, E87.6, E87.1, K80.20, E11.9, Z79.84, I10**Rationale:****CPT® code:** Subcategory—Initial Hospital Care (3 of 3 key components)

History—Comprehensive (HPI—Extended, ROS—Complete, PFSH—Complete)

Exam—Comprehensive (8 organ systems)

MDM—Moderate Complexity (Extensive diagnoses, Limited data [reviewed radiology & labs, ordered labs], Risk—Moderate [IV hydration with additives]).

ICD-10-CM codes:

1. Nausea, vomiting, diarrhea, likely gastroenteritis (gastroenteritis is only a possible diagnosis, nausea, vomiting and diarrhea are symptoms, but the cause is undetermined, so they are coded). Look in the ICD-10-CM Alphabetic Index for Nausea/with vomiting R11.2 and Diarrhea, diarrheal R19.7.
2. Cystitis—Look in the Alphabetic Index for Cystitis. There are no other descriptors N30.90.
3. Hypokalemia—Look in the Alphabetic Index for Hypokalemia E87.6.
4. Hyponatremia—Look in the Alphabetic Index for Hyponatremia E87.1.
5. Cholelithiasis—Look in the Alphabetic Index for Cholelithiasis – see Calculus, gallbladder. Look for Calculus, calculi, calculus/gallbladder K80.20.
6. Diabetes mellitus type 2—Look in the Alphabetic Index for Diabetes, diabetic/type 2 E11.9.
7. The patient is on long-term metformin to control her blood sugar. Look in the Alphabetic Index for Long-term (current) (prophylactic) drug therapy (use of)/oral/hypoglycemia Z79.84.
8. Hypertension— Look in the Alphabetic Index for Hypertension I10.

Verify code selections in the Tabular List.

Case 10

Established Patient**Chief Complaint:** Thoracic spine pain ^[1]**Problem List:**

1. Rheumatoid arthritis, right and left hands.
2. Compression fracture of the thoracic spine T11.
3. Alcoholism.
4. Depression/anxiety.

Review of Systems: His pain is significantly improved ^[2] in his thoracic spine. ^[3] He does have low back pain. ^[4] He has a history of chronic low back pain. He is still wearing a thoracic support brace. He is going to follow up with Dr. X's office in about six weeks or so. ^[5] Since I have seen him last he had a small flare of arthritis after his Humira injection. ^[6] This resolved after 2–3 days. ^[7] He had pain and stiffness in his hands. Currently he denies any pain and stiffness in his hands. He has one cystic mass on his left hand, second distal pad that is bothersome. ^[8]

Current Medications: Vasotec 20 mg a day, Folic Acid 1mg a day, Norvasc 5 mg a day, Pravachol 40 mg a day, Plaquenil 400 mg a day, Humira 40 mg every other week, Celexa 20 mg, a day, Klonopin .5 mg as needed, aspirin 81 mg a day, Ambien 10 mg as needed, Hydrocodone as needed. ^[9]

Physical Exam: He is alert and oriented in no distress. Gait is unimpaired. He is wearing the thoracic brace. Spine ROM is not assessed. ^[10] Lungs: Clear. ^[11] Heart: Rate and rhythm are regular. ^[12]

Musculoskeletal Exam: There is generalized swelling of the finger joints without any significant synovitis or tenderness. There is a cystic mass on the pad of his second left finger, which is tender. Remaining joints are without tenderness or synovitis. ^[13]

Review of DEXA (Dual Energy X-ray Absorptiometry) Scan: (Performed in office today) There is low bone density with a total T-score of -1.1 of the lumbar spine. Compared to previous it was -0.8. There has been a reduction by 3.6%. T-score of the left femoral neck -1.1, Ward's triangle -2.4, and total T-score is -0.8 compared to previous there has been a 7% reduction from 2005. ^[14]

Assessment:

1. Seronegative rheumatoid arthritis in both hands. ^[15] He is doing fairly well. He does have a cystic mass, which seems to be a synovial cyst of the left second digit. He was wondering if he could have this aspirated.
2. Senile osteoporosis and continued care for compression pathologic fracture. ^[16] He is being treated for osteoporosis because of this. He is tolerating Fosamax well. He is also using Miacalcin nasal spray temporarily to help and it has been effective.

Plan:

1. Continue current therapy.
2. Aspirate the synovial cyst in the left second finger. ^[17]
3. Follow up in about 6–8 weeks.
4. Repeat labs prior to visit.

Procedure Note: With sterile technique and Betadine prep, the radial side of the second finger ^[18] is anesthetized with 1 cc 1% Lidocaine for a distal finger block. Then the synovial cyst is punctured and material was expressed under the skin. ^[19] I injected it with 20 mg of Depo-Medrol. ^[20] He will keep it clean and dry. If it has any signs or symptoms of infection, he will let me know.

^[1] Chief complaint.

^[2] HPI: Quality.

^[3] HPI: Location.

^[4] HPI: Associated Signs and Symptoms.

^[5] ROS: Musculoskeletal.

^[6] HPI: Modifying factor with affect.

^[7] HPI: Duration.

^[8] ROS: more Musculoskeletal.

^[9] PFSH: Past Medical History.

^[10] Exam: Musculoskeletal.

^[11] Exam: Respiratory.

^[12] Exam: Cardiovascular.

^[13] Exam: Musculoskeletal.

^[14] DXA of the spine.

^[15] Primary diagnosis.

^[16] Second and tertiary diagnoses.

- [17] Decision to aspirate the cyst is after full workup.
- [18] Second finger—F1 modifier.
- [19] Aspiration of joint.
- [20] Injection of joint.

What are the CPT® and ICD-10-CM code(s) reported?

CPT® codes: 99213-25, 20612-F1, 77080, J1020

ICD-10-CM codes: M06.041, M06.042, M71.342, M80.08XD

Rationale:

CPT® codes: Subcategory—Office visit, established patient (requires 2 of 3 key components)

History—Expanded Problem Focused (HPI—Extended, ROS—Problem pertinent, PFSH—pertinent)

Exam—Expanded Problem Focused (3 organ systems)

MDM—Low complexity (2 diagnoses-stable, risk-moderate (two stable chronic conditions))

During the office visit, a DXA scan of the spine (axial skeleton) was performed. In the CPT® Index, look for Dual X-ray Absorptiometry (DXA)/Axial Skeleton and you are directed to 77080.

There was also a decision to aspirate the synovial cyst on the second finger. Look in the CPT® Index for Synovial/Cyst – See Ganglion; Ganglion/Cyst/Aspiration/Injection and you are directed to code 20612. Modifier 25 is appended to the office visit to indicate it is separately identifiable from the procedure. Depo-Medrol was injected. Look in the HCPCS Table of Drugs for Depo-Medrol and you are directed to see Methylprednisolone Acetate. Methylprednisolone Acetate, 20 mg directs you to J1020. J1020 reports Depo-Medrol, 20 mg.

ICD-10-CM codes: Seronegative rheumatoid arthritis is the first listed diagnosis in the Assessment.

In the ICD-10-CM Alphabetic Index, look for Arthritis/rheumatoid/seronegative/hand joint M06.04-. The Tabular List provides two codes to report this condition in both hands, M06.041 and M06.042. The second diagnosis is for the synovial cyst that was identified and a procedure was performed. In the Alphabetic Index, look for Cyst/synovial referring you to – see also Cyst, bursa. In the Alphabetic Index, look for Cyst/bursa, bursal NEC/hand M71.34-. Complete the code in the Tabular List, the cyst is on the left hand reporting M71.342. The next diagnosis to report is osteoporosis. In the Alphabetic Index, look for Osteoporosis/senile- see Osteoporosis, age-related. Look for Osteoporosis/age-related/with current pathologic fracture/vertebra M80.08-. In the Tabular List, a 6th character X is reported. The 7th character D is reported because this is not the initial encounter for the compression fracture and the assessment indicates continued care indicating aftercare. The correct code is M80.08XD. Verify all codes in the Tabular List.



Case 1

Pre-procedure Diagnosis: Asthma

Post-procedure Diagnosis: Asthma ^[1]

Procedure: Psychophysiological Therapy Biofeedback

The patient returned to clinic with daily diary documenting home peak flow readings and asthma symptoms. Diary was assessed and discussed with patient. Patient reports reduced dosing with inhaled steroids and fewer asthmatic episodes. Lungs and respiratory resistance assessed. Lungs clear, no wheezes or rhonchi noted. ^[2]

HRV biofeedback was performed using a physiograph. ^[3] ECG data were collected from the left arm and right leg, and were digitized at 510 Hz. EEG biofeedback equipment attached and baroreflex gain was assessed with beat-to-beat BP recordings and digitized at a rate of 252 samples per second. The sensor was placed on the participant's right middle finger, and the hand was elevated on a table to approximately the level of the heart.

Respiratory system impedance (Zrs) [between 2 and 32 Hz with 2-Hz increments] was measured using a pseudorandom noise forced oscillation system. It was presented in 40, 2-second bursts spaced equally throughout.

In order to minimize the effects of possible partial glottal closure during exhalation, each burst was triggered by the beginning of an inhalation.

Post procedure, spirometer readings were recorded. Asthma symptoms were scored with the patient. Biofeedback procedure lasted approximately 28 minutes. ^[4]

The patient is to return to clinic in two weeks with daily diary. It is expected the patient will continue with reduced regiment and asthmatic episodes.

^[1] Post procedural diagnosis used for coding.

^[2] Psychophysiological training.

^[3] Biofeedback documentation.

^[4] Biofeedback time.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 90875

ICD-10-CM code: J45.909

Rationale:

CPT® code: Biofeedback is found in the index under Training/Biofeedback which refers you to codes 90875, 90901–90911. Under the heading for Biofeedback, there is a parenthetical instruction “for psychophysiological therapy incorporating biofeedback, see 90875, 90876”. The code selection is based on minutes. 28 minutes is coded with 90875. 90901 is not reported separately. 90875 also includes the psychotherapy for behavior modification.

ICD-10-CM code: The patient has asthma. Look in the ICD-10-CM Alphabetic Index for Asthma, asthmatic J45.909. The asthma is not stated as having status asthmaticus or acute exacerbation. Verify code selection in the Tabular List.

Case 2

Performed in the office

Pre-procedure Diagnosis: Gastro-esophageal reflux disease (GERD), Heartburn

Post-procedure Diagnosis: GERD ^[1]

Procedure: Esophageal pH monitoring with Bravo pH Capsule ^[2]

Patient was placed in supine position on examining bed, IV moderate sedation was administered. Visualization of esophagus with anatomic markers located during endoscopy. Endoscopy was removed and the Bravo pH Capsule delivery system was passed into the esophagus using the oral passage until the attachment site was obtained at approximately 5 cm proximal to the upper margin of the LES. The external vacuum pump was activated pulling the adjacent esophageal mucosa into the fastening well. Vacuum gauge at 600 mm Hg and held for 10 seconds.

The plastic safety guard on handle was then removed and the activation button was depressed and turned **attaching the pH capsule to the esophageal wall**. ^[3] The activation button on handle was then twisted 90 degrees and re-extended, releasing the pH capsule. Esophagoscopy was repeated to verify capsule attachment.

Prior to procedure, the Bravo pH capsule was activated and calibrated by submersion in pH buffer solutions.

The patient tolerated the procedure well and was transferred into the recovery room.

The patient returned to the office two days later for download of the recording. The information was analyzed and interpreted.

^[1] Post procedure diagnosis used for coding.

^[2] Acid reflux testing.

^[3] Placement of electrode placement.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 91035

ICD-10-CM code: K21.9

Rationale:

CPT® code: Esophageal pH monitoring with Bravo pH Capsule is a test performed for acid reflux. In the CPT® Index, look for Esophagus/Acid Reflux Tests. The test is performed by attaching a telemetry electrode to the esophageal mucus making 91035 the correct code. The rest of the codes are performed by nasal catheter.

ICD-10-CM code: GERD is found in the ICD-10-CM Alphabetic Index by looking for GERD (gastroesophageal reflux disease) or by looking for Disease, diseased/gastroesophageal reflux (GERD) K21.9. Verify code selection in the Tabular List.

Case 3

Pre-procedure Diagnosis: Sleep Apnea

Post-procedure Diagnosis: Obstructive sleep apnea

Procedure: Overnight Sleep Study

The 35 year-old patient in a Hospital Sleep Lab for attended, **overnight polysomnogram**. ^[1] Patient oriented to room and changed into overnight clothing and brought into lab by patient.

Latency to sleep onset slightly prolonged at 32.3 minutes. During the first 82 minutes of sleep, 80 obstructive apneas were manifested. The lowest SpO₂ during the non-supplemented sleep period was 73%. CPAP was then applied at 5 cm H₂O, and sequentially titrated to a final pressure of 18 cm H₂O. The Apnea-hypopnea index (AHI) changed from 60 events/hr to 4 events/hr. SpO₂ increased to 90%.

The sleep study with and without CPAP shows severe obstructive sleep apnea with improvement with CPAP settings at 18 cm H₂O. Based on the improved SpO₂ levels with CPAP, it is recommended this patient use a BIPAP machine during sleep hours due to obstructive sleep apnea events.

^[1] Polysomnogram

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 95808

ICD-10-CM code: G47.33

Rationale:

CPT® code: In the CPT® Index, look for Polysomnography and you are directed codes 95782, 95783, 95808–95811. The codes are based on sleep staging parameters. The code selection is based on parameters of sleep as defined in the sleep testing guidelines. For this case, there are less than four additional parameters performed. The additional parameters are the following: Oxyhemoglobin saturation (SpO₂) and sleep latency.

ICD-10-CM code: The patient is diagnosed as having obstructive sleep apnea. In the ICD-10-CM Alphabetic Index, look for Apnea, apneic/sleep/obstructive (adult) (pediatric) G47.33. Verify code selection in the Tabular List.

Case 4

Pre-procedure Diagnosis: Excessive Daytime Sleepiness, Snoring, Epworth Score 18

Post-procedure Diagnosis: Sleep Study

Procedure: Polysomnogram, attended

This 25 year-old patient underwent overnight polysomnogram with the recording of EEG, ^[1] EOG, ^[2] submental and anterior tibialis EMG, ^[3] respiratory effort, ^[4] nasal and oral airflow, ^[5] EKG, ^[6] continuous pulse oximetry. ^[7] Total time in bed of 386 minutes and a total of sleep time of 221 minutes. The sleep latency was 24 minutes and the REM sleep latency was 18 minutes. Throughout the night, the patient had a total of 256 episodes of arousals and 6 awakenings. Sleep efficiency was 56%. No apparent parasomnia noted. The average oxygen saturation was reported to be 95% with the lowest saturation being 84%. There were no periodic leg movements for an index of 0.0 and cardiac arrhythmias were not present.

Impression: Mild sleep apnea ^[8]

^[1] Parameter 1.

^[2] Parameter 2.

^[3] Parameter 3.

^[4] Parameter 4.

- ⁵ Parameter 5.
 - ⁶ Parameter 6.
 - ⁷ Parameter 7.
 - ⁸ Post-procedure diagnosis.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 95810

ICD-10-CM code: G47.30

Rationale:

CPT® code: In the CPT® Index, look for Polysomnography and you are directed to codes 95782, 95783, 95808–95811. There are 7 parameters indicated making the correct code choice 95810.

ICD-10-CM code: In the ICD-10-CM Alphabetic Index, look for Apnea, apneic/sleep/with sleep G47.30. Verify code selection in the Tabular List.

Case 5

Pre-procedure Diagnosis: Analysis of Vagal Nerve Stimulator (VNS), epilepsy with history of seizures

Post-procedure Diagnosis: Analysis of Vagal Nerve Stimulator (VNS), epilepsy with history of seizures ¹

Procedure: Vagal Nerve Stimulator Analysis ²

Patient here for VNS implant analysis with possible adjustments.

The programming head was placed over the implanted neurostimulator located within the patient's neck-left side. Impedance was verified insuring parameters within normal limits. Parameters charted on flowchart within medical record. Operating status of neurostimulator reflects on. Estimated time for analysis/interrogation was 20 minutes in duration.

Patient denies questions at this time. Will repeat analysis in three months.

¹ Post procedural diagnosis

² VNS analysis

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 95970

ICD-10-CM codes: Z96.89, G40.909

Rationale:

CPT® code: Look in the CPT® Index for Neurostimulators/Analysis/Cranial Nerve. You are referred to 95974, 95975. These codes are both intraoperative which does not apply to this case. Look for Neurostimulators/Analysis/Brain and you are referred to 95970, 95978, and 95979. The vagus nerve is a cranial nerve. The correct code is 95970 for without reprogramming.

ICD-10-CM codes: The purpose of the visit is for the analysis of the neurostimulator. Look in the ICD-10-CM Alphabetic Index for Interrogation/neurostimulator referring you to Z46.2. Next, in the ICD-10-CM Alphabetic Index, look for Epilepsy, epileptic, epilepsy referring you to G40.909. The code for status of presence of a neurostimulator is not reported because Z46.2 already indicates the patient has a neurostimulator. Refer to ICD-10-CM coding guideline I.C.21.c.3. Verify code selection in the Tabular List.

Case 6

Pre-procedure Diagnosis: Aortic insufficiency; hypertension

Post-procedure Diagnosis: **Borderline Left Ventricular Hypertrophy, Mild Aortic Insufficiency,** ^[1] **Left ventricular Ejection Fraction 80%** ^[2]

Procedure: **2D with M-mode Echocardiogram** ^[3] with **pulsed continuous wave with spectral display** ^[4] and **Doppler color flow mapping** ^[5]

Patient positioned in supine position on exam table.

Echocardiogram proceeded without incidence.

Findings:

1. Borderline left ventricular hypertrophy.
2. Mild aortic insufficiency.
3. Left ventricular ejection fraction 80%.

^[1] Post-procedure diagnosis used for coding.

^[2] Indicates severity.

^[3] 2D echo, M-Mode.

^[4] Spectral Doppler.

^[5] Doppler Color Flow.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 93306

ICD-10-CM codes: I51.7, I35.1

Rationale:

CPT® code: Transthoracic echocardiogram is also known as a standard echocardiogram. It is obtained by applying an ultrasound transducer to the front of the chest. Look in the CPT® Index under Echocardiography/Transthoracic and you are directed to code range 93306–93308, 93350–93352. 93306 includes the 2D, M-Mode, spectral Doppler, and Doppler color flow.

ICD-10-CM codes: In the ICD-10-CM Alphabetic Index, look for Hypertrophy, hypertrophic/ventricle, ventricular (heart) and you are directed to *see also* Hypertrophy, cardiac. Hypertrophy, hypertrophic/cardiac I51.7. Then look for Insufficiency, insufficient/aortic (valve) I35.1. Verify code selection in the Tabular List.

Case 7

Pre-procedure Diagnosis: Persistent Right and Left Leg pains; Extensive varicose vein disease

Post-procedure Diagnosis: Varicose vein disease with inflammation, venous insufficiency, leg pains due to varicose veins^[1]

Procedure: Peripheral Vascular Duplex Ultrasound Evaluation of the Venous Anatomy of the Lower Extremities

Patient's right and left leg^[2] venous anatomy^[3] was examined in the standing position utilizing a B-Mode Duplex ultrasound^[4] machine with a 12 MHz probe. The focus was to determine the location and flow characteristics of both the deep and superficial venous systems. The evaluations included dynamically focused gray-scale and color imaging supplemented by Doppler spectroanalysis^[5]. Valsalva maneuver as well as calf and thigh compressions were performed^[6] to determine the patency and direction of blood flow, the exact paths of venous reflux in the major venous trunks, tributaries, and perforator veins. Ultrasonic mapping included images of major deep veins of the leg, saphenofemoral junction, the great saphenous vein above and below the knee, and the short saphenous vein system below the knee. Measurements and flow characteristics were obtained and listed on venous map in chart.

Bilaterally, the great saphenous veins were absent beginning at the saphenofemoral junction, due to previous surgery. Noted was venous reflux and enlargement of neovascular and tributary portions of the vein systems in the upper and lower legs. Abnormalities and associated perforator veins were documented on venous map in chart. The internal diameters of the leg varicosities varied to 5 and 3.8 mm in diameter, bilaterally. No evidence of deep venous reflux or thrombosis noted within the femoral, popliteal, gastrocnemius, or posterior tibial vessels. Photocopies were taken of the venous abnormalities and are included in the medical record.

Findings:

1. Varicose vein disease with inflammation
2. Venous insufficiency
3. Leg pains due to varicose veins

^[1] Post procedural diagnosis is used for coding.

^[2] Bilateral.

^[3] Venous study.

^[4] Duplex.

^[5] Spectral Doppler.

^[6] Maneuvers performed.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 93970

ICD-10-CM codes: I83.11, I83.12, I83.813

Rationale:

CPT® code: In the CPT® Index, look for Duplex Scan/Venous Studies/Extremity and you are referred to 93970, 93971. Duplex scan for bilateral lower extremities is coded with 93970.

ICD-10-CM codes: Look in the ICD-10-CM Alphabetic Index for Varicose/vein and you are directed to *see* Varix, leg, with, inflammation. Both legs have the condition. Look for Varix/leg/right/with inflammation I83.11. Then, look for Varix/leg/left/with inflammation I83.12. Varix/leg/bilateral/with/pain I83.813. Verify code selection in the Tabular List. Code I87.2 for venous insufficiency is not coded, because of the Excludes1 note found in the Tabular List that indicates this code is not reported with I83.1-, I83.2-.

Case 8

Pre-procedure Diagnosis: Extensive keratosis lesions of left anterior neck

Post-procedure Diagnosis: Keratosis lesions left anterior neck ^[1]

Procedure: Blue Light ^[2] Photodynamic Therapy ^[3] with topical skin sensitizing agent

Patient here for photodynamic therapy. Verbal instruction of procedure given to patient with patient verbalizing understanding.

Patient positioned self in supine position on exam table. Safety goggles applied to eyes, noting patent seal and full coverage of ocular orbital areas. Application of topical Levulan® Kerastick® ^[4] applied to left anterior neck keratosis lesions. Blue light lamp adjusted to reflect on left anterior neck. Phototherapy duration: 15 minutes.

Post procedure skin was slightly reddened, no swelling noted. Post-procedure instructions were discussed with patient. Patient to return to office in eight weeks for assessment and possible repeat treatment.

Procedure performed by the physician.

^[1] Post procedure diagnosis.

^[2] External application.

^[3] Photodynamic therapy.

^[4] Topical agent applied.

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 96573, J7308

ICD-10-CM code: L57.0

Rationale:

CPT® codes: In the CPT® Index, look for Photodynamic Therapy/for Lesion and you are directed to 67221, 67225, 96567, 96573, and 96574. The code is reported once per session. Some insurance carriers will allow you to bill the topical anesthetic, which would be reported with J7308. The anesthetic is indexed in the HCPCS II code book in the Table of Drugs under Levulan® Kerastick®.

ICD-10-CM code: In the ICD-10-CM Alphabetic Index, look for Keratosis. Without any further description, use code L57.0. Verify code selection in the Tabular List.

Case 9

Pre-procedure Diagnosis: Palpable Pulsating Abdominal Mass

Post-procedure Diagnosis: AAA ^[1]

Procedure: Abdominal Aorta Duplex Ultrasound ^[2] by ultrasound technician

The patient was placed on the examining table in a supine position.

Conductive gel was applied to the abdomen. The transducer was gently moved over the abdomen. An aortic mass was identified within the inferior aorta at approximately the 3.2 cm mark. Measurements were marked and recorded. Anterior-posterior measurement equaled 4.8 cm and transverse measurement equaled 5.7 cm.

Report views and results were given to the ER physician caring for the patient by the radiologist who interpreted the ultrasound. ^[3]

^[1] Abdominal Aortic Aneurysm.

^[2] Duplex ultrasound used.

^[3] Hospital service.

What are the CPT® and ICD-10-CM codes reported?

CPT® code: 93979–26

ICD-10-CM code: I71.4

Rationale:

CPT® code: Patient has a duplex scan of the abdominal aorta. Look in the CPT® Index for Duplex Scan/Arterial Studies/Aorta and you are directed to 93978, 93979. This was a limited study of the aorta; therefore, the correct code is 93979. This was performed on a patient through the ED indicating it was performed at the hospital. Modifier 26 should be appended to the code to indicate it is the professional component only.

ICD-10-CM code: Look in the ICD-10-CM Alphabetic Index for Aneurysm/abdominal (aorta) I71.4. Verify code selection in the Tabular List.

Case 10

A 10 year-old **established patient** ^[1] presents today for **well child check** ^[2] with mother with complaints of frequent urination during the day.

The patient has two sisters and sees dad sporadically. Lives in a smoke free environment. One dog, one rabbit.

Denies dysuria, abdominal pain, or rashes; all other systems are reviewed and negative.

Patient going into fourth grade with good grades. No parental concerns. Patient cooperates but does tend to back talk. Doing well on Concerta.

Exam

General: Normal

Head: Normal

Eyes: Normal

Ears: Normal

Nose: Normal

Mouth/throat: Normal

Neck: Normal

Abdomen: Normal

Rectal: Not examined

Genitals: Normal

Skin: 3 mm papule on dorsal R hand without disruption of creases

Urinalysis: Ketones, nitrite, leukocytes normal; trace blood, low specific gravity.

Counseled patient on the use of seat belts, bicycle/skate helmets, gun safety, water/sun safety.

Assessment: Well Child Check, ADHD, Wart, Frequent Urination ^[3]

Refill Concerta 18 mg PO q AM

Wart cleansed with alcohol. Histofreeze x 25 seconds ^[4] was performed to destroy the wart.

Varicella Vaccine #2 ^[5] administered without any complications.

-
- ^[1] The patient is established.
 - ^[2] Patient presents for a preventive exam.
 - ^[3] Preventive exam and problems treated.
 - ^[4] Wart is destroyed.
 - ^[5] Vaccination is administered.
-

What are the CPT® and ICD-10-CM codes reported?

CPT® codes: 99393-25, 17110, 90471, 90716, 81002

ICD-10-CM codes: Z00.121, F90.9, B07.9, R35.0, Z23

Rationale:

CPT® codes: The patient presents for a well-child check which is a preventive exam. The code is selected based on whether the patient is new or established and the age of the patient. The patient is established and 10 years-old which is reported with 99393. Modifier 25 is appended to report a separate and significant E/M in addition to other procedures (wart destruction and vaccination). Next select the code for the wart destruction. In the CPT® Index, look for Destruction/Warts/Flat. You are referred to 17110–17111. The correct code is selected based on the number of warts destroyed. In this case, it is one which is reported with 17110. A varicella vaccination is administered via an injection. Two codes are required, one for the administration and one for the vaccine. In the CPT® Index, look for Administration/Immunization/One Vaccine/Toxoid. There is no indication that counseling for the vaccination was performed which makes 90471 the correct code. Next select the code for the vaccine which is located under Vaccines and Toxoids/Varicella (Chicken Pox) (VAR). You are referred to 90716. A urinalysis is also performed. Look in the CPT® Index for Urinalysis/without Microscopy and you are referred to code 81002.

ICD-10-CM codes: The patient presents for a well-child check. In the ICD-10-CM Alphabetic Index, look for Examination/child (over 28 days-old)/with abnormal findings Z00.121. According to the ICD-10-CM guideline I.C.21.c.13, when additional conditions are treated during a screening exam, report the additional diagnoses and there is an instructional note in the Tabular List to “Use additional code to identify abnormal findings.” The patient is diagnosed with ADHD for which a prescription is renewed. Look for Disorder/attention-deficit hyperactivity (adolescent) (adult) (child) F90.9. Next, look for Wart B07.9. Then, look for Urine/frequency R35.0. Varicella vaccination was administered. Look for Vaccination (prophylactic)/encounter Z23. Verify all codes in the Tabular List.

