2016

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 2016 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

The Business of Medicine

Exercise 1

1. What type of profession might a skilled coder enter?

   Answer: Consultants, educators, medical auditors

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

   Answer: Outpatient coders will focus on learning CPT®, HCPCS Level II, and ICD-10-CM codes. They will work in physician offices, outpatient clinics, and facility outpatient departments. Outpatient facility coders will also work with Ambulatory Payment Classifications (APCs).

   Inpatient hospital coding focuses on a different subset of skills, where coders will work with ICD-10-CM and ICD-10-PCS. These coders also will assign MS-DRGs for reimbursement. Outpatient coders usually will have more interaction throughout the day, and must communicate well with physicians; 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 helps to cover medically-necessary doctors' services, outpatient care, and other medical services (including some preventive services) not covered under Medicare Part A. Medicare Part B is an optional benefit for which the patient must pay a premium, and which generally requires a yearly co-pay. Coders working in physician offices will mainly deal with Medicare Part B.
   - 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 (PPOs), Health Maintenance Organizations (HMOs), and others.
   - Medicare Part D is a prescription drug coverage program available to all Medicare beneficiaries. Private companies approved by Medicare provide the coverage.

5. Evaluation and management services are often provided in a standard format such as SOAP. 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 services performed 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 it is ordering additional tests, or taking over the counter medications, etc.

6. What are five tips for coding operative 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 findings of the operative report. If a pathology report is available, use the findings from the pathology report for the diagnosis.

   2. Start with the procedures listed—For the coder who is new to coding a procedure, one way of quickly starting the research process 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 will help a coder with a place to start.

   3. Look for key words—Key words may include locations and anatomical structures involved, 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—Words you are not familiar with should be highlighted and researched for understanding.

   5. Read the body—All procedures reported should be documented within the body of the report. The body may indicate a procedure was abandoned or complicated, possibly indicating the need for a different procedure code or the 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 (LCD), and commercial Medical Policies.

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

   Answer:

   - Medicare does not pay for the procedure/service for the patient's condition.
   - Medicare does not pay for the procedure/service as frequently as proposed.
   - Medicare does not 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 and Human Services (HHS) when disclosure of information is required under the Privacy Rule for enforcement purposes.
- Uses or disclosures that are required by other law.

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

Answer:

- Conduct internal monitoring and auditing through the performance of periodic audits.
- Implement compliance and practice standards through the development of written standards and procedures.
- Designate a compliance officer or contact(s) to monitor compliance efforts and enforce practice standards.
- Conduct appropriate training and education on practice standards and procedures.
- Respond appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate government entities.
- Develop 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.
- Enforce 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."

   What is the cornua referred to?

   Answer: The cornua is where the fallopian tubes connect to the fundus.

5. Surgical Procedure: Myringotomy

   What anatomic location is being operated on?

   Answer: Ear

6. Documentation: There was no cleft of the uvula or sub mucosal 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 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 codebook, locate the diagnosis codes for the following conditions.

1. Fever

   Answer: R50.9

   Rationale: From the Index to Diseases and Injuries, look for Fever. There is no additional information provided. The default code is R50.9. Review the code in the Tabular List to verify code accuracy.

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

   Answer: G43.701

   Rationale: Determine the main term which is headache. From the Index to Diseases and Injuries, look for Headache/migraine (type) (*see also* Migraine). 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. Refer to the code in the Tabular List.

3. Otitis media, left ear

   Answer: H66.92

   Rationale: The main term is otitis. From the Index to Diseases and Injuries, 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 fifth character. Under subcategory H66.9, you will see Otitis Media NOS listed. The fifth 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. From the Index to Diseases and Injuries, look for Pain/epigastric, epigastrium. You are referred to R10.13. Review the code in the Tabular List to verify code accuracy.

5. Acute asthma exacerbation

   Answer: J45.901

   Rationale: The main term is asthma. From the Index to Diseases and Injuries, look for Asthma, asthmatic/with/exacerbation (acute). The correct code is J45.901. Review the code in the Tabular List to verify code accuracy. Note that there is a category note for J45 to code also exposure to, use of, or dependence of tobacco. This is coded if known.

6. Acute myocardial infarction

   Answer: I21.3

   Rationale: The main term is infarction. From the Index to Diseases and Injuries, look for Infarct, infarction/myocardium, myocardial (acute). You are referred to I21.3. Refer to the Tabular List. This is the correct code because it lists Myocardial infarction (acute) NOS under the code. Note that there is a category note for I21 to code also 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. From the Index to Diseases and Injuries, look for Disease/heart/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 code accuracy. Note that there is a category note for I10-I15 to code also exposure to, use of, or dependence of tobacco. This is coded if known.

8. Syncope

   Answer: R55

   Rationale: Look for Syncope in the Index to Diseases and Injuries. You are referred to R55. Review the code in the Tabular List to verify code accuracy.

9. Nausea and vomiting

   Answer: R11.2

   Rationale: Nausea and vomiting are both main terms. From the Index to Diseases and Injuries, look for Nausea/with vomiting or Vomiting/with nausea. You are referred to R11.2. Review the code in the Tabular List to verify 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. From the Index to Diseases and Injuries, 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 code accuracy. GERD can also be found in the Index to Diseases and Injuries under Disease, Reflux/gastroesophageal which also leads to K21.9.

11. Chlamydial inflammation of the testes

    Answer: A56.19

    Rationale: Inflammation and Chlamydia are both main terms. From the Index to Diseases and Injuries, look for Inflammation/testes which directs you to see Orchitis. Orchitis is the inflammation of the testes. Look for Orchitis/chlamydia or Chlamydia, chlamydial/orchitis. You are referred to A56.19. Review the code in the Tabular List to verify code accuracy. Code A56.19 reports Other chlamydial genitorurinary infection; under that code Chlamydial orchitis is listed.

12. Sickle-cell anemia

    Answer: D57.1

    Rationale: The main term is anemia. From the Index to Diseases and Injuries look for Anemia/sickle-cell – see Disease/sickle-cell. Diseases/sickle cell directs you to D57.1. Review the code in the Tabular List to verify code accuracy. Note there is a category note under D57 to use an additional code for 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 Index to Diseases and Injuries, look for Rupture, ruptured/spleen/nontraumatic. You are referred to D73.5. Review the code in the Tabular List to verify code accuracy. The diagnosis documents that the rupture of the spleen was not due an injury, nontraumatic.

14. Cellulitis of the arm

    Answer: L03.119

    Rationale: The main term is cellulitis. From the Index to Diseases and Injuries, look for Cellulitis/arm – see Cellulitis, upper limb. Look for Cellulitis/upper limb 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 sixth character and verify code accuracy. The diagnosis does not specify if the cellulitis is in the left or right arm report L03.119.

15. Chest mass

    Answer: R22.2

    Rationale: The main term is Mass. From the Index to Diseases and Injuries, look for Mass/chest. You are referred to R22.2. Review the code in the Tabular List to verify code accuracy.

16. Novel H1N1 flu

    Answer: J10.1

    Rationale: The main term is Flu. From the Index to Diseases and Injuries, 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 code accuracy. Note the code also notes if applicable.

17. Uncontrolled diabetes with diabetic cataracts

    Answer: E13.36

    Rationale: The main term is diabetes. From the Index to Diseases and Injuries, look for Diabetes, diabetic/with/cataract. You are referred to E13.36. Review the code in the Tabular List to verify code accuracy.

18. Left outer cheek abrasion, initial encounter

    Answer: S00.81XA

    Rationale: The main term is abrasion. From the Index to Diseases and Injuries, look for Abrasion/cheek. You are referred to S00.81. Review the code in the Tabular List to assign the seventh character and to verify code accuracy. Because this code needs seven characters the letter X is used as a placeholder for the sixth character and the seventh 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. From the Index to Diseases and Injuries, look for Cholecystitis/acute/with/chronic cholecystitis. You are referred to K81.2. Review the code in the Tabular List to verify 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. From the Index to Diseases and Injuries, look for Laceration/eyebrow – see Laceration, eyelid. Look for Laceration/eyelid you are referred to S01.11-. Review the code in the Tabular List to report sixth and seventh characters and to verify code accuracy. S01.111D is the correct code to report because the laceration is the on the right side. The seventh character D is reported to indicate subsequent encounter.

Case 1

Operative Report

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

Postoperative Diagnoses: Splenic abscess and multiple intra-abdominal abscess, 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 abscess 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 consult 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 under 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 was 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.

At this point, 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 gastrics 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 2 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 2 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 4 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.

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[1] Postoperative diagnoses are reported.

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

[3] Confirms the location of the abscess.

[4] Location of abscesses.

What diagnosis/es 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 Official Coding Guidelines 1.C.1.a.2., if a patient is admitted for an HIV-related condition, the principal diagnosis should be B20, followed by additional diagnosis codes for all reported HIV-related conditions. In the Index to Diseases and Injuries, look for AIDS; you are referred to B20. In the Tabular List, category B20 instructions are to use additional code(s) to identify all manifestations of HIV infection. The spleen and abdominal abscesses are HIV-related conditions. In the Index to Diseases and Injuries, look for Abscess/spleen and you are referred to D73.3; locate Abscess/intra-abdominal (*see also* abscess, peritoneum) and you are referred to K65.1. The diagnosis for hepatitis C is relevant and should be reported because hepatitis C may have an impact on the patient's recovery. From the Index to Diseases and Injuries, 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 2

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, PERLA, 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, stage IV, 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.

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[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/es 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 Index to Diseases and Injuries, 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 from the Malignant Primary column. You are referred to C50.9-. Refer to the Tabular List for the fifth and sixth 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 the pain is due to cancer. From the Index to Diseases and Injuries, look up Pain(s)/acute or chronic/neoplasm related. You are referred to G89.3. Verify 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 1.C.6.b.5. indicates that this code is assigned regardless of whether the pain is acute or chronic. The same guideline also sates, 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 diagnosis. In the Index to Diseases and Injuries, look for Pain(s)/neck NEC referring you to code M54.2. There is an instructional note under category code C50 to Use additional code to identify estrogen receptor status. Look for Status/estrogen receptor/positive [ER+]. You are referred to Z17.0. The patient is continuing with tamoxifen, look for Long-term (current) (prophylactic) drug therapy (use of)/tamoxifen (Nalvadex) referring you to code Z79.810.

Case 3

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 mildly inflamed with moderate postnasal drainage.

NECK: No significant adenopathy.

LUNGS: Clear.

HEART: Regular rate and rhythm.

ABDOMEN: Soft, obese, and nontender. Multiple lipomas are palpated.

Assessment:

1. Diabetes mellitus, type I. [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.

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[1] The definitive diagnoses are reported.

[2] Provider treated the acute sinusitis.

What diagnosis/es code(s) are reported?

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

Rationale: The patient is diagnosed with Type I diabetes. The patient has diabetic neuropathy, which is a diabetic manifestation. From the Index to Diseases and Injuries, look for Diabetes, diabetic/type I/with/neuropathy. You are referred to E10.40. To locate the code for acute sinusitis, look for Sinusitis/acute. You are referred to J01.90. Verify code selection in the Tabular List.

Case 4

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 does state that he's eating more. We've been attempting to titrate up his carvedilol to 25 mg twice a day from initially the 6.25. He has tolerated the titration quite well. He does get cephalgias on occasion. He states he has a weak spell but this is before he takes his morning medicine. I did update his medical list here today. I did give 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 for two months' supply that I have.
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/es code(s) are reported?

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

Rationale: From the Index to Diseases and Injuries, look for Disease, diseased/artery/coronary. You are referred to I25.10. The patient also has hyperlipidemia. In the Index to Diseases and Injuries, look for Hyperlipemia, hyperlipidemia. You are referred to E78.5. There is an instructional note under category code I25, Use 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. Because there is reevaluation of medication the patient is taking for CAD and hyperlipidemia, code Z79.899 is reported. Look for Long-term (current) (prophylactic) drug therapy (use of)/drug, specified NEC Z79.899. Verify the codes in the Tabular List.

Case 5

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 postauricular 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 be working 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 then made and the device was then inserted into the cochleostomy with an advance-off stylet technique. A small piece of temporalis muscle was then packed around the cochleostomy and the wound was then closed in layers using 3-0 and 4–0 Monocryl and Steri-Strips. A standard mastoid dressing was applied. The patient was returned to the anesthesia, where she was awakened, extubated, and taken to the recovery room in stable condition.

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[1] Report the postoperative diagnosis.

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

What diagnosis/es code(s) are reported?

ICD-10-CM Code: H90.3

Rationale: The patient has bilateral sensorineural hearing loss. From the Index to Diseases and Injuries, look for Loss (of)/ hearing (*see also* Deafness). Look for Deafness/ sensorineural/bilateral. You are referred to H90.3. Refer to the Tabular List to verify the code accuracy.

Case 6

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 in 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 cauter. 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 Supersharp blade. A 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 an 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 Cystalens 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 Vigainox 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/es code(s) are reported?

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

Rationale: The patient is diagnosed with cataract and presbyopia. From the Index to Diseases and Injuries, look for Cataract. You are referred to H26.9. For the additional diagnosis, look for Presbyopia which is reported with H52.4. Verify both codes in the Tabular List.

Case 7

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 a well appearing, 50-year-old, white female. Abdomen is soft, nontender, nondistended.

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/es code(s) are reported?

ICD-10-CM Code: K62.5

Rationale: From the Index to Diseases and Injuries, look for Bleeding/rectum, rectal. You are referred to K62.5. Verify the code in the Tabular List.

Case 8

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 myself in 1 month, sooner as needed if has any other problems in the meantime. Will also check a creatinine and potassium today as well.

---

[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.

What diagnosis/es code(s) are reported?

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

Rationale: From the Index to Diseases and Injuries, look for Fibrillation/atrial or auricular. You are referred to I48.91. For the next diagnosis, look for Long-term (current) (prophylactic) drug therapy (use of)/anticoagulants. You are referred to Z79.01. Verify both codes in the Tabular List.

Case 9

Follow-Up Visit: The patient has some memory problems. [1] 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. Nontender. Extremities no clubbing or edema. Foot exam shows some bunion deformity but otherwise healthy as consequence. Light touch is preserved. There is no ankle edema or stasis change. Examination of the upper arms reveal good range of motion. There is significant pain in her shoulder with rotational movements. It 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. Type 2 diabetes good control. [2] Most recent AlC done today 5.9%. Liver test normal. Cholesterol 199, LDL a little high at 115.
2. Right shoulder pain. [3]
3. Benign hypertensive cardiovascular disease. [3]
4. Dementia [3]

Plans:

1. I offered her and her family neuropsych eval 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 much rather initiate treatment than go through an exhaustive neuropsych 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 aspired. 1 cc of 0.25% Marcaine mixed with 80 mg Depomedrol was deposited. Needle withdrawn. Band-Aid 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.

_____

[1] A presenting problem.

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

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

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

[5] Treatment documented for right shoulder pain.

_____

What diagnosis/es code(s) are reported?

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

Rationale: The patient has multiple diagnoses. It is 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 the patient has controlled Type II diabetes. From the Index to Diseases and Injuries, look for Diabetes, diabetic/type 2 referring you to code E11.9. The provider performs a joint injection to treat the patient's right shoulder pain. From the Index to Diseases, look for Pain(s)/joint/shoulder. You are referred to M25.51-. Turn to the Tabular List for the sixth 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. From the Index to Diseases and Injuries, look for Hypertension, hypertensive (benign)/cardiovascular/ disease (arteriosclerotic) (sclerotic) – *see* Hypertension, heart. Look for Hypertension, hypertensive (benign)/heart. You are referred to I11.9. The last diagnosis listed is dementia. The provider is not sure of the cause. Look for Dementia. You are referred to F03.90. Verify codes in the Tabular List for accuracy.

Case 10

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/es code(s) are reported?

ICD-10-CM Codes: I10

Rationale: From the Index to Diseases and Injuries look for Hypertension, hypertensive. You are referred to code I10. Verify the code selection in the Tabular List.

Case 1

Reason For Consult: Acute Renal Failure [1]

HPI: Patient 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 "dehydration." [2] The patient is currently 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 sclerae, 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 no improvement with volume repletion.

---

[1] Indication for the visit.

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

[3] Code the defintive diagnoses documented by the provider.

What diagnosis/es 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. From the Index to Diseases and Injuries, 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 which is reported with I95.9. Verify all codes in the Tabular List.

Case 2

Progress Note

Chief Complaint: Multiple Ulcers

S: Jane 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 much better controlled.

O: Exam reveals marked improvement of the edema [1] of both lower legs, right better than 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 is considerable bony abnormality and/or tophaceous deposits which have distorted the bottom of her foot dramatically. In order 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 Samuel Myers, PA.

A: Ulcers on the feet. [4] Edema in the lower extremities. Foot pain [5] treated with nerve block. Fantastic course to date thanks to her caregiver.

P: 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 tophaneou 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/es 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 the ulcers are pressure ulcers or decubitus ulcers. In the Index to Diseases and Injuries, look for Ulcer/lower limb/foot/left/with skin breakdown only and Ulcer/lower limb/foot/right/with skin breakdown only. You are referred to L97.521 and L97.511. Although it is improving, the patient still has edema. From the Index to Diseases and Injuries, look for Edema, edematous/legs. You are referred to R60.0. The patient also has foot pain which is treated with a nerve block. From the Index to Diseases and Injuries, look for Pain(s)/foot-*see* Pain, limb, lower; Pain/limb/lower/foot. You are referred to M79.67-. You need to assign a sixth 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 3

S: The patient presents today after having a cabinet fall on her. [1] She states that the people that 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, any smell changes. The patient has marked amount of tenderness across the superior trapezius. [3]

O: 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.

A: 1. Cephalgia [4]
2. Thoracic somatic dysfunction [4]

P: 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 occured.

[2] Patient complaint.

[3] Patient complaint.

[4] Select codes for definitive diagnosis.

What diagnosis/es 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. From the Index to Diseases and Injuries, 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 is not assigned during the acute phase of an injury. Because this is during the acute phase of this injury, a G44.3- code is not reported. Next, look 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 Index to External Causes of Injury, 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 were 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 4

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 though 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 though he did have 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 reviewed and 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: Nontender to palpation in the posterior midline. The trachea is midline. There is no subcutaneous emphysema. There is no tenderness over the paraspinous 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 does complain 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, nondistended. Nontender.

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 going to discharge the patient home, have him use ice packs, doing prescriptions for pain medications and have him return for any 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/es 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 shoulder injury. From the Index to Diseases and Injuries, look for Contusion/chest (wall) – *see* Contusion, thorax; Contusion/thorax (wall)/back and Contusion/thorax (wall)/front. Because there are subterms 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 sixth and seventh characters. The exam documentation states that it was on the right side of the chest, so your sixth character is 1. Letter A is the seventh 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. From the Index to External Causes, look for Caught/between/objects. 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. This is an initial injury; you will report A as the seventh character. An External Cause code can also be reported to indicate the location of the accident which is in this case is a supermarket. From the Index to External Causes, look for Place of occurrence/supermarket. You are referred to Y92.512. Verify all codes in the Tabular List.

Case 5

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

Abdominal: Soft. Nontender

Vagina: Blood Clots size: 1.5 cm and amount 2.Discharge: Pink
No Hyphae, BV or TRICH and CX not irritated

Cervix: Deffered

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: Pt continues with contractions mildly, but does not feel it. Pt 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/es 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 Official Coding Guidelines, when a condition is documented as "threatened," look for the condition under the main term Threatened. 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, due to the patient being in her second trimester. There is a use additional code note at the beginning of this ICD-10-CM chapter that states to also report the weeks of gestation. Look in the Index to Diseases and Injuries for Pregnancy/weeks of gestation/25 weeks Z3A.25.

Case 6

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/es code(s) are reported?

ICD-10-CM Code: M77.30

Rationale: The patient is diagnosed with a heel spur. The pain the patient is complaining of is a symptom of the heel spur and should not be reported separately.

From the Index to Diseases and Injuries, look for Spur, bone/calcaneal. The calcaneous is the heel. You are referred to M77.3-. Verify the code in the Tabular List to assign the fifth character; M77.30 is reported, because the documentation does not indicate if the spur is in the right or left heel.

Case 7

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 totalling 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 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 appear 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 then infiltrated into the three wounds. They were then thoroughly cleansed with soap and closure was begun on the upper eyelid to begin with. We used 6-0 Vicryl subcutaneous sutures to attack 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, 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, do not let crust form. She was also instructed in 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 CAT 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/es code(s) are reported?

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

Rationale: The patient has multiple lacerations. From the Index to Diseases and Injuries, look for Laceration/eyelid. You are referred to S01.11-. A review in the Tabular List reveals that you need to report sixth and seventh characters. The correct code is S01.111A to indicate the laceration is on the right eyelid w/o 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 guidelines, it is only reported once. The code for the eyelids is sequenced first since 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 seventh 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 that the patient fell from her motorized wheelchair. In the Index to External Causes of Injury, look for Fall, falling/out of/wheelchair/powered – *see* Accident; look for Accident/transport/pedestrian/conveyance/wheelchair (powered)/fall. You are referred to V00.811. In the Tabular List you need a seventh character. 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 8

Preoperative Diagnosis:

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

Postoperative Diagnosis:

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

Anesthesia: Axillary block with general.

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 and the overriding fracture was manipulated with gentle traction and manipulation and the fracture reduced. This effectively reduced the distal radioulnar joint. [3]

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 3 screws distal, 4 screws proximal, and the last hole was at the area of the fracture. Initially to achieve satisfactory bone to plate contact, 3 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 recovery room in satisfactory condition. Sponge and needle count correct x2. Estimated blood loss minimal.

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[1] The postoperative diagnosis is reported. The subluxation is described as possible and should not be coded.

[2] A fracture is confirmed.

[3] Location of the fracture.

What diagnosis/es code(s) are reported?

ICD-10-CM Code: S52.301A

Rationale: In this case, the patient is diagnosed with a right forearm shaft radius fracture. The subluxation is documented as probable and should not be coded. From the Index to Diseases and Injuries, look for Fracture, traumatic/radius/shaft. There is no indication the fracture is open so it is coded as closed according to the Official Coding Guidelines. You are referred to S52.30. Verify the code in the Tabular List to report the sixth and seventh characters. The complete code is S52.301A.

Case 9

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. However, did well for the first several weeks; however, then developed to have a large head. Mom noticed full fontanelle arid in the last week or so, they have noticed the eyes have decreased mobility. He tends to stare straight. Has some troubles looking up and even to the sides bilaterally. Therefore, reported to her pediatrician. Pediatrician got a CT scan and referred the patient and I saw the patient yesterday in clinic. We ordered an HRI, HRT was done this morning. PIRI shows the congenital hydrocephalus [2] and cyst in the posterior fossa; however, it is not a Dandy-Walker. We had a discussion with the family about risks, benefits, potential complications, and also 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 are comfortable with this, bringing him to the OR today for shunting.

---

[1] Report the definitive diagnosis.

[2] The diagnosis is confirmed.

What diagnosis/es code(s) are reported?

ICD-10-CM Code: Q03.9

Rationale: The condition is documented as congenital hydrocephalus. From the Index to Diseases and Injuries, look for Hydrocephalus/congenital. You are referred to Q03.9. According to the Official Coding Guidelines, report congenital conditions as long as they exist. Verify the code in the Tabular List.

Case 10

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 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 lb. 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 preseted for a screening exam and also was treated for a complaint.

_____

What diagnosis/es code(s) are reported?

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

Rationale: According to the Official Coding Guidelines, 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. From the Index to Diseases and Injuries, look for Examination/gynecological/with abnormal findings which is reported with Z01.411. The gynecological exam did have an abnormal finding of vaginal discharge. Next, look for Discharge/vaginal which is reported with N89.8. Verify both codes in the Tabular List.

Exercise 1

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

1. Pyloroplasty

   Answer: 43800

   Rationale: In the index, look for Pyloroplasty.

2. Deep biopsy of soft tissue of the ankle

   Answer: 27614

   Rationale: In the index, look for Biopsy/Ankle or for Ankle/Biopsy and you are directed to 27613–27614, 27620. 27620 is for an anthrotomy. 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 index, look for Osteotomy/Humerus and you are directed to 24400–24410. 24400 indicates "with or without internal fixation."

4. Renal biopsy, percutaneous, needle

   Answer: 50200

   Rationale: Renal means kidney. In the index, look for Kidney/Biopsy and you are directed to 50200–50205. 50200 is for a needle or trocar biopsy. 50205 is for an open surgical procedure biopsy.

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

   Answer: 17282

   Rationale: In the index, look for Destruction/Lesion/Skin/Malignant and you are directed to 17260–17286, 96567. Code range 17260–17286 is for the destruction of a malignant lesion by any method. The codes are further subdivided based on location. Code range 17280–17286 are used for lesions on the face. Code selection is then based on the size. Code 17282 is for a lesion diameter of 1.1 to 2.0 cm.

6. Emergency endotracheal intubation

   Answer: 31500

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

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

   Answer: 80051

   Rationale: In the index, look for Panel and you are directed to see Blood Tests; Organ and Disease-Oriented Panel. Looking at Blood Tests, there is a subterm for Panels/Electrolyte which directs you to 80051.

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

   Answer: 71020

   Rationale: In the index, look for X-ray/Chest and you are directed to code range 71010–71035. Viewing the descriptors, code 71020 is for 2 views, frontal and lateral chest X-ray.

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

    Answer: 1050F

    Rationale: In the index, look for Performance Measures/Melanoma/History/ Moles and you are directed to 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 during a postoperative period

   Answer: Modifier 24

6. Staged or related procedure or service by the same physician during the postoperative period

   Answer: Modifier 58

7. Significant, separately identifiable E/M service by the same physician 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: Rapidly enlarging suspicious lesion of patient's right forehead. [1]

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

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

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

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

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 keroacanthoma.

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

ICD-10-CM Codes: The diagnosis is stated as keratoacanthoma, possible squamous cell carcinoma (SCC). The SCC is considered possible and therefore not coded. To find the diagnosis code for keratoacanthoma, in the ICD-10-CM Alphabetic Index look for keratoacanthoma. You are directed to L85.8. Verify code selection in the Tabular List.

Case 2

Preoperative Diagnosis: Basal cell carcinoma

Postoperative Diagnosis: Same [1]

Operation: Mohs Surgery [2]

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

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

Condition at Termination of Therapy: Carcinoma removed.

Pathology report on file.

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[1] Post-Operative diagnosis is the same as pre-operative diagnosis, which is Basal cell carcinoma.

[2] Mohs surgery is performed.

[3] Location is noted as the nasal tip.

[4] The basal cell is 8 x 7 mm.

[5] Stage 1.

[6] Local anesthesia was used.

[7] Noting the tumor has been removed, which supports Stage 1.

[8] The tissue is divided into two tissue blocks.

[9] Size and depth of the defect.

[10] A Burrow's graft indicates an adjacent tissue graft.

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

CPT® Codes: 14060, 17311-51

ICD-10-CM Code: C44.311

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

ICD-10-CM Code: The diagnosis is basal cell carcinoma of the nose. Basal cell carcinoma is a malignant neoplasm of the skin. From the Index to Diseases and Injuries, look for Carcinoma/basal cell (pigmented) (*see also* Neoplasm, skin malignant). Go to the Table of Neoplasms, look for Neoplasm, neoplastic/nose, nasal/skin/ basal cell carcinoma/Malignant Primary column. Verify code selection in the Tabular List.

Case 3

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] Diagnosis to report and 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: The removal of a hidradenitis is indexed in CPT® under Hidradenitis/Excision referring you to 11450–11471. These codes are chosen by location and type of repair. Case note documents the hidradenitis being removed from the axilla and the repair is intermediate. The 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)(supporative). You are referred to code L73.2. Verify code selection in the Tabular List.

Case 4

Preoperative Diagnosis: Segmental obesity of posterior thighs.

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

Operative Procedure: Posterior thigh lift with 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, but not limited to, the risk of anesthesia, bleeding, infection, wound healing problems, unfavorable scarring, and potential need for secondary surgery. She understood and desired to proceed.

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

There was no residual flap or dead space and the fascia was closed at the deep level with 0 PDS and then in layers anatomically the closure was completed with 2-0, 3-0, and 4-0 PDS. Dermabond and Steri-Strips were applied. The medial third was also closed with a 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

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, you are referred to code range 15876–15879. Code selection is based on location. This procedure was performed on the right and left posterior medial thighs, requiring use of 15879. The procedure was performed on both the right and left medial thighs (bilaterally) reported as 15879-50 or 15879-RT, 15879-LT.

ICD-10-CM Code: The patient's diagnosis is segmental obesity. In the ICD-10-CM Alphabetic Index look for Obesity. Segmental indicates the obesity is in segments instead of generalized. There is no subterm for segmental, so we default to Obesity, Specified type NEC. The type is specified as segmental. You are referred to code E66.8. Verify code selection in the Tabular List. There is a 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: 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 and for the above procedure. She understood the potential risks and complications including but not limited to the risks of anesthesia, bleeding, infection, wound healing problems, unfavorable scaring, and potential need for secondary surgery, and she desired to proceed. She also understood the possibility of impaired circulation to the flaps and hematoma/seroma formation.

Procedure in Detail: The patient was placed on the operating table in supine position. 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 the 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 then 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.

---

[1] Postoperative diagnosis is used for coding.

[2] Procedure performed is abdominoplasty.

[3] General anesthesia used.

[4] Excessive skin.

[5] Separation between the right and left sides of the rectus abdominis muscle.

[6] Closure of the rectus abdominis muscle.

[7] Excision of excessive skin.

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 first procedure performed was the removal of excess skin of the abdomen. An incision was made in the suprapubic natural skin crease, and the skin flap was elevated to the umbilicus. The umbilicus was dissected from the skin, and the skin flap continued to be elevated to the subcostal margin. The excessive skin was excised. Look in CPT® for Panniculectomy and you are referred to *See* Lipectomy. Look in the CPT® Index for Lipectomy/Excision and you are referred to 15830–15839, 15847. Code 15830, describes the removal of the excessive skin and subcutaneous tissue of the abdomen. The next procedure was the repair of the diastasis recti, also known as abdominal separation (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 15830 describes the panniculectomy, the removal of excess skin and subcutaneous tissue. 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.

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 under 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 M62.08. Verify code selection in the Tabular List.

Case 6

Preoperative Diagnosis: Hypoplasia of the breast.

Postoperative Diagnosis: Hypoplasia of the breast. [1]

Operative Procedure: Bilateral augmentation mammoplasty. [2]

Anesthesla: 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 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 Allergan silicone filled high profile textured implant was used and placed into the pocket. [5] It was 300 cc. The skin was then closed using 4-0 Vicryl in an interrupted fashion for the deep subcutaneous tissue 4-0 Monocryl in an interrupted fashion was used for the superficial subcutaneous tissue and the skin was closed using 4-0 Monocryl in a subcuticular fashion. Antibiotic ointment and Tegaderm were applied. The right breast [6] was operated 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.

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[1] Postoperative diagnosis is used for coding.

[2] Breast augmentation performed bilaterally.

[3] General anesthesia.

[4] Left breast.

[5] Prosthetic implant used on the left breast.

[6] Right breast.

[7] Prosthetic implant used on the right breast.

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 is dependent upon whether implants were used. In this case, implants were used in both the right and left breasts. The correct code is 19325. The procedure was performed on both breasts necessitating the use of modifier 50 or modifiers RT and LT. If the provider supplied the breast implants, a HCPCS Level II code is reported (L8600 x 2).

ICD-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 7

Preoperative Diagnoses: Dysplastic nevus, right chest.

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

Procedures Performed: Excision, dysplastic nevus, right chest [2] with excised diameter of 1.2 cm [3] and complex repair of 3 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 sutured at superior tip, 12 o'clock for permanent pathology.

Indications for Surgery: The patient is a 49-year-old white woman with a dysplastic nevus of her right chest, [6] which I marked for elliptical excision in the relaxed skin tension lines of her chest with gross normal margins of around 0.3 cm [7] and I drew my best guess at the resultant scar and she observed these markings well and we proceeded.

Description of Procedure: We started with the patient prone. The area has been infiltrated with local anesthetic. The chest prepped and draped in sterile fashion. I excised the dysplastic nevus [8] as drawn into the subcutaneous fat. Hemostasis achieved using the Bovie cautery. Defects were created at each of the wounds [9] to optimize the primary repair. [10] Thus, I considered a complex repair and the wound is closed in layers [11] 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.

[4] Complex repair measured 3 cm.

[5] Local anesthesia.

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

[7] Margins of the lesion were 0.3 cm.

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

[9] Defects were created at each of the wounds.

[10] Primary repair was used.

[11] The wound repair is stated as complex.

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

CPT® Codes: 13101, 11402-51

ICD-10-CM Code: D22.5

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

ICD-10-CM Codes: The diagnosis is a dysplastic nevus, right chest. For the dysplastic nevus on the chest, look in the ICD-10-CM Alphabetic Index for Nevus/skin/chest wall and you are directed to D22.5. Verify code selection in the Tabular List.

Case 8

Preoperative Diagnoses:

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

Postoperative Diagnoses: Same

Procedures Performed:

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

Anesthesia: Local [6] using 8 cc of 1% lidocaine with epinephrine and 3 cc of 1% plain lidocaine.

Indications for Surgery: The patient is a 77-year-old white woman with a biopsy-proven basal cell carcinoma of right temple that appeared to be recurrent and a biopsy-proven squamous cell carcinoma of her left hand. I marked the lesion of her temple for elliptical excision in the relaxed skin tension lines of her face with gross normal margins of around 2–3 mm [7] and I 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, that is the anesthetic with epinephrine. The face and left upper extremity were prepped, draped in sterile fashion. I excised the lesion of her right temple and left hand [9] as drawn to the subcutaneous fat. Hemostasis achieved with Bovie cautery. It took a few more passes to get the margins clear from the basal cell carcinoma right temple. [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. Thus 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 this area prepped and draped in a sterile fashion. I infiltrated with a plain lidocaine. The full-thickness skin graft [13] harvested and defatted using scissors. Meticulous hemostasis achieved in the donor site using the Bovie cautery. The skin graft inset into the temple [14] wound using 5-0 plain gut suture. The skin graft was vented and then a Xeroform bolster was placed using Xeroform and nylon. The donor site was closed in layers using 4-0 Monocryl and 5-0 Prolene. My attention turned to the hand. [15] The margins had been cleared from that region even though it did take 2 passes. [16] I incised the rhomboid flap and elevated with a full-thickness subcutaneous fat. Hemostasis achieved in the wound and the donor site using Bovie cautery. The flap rotated in [17] the defect. The donor site closed with flap inset in layers using 4-0 Monocryl and 5-0 Prolene. Loupe magnification was used. The patient tolerated the procedure well.

---

[1] The postoperative diagnosis is the same as the pre-operative diagnosis, so the pre-operative diagnosis will be used for coding.

[2] Right temple malignant lesion (Basal Cell Carcinoma) excised diameter of 2.2 cm.

[3] Full thickness skin graft is 4 cm^2.

[4] Excision malignant lesion left hand.

[5] Flap repair of 2.5 cm^2.

[6] Anesthesia local.

[7] Margins of temple excision.

[8] Margins of hand excision.

[9] Lesion on the right temple and left had were excised.

[10] The right temple was excised outside of the parameters initially drawn.

[11] The decision was made to repair with a skin graft due to the size of the wound.

[12] Donor site is the right clavicle making this a free graft (when the skin is cut free of one area and moved to another for re-attachment).

[13] The graft was full-thickness.

[14] Skin graft inserted in the temple.

[15] Here, we begin the description of the closure of the hand.

[16] Additional margins were excised.

[17] A rotation flap was used.

What are the CPT® and ICD-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, look in the CPT® Index look for Excision/Skin/Lesion, Malignant, you are referred to code range 11600–11646. Narrowing down the location and the size, the correct code is 11643.

After excising the lesion on the temple, the physician performed a full thickness free graft (moving skin from the clavicle to the temple). To find in the CPT® Index, look for Skin/Grafts/Free and you are directed to 15050-15157, 15200–15261, 15757. Free skin graft codes are selected based on the thickness of the graft, location and size. Full thickness free grafts are coded from range 15200–15261. The temple area is considered the forehead, or cheek area, both code to range 15240–15241 based on the size. The size in the procedure detail is stated as, "approximately the size of a quarter." Size is clarified in the procedures listed at the top as 4 sq cm^2. The correct code for this is 15240.

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

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

ICD-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, you are directed to *see also* Neoplasm/skin/malignant. In the Table of Neoplasms, look for Neoplasm, neoplastic/skin/temple which refers you to *see also* Neoplasm, neoplasatic/skin/face/basal cell carcinoma, and you are referred to C44.310. In reviewing this code in the Tabular List, 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 for finding the code for squamous cell carcinoma for the hand. In the Table of Neoplasms, look for Neoplasm, neoplastic/skin/hand and you are referred to *see also* Neoplasm, skin, limb, upper. Look for Skin/limb NEC/upper/squamous cell carcinoma and you are referred to C44.62-. In the Tabular List, sixth character 9 indicates the left hand. Report code C44.629.

Case 9

Preoperative Diagnosis: Right breast mass.

Postoperative Diagnosis: Right breast mass. [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 right breast mass. 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 upper outer quadrant. [5] I therefore 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 then carefully dissected this mass out from the surrounding tissue. Once it was removed from the field,

the traction suture was removed and the mass was sent in formalin to pathology. The wound was then inspected for hemostasis, which was achieved with electrocautery. I then reapproximated the breast tissue deep with interrupted 3-0 Vicryl suture and then another 3-0 Vicryl suture in the superficial breast tissue. The skin was then closed 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 a dry sterile pressure were then applied. The patient tolerated the procedure well and was taken back to the short stay area in good condition.

---

[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

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. Modifier RT is appended to report the procedure is performed on the right breast.

ICD-10-CM Code: The diagnosis from the operative report indicated this mass appeared to be a fibroadenoma. The use of the phrase "appeared to be" indicates the fibroadenoma is not a confirmed diagnosis. The diagnosis to code is a right breast mass. To find this in ICD-10-CM, look in the Alphabetic Index for Mass/breast and you are directed to code N63. Verification in the Tabular List confirms code selection.

Case 10

Preoperative Diagnosis: Necrotizing fasciitis.

Postoperative Diagnosis: Necrotizing fasciitis.

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

Findings and Indications: This very unfortunate gentleman with liver failure, renal failure, pulmonary failure, and overwhelming sepsis was found to have necrotizing fasciitis last week. We excised the necrotizing wound. [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 was an area on the lateral thigh that we thought may be able to be closed with a skin graft eventually for a viable above-the-knee amputation.

Procedure in Detail: After informed consent, the patient was brought to the operating room and placed in supine position on the operating table. The above findings were noted. Debridement [3] sharply with the curved Mayo scissors and the scalpel were helpful in demonstrating the findings noted above. Because of the unviability of this area, it was felt that we would not perform a homografting to this area. However, the lateral thigh appeared to be viable and this was excised further with curved Mayo scissors. [4] Hemostasis was achieved without significant difficulty and the homograft meshed 1.5:1 was 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 also 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 then dressed with moist dressing with incorporated catheters. The patient was taken back to the ICU in satisfactory condition.

---

[1] The necrotizing wound was excised the week before. We are still in the global period of the original surgery.

[2] A return to the operating room indicates to look for possible modifiers.

[3] Debridement of the wound.

[4] The wound on the lateral thigh was excised to prep for homograft placement.

[5] Homograft mesh placed.

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

What are the CPT® and ICD-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 code range 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. The size is not stated, so you can only code the smallest size, 15271. The preparation of the wound (debriding and excising to prepare a clean and viable wound for graft placement) can also be coded when performed. There is indication in the note this was performed. To find in the CPT® Index, look for Excision/Skin Graft/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.

This is a staged procedure. The wounds were excised the week before. They brought the patient to the operating room on this date to check the progress. They determined a homograft was needed and plan to perform an above the knee amputation when the wound on the thigh heals. A modifier 58 is appended to both surgery codes. A modifier 51 is needed on 15271 to indicate a multiple procedure.

ICD-10-CM Code: The diagnosis is necrotizing fasciitis. 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 1

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 fracture 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 risk and benefits of the surgical procedure were discussed. She stated understanding 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 carried out down to the fracture site. The fracture site was identified. The fragments were mobilized and the humeral head fragments 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 were placed in key positions for closure of the tuberosities down to the shaft including sutures through the shaft. The shaft was then 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 then 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 also staples in the epidermis. A sterile dressing and sling was applied. The patient was taken to recovery in stable condition. No immediate complications.

---

[1] Postoperative diagnosis is used for coding.

[2] Working procedure until report is read.

[3] General anesthesia is used.

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

[5] This is confirmation of diagnosis. Keep in mind that the proximal end of the humerus is the shoulder area.

[6] Indicates the approach.

[7] This further explains the comminuted fracture.

[8] This is explaining the placement of the prosthesis.

[9] Bone grafts are common in prosthetic placement. It gives a matrix for new bone to grow on and further stabilize the prosthesis. These are not charged 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 code range 23615–23616. A humeral prosthetic treatment is performed to repair the fracture which is reported with 23616. Modifier LT should be appended to indicate it is the left humerus.

ICD-10-CM Code: The diagnosis is listed as a 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. There is mention of the fracture being a comminuted fracture which is a closed fracture. Fracture, traumatic/humerus/upper end directs you to S42.20-. In the Tabular List, sixth character 2 is reported for the left side and seventh character A indicates initial encounter (reported for active treatment - surgery). There is no documentation for the circumstances surrounding the injury so external cause codes cannot be reported.

Case 2

Preoperative Diagnosis: Painful L2 vertebral pathological compression fracture.

Postoperative Diagnosis: Painful L2 vertebral pathological compression fracture. [1]

Name of Operation: L2 kyphoplasty. [2]

Findings Preoperatively: She had compression fractures at T 11 and L1, which underwent kyphoplasty and she initially had very good results, but then developed back pain once again. Repeat MRI a couple of weeks later showed that she had fresh high intensity signal changes in the body of L2 and some scalping of the superior end plate consistent with a compression fracture at L2. [3] After some preoperative discussion and some patience to see if she would get better, she was admitted to the hospital for L2 kyphoplasty when she was not getting better. 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 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 out. 0.5 Marcaine with epinephrine was injected. Initially on the left side, a Xyphon trocar was passed down to the superior lateral edge of the pedicle and then passed down through the pedicle and into the vertebral body—uneventfully in the usual fashion. [5] The drill was then placed into the vertebral body and then the Kyphon bone tamp. In a similar fashion, the same thing was done on the other side. Balloons were then inflated uneventfully. The balloons were then deflated and removed and the cement when it was in the doughy state was then injected into the 2 sides in the usual fashion. [6] This was done carefully and sequentially to make sure that there were no cement extrusions and in fact there were none, there was a good fill to the edges of vertebral body up towards the superior end plate and across the midline. The bone filling devices were then removed and the trocars 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] Postoperative diagnosis is used for coding.

[2] Working procedure.

[3] Confirmation of diagnosis.

[4] General anesthesia was used.

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

[6] This is describing how the area is prepped to be enlarged and receive the cement that is placed in a kyphoplasty procedure.

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

CPT® Code: 22514

ICD-10-CM Code: M84.48XA

Rationale: CPT® Code: In the CPT® Index, look for Kyphoplasty and you are directed to the range of codes 22513–22515. The code selection is based on location. 22514 is the correct code for the lumbar spine. Codes 22513–22515 include radiologic supervision and interpretation, and is not reported separately.

ICD-10-CM Code: In the ICD-10-CM Alphabetic Index, look for Fracture, pathological/vertebra and you are directed to M84.48. In the Tabular List, a seventh character is required. This is an initial encounter because the report documents she had a repeat MRI due to her complaining of back pain and the MRI showed she had a pathological compression fracture. A is reported for the seventh character. An X is reported in the sixth positon to keep the seventh character in the seventh position. If the pathological reason has been identified, such as osteoporosis, then that becomes the additional code. Our report does not mention that however, so the only code reported is M84.48XA.

Case 3

Preoperative Diagnosis: Comminuted intraarticular distal radial Colles' fracture left wrist.

Postoperative Diagnosis: Comminuted intraarticular distal radial Colles' fracture left wrist. [1]

Procedure: Application 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 endotracheal 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 millimeters of mercury. We first placed two half pins distally over the dorsoradial aspect of the second metacarpal first placing first pin in freehand technique making an incision, spreading with 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 then connected these 2 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 dorsal and volar comminution [6] and intraarticular fractures and was significantly shortened and telescoped. We obtained the best reduction possible and then 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] Postoperative diagnosis is used for coding.

[2] This will assist in coding the procedure.

[3] General anesthesia used.

[4] External fixation.

[5] Closed reduction under fluoroscopy.

[6] Comminuted aspect.

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. Code 25605 is correct because a reduction (manipulation) was performed. The codes for Colles' fracture repair (25600–25605), do not include the external fixation. Look in the index for External Fixation/Application/Uniplane and you are referred to code 20690. Modifier LT should be appended 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'– *see* Colles' fracture. Look for Colles' fracture and you are directed to subcategory code S52.53-. Verification in the Tabular List indicates that you need seven characters to complete the code. The Colles' fracture was on the left wrist, S52.532-; the seventh character is A for the initial encounter. The circumstance surrounding the injury are unknown so the external cause codes cannot be reported.

Case 4

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 that sustained a dislocation of his right elbow. [4] The risks and benefits of surgical treatment were discussed with the family who stated understanding and desired to proceed.

Description of Procedure: On the day of procedure after obtaining informed consent, the patient was taken to the main Operating Room where general anesthia was induced. Once he was under adequate anesthesia the reduction maneuver was performed. [5] The elbow was reduced and was stable. Through a full range of motion there was noted to be a slight crepitus on the medial elbow and it was felt some mobility in the medial epicondyle. Examination under C-arm imagery [6] revealed a concentric reduction of the elbow but with mildly unstable medial epicondyle. When the elbow was held in the appropriate position the [8] medial epicondyle was well reduced in acceptable position [7] and it was elevated to treat this non-surgically and therefore 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] Postoperative diagnosis is used for coding.

[2] Working procedure.

[3] General anesthesia used.

[4] Backs up diagnosis.

[5] This indicates a closed method of reduction. There is no indication the skin was cut.

[6] Indicates fluoroscopy.

[7] Manipulation of the medial epicondyle.

[8] This is showing the fracture, reduced and set. No indication that the skin was broken.

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 is based on whether manipulation is used. 24565 is the correct code for the repair of the epicondyle 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. The code selection between codes 24600 and 24605 is based on whether anesthesia is used. In this case, general anesthesia was used, making 24605 the correct code choice. Typically the reduction of a dislocation would be included in the fracture repair, but in this case it is not because there are two different sites of the elbow performed on. Modifier 51 is appended to show more than one procedure is performed. Modifier RT would also be used to indicate it was on the right elbow.

ICD-10-CM Codes: The diagnosis is stated as dislocation of 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 your 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 - *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 in to place. In the Tabular List you need to complete the code with seven characters. The fracture was on the right elbow and this is the initial encounter, S42.441A. For the dislocation of the elbow, look for Dislocation/elbow/traumatic and you are directed to S53.10-. Documentation was specific about the fracture of the elbow being located on the medial epicondyle, but there is no documentation that supports what part of the elbow was dislocated. Turn to the Tabular List to report the sixth and seventh characters. The complete code for the dislocated right elbow is S53.104A.The circumstances surrounding the injury are not known and therefore external cause codes cannot be reported.

Case 5

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

Postoperative Diagnosis: Right long finger trigger finger. [1]
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.

Descripton of Procedure: The patient was taken to the operating room where he was given appropriate anesthesia. The right upper extremity was prepped and draped in the usual sterile fashion. While the draping was going on, the left shoulder was prepped with Betadine and using Xylocaine. Marcaine and Celestone, 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 Esmarch and tourniquet inflated to 250 millimeters of mercury. 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 Al 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. Clean dressing was applied. The patient was awakened and taken to the recovery room in stable condition.

---

[1] Postoperative diagnosis is used for coding.

[2] General anesthesia used.

[3] Shoulder injection.

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

[5] The release of the nerve.

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. Reading the descriptor, we see tendon sheath incision, (eg, Trigger finger). For the shoulder injection, look in the CPT® Index for Injection/Joint, you are directed to code range 20600–20611. The code selection is based on the joint and if an ultrasound was used. The shoulder is considered a major joint making 20610 the correct code and an ultrasound was not used. Modifier 51 should be appended to indicate multiple procedures. An F7 should be appended to the trigger finger release on the long finger and an LT should be appended to the shoulder injection. 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, sixth character 1 is reported for the right finger. For the left shoulder, look for Bursitis/shoulder and you are directed to M75.5-. In the Tabular List, fifth character 2 is reported for the left shoulder. There is no index for impingement of the shoulder. Bursitis can be a cause of shoulder impingement (or rub).

Case 6

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, and then I injected 0.5% Marcaine into the area of the screw heads,

both on the lateral side of the foot and then dorsal midfoot, about 5 mL each area. A small incision through the skin 0.5 cm, and blunt dissection down to the screw head. The screw was removed with the screwdrivers. [4] They 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 retained for the medical record. The following items were discussed: diet, activity, wound care medications if applicable, when to call the physician, and follow-up care.

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[1] Postoperative diagnosis is used for coding.

[2] Stated procedure.

[3] Confirmation of diagnosis.

[4] Removal of hardware.

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 and you are directed to code range 20670–20680. The code selection is based on whether the implant (hardware) is superficial or deep. In the description of 20680, you will see screws are considered deep. The correct code is 20680. Modifier LT should be appended to indicate it is 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); Complications/orthopedic/device or implant/pain refers you to code T84.84. Turn to the Tabular List to complete the code; T84.84XA. According to ICD-10-CM guidelines the seventh character A is reported while the patient is receiving active treatment. ICD-10-CM Guideline I.C.6.b.3(b) states: Postoperative pain associated with specific postoperative complication (such as painful wire sutures) is assigned to the appropriate code(s) 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). The same guideline under I.C.6.b.3 states this: The default for post-thoracotomy and other postoperative pain not specified as acute or chronic is the code for the acute form. In the Index to Diseases and Injuries, 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 7

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 was explained the risks, including but not limited to bleeding, infection, nerve damage and no guarantee of symptom relief. The patient has metastatic lung cancer [4] and has had a right lung resection. The patient agreed and the informed consent was signed.

I palpated for areas of maximal tenderness. Five spots were marked into the right-sided thoracic paraspinal musculature. I then cleaned off his back with chlorhexidine x2. Then a 25 gauge 1.5 inch needle on a 10 cc controlled syringe with Depo-Medrol, 40 mg/mL was used. 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 also going to refill the patient's pain medication. He is seeing an oncologist and is getting Percocet 7.5/500. He takes four a day. That does provide him with pain relief. We are going to 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 which time we will get a urine for follow-up. Emphasized to the patient once again that he had to bring his pills to every appointment according to the opioid contract.

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[1] Postoperative diagnosis is used for coding.

[2] Procedure performed.

[3] Three muscles injected.

[4] Secondary diagnosis for the visit.

[5] This verifies the trigger points injected.

[6] This is the amount and name of of 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). Under trigger point(s) you have a selection between One or Two Muscles and Three or More muscles. The documentation states 3 muscles were injected, directing us to 20553. Verification of 20553 confirms the code selection. RT modifier is appended to indicate the procedure was performed on the right side of the body. The drug used for the procedure is billable also, looking in the HCPCS Level II codebook at the drug table for Depo-Medrol, we are directed to Methylprednisolone acetate, code J1030 each 40 mg. Verifying it in the tabular of the HCPCS Level II codebook, J1030 is billed 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 CA. 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, fifth character 1 is reported to indicate the right lung. Documentation states, "The patient has metastatic lung cancer and has had right lung resection." There is no mention the pain is neoplasm related, so a code from category G89 is not reported.

Case 8

Operative report

Preoperative Diagnosis: Plantar fasciitis left.

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, surgical site was prepped and draped in the normal sterile fashion. Attention was then directed to the left heel where, utilizing a 61 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 then flushed with saline. 1 cc of Depo-Medrol was injected in the op site. Site was dressed with a light compressive dressing. Excellent capillary refill to all the digits was observed without excessive bleeding noted.

Hemostasis: None.

Estimated Blood Loss: Minimal.

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

Pathology: No specimen sent.

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

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

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[1] Postoperative diagnosis is used for coding. In this case, it is the same as the preoperative diagnosis.

[2] Listed procedure.

[3] Description of the fasciotomy.

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, we are directed to 28008. Reading the descriptor, it is indeed an incision into the foot. Modifier LT for the designation of the foot operated on.

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

Case 9

Anesthesia: General anesthesia

Preoperative Diagnosis: Left Achilles' tendon rupture.

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

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

Indications: The patient is 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 some 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 [3] the patient was placed prone on the operating table and all bony prominences were well-padded. The patient received a dose of one gram of Ancef. Under tourniquet control of 250 mm Hg, a longitudinal incision was made followed by an 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. Using a #2 FiberWire® this was placed in a Bunnell type fashion in both the proximal and distal portions of the Achilles' tendon. Another #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 nice secure repair was noted. The ends of the repair were also further augmented with a 2-0 Vicryl suture. The wound was thoroughly irrigated with antibiotics 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 then placed into a short leg cast [6] with the foot slightly plantar-flexed. In addition, the anterior aspect of the cast was then univalved. The tourniquet was deflated for a total tourniquet time of 42 minutes.

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

---

[1] Postoperative diagnosis is used for coding.

[2] Stated procedure.

[3] General anesthesia used.

[4] Rupture of Achilles' tendon verified.

[5] Repair of Achilles's tendon with sutures.

[6] Short leg cast 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 and you are directed to code range 27650–27654. This is a primary repair and no graft was used. 27650 is the correct code.

ICD-10-CM Codes: The rupture is the left Achilles' tendon. In the ICD-10-CM Alphabetic Index, look for Rupture, ruptured/tendon (traumatic) – *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-. It is coded as traumatic because the diagnosis is a result of an injury from the patient playing basketball. Turn to the Tabular List to complete the code; S86.012A. External cause codes are reported to describe the circumstances. The patient was playing basketball and hit by another player. Go to the External Cause of Injuries Index and look for Hit, hitting (accidental) by – *see* Struck by; Struck (accidently) by/other person(s) refers you to W50.0-. Turn to the Tabular List to complete the code; W50.0XXA. The next code is under Activity/basketball directing you to code Y93.67. Because documentation indicates the patient was playing a sport, we can 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. We do not have the location of the activity, so it is not reported.

Case 10

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. Explained to the patient are indications for ORIF as well as possible risks and complications which include but are not limited to infection, bleeding, stiffness, hardware pain, need for hardware removal, no guarantee of functional ambulatory result. The patient and the family understood and wished to proceed.

Procedure in Detail: The patient was brought back to operating room and placed on an operating table, given a general anesthetic without any complications, given preoperative antibiotics per usual routine. He had 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 reduced the triplane fracture. [6] It was confirmed on both AP and lateral X-ray images that the gap was reduced. The patient then had guidewires taken from the Synthes 4.0 mm cannulated screw set, placed one from medial along the epiphysis on the anterior half of the epiphysis and parallel to the joint to catch the lateral aspect of the epiphysis. Then one screw was placed above the physis from anterior to posterior to capture that spike. Once wires were in appropriate position, length was measured, partially threaded 4.0 mm cancellous screws were selected so that all threads were across the fracture site. [7] Appropriate length screws were placed, confirmed by X-ray to be in good position. Fracture was anatomically reduced, and ankle joint was anatomic. The patient had wounds copiously irrigated out. Closure was done with interrupted horizontal mattress 3-0 nylon suture. The patient had sterile compressive dressing, was placed into a 3-sided posterior mold splint, was extubated and brought to 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.

---

[1] Postoperative diagnosis is used for coding.

[2] Stated procedure.

[3] General endotracheal anesthesia used.

[4] Radiologic guidance used.

[5] Confirms fracture and treatment were of the distal tibia.

[6] Fracture reduced.

[7] Internal fixation 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. This code range is for open treatment with internal fixation (ORIF). The treatment was of the distal tibia making 27827 the correct code selection.

ICD-10-CM Code: The diagnosis is stated as a right ankle triplane fracture. 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, this refers you to *see* Fracture, tibia, lower end. Look for Fracture, traumatic/tibia (shaft)/lower end/specified NEC, you are directed to S82.39-. In the Tabular List, the complete code is S82.391A. The only information we have about the injury is that it is the result of a fall. Look in the External Cause of Injuries Index for Fall, falling (accidental) W19.-. In the Tabular List, a seventh character is required for a complete code of W19.XXXA.

Case 1

Preoperative Diagnosis: Recurrent Pleural effusion, Stage IV lung cancer

Postoperative Diagnosis: Recurrent Pleural effusion, Stage IV 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. 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 ChloraPrep, sterile towels, sheets and drapes. We had excellent isolation of the lung. However, we had poor exposure because there were a number of fibrous adhesions, a few of which 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 well and was taken to the recovery room in stable condition.

---

[1] Diagnoses to report if no further positive findings are found in the note.

[2] Indication the procedure is being performed by VATS.

[3] Indicating pleural effusion (fluid around the lung, in the pleural space).

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

[5] Pleurodesis.

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

CPT® Code: 32650

ICD-10-CM Codes: J90, C34.90

Rationale: CPT® Code: For this case the physician is performing a video assisted surgical thoracoscopy (VATS-examining the inside of the chest cavity through an endoscope by the use of a video camera). In this case, an irritant (such as the talc powder) is instilled inside the space between the pleura (the two layers of tissue lining the lungs) to create inflammation which makes an abnormal connection bringing the two pleura together. This procedure (pleurodesis) obliterates the space (pleural cavity) between the pleura and prevents the re-accumulation of fluid. In the CPT® Index look for Pleurodesis/ Thoracoscopic referring you to 32650.

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 guiding 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. 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) guiding you to code C34.9-. In the Tabular List, the complete code C34.90 is reported as there is no documentation as to which lung is affected by the lung cancer.

Case 2

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; tracheostomy [2] tube is inserted and secured with sutures. Patient tolerated procedure well and is sent to recovery without complications.

---

[1] Diagnosis to report for the procedure.

[2] Procedure being performed.

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 guiding 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 when an emergency tracheostomy is performed would be in the Emergency Department in which 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 a planned tracheostomy will be reported. Code 31600 will be reported since there is no age that was documented in the note.

ICD-10-CM Code: In the ICD-10-CM Alphabetic Index, look in the Table of Neoplasms 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 report does not give us that information, so an additional code is not reported.

Case 3

Preoperative Diagnosis: Pedestrian involved in an MVA, left pneumothorax

Postoperative Diagnosis: Pedestrian involved in an MVA, 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. 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 any unexpected trauma. The bronchoscopy was terminated at that time. [4]

A double lumen endotracheal tube was placed per anesthesia. 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 between two ribs and a standard port placement was utilized to gain access to the thoracic cavity. An endoscope is inserted into the chest cavity. Initially we had excellent exposure with good isolation of the lung. [5] We were able to identify a large bleb at the apex of the left lung that was likely to be the source of the chronic air leak. We removed the apex with

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] Diagnosis to report if no further positive finding are found in the operative note.

[2] Indication of two procedures being performed.

[3] Traumatic pneumothorax.

[4] Diagnostic bronchoscopy.

[5] Thoracoscope 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 since there were two different scopes used in two different sites. The first procedure to report is the surgical thoracoscopy removing a wedge section of the left lung through an endoscope. In the CPT® Index look for Thoracoscopy/Surgical/with Therapeutic Wedge Resection of Lung guiding you to codes 32666 and 32667. Code 32667 is an add-on code for additional resections. Therefore, the correct code for this case is 32666. The second procedure code to report is a diagnostic bronchoscopy, which was performed to examine the bronchus for any trauma in that area. In the CPT® Index look for Bronchoscopy/Exploration guiding you to code 31622, 31634, 31647, 31651. There is no mention of balloon occlusion making 31622 the correct code. Modifier 51 is appended to code 31622 to indicate an additional procedure was performed at the same surgical session by the same physician.

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. In the ICD-10-CM Alphabetic Index look for Pneumothorax NOS/traumatic guiding you to code S27.0-. In the Tabular List, a seventh character is required. The complete code is S27.0XXA. Documentation in the Pre and Postoperative headings of the note indicate this was a MVA accident. In the Index to External Cause of Injuries look for Accident/transport/pedestrian/on foot/collision (with)/car guiding you to V03.90-. In the Tabular List, seventh character A is reported for a complete code of V03.90XA.

Case 4

Preoperative Diagnosis:

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

Postoperative Diagnosis: Same.

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

Operative Procedure:
Left sinusotomy (three or more sinuses) to include:

- 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) to include:

- 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] with obscuring of all of the normal landmarks. The right middle turbinate was found and preserved. The residual bode 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 adequately obtained. 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 on the left and right sides. The cottonoids were removed.

The 30-degree wide-angle sinus telescope with endoscrub 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 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] In the above manner, the ethmoid, sphenoid, and maxillary sinuses were cleaned of debris and inspissated mucus suctioned from the frontal recesses.

The patient was then suctioned free of secretions, adequate hemostasis noted. Gelfilm was soaked, rolled, and placed in the middle meati). Telfa gauze was impregnated 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, adequate hemostasis noted, and the procedure terminated. He tolerated it well and left the operating room in satisfactory condition.

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[1] Diagnosis to report if no further positive findings are found in the note.

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

[3] Diagnosis to report for the intranasal polyps.

[4] Diagnosis to report for sinus polyps.

[5] Endoscope being used for the surgical excision. A total excision will be performed with the op note indicating removal performed anteriorly and posteriorly.

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

[7] Maxillary antrostomy.

[8] Diseased tissue removed in the maxillary sinus.

[9] Indicating this is a bilateral procedure.

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

CPT® Codes: 31255-50, 31267-50-51, 31288-50-51

ICD-10-CM Codes: J33.0, J33.8, J33.9

Rationale: CPT® Codes: For this case, the patient is having removal of diseased tissue (including polyps) from three different areas of the sinus cavity through an endoscope. There will be three procedure codes reported for this case. The first code to report is the ethmoidectomy. In the CPT® Index look for Sinus/ Ethmoid/ Excision/with Nasal/Sinus Endoscopy guiding you to codes 31254, 31255. Code 31255 is the correct code to report since the operative note documents anterior and posterior.

In the index look for Sinus/Maxillary/Antrostomy guiding you to codes 31256–31267. Antrostomy means making a surgical opening into the nasal cavity. Code 31267 is the correct code to report. In the index look for Sinus/Sphenoid/ Incision/with Nasal/Sinus Endoscopy guiding you to codes 31287–31288. Code 31288 is the correct code to report.

Modifier 50 is appended to all three codes since these areas were performed bilaterally. Modifier 51 will be appended to codes 31267 and 31288 to indicate additional procedure codes were performed at the same surgical session by the same physician.

ICD-10-CM Codes: Hyperplastic rhinosinusitis is when one has chronic sinus inflammation, which may include polyp formation in the nose and sinuses. In the ICD-10-CM Alphabetic Index look for Hyperplasia, hyperplastic/nose/polypoid guiding you to code J33.9. Documentation in the operative notes states polyps are in the nose and sinuses. In the Alphabetic Index, look for Polyp, polypus/sinus guiding you to code J33.8. Polyp, polypus/nasal/cavity guiding you to code J33.0. Verify code selection in the Tabular List.

Case 5

Preoperative Diagnoses:

1. Sarcoid [1]
2. New onset paratracheal adenopathy [1]

Postoperative Diagnoses:

1. Sarcoid
2. New onset paratracheal adenopathy

Procedure Performed: Mediastinotomy [2]

Description of Procedure: The patient was brought into the OR 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. Standard linear incision was made over the trachea. [3] We were able to dissect down to the pretracheal fascia 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] Hemostasis was obtained without difficulty. The region was impregnated with marcaine, lidocaine, epinepherine mixture. The specimen was sent to pathology. The wound was closed in layers. The skin was closed with subcu stitch and covered with Dermabond. The patient tolerated the procedure well and was taken to the recovery room in stable condition.

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[1] Diagnoses to report if no further positive findings are found in the operative note.

[2] Indication of what procedure is being performed.

[3] Procedure performed with the 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 with an incision 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 biopsy performed.

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 in the trachea. In the Alphabetic Index, look for Sarcoid which directs you to *see also* Sarcoidosis. Look for Sarcoidosis/lymph nodes guiding you to code D86.1. The second diagnosis code is indexed under Adenopathy (lymph gland)/localized guiding you to code R59.0. The localized code is reported because the operative report indicates paratracheal adenopathy. Verify code selection in the Tabular List.

Case 6

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] Catheter was advanced and we were unable to aspirate any fluid. The catheter was removed. Sterile dressings were applied. Chest X-ray will be obtained for followup. Patient tolerated the procedure well.

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[1] Diagnosis to report for this procedure.

[2] Imaging guidance performed.

[3] 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 a thoracentesis and attempted to perform an aspiration (removing fluid) from the pleural cavity (between the lungs and the chest wall) by puncturing the chest with a needle to drain the fluid (thoracentesis). 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, because the 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.

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 guiding you to code J90. Verification in the Tabular List confirms code selection.

Case 7

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 into the operative suite and comfortably positioned on the table. General endotracheal anesthesia was induced. The bed was turned 90 degrees in a clockwise fashion. The alveolar guard was placed over the upper alveolus to protect the teeth. Appropriate drapes were placed. The anterior laryngoscope was then 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 elevation of the mucous membrane off 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 any injury. The 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.

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.

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[1] Diagnoses to report 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] Confirmation to report 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: FFor this case the tumor is on the left vocal cord in the larynx and is removed by direct laryngoscopy using an operating microscope. In the CPT® Index look for Laryngoscopy/Direct 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. Laryngoscope is a type of endoscope. Review the codes; code 31541 is the correct code to report for the procedure performed.

ICD-10-CM Code: The tumor was on the vocal cord. Look in the ICD-10-CM Alphabetic Index for Tumor 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 8

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 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. 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 was started 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 was then 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 patient was sent to recovery in stable condition. Pathology confirmed carcinoma. [4]

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[1] Diagnosis to report if no further findings are found in the operative report.

[2] Video Assisted Thoracoscopy (VATS).

[3] Tumor 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 (video assisted surgical thoracoscopy (VATS)-examining the inside of the chest cavity through an endoscope by the use of a video camera by making an incision between two ribs, and inserting a trocar into the chest cavity). In the CPT® Index look for Thoracoscopy/Surgical/with Lobectomy guiding you to code 32663. The RT modifier is appended to indicate the right lung the procedure is being performed in.

ICD-10-CM Code: You would not code mass of the lung because the operative report indicates that 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) guiding you to code C34.1-. In the Tabular List, fifth character 1 is reported for the right lung. The complete code is C34.11.

Case 9

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 the harmonic scalpel was started distally near the vertex of the femoral triangle towards the fossa ovalis, where safena vein was identified, clipped, and divided, and 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 were kept until the drainage reached 50 mL or less in 24 h. Patient tolerated procedure well and was transferred to recovery in stable condition.

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[1] Diagnoses to report if no further positive findings are in the operative note.

[2] Indication procedure is being performed through a laprascope.

[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 guiding you to codes 38571, 38572. Code 38571 is the correct code since there is documentation of only the pelvic lymph nodes being removed.

ICD-10-CM Codes: According to ICD-10-CM guidelines (Section I.C.2.1.2): *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 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, inquinal/ Malignant Secondary (column)guiding you to code C77.4. Next, look for Neoplasm, neoplastic/penis/Malignant Primary (column) guiding you to code C60.9. Verify codes in the Tabular List.

Case 10

Preoperative Diagnosis: Carcinoma, right lung and bronchus intermedius

Procedure Performed: Bronchoscopy

Description of Procedure: Two liters of oxygen was 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 and 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 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 any complications.

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[1] Indication procedure being performed with a bronchoscope.

[2] Tumor location.

[3] Surgical bronchoscopy of biopsies and brushings.

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

CPT® Codes: 31625-RT, 31623-51-RT

ICD-10-CM Code: C34.81

Rationale: CPT® Codes: For this case two surgical bronchoscopy codes will be reported. The first code reported is for removing 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 of 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. Modifier 51 is appended to this code to indicate an additional procedure code was performed at the same surgical session by the same physician. The RT modifier is appended to indicate the right side of the bronchus.

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) guiding you to code C34.8-. In the Tabular List, fifth character 1 is reported for the right lung. The complete code is C34.81.

Case 1

Preoperative Diagnosis: Severe two-vessel coronary artery disease and moderate 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. He underwent coronary angiography and was found to have a 70% distal left main, an 80% proximal LAD, a 95% proximal ramus intermedius, and a 70% lesion in the proximal diagonal branch. [3] The right coronary artery had no significant lesions. His aortic valve gradient was 40 mm Hg by cath and echo. Because of his presentation with new onset of angina pectoris and significant coronary artery disease, [4] 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. [5] Simultaneously, the greater saphenous vein was harvested from the left leg [6] endoscopically using a small incision. [7] This was then closed in layers with Vicryl and Dermabond. 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 [8] 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 1mm in diameter. The ramus intermedius was identified as well as the diagonal branch which was small. [9] 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 [10] 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 [11] 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 [12] 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 [13] was encountered. This was excised and the annulus debrided of a small amount of calcium. The left ventricle was irrigated with saline. The annulus sized to a 23 mm pericardial tissue valve (Model #3000, Serial # 55555555). The valve was sutured in; [14] in a supra-annular fashion with interrupted 2-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 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 Cable System using four figure-of-eight cables. After pulse irrigating, pulse lavaging and 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.

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[1] Two separate diagnoses, the coronary atherosclerosis and the aortic stenosis, two separate areas of the heart, two separate diagnoses.

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

[3] When vessels have any blockage, that can cause ischemia.

[4] Referring back to the blockages.

[5] This is describing the harvesting of the mammary artery.

[6] This is describing the harvesting of the saphenous vein.

[7] This is the mention of the endoscopic approach vs. an open approach.

[8] This is the indication that coronary bypass was used to complete this procedure.

[9] This indicates the coronary vessels to be grafted and the number in question. Although "native" vessel is not referred to, his symptoms are new, and there is no evidence of previous coronary artery surgery.

[10] This is describing one vein graft.

[11] This describes another vein graft.

[12] This is the third graft, which is an artery graft.

[13] This describes the disorder with the valve.

[14] This describes the valve replacement procedure. This note describes the prosthetic valve being used.

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

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

ICD-10-CM Codes: I35.8, I25.10

Rationale: CPT® Codes: The aortic valve replacement is the most work-intensive procedure and it is located in the CPT® Index under Replacement/Aortic Valve, which directs us 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 and the codebook requires us to *see* Coronary Artery Bypass Graft (CABG). The Index lists several codes and ranges of codes. Reading through the range, 33533 is listed as an arterial graft. The internal mammary artery is the arterial graft. The Index then directs us to Arterial-Venous codes 33517–33523. Code 33518 is the add-on code for 2 venous grafts, listed separately in addition to the arterial graft. Modifier 51 is used because multiple procedures are performed in two distinct areas of the heart. Neither procedure is related to the other. 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 describing the endoscopic method used. Referring to the CPT® Index, look for Bypass Graft/Harvest/Endoscopic to find 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: There are two codes; one for each procedure. Each of the ICD-10-CM codes provide the medical necessity for the procedures. The aortic valve is replaced because of calcification of the aortic valve described within the notes. In the ICD-10-CM Alphabetic Index, look for Calcification/heart/valve, *see* Endocarditis. Look for Endocarditis/aortic (heart) (nonrheumatic) (valve), you are directed to I35.8. For the second diagnosis look in the Alphabetic Index for Disease, diseased/coronary (artery), which directs you to *see* Disease, heart, ischemic, atherosclerotic. This directs you to code I25.10. Verify code selection in the Tabular List.

Case 2

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, hypertension, and mild to moderate obesity, who presents with a positive stress test. Catheterization revealed the left main, circumflex disease as well as total right coronary artery disease. [8]

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

The patient was heparinized. The conduits were prepared for bypass. We proceeded to open 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 proceeded to place a cross-clamp on the ascending aorta and arrested the heart with antegrade and retrograde cardioplegia, topical ice, and cooled down to 32C.

At this point, we exposed the territory of the RPDS. It was found to be a modest target. A reverse saphenous vein [12] graft to right posterior descending artery graft 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 proceeded to perform 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.

At this point, we proceeded to rewarm the patient. The territory of the left anterior descending artery was exposed. The RIMA was prepared. The RIMA to 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 proceeded to de-air the root of the aorta, and at this point proceeded to remove

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| One diagnosis code.

|2| A second diagnosis code.

|3| CABG performed; four vessels.

|4| Bypass 1

|5| Bypass 2

|6| Bypass 3

|7| Bypass 4

|8| Primary Diagnosis, WHY the bypass is necessary.

|9| Endoscopic harvest of vein of lower extremity.

|10| LIMA (Left Internal Mammary Artery) and RIMA (Right Internal Mammary Artery).

|11| Procedure was done with cardiopulmonary bypass.

|12| Reverse saphenous vein grafts are a method of putting the vein in reverse to the arterial blood flow in order to maintain good blood flow without clearing all the valves from the vein before it is utilized.

|13| This describes the first venous graft.

|14| This describes the second venous graft.

|15| This is the first arterial graft.

|16| This was the second arterial graft.

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

CPT® Codes: 33534, 33518, 33508

ICD-10-CM Codes: I25.10, E78.0

Rationale: CPT® Codes: When looking up the codes in the CPT® Index, you first look at CABG because this was the main procedure. CPT® requires us to *see* Coronary Artery Bypass Graft (CABG). Coronary Artery Bypass Graft (CABG)/ Arterial Bypass lists 33533-33536. Reading through the range, 33534 is listed as an arterial graft, 2 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 us to Arterial-Venous codes, 33517–33519, 33521-33523, 33531. When the descriptors are read, 33518 is the add-on code for 2 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 we have the notes to describe the endoscopic method used. Referring to the CPT® Index, see 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: 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 E78.0. Verify code selection in the Tabular List.

Case 3

Preoperative Diagnoses: Critical aortic 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 stenosis. [7] Cath confirmed this diagnosis as well as two-vessel coronary artery disease [8] with a tight proximal left anterior descending artery lesion as well as a tight circumflex lesion, and a 40% right coronary artery lesion.

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

We proceeded to harvest the 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. At this point, we proceeded to cross-clamp 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.

At this point, we proceeded to perform a hockey-stick incision of the aorta approximately 1.5 cm above the right coronary artery. We proceeded to use 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 ventriculoaortic fashion circumferentially. They were then passed through the valve. The valve was seated and tied down [15] without any difficulty. The right and left coronary ostia appeared to be intact and free of any obstruction. There appeared to be no evidence of weakness around the annulus.

We proceeded to rewarm 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 proceeded to remove the cross-clamp and normal sinus rhythm was reinstituted.

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

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[1] These are tertiary diagnoses that will affect her treatment.

[2] Aortic valve replacement.

[3] Coronary artery bypass of two artery grafts.

[4] Both grafts accomplished with venous grafts.

[5] Here are three diagnoses.

[6] This is not considered as a diagnosis because it is a symptom of the aortic stenosis.

[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 to the arterial blood flow in order to maintain good blood flow without clearing all the valves from the vein before it is utilized.

[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: I35.8, I25.10, I10, E11.9

Rationale: CPT® Codes: Modifier 51 is used because multiple procedures are performed in two distinct areas of the heart. Neither procedure is related to the other. The aortic valve replacement can be located in the CPT® Index under Replacement/Aortic Valve, which directs us 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 Index, Coronary Artery Bypass Graft (CABG)/Venous Bypass gives us 33510–33516. Codes 33510–33516 are for venous grafting only. Code 33511 describes 2 coronary 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. Referring to the CPT® Index, we see Bypass Graft/Harvest/Endoscopic, to find 33508.

ICD-10-CM Codes: Each of the ICD-10-CM codes allow for the medical necessity for the procedure. The aortic valve is being replaced because of calcification of the aortic valve described within the notes. Look in the ICD-10-CM Alphabetic Index, for Calcification/heart/valve, see Endocarditis. Look for Endocarditis/aortic (heart) (nonrheumatic) (valve), you are directed to I35.8 *Other nonrheumatic aortic valve disorders*. For the second diagnosis, look in the Alphabetic Index for, Disease, diseased/coronary. You are directed to- *see* Disease, heart, ischemic, atherosclerotic. This refers you to code I25.10.

Next, look in the Alphabetic Index for Hypertension, hypertensive, you are directed to I10. For the final diagnosis look for Diabetes, diabetic you are directed to E11.9. Verify code selection in the Tabular List.

Case 4

Preoperative Diagnosis: Ischemic cardiomyopathy. Intraventricular conduction delay. Congestive heart failure. [1] 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 reapproximate 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.

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

[2] Procedure completed. 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 the leads for the pacemaker and where they were placed.

[7] This describes the new generator and placement.

[8] This is describing the generator was 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, 33229-51, 33225

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

Rationale: CPT® Codes: For this case, the provider opened the chest (thoracotomy), placed two epicardial (on the surface of the heart) leads. 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. The second procedure performed is replacement of the pacemaker pulse generator. Look in the CPT® Index for Pacemaker, Heart/Replacement/Pulse Generator 33227-33229. Report 33229 *Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system*. You must also code the add-on 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. This is found in the CPT® Index under Insertion/Electrode/Heart. Report 33225 *Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of implantable defibrillator or pacemaker pulse generator (eg. for upgrade to dual chamber system.) (List separately in addition to code for primary procedure)*. Check the notes under 33225 and you will see it can be coded in conjunction with 33229. The correct order of the codes is 33202, 33229-51 33225. Modifier 51 is needed to show an additional procedure performed during the same session. Add-on codes are modifier 51 exempt.

ICD-10-CM Codes: Looking in the ICD-10-CM Alphabetic Index for Cardiomyopathy/ischemic, we are directed to I25.54. For the conduction diagnosis, look in the Alphabetic Index for Disorder/conduction, heart and you are referred to I45.9. For the last diagnosis, look in the Alphabetic Index for Failure, failed/heart/congestive, which directs you to I50.9. Verify code selection in the Tabular List.

Case 5

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 any 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 ACT which was greater than 550. The ascending aorta was cannulated without any 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 adhesed, 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 and 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 then proceeded to size 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 proceeded to close the aorta, de-aired the heart with standard maneuvers and removed the cross-clamp. We then weaned the patient off of bypass. There was no aortic insufficiency, good function of the aortic valve, no flow into the aneurysm anymore, with a nice patch repair. We then 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]

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[1] Working diagnosis unless report gives different or more information.

[2] Procedure performed. We will look at the notes to ensure that this is the procedure.

[3] This describes the approach.

[4] Patient was placed on cardiopulmonary bypass.

[5] This is describing how the bypass was performed, not important to the procedure itself. Very important from a legal perspective.

[6] This is the documentation of the aneurysm.

[7] This is telling 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.

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

CPT® Code: 33720

ICD-10-CM Code: Q25.4

Rationale: CPT® Code: Looking in the CPT® Index under Repair/Sinus of Valsalva, or directly under Sinus of Valsalva/Repair, we are given a range of codes, 33702–33722. Reading through these selections, we see 33720 *Repair sinus of Valsalva Aneurysm, with cardiopulmonary bypass.*

ICD-10-CM Code: Look in the ICD-10-CM Alphabetic Index for Aneurysm/sinus of Valsalva, we are lead to Q25.4. In the Tabular List, Aneurysm of sinus of Valsalva (ruptured) is listed under this code as an inclusion term.

Case 6

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 we proceeded at this point to prepare and drape the patient in the usual sterile fashion.

At this point we proceeded to perform a left posterolateral thoracotomy, [5] dividing the muscles the fourth intercostal space was entered. The lung was completely deflated. At the same time we proceeded to expose the left common femoral vein as well as the left common femoral artery and at this point 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. At this point, we proceeded to place 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 proceeded to size the aorta to a 34 mm aortic graft [7] and we proceeded to fashion the proximal anastomosis using 3-0 Prolene with a large needle in a running fashion. We proceeded to nerve hook this suture line and proceeded to tie this down. The posterior suture line of the proximal anastomosis was reinforced with 4-0 Prolene pledgeted stitches. At this point, we removed the cross-clamp and pressurized the anastomoses. Areas of leak were controlled with 4-0 Prolene. At this point, the graft was cut to length and after examining our distal aorta and making sure an appropriate fenestration had been performed we proceeded to fashion an anastomosis again using 3-0 Prolene with a large needle. Before removing the proximal cross-clamp we proceeded to de-air 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 reinstituted 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] Working diagnosis, until report is reviewed.

[2] Surgical approach.

[3] Surgical procedure.

[4] Our first indication cardiopulmonary bypass was used.

[5] This is our approach to this surgery.

[6] Here we note the aneurysm.

[7] Here 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 is included in 33875. Therefore, 33875 describes the procedure.

ICD-10-CM Code: Look in the ICD-10-CM Alphabetic Index for Aneurysm/aorta, aortic/descending/thoracic I71.2. Look in the Alphabetic Index for Dissection/aorta/thoracic and you are directed to I71.01. Verify code selection in the Tabular List.

Case 7

Preoperative Diagnosis: Prosthetic valve endocarditis [1]

Postoperative Diagnosis: Same

Operation: Re-replacement of 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 cave 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 and the annulus debrided, and any thrombus debrided and irrigated. The valve was sized and a 31 mm valve was selected. [5]

Pledgeted 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 reapproximated 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] Working Diagnosis, until the note is read.

[2] This is the working procedure note. 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.

[6] This documents 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 *Replacement, tricuspid valve, with cardiopulmonary bypass*. 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 needs a seventh character. The complete code is T82.6XXA. 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 which directs you to I07.9. Verify code selection in the Tabular List.

Case 8

Preoperative Diagnosis: Multiple varicose veins with severe pain in the leg. [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] Dilated tortuous segments of the greater saphenous vein and lesser saphenous vein were also removed. Most of the greater saphenous vein was removed. 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] Working diagnosis.

[2] Working procedure until note is reviewed.

[3] This is the documentation of removal. Reading the long and the shorter saphenous veins as those that were done.

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, we are directed to a range, 37718–37735, and 37780. There is also an entry for Varicose, 37765–37766. Looking at the Varicose vein entries, we see these are stab phlebotomies of the extremities. When we read the entries for the saphenous veins, we see that 37718 is the short saphenous vein, and 37722 is the long (greater) saphenous vein. There is no note excluding the coding of both, so we use 37722 with modifier RT to designate the right side, and 37718 for the lesser (short) saphenous, with modifier RT for the right side of the body. Modifier 51 denotes additional procedures during the same session.

ICD-10-CM Code: Looking in the 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 section in the report indicates that the right leg is performed on. Verify code selection in the Tabular List.

Case 9

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 with staples. At the end of the procedure the patient's condition remained stable.

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[1] Working diagnosis until note is read.

[2] Working procedure code, until report is read.

[3] Approach used to gain access to the pericardium.

[4] The pericardium is cut open for drainage.

[5] All body fluids retrieved during any procedure are sent to the lab for pathological workup.

[6] A tube is placed and left in the chest.

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 draining tube is placed to allow continuous drainage. In the CPT® Index look for Pericardial Window/Creation/for Drainage directs you to codes 32659, 33025. Code 33025 is reported for an open procedure. Code 33015 is reported 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 code I31.4. Verification in the Tabular List for I31.4 instructs you to code first the underlying cause. We are given malignant effusion due to the pericardial metastasis from the lung in the diagnostic statement. ICD-10-CM Coding Guideline, I.C.2.f., Admission/Encounter to determine 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 — *see* Neoplasm, malignant, by site. Go to the Table of Neoplasms and look for Neoplasm/heart/Malignant Secondary C79.89 and Neoplasm/lung/Malignant Primary C34.9-. Verify in the Tabular List. C79.89 Secondary malignant neoplasm of other specified site, and C34.90 Malignant neoplasm of unspecified part of unspecified bronchus or lung. Report only C79.89, C34.90. The effusion is a symptom of secondary metastasis of the pericardium.

Case 10

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-Catheter 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 applied. The patient is to be transported to the ICU where a postprocedural X-ray will be taken.

_____

[1] Working diagnosis until report is read.

[2] Catheter.

[3] Working description of 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/Central/non-tunneled, we 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 Alphabetic Index for Failure, failed/renal/acute, you are directed to code N17.9. Verify code selection in the Tabular List.

Case 1

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 carefully 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 divided with a 10 mm LigaSure Impact. The bowel was circumferentially cleared of fat proximally and distally and each end 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.

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[1] General Anesthesia.

[2] Lying on back with legs in stirrups.

[3] Cutting around the outlet to release it from the abdomen 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.

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 at a stoma (ileostomy), 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 bowl. In the CPT® Index, look for Enterostomy/closure. This guides you to 44227, 44620, 44625, 44626; 44626 includes colorectal anastomosis (reconnection of the colon and rectum). This note supports only the bowel reconnection, as reported using 44625.

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, which refers you to Z43.2. The second code describes history of rectal carcinoma. In the Alphabetic Index look for History/personal (of)/malignant neoplasm (of)/rectum NEC, which guides you to Z85.048.Verify code selection in the Tabular List.

Case 2

Preoperative Diagnosis: Right-sided colonic polyps

Postoperative Diagnosis: Right-sided colonic polyps

Procedure: Laparoscopic right hemicolectomy with ileocolic anastomosis.

Procedure as Follows: 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 canula. 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 divided with a GIA 100 mm stapler with 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 with a GIA 100 mm stapling device with blue cartridge between the remaining ileum and colon. [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 secured with a GIA 100 mm stapling device with 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 #1 Vicryl plus figure-of-eight sutures. The subcutaneous layers were irrigated and verification of meticulous hemostasis. 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.

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[1] General anesthesia.

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

[3] Type of Laparoscopic instrument.

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

[5] These instruments slide into the post on the trocar.

[6] Pulled to outside the cavity thru the extended incision.

[7] The division of the colon.

[8] Device used to seal or divide.

[9] Reattachment of the two ends of the colon; ileocolostomy.

[10] The externalized colon is reinserted into the abdominal cavity.

[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). From the CPT® Index, look up Colectomy/Partial/with Ileocolostomy Laparoscopic, which leads to 44205.

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

Case 3

Procedure: Uvulopalatopharyngoplasty.

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

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 [1] with a combination of blunt and cautery dissection. The posterior pillar remained intact as I proceeded to do the similar mobilization of the left tonsil. [2] 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. 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 en toto. 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 returned to Anesthesia, extubated, and brought safely to the recovery room.

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[1] Right tonsillectomy; not billable included in the primary procedure.

[2] Left tonsillectomy; not billable 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 uvulo-

palatopharyngoplasty, as reported by 42145. The operative note documents that the uvula, edge of the soft palate, and both tonsils were removed, which also points to 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 G47.33. The Tabular List verifies that G47.33 is correct for obstructive sleep apnea.

Case 4

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 preop 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] CO_2 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 is 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 mL in diameter. The staple line is then oversewn with a running 2-0 Vicryl suture. Good hemostasis was achieved.

Then I proceeded to perform 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.

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[1] Longitudinal—Sleeve.

[2] Laparoscopic procedure.

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

[4] This is done to verify there is not bleeding, punctures, etc and is not reported separately.

[5] The small incisions are closed—and 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 intraoperative esophagogastroduodenoscopy is performed to make sure that there is no post-op bleeding or leakage in the upper GI and is 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, which guides you to E66.01. The next code is for the body mass index (BMI) of the patient. A color prompt note with subcategory code E66 indicates to use an additional code to identify body mass index (BMI), if known (Z68.-). Code Z68.41 describes a BMI of 40. This can be located in the Alphabetic Index under Body, bodies/mass index/adult/40.0-44.9. Verify code selection the Tabular List.

Case 5

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. They were 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-proline were placed and the abdomen was entered under direct vision. A Hassan canula [2] was anchored in place with the stay sutures and the abdomen was insufflated to 15 mm Hg with CO_2 gas.

A 10 mm, 30-degree scope was assembled, focused, white-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 Trendelenberg position [3] with 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 were hemostatic.

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's 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.

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

[2] Brand of Laparoscopic instrument.

[3] Head up.

[4] This is a fluoroscopic look at the bile ducts to that the contrast agent/dye has reached the areas of the bile ducts. 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, K85.9

Rationale: CPT® Code: The gallbladder is removed laparoscopically. X-ray examination, including injection of a contrast dye in to 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, 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 we need to see a separate report or addendum for the interpretation of the cholangiogram and who interpreted it.

ICD-10-CM Codes: The 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, which directs you to K80.10. Next, look for Pancreatitis/acute K85.9. Verify code selection in the Tabular List.

Case 6

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, placed on the OR table in supine position. Once endotracheal anesthesia was achieved and preop 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. CO_2 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 this was done under appropriate videoscopic observation. [2]

The procedure begins with identification of the GE 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 Steri-Strips, creating a pouch, which is 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 suture 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 is 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.

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[1] Demonstrates medical necessity.

[2] This is a laparoscopic procedure.

[3] Where the stomach connects to the esophagus.

[4] The angle of His is the acute angle created between the cardia at the entrance to 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] Gastroentestinal tube used for analysis and emptying the stomach names after the man who designed it.

[6] Useful landmark for finding the beginning of the jejunum.

[7] A blue dye is sent thru 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 and performing a small bowel division with anastomosis to the proximal stomach (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. The first code is found in the ICD-10-CM Alphabetic Index, under Obesity/severe E66.01. The second code is found under Hypertension I10. In the Tabular List, category E66 indicates to report an additional code for the body mass index (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 7

Extent of Examination: Upper Gastrointestinal Endoscopy

Reason(s) for Examination: GERD

Description of Procedure: Informed consent was obtained with the benefits, risks, and alternatives to upper GI endoscopy explained, including the risk of perforation, and the patient agreed to proceed. No contraindications were noted on physical exam. Anesthesia administered by Intensive Care Unit Staff. (See Anesthesiologist report) Monitored anesthesia care (MAC) was administered. The procedure was performed with the patient in the left lateral decubitus position. The instrument was inserted 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. [1]

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[1] The highlighted areas were seen and constitute 43235.

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 correct code for this case.

ICD-10-CM Code: The indication for this procedure is gastroesophageal reflux (GERD). In the ICD-10-CM Alphabetic Index, look for Reflux/gastroesophageal K21.9. 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 with the benefits, risks, and alternatives to colonoscopy explained, including the risk of perforation, and the patient agreed to proceed. No contraindications were noted on physical exam. Monitored anesthesia care (MAC) [1] was administered. The bowel was prepared with GO-LYTELY 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 and hemorrhoid is noted.

The procedure was performed with the patient in the left lateral decubitus position. [2] The instrument was inserted to the terminal ileum. [3] The cecum was identified by the following: the ileocecal valve, 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 or granularity. 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 or ulcerations. 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] Lying on his left side—semi fetal position.

[3] Scope inserted in rectal area to ileum.

[4] Biopsy taken from two locations.

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 up Colonoscopy/Flexible/Biopsy, which refers you to 45380, 45392. Code 45380 is correct in this case.

ICD-10-CM Codes: The indication for this procedure is for iron [Fe] deficiency anemia. This is found in the ICD-10-CM Alphabetic Index under Anemia/deficiency/iron D50.9. The operative note documents that internal hemorrhoids were seen in the examination. This is indexed under Hemorrhoids/internal 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 LAR and colonic J pouch for closure of loop ileostomy [1]

Description of Procedure: Informed consent was obtained with the benefits, risks, and alternatives to colonoscopy explained, including the risk of perforation, and 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 exam a digital 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 following: 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, hypervascularity was seen. There was no mucosal bleeding. In the proximal descending colon, moderate segmental inflammation with erythema, granularity, friability, hypervascularity was seen. In the rectum, an abnormality was noted:

Anastomosis—patent and normal. [4] No evidence of polyp. Just proximal to anastomosis—significant diffuse colitis. [5]

---

[1] Patient has had previous surgical procedure—this is a "look-see" for any further problems.

[2] IV anesthesia with medications—not general anesthesia.

[3] Lying on left side in semi-fetal position.

[4] Area with sutures placed previously 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. This is found in the ICD-10-CM Alphabetic Index under Colitis K52.9. The second code is for the history of rectal cancer. This is indexed under History/personal(of)/malignant neoplasm (of)/rectum Z85.048.

Case 10

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, and alternatives to sigmoidoscopy explained, including the risk of perforation, and the patient agreed to proceed. No contraindications were noted on physical exam. Patient re-examined; and no interval changes noted from preoperative History & Physical. After being placed on the table, patient identification was verified prior to the procedure. Immediately prior to sedation for endoscopy the patients ASA Classification was Class 2: Mild systemic disease. Monitored anesthesia care (MAC) was administered. [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 sigmoidscope 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 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.

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[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.

Urinary System and Male Genital System

Case 1

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 and 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 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]

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[1] Diagnosis to report, if no further positive findings are found in the report.

[2] Anesthesia, local or general, is usually not reported by the physician performing the procedure. This information is for documentation purposes only.

[3] The surgery will be performed through a cystourethroscopy.

[4] The location of the tumor to report as the definitive diagnosis.

[5] Retrograde radiological imaging (supervision & interpretation) of the kidneys and ureters.

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, 52234–52240. 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 location, so modifier 26 is appended. 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.

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 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) referring you to code C67.4. Verify code selection in the Tabular List.

Case 2

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. 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 of 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 has 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]

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[1] Diagnosis if no other positive findings are found in the operative note.

[2] Indication that the surgical procedure will be performed through a cystoscope.

[3] Transurethral resection of the bladder tumor.

[4] Pathology report indicating carcinoma and diagnoses to report.

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 is having a large bladder tumor removed by excision through a cystoscope. In the CPT® Index, look for Bladder/Endoscopy/Excision/Tumor (52234, 52235, 52240, 52355).

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 reports using 52240.

Catheter insertion is not a reportable procedure within cystoscopy procedures, unless otherwise stated.

ICD-10-CM Codes: The postoperative heading in the operative report has the diagnosis as Bladder/prostate tumor. In the operative note the pathology report confirmed cancer. These diagnoses are reported instead because the cancer has been proven by the pathology report. 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), which guides you to 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 code selection in the Tabular List.

Case 3

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] Diagnosis to report if no further findings are found in the operative note.

[3] Indication of a diagnostic cystoscopy.

[4] Indication that a surgical endoscopy was not performed.

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

CPT® Codes: 52000

ICD-10-CM Codes: N32.9

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/Endsocopy (52000).

ICD-10-CM Codes: Because there were findings of new bladder lesions, you will 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," you will report N32.9. Do not report a bladder cancer code because that diagnosis has yet to be proven. The patient had bladder cancer in January. In the Alphabetic Index, look for History/personal (of)/malignant neoplasm (of)/bladder Z85.51.

Case 4

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 2 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 2 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 reapproximated 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.

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[1] Diagnosis to report for this surgery if there are no further findings in the operative note.

[2] Age of the patient.

[3] Type of penile nerve block provided for the circumcision.

[4] Surgical incision being made, instead of using a clamp or device.

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 have only to decide the age of the patient to determine the appropriate CPT® code. In the CPT® Index, look up Circumcision/Surgical Excision (54161). This is the correct because this patient is not a newborn (less than 28 days old). Penile block would not be reported because this is inclusive in the surgical services.

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 5

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 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 identify the renal vein and then with these structures localized, the ureter was identified.

Careful dissection was done to mobilize the ureter and identify the area of the stone impaction by palpation.

The ureter was then opened longitudinally and ureteral stent was identified. The multiple 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 reapproximated 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 recovery area in satisfactory condition.

_____

[1] Diagnosis to be reported if no further positive findings are found in the operative note.

[2] Indication that this surgery was performed by open approach.

[3] Surgical removal of the stone 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 incision in the ureter to remove the stone 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 will notice in the "Intraoperative Findings" that the surgeon states the proximal ureter is the area of concern. Therefore, you would code this procedure 50610. There are no other reportable procedures within this report.

ICD-10-CM Code: In the ICD-10-CM Alphabetic Index, look for Calculus, calculi, calculous/ureter, which guides you to N20.1. Verify code selection in the Tabular List.

Case 6

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 he 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 midline 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. Did 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 2 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 continence. [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 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 5 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 and his catheter was again irrigated with return of blue urine. No clots.

The patient was extubated, taken to the recovery room in good condition.

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[1] Diagnosis to report for the surgery if there are no further positive findings found in the operative note.

[2] Indication that 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: In the index, look for Prostatectomy. The operative note documents that a radical prostatectomy was performed via an incision in the retropubic space, which guides you to 55840–55845, 55866. Code 55845 is correct because there was a 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 7

Operative Note

Preoperative Diagnosis: Left renal calculus

Postoperative Diagnosis: Left renal calculus [1]

Procedure: ESWL 2300 shocks at 22kV.

Description of Procedure: After 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 where with fluoro whether that was still present. The patient appeared to tolerate the procedure well and was brought to recovery room in stable condition. He will follow up in 1 week for possible stent removal, KUB prior to procedure.

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[1] Diagnosis to report if 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 index, look for Shock Wave Lithotripsy (50590). 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 8

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 were 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] Diagnosis to report if no further positive findings are found in the operative note.

[2] 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. 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.

Had there been no documentation that the ultrasound department assisted in the ultrasound imaging, you also would report 76942 with modifier 26 appended. The radiology department would report 76942, with modifier TC appended. The documentation here does show the ultrasound department assisting with the imaging, indicating that the Radiology department 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 9

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 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 then very carefully dissected down to the level of the internal ring. [4] There did not appear to be any 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. Therefore, 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 Scarpas 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 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 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.

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[1] Diagnoses to report if no further positive findings are found in the operative note.

[2] 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] Left side is indicated as being surgically preformed, making it a bilateral procedure.

[7] Hernia repair.

[8] Fixation of the left undescended testicle.

[9] Surgical circumcision being performed.

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

CPT® Codes: 49505-50, 54640-50-51, 54161-51

ICD-10-CM Codes: K40.90, Q53.20, 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. 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, in reporting the bilateral orchiopexy and bilateral hernia repair, you would report codes 49505 and 54640 with modifier 50 appended to both codes.

Circumcision codes are 54150–54163. By reading the descriptions of the circumcision procedures, you would immediately 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.

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, hernial/inguinal K40.90. Next, look for Undescended/testicle - *see* Cryptorchid. Cryptorchid, cryptorchism, cryptorchidism/bilateral guides you to Q53.20. Next, look for Circumcision which guides you to Z41.2. Verify code selection in the Tabular List.

Case 10

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 anymore 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.

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[1] Diagnoses to report if no further positive findings are found 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. It is injected into the tissues of the urethra. The Durasphere is not reported by the physician; however, it is appropriate for the facility to report the Durasphere on their claim.

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 also report any 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 1

Diagnoses: Stage III cystocele, stage II uterine prolapse. [1]

Procedure: Pessary fitting.

Indications: A 75-year-old, gravida 2, para 2, [2] female with pelvic organ prolapse. She had atrophic vaginitis so we had her use Premarin vaginal cream twice a week for 6 weeks. She is back for a pessary fitting today.

Findings: She has a third-degree cystocele, and now third-degree uterine prolapse. [3] Her vaginal tissues are improved, although still atrophic, but much less thin than prior appointment. She has a stage I, rectocele.

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 it in for 10 or 15 minutes and went up and down the stairs. She definitely was able to void easily with that 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 over night. 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.

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[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 two pregnancies with two term births.

[3] The diagnosis is cystocele with uterine prolapse. Stage 3 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. From 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 II; however, in the findings it is stage III prolapse. In the ICD-10-CM Alphabetic Index, look for Cystocele/female/with prolapse of uterus - *see* Prolapse, uterus. Prolapse, prolapsed/urterus/third degree guides you to N81.3. Verify the code selection in the Tabular List.

Case 2

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, [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 but the endometrial biopsy showed evidence of active endometritis. 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 so we did put her in lithotomy position using Yellofin stirrups, but kept her legs without any bend and positioned 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 could be entered safely using Mayo scissors. The cardinal ligaments were clamped and cut bilaterally. The utero-ovarian 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. 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. [10] 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 [11] and the rectovaginal fascia posteriorly [12] 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. [13]

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 had been 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.

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[1] Procidential means prolapse.

[2] UTI.

[3] Select codes for the definitive diagnoses.

[4] All of these problems will be 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.

[6] Lithotomy is typically supine with the knees bent and legs elevated in stirrups but this unusual position does not change 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 ovaries were not removed, only examined. The final code choice includes this information.

[19] Control of bleeding is included in surgical procedures and cannot be billed separately unless it is performed at a separate surgical session.

[11] Anterior colporrhaphy.

[12] Posterior colporrhaphy.

[13] Colpopexy using uterosacral ligaments by vaginal approach.

[14] Cystoscopy performed only to verify that there was no damage to the bladder during the procedure cannot be billed separately but in this case the patient's recurrent infections support the separate medical necessity allowing the procedure to be billed.

[15] This is a thickening of the bladder muscle.

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

CPT® Code: 58260-51, 52000-59

ICD-10-CM Code: N81.3, N95.0, N39.0, N32.89

Rationale: CPT® Codes: A vaginal hysterectomy where the uterus is not weighed must be coded to the lesser weight, which is reported with 58260. In the CPT® Index, look for Hysterectomy/Vaginal. The colpopexy (57283) and anteroposterior colporrhaphy (57260) are included in 58260, because the pelvic floor must be closed following a vaginal hysterectomy. Code 52000 reports the cystoscopy. This would usually be bundled into the other procedures when it is performed only to verify that there is no damage to the bladder during the procedure but in this case the patient's recurrent bladder infections (UTIs) support the separate medical necessity allowing the procedure to be billed. Modifier 59 is reported on code 52000 because this is a separate procedure; per CPT® guidelines modifier 59 is reported on a separate procedure code to indicate that the procedure is not considered to be a component of another procedure but distinct, independent procedure.

ICD-10-CM Codes: The patient is diagnosed with a cystocele and the uterine prolapse. From 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 patient is also diagnosed with a recurrent UTI which is found in the Alphabetic Index under Infection/urinary (tract) N39.0. The cystoscopy showed trabeculation of the bladder. Look in the Alphabetic Index for Trabeculation, bladder referring you to N32.89. Verify code selection in the Tabular List.

Case 3

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 grossly normal. Vagina is long, need extra long Pederson speculum. 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. 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 3 times, has given birth to a term infant one time, has had 2 abortions/miscarriages and has 1 living child.

[2] Abnormal cervical Pap smear would be the diagnosis.

[3] Low-Grade Squamous Intraepithelial Lesion is documented as possible so it would not be 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 LEEP biopsy and Pap smear test. In the CPT® Index, look for LEEP Procedure. You are referred to 57460. Review the code description to verify the code accuracy.

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) which is R87.819. Verify code selection in the Tabular List.

Case 4

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 4086 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 3 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 Mirena IUD 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 noted at the tenaculum site after removal.

The patient tolerated the procedure well and was given 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 intrauterine birth control device.

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

CPT® Code: 58300, J7302

ICD-10-CM Code: Z30.430

Rationale: CPT® Code: The provider inserts an IUD. To locate the code, look for Insertion/Intrauterine Device (IUD). Review of the code description verifies that 58300 is the correct code. Because the Mirena IUD is inserted in an office setting, the physician can report a HCPCS code for the product/supply. In the HCPCS codebook go to the Table of Drugs and Biologicals and look for Mirena which directs you to see Levonorgestrel Releasing Intrauterine Contraceptive; this refers you to code J7302.

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 5

ABC Hospital

Indication: A 30-year-old G0P0Ab0 [1] with irregular periods and mild male factor. She is infertile and would like to start a clomid/iui [2] cycle and requires hysterosalpingogram for evaluation.

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 3 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 insufflated 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] Clomid is a fertility drug known as an ovulatory stimulant. IUI stands for intrauterine insemination.

[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 S&I of a hysterosalpingography. This procedure is 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 6

Procedure Performed: Amniocentesis.

Indications: The patient is a 28-year-old G4 P2103 [1] at 36 2/7, 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 fetal cardiac activity was seen following the procedure. The patient was sent for a follow-up NST. Rhogam is not indicated as the patient is already sensitized.

---

[1] This patient has been pregnant 4 times (counting her current pregnancy), She has had a term birth 2 times. One of the deliveries produced twins the other was a single birth thus she currently has 3 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 there is no diagnosis specified in this note we can pull the diagnosis and medical necessity from the indications. If this information was not present here the service could not be billed without 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: O36.0930, O09.893, Z3A.36

Rationale: CPT® Codes: The provider performs amniocentesis with ultrasound guidance in the office. To locate the code, look for Amniocentesis/Diagnostic in the CPT® Index. You are referred to 59000. There is a parenthetical statement under code 59000, which instructs you to report code 76946 for radiologic S&I. This procedure was performed in the provider's office so 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 the ICD-10-CM Alphabetic Index, look for Pregnancy/complicated by/Rh immunization, incompatibility or sensitization NEC O36.09-. In the Tabular List, additional characters are required. The patient is 36 weeks pregnant, placing her in the third trimester (O36.093-). The code requires a seventh character to indicate the fetus affected. 0 is reported for single gestation making the complete code O36.0930. A patient with Rh isoimmunization is a high risk pregnancy patient. In the Alphabetic Index to Diseases, look for Pregnancy/complicated by/high-risk - *see* Supervision (of)(for), high-risk; Pregnancy/supervision/high-risk/specified NEC refers you to O09.89-. In the Tabular List, sixth character 3 is reported for the third trimester. 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 7

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 2nd 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 8 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 3 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.

[5] This is an additional diagnosis.

[6] This is an occipital posterior presentation with the cord not around the baby's neck.

[7] This is a measure of the health of the baby at birth. 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. 2nd degree laceration makes this delivery complicated and code 650 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. There is no mention of an incision made for a Ceserean delivery. Code 59400 represents routine obstetric care antepartum and postpartum and the vaginal delivery. To locate the code in CPT® Index, look for Vaginal Delivery/routine care.

ICD-10-CM Codes: This is a complicated pregnancy by the 2nd 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 O70.1. Also documented is meconium in the amniotic fluid. Look in the Alphabetic Index for Delivery/complicated by/meconium in amniotic fluid O77.0. According to ICD-10-CM Guidelines, Section I.C.15.b.5. indicates a code from category Z37, Outcome of delivery 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, Weeks of gestation, to identify the specific week of pregnancy. Look in the Alphabetic Index for Pregnancy/weeks of gestation/39 weeks which directs you to Z3A.39. Verify code selection in the Tabular List.

Case 8

Diagnosis: Intrauterine pregnancy at 20-5/7 weeks with multiple fetal anomalies.

Procedure: D&E [1]

Anesthesia: Moderate sedation.

Indications: The patient is a 29-year-old gravida 1 [2] at 20-5/7 weeks with multiple fetal anomalies, who desires a termination of pregnancy. She has previously had dilators placed. [3]

Description of Procedure: The patient was brought to the operating room, and moderate sedation [4] was administered. The patient then placed in the dorsal lithotomy [5] position and was prepped and draped in usual sterile fashion.

The dilators 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. [8] There was no respiratory or cardiac effort noted. Bierer forceps were then used to remove the placenta intact. A speculum was placed, and an atraumatic tenaculum was placed on the anterior lip of the cervix and a standard D&C was then performed until the characteristically gritty texture was noted on the endometrium. 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 to this 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

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[1] Dilation and evacuation.

[2] Gravida represents number of pregnancies the woman has had. Thus, gravida 1 means this is her first pregnancy.

[1] Placement of cervical dilators may be separately billed with code 59200 if not performed on the day of another procedure performed through vaginal approach.

[4] Although the abortion codes do not include conscious sedation, MAC anesthesia implies that this 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] This indicates the dilation was 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.

[8] This is the evacuation of the uterus. The fetus and placenta were removed separately due to the size of the fetus and then the uterus was curettaged to remove any retained products.

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

CPT® Code: 59841-22

ICD-10-CM Codes: O35.9XX0, Z33.2, Z3A.20

Rationale: CPT® Code: The procedure performed is an induced abortion with dilation and evacuation due to the management of the mother caused by fetal abnormalities. From the CPT® Index, look for Abortion/induced/by dilation and evacuation. Modifier 22 is reported because the patient is over a 20 week gestation period.

ICD-10-CM Codes: The encounter is for an induced legal abortion due to fetal abnormalities (termination of the pregnancy). Code O35.9XX0 represents a known or suspected fetal abnormality affecting the management of the mother. Look in the ICD-10-CM Alphabetic Index for Pregnancy/complicated by/fetal abnormality or damage O35.9-. In the Tabular List, seventh character 0 indicates single gestation. Two dummy placeholders (Xs) are used to keep the seventh character in the seventh position for a complete code of O35.9XX0. In the Alphabetic Index, look for Termination/pregnancy, elective which refers you to Z33.2. In the Tabular List, at the beginning of Chapter 15 for Pregnancy, Childbirth and the Puerperium, a note indicates to report an additional code from category Z3A, Weeks of gestation, to identify the specific week of pregnancy. Look in the Alphabetic Index for Pregnancy/weeks of gestation/20 weeks which directs you to Z3A.20.

Case 9

Anesthesia: General with LMA.

Preoperative Diagnosis: Sterilization

Postoperative Diagnosis: Sterilization [1]

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 with insufflation 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 for the postoperative diagnosis.

[2] Indicates method of the tubal ligation.

[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 rings on the right and left tubes. The method dictates the proper code selection. In the CPT® Index, look for Fallopian Tube/Occlusion/Endoscopic. You are referred to 58671.

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 10

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 three o'clock and nine 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 twelve 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.

Case 1

Preoperative Diagnosis: Right thyroid follicular lesion.

Postoperative Diagnosis: Right thyroid follicular lesion. [1]

Operative Procedure: Right thyroid lobectomy.

Findings: A large thyroid mass in the inferior aspect of the right thyroid. [2] 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 as 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 the prepped and draped in a standard surgical fashion. Using a #15 blade, a linear incision was made approximately two centimeters 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 left thyroid lobe. [3] 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 then 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 8, 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 positive findings are found in the note.

[2] Findings used for diagnosis.

[3] Isthmus was removed with the right thyroid lobe.

[4] 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. 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. 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.

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. [2] Using the harmonic scalpel, two-thirds of the left thyroid lobe was removed and the isthmus was removed sparing the parathyroids and staying clear from the recurrent laryngeal nerve. [3] Once this was completed, hemostasis was achieved using electrocautery and Surgicel. Due to some bleeding around the parathyroid gland, Gelfoam and thrombin were placed over this area and the bleeding had 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] Right thyroid lobe removed.

[3] Two-thirds of the thyroid is 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. 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 isthusectomy.

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 Table of Neoplasms for Neoplasm, neoplastic/thyroid (gland)/Malignant Primary (column) 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: 85% thyroidectomy (subtotal)

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 2006 with a papillary carcinoma of the thyroid. [3] Thyroidectomy was recommended to her; however due to the fact that 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 scanning, sestamibi scan for metastatic disease, etc. I recommended to her that we proceed with a subtotal thyroidectomy, i.e. 85% resection 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 through the platysma muscle and then flaps were 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, entirely a different feel from that of the right lobe.
We began on the left side with mobilization of the interior pole. Vessels were serially clamped, cut, ligated, on the thyroid side. 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 [4] 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. [5] 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 removed the left lobe [6] 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 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. [7] We mobilized the right lobe of the thyroid and left approximately 10% of the right lobe of the thyroid intact [8] 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, drain secured with a 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 80cc. Sponge and needle counts were correct times two.

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[1] Diagnosis to report if no further positive findings are found in the note.

[2] This is a working diagnosis, there is no confirmation of this in this record.

[3] Confirmation of diagnosis.

[4] Lymph node attached to gland is removed with the gland.

[5] Several large lymph nodes removed as well.

[6] Left lobe removed.

[7] Biopsy negative for parathyroid cancer.

[8] Part of the right lobe 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.

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)/Malignant Primary (column) C73. Verify code selection in the Tabular List. If the lymph nodes appearing metastatic are confirmed by pathology before coding, it would be coded as a secondary CA in addition to the thyroid CA.

Case 4

Preoperative Diagnosis: Post-hemorrhagic hydrocephalus.

Postoperative Diagnosis: Post-hemorrhagic hydrocephalus. [1]

Operation:

1. Insertion of left frontal ventriculoperitoneal shunt.
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 2nd 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 secured then the deep rectus fascia with hemostats, elevated this, and opened this sharply. The underlying peritoneum was visible. This was secured and opened, allowing passage easily 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 retroauricular 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 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 2 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] There is no documentation to support the removal.

[3] This tells us we are still in the post op period of the EVD.

[4] This was a planned procedure.

[5] Peritoneal portion of the ventriculo-peritoneal shunt.

[6] Burr hole created, but is included in placement of the shunt.

[7] Ventricular portion of the ventriculo-peritoneal shunt.

[8] Insertion of ventriculoperitoneal shunt.

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

CPT® Code: 62223-58

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. 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 ventriculo-peritoneal shunt which is reported with 62223. Modifier 58 should be used to indicate it is a related, more extensive procedure.

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

Preoperative Diagnosis: Acute epidural hematoma [1]

Postoperative Diagnosis: As above

Anesthetic Agent: General Endotracheal

Operation: Left craniotomy for evacuation of epidural [2] hematoma (emergent)

Indications: The patient presented with a history of a motor vehicle accident. [3] He presented to the emergency room neurologically intact but while there became gradually less responsive and required intubation. [4] 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, prepped and draped in the usual sterile fashion for a left frontotemporal parietal craniotomy. [5] A curvilinear incision was made beginning just anterior to the left ear curving posteriorly than upward and anteriorly to and at the hair line just off the midline. The resulting musculocutaneous flap was then reflected anteriorly. Multiple burr holes [6] 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 clots 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 correlation. 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] The location of the hematoma will assist in CPT® code selection.

[3] The patient is in the acute phase of treatment for injuries caused by the MVA requiring an E code.

[4] Indicating loss of consciousness.

[5] Procedure performed. Knowing this is a parietal craniotomy will assist in code selection.

[6] Burr holes 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. 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 sixth character identifies if there is a loss of consciousness and for how long and the seventh character is for the type of encounter. The patient became less responsive, but there is no statement of loss of consciousness. With no loss of consciousness, a sixth character 0 is reported (S06.4X0-). The seventh character is A for an initial encounter. Complete code is S06.4X0A.

The patient was brought in after a motor vehicle accident, requiring an external cause code. In the Index to External Cause of Injuries, look for Accident/motor vehicle NOS and the default code is V89.2- (Documentation does not tell what type of traffic accident it was). Turn to the Tabular List to complete the code. V89.2XXA is the correct code.

Case 6

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 L4–L5 and L5–S1 with fluoroscopic guidance.

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 fluoroscopy assistance, [2] first to the right and then to the left 20-degree, the scotty-dog view was identified, and we were able to place the spinal 22-gauge needle first to the right L4–L5, then right L5–S1, then to the left L4–L5, and then to left L5–S1. [3] 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 and 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.

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[1] Diagnosis to report if no further positive findings are found in the note.

[2] Fluoroscopic guidance used.

[3] Injection points.

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. The code selection is dependent on the location of the injection and how many levels are injected. Code range 64493–64495 are for the lumbar or sacral. 64493 is reported for the first level (L4–L5). 64494 is reported for the second level (L5–S1). Modifier 50 is appended since both levels were bilateral. Flouroscopy is included and therefore, 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/disc disease and you are directed to *see* Degeneration/intervertebral disc NEC. Look in the Alphabetic Index for Degeneration/intervertebral disc/lumbar region M51.36. Verify code selection in the Tabular List.

Case 7

Operation Performed: Right-sided hemicraniectomy with duraplasty.

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 [1] to his right MCA [2] territory which converted to hemorrhagic [3] transformation. The significant shift was following commands on the right side and hemiplegic 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 patients 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 incision was taken through midline. This area was sterilely prepped and draped in usual fashion. A#1O blade was used to make an incision sharply. Raney clips were applied to the skin edges. The temporalis fascia and muscle was 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 6 and a footplate was then put on to perform the hemicraniectomy. [4] We ensured that we were off midline to ensure that we did not get into the sagittal sinus or any draining veins associated with this. Once the bone was removed, hemostasis was obtained and the dura was opened in the C-shaped fashion. and a large piece of Durepair was placed underneath this. There was a small subdural which was also evacuated and a large piece of Durepair was then used to create a duraplasty. [5] 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 was then reapproximated with 0 Vicryl interrupted fashion, overlying galea was reapproximated 0 Vicryl 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.

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[1] Ischemic infarct is the initial diagnosis.

[2] MCA is the Middle Cerebral Artery.

[3] The infarct converted to a hemorrhage.

[4] Hemicraniectomy documentation.

[5] Duraplasty performed.

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 craniectomy with duraplasty. Burr holes are placed to perform the decompressive craniectomy. A dural opening is made to remove the clot. Then, a reconstructive operation on the dura mater (duraplasty) is performed using the Durepair for closure. This procedure is indexed under Craniectomy/Decompression. Code 61322 is 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/artery/brain and you are directed to *see* Hemorrhage, intracranial, intracerebral. Look for Hemorrahage/intracranial/intracerebral (nontraumatic) (in) I61.9. Verify code selection in the Tabular List.

Case 8

Preoperative Diagnosis: Dorsal column stimulator battery malfunction.

Postoperative Diagnosis: Dorsal column stimulator battery malfunction.

Procedure Performed: Replacement of dorsal column stimulator generator. [1]

Attending: MD

Anesthesia: Monitored anesthetic coverage with local.

Estimated Blood Loss: Less than 5 mL

Specimens: None.

Drains: None.

Complications: None.

Implants: Medtronics 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. [2] The device was interrogated approximately a week prior to this procedure and telemetry was obtainable, indicating a breakdown of the battery. 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, positioned on the table in the left lateral decubitus position. Sedation was induced and a dose of antibiotics was administered IV. 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 battery was entered. The battery was explanted, a new prime advanced generator was prepared. [3] The leads were disconnected from the old generator and connected to the new generator in the same orientation. [4] 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 irri-

gated 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 recovery area in good condition. All final needle arid sponge counts were correct. There were no apparent complications.

_____

[1] Battery.

[2] Device malfunction is the reason for the surgery.

[3] The old battery is taken out and replaced with a new battery.

[4] The same leads are used.

_____

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

CPT® Code: 63685

ICD-10-CM Code: T85.112A

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, which is the correct code. 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/spinal cord/mechanical/breakdown and you are directed to T85.112. Turn to the Tabular List to complete the code for the type of encounter. The complete code is T85.112A. 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: Right L4–L5 laminotomy, foraminotomy, decompression, bilateral decompression of the lateral recess

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. [1]

Operative Indications: The patient is a 51-year-old gentleman. He has had ongoing lower extremity pain with numbness and tingling on the right hand side more so than the left side. [2] 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 with an MRI scan that shows 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 [3] 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 pedicle. [4] A foraminotomy was performed with a #3 Kerrison punch for the exiting right L5 nerve root. [5] 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. 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. [7] 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.

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[1] Confirmation of postoperative diagnosis.

[2] Neurogenic claudication.

[3] Intra-operative fluoroscopy used.

[4] Laminotomy.

[5] Foraminotomy.

[6] Decompression.

[7] Decompression of the left and right sides.

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

CPT® Code: 63030-50 or 63030-RT, 63030-LT

ICD-10-CM Code: M48.06

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. The code selection is based on the location. This was performed on the lumbar spine making 63030 the correct code choice. This code also includes the decompression and the foraminotomy. The decompression was performed on both sides, so a modifier 50 is indicated or modifiers RT and LT.

ICD-10-CM Code: For spinal stenosis, look in the ICD-10-CM Alphabetic Index for Stenosis/spinal/lumbar region M48.06. 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: Hemilaminectomy with left L5–S1 foraminotomy; microsurgical technique.

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 disk. [2] 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. Preop dose of antibiotics was administered IV. The skin was incised, 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. Paraspinous 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 3rd of the facet complex. [3] Microscope was then employed for magnification and illumination. [4] 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. [5] A probe could then be admitted through the neural foramen. For this aspect of the procedure, the microscope was utilized for magnification and illumination. [6] 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. [7] Hemostasis was achieved with bipolar coagulation. A bulging of the disk was appreciated, but the decision was made to forego a diskectomy. 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] Postoperative diagnosis used for coding.

[2] Indicates a re-exploration.

[3] Laminotomy.

[4] Use of surgical microscope.

[5] Decompression.

[6] Surgical microscope again.

[7] Confirmation of foraminotomy.

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

CPT® Code: 63042-LT

ICD-10-CM Codes: M54.16, M48.06

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. Code range 63040–63044 are for re-explorations. The code selection is further defined by location. 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 following 69990, according to NCCI the microscope is bundled. Add a note in your codebook 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 ICD-10-CM Alphabetic Index for Stenosis/spine/lumbar region M48.06. Verify code selection 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. Refer to 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 Repair of retinal detachment; by injection of air or other gas. 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 he examines the retina. To determine the ICD-10-CM code, look in the Alphabetic Index for Detachment/retina/with retinal/break/multiple H33.02-. In the Tabular List, sixth 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 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. Then 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: During this encounter, the provider probes the nasolacriminal duct on the right and left eye. When this procedure is performed using general anesthesia, the proper code selection is 68811. There is a parenthetical note to append modifier 50 if the procedure is performed bilaterally. In the CPT® Index look for Nasolacrimal Duct/Exploration/ with Anesthesia.

ICD-10-CM Code: The patient is diagnosed with dacryostenosis. From ICD-10-CM Alphabetic Index, look for Dacryostenosis which instructs you to - *see also* Stenosis, lacrimal. There is no indication the condition is congenital. Look for Stenosis/lacrimal/duct. This directs you to subcategory code H04.55. In the Tabular List, sixth 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 in the supine position. She was 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, therefore, 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. So in this, 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 in 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: Q17.8

Rationale: CPT® Code: In this case an otoplasty is performed with is a surgical fixation of the external ear. The patient has protruding ears which are being corrected. From the CPT® Index, look for Otoplasty. You are referred to 69300. The code description matches the procedure performed. There is a parenthetical note that states if performed bilaterally to append modifier 50.

ICD-10-CM Code: To determine the diagnosis code, look in the Alphabetic Index for Malformation/ear/external/specified type NEC Q17.8. The cause of protruding ears develops at birth and the appearance of the protrusion can be seen later in life.

Case 4

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 OR and placed in the supine position. 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 separate 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/with Footplate Drill Out 69661. The footplate was picked out. 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 drillout). This is not the case. 69660 is the correct code. Modifier RT is appended to the procedure codes to report the procedures are 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. From 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 is reported H80.8-. In the Tabular List, fifth character 1 is reported for the right ear. Conductive hearing loss is a sign/symptom of otosclerosis and is not reported. Verify the code description in the Tabular List for accuracy.

Case 5

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-Activent type, Adenoidectomy.

Anesthesia: General [2]

Estimated Blood Loss: Less than 5 mL.

Findings: Patient s a 1 ½ -year-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-Activent tube was followed by Ciprodex otic [6] drops. The same procedure was performed on the contralateral side. [7] The bed was turned 30° m 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 cautery 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. Reevaluation 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.

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[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, 69436-50-51

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 since 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. In the ICD-10-CM Alphabetic Index, look for Hypertrophy, hypertrophic/adenoids (infective) referring you to code J35.2. Verify code in the Tabular List. The patient 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 refers you to code 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 6

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.

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[1] Code the postoperative diagnosis. Two codes are required to fully describe the patient's diagnosis.

[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 you to 69620. The description includes "confined to drum head and donor area" which describes our procedure. 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. From the ICD-10-CM Alphabetic Index, look for Perforation/tympanum, tympanic/central. You are referred to H72.0-. In the Tabular List, fifth character 1 is reported for the right ear. For the next diagnosis code, look for Loss (of)/hearing. There is not a subterm for conductive, but there is an instruction to *see also* Deafness. Look in the Alphabetic Index for Deafness/conductive/unilateral. You are referred to H90.1-. In the Tabular List, fifth character 1 is reported for the right ear. For the last diagnosis, look for Tympanosclerosis H74.0. In the Tabular List, fifth character 1 is reported for the right ear.

Case 7

Operative Report

Preoperative Diagnosis: Foreign body, right external ear canal.

Anesthetic: General. TIME BEGAN: 1015 TIME ENDED: 1035

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: 1021 TIME ENDED: 1022

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.

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[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, seventh character A is reported for the initial visit. Two dummy placeholder Xs are reported to keep the seventh character in the seventh position.

Case 8

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 and 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 on the operating room table in the supine position 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. 3 mm markings 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 tarsoconjunctival 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.

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[1] The postoperative diagnosis is used for coding.

[2] Listed procedure.

[3] MAC anesthesia used.

[4] 3 mm margin is excised in addition to the lesion.

[5] The size of the lesion is 1/3 of the left lower eyelid.

[6] An additional 2 mm is excised.

[7] A flap is used to close the defect.

[8] A FTSK from the upper eyelid is used to repair the defect of the lower eyelid.

[9] A tarsorrhaphy is performed.

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

CPT® Codes: 15260, 67966-51-E2, 67971-51-E2, 67875-51-E2

ICD-10-CM Code: C44.119

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. From 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." 67961 is the code 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 codes for this case. In the CPT® Index, look for Repair/Eyelid/Excisional. A tarsorrhaphy (eyelids sewn shut) is performed. Look in the CPT® Index for Tarsorrhaphy you are referred 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 67966 and 67971 and 67875 are performed on the left lower eyelid which is reported with modifier E2. 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 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. You are referred to C44.11-. In the Tabular List, sixth character 9 is reported for the left eyelid.

Case 9

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, 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.

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[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. The procedures performed are reported with 66982. 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. From 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 10

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 on the operating table in the supine position. 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 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. This procedure is reported with 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. You are referred to H26.9. There is no additional information provided to select a more specific diagnosis code. Verify code selection in the Tabular List.

Case 1

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]

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[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, fifth character 0 is reported for unspecified knee.

Time: The anesthesia time is noted as 9:30–10:06, which is 36 minutes.

Case 2

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 185.

[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 3

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 Osteoarthosis

Postoperative Diagnosis: Left Knee Osteoarthrosis, 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

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[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 Osteoarthrosis, localized, primary.

[6] Diagnosis of Acute pos-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 osteoarthrosis, localized, primary. Look in the ICD-10-CM Alphabetic Index for Osteoarthrosis - *see also* Osteoarthritis. Look for Osteoarthritis/primary/knee to find M17.1-. In the Tabular List, fifth 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 4

Anesthesia Start: 14:07 [1] **Anesthesia End:** 17:33 [1]

Physical Status 3 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 morphogenic 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 sterilely 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 morphogenic 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.

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[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 morphogenic 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: M48.06

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. According to 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 *Anesthesia for procedures in lumbar region; not otherwise specified*. 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 located in the lumbar region. To locate the ICD-10-CM code, look in the Alphabetic Index for Stenosis/spinal/lumbar region. You are referred to M48.06. 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 5

CRNA directly supervised by anesthesiologist [1] who is directing two other cases. [1]

CRNA inserted Swan-Ganz catheter, [2] a separate CVP, [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, 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.

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[1] CRNA directly supervised by the Anesthesiologist supports modifer 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, 93503, 36620, 36556-59

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 also inserted a Swan-Ganz catheter in the right pulmonary artery (93503) and placed a central venous catheter in the left subclavian (36556). Anesthesia modifiers are not used on surgical procedure codes. A central line 36556 is bundled with 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. Code 93503 is modifier 51 exempt. The CRNA also inserted an A-Line (arterial line) which is coded separately with 36620.

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 6

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]

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[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, musee 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 *Anesthesia for procedures on male genitalia* 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 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

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.

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

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.

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[1] Use modifier AA to indicate the Anesthesiologist personally performed the case.

[2] Anesthesia time is 37 minutes.

[31] Physical status 3 - use P3 modifier.

[4] Post-operative diagnosis confirmsl 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, fifth 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 9

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 discharged 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.

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[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: L76.22

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 *Anesthesia for procedures on upper anterior abdominal wall* 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, hemorrhage; Complication/postprocedural/hemorrhage (hematoma) (of)/skin and subcutaneous tissue/following a procedure on other organ directs you to L76.22. 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 10

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 sesrvices 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 index for Anesthesia/Urinary Tract, and you are directed to 00860 *Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified.* 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 1

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]

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[1] Performed at the hospital, the radiologist will only code for the professional component.

[1] Three separate CT scan performed:
Thorax (chest)
Abdomen
Pelvis

[3] Pt has non-small cell lung CA.

[4] Contrast used.

[5] Chest CT findings.

[6] Mass is in the left upper lobe.

[7] Abdomen CT findings.

[8] Pelvis CT findings.

[9] The mass is part of the lung CA.

[10] 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®, look in the Index 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 C34.1-. In the Tabular List, fifth character 2 is reported for the left lung. The radiologist also notes a secondary diagnosis of coronary arteriosclerosis. Look in the ICD-10-CM Alphabetic Index for Arteriosclerosis/coronary (artery) or Disease, diseased/artery/coronary and you are directed to I25.10. Verify code selection in the Tabular List.

Case 2

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.

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[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, G93.89

Rationale: CPT® Code: In the CPT® Index, CT Scan/without and with Contrast/Brain gives you 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 ICD-10-CM 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 (I67.2). Cerebral lesions are found by locating Lesion(s)/brain (G93.9). Basal ganglia are located in the cerebral cortex. Next, look for Calcification/cerebral (cortex) which directs you to G93.89. Verify codes 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 are unremarkable.

Impression: BIRADS 1—Negative [5]

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[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: 77057, 77052

ICD-10-CM Codes: Z12.31, Z80.3

Rationale: CPT® Codes: Look in the CPT® Index for Mammography/Screening (77057) and for Mammography/with Computer-Aided Detection (77051–77052). The parenthetical note under 77057 states, "use 77057 in conjunction with 77052 for computer-aided detection applied to a screening mammogram). Both 77057 and 77052 are reported. 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 which refers you to Z12.31. A secondary diagnosis of family history of breast cancer is also reported. To locate the history code, look in the Alphabetic Index for History/family (of)/malignant neoplasm (of)/breast Z80.3. Verify code selection in the Tabular List.

Case 4

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.

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[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

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 Radiologic examination, femur, minimum 2 views is supported by the AP 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).

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 and you are directed to M79.60-. In the Tabular List, sixth character 5 is reported for the left leg.

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.

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[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 evaluatied.

[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, under 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) 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 (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) (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]

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.

Following preprocedure assessment, informed consent was obtained. Conscious sedation [6] was monitored by the radiology nursing section (see separate notes) monitored by the attending radiologist for 60 minutes. Vital signs, pre- and post-procedure monitoring were done by nurse in attendance with radiologists supervision. 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.

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[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.

[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

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; however, the bulls eye next to code 44500 indicates that moderate sedation is included.

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 R10.9. Look in the Alphabetic Index for Diarrhea (R19.7), as well as Weight loss (R63.4). Verify code selection in the Tabular List.

Case 7

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 you are referred 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 8

Location: Regional Hospital

Exam:

Renal and bladder ultrasound dated 10/01/20XX

Renal artery [1] 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 in 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]

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]

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[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, because the disc protrusion is at L4–L5 so we look for lumbar, directing you to M51.26. 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 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.

Conscious Sedation: Under continuous hemodynamic monitoring, 1 mg of Versed and 50 mcg of Fentanyl were given intravenously.

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.

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[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® codebook). 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/intestine K55.9 for unspecified. There is 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]

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[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. From the CPT® Index, look up Infectious Agent/Nucleic acid Probe/Staphylococcus Aureus. You are referred to 87640–87641. The findings confirm it is Methicillin resistant which is coded with 87641.

ICD-10-CM Code: The diagnosis is MRSA. From 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

Anatomic Pathology

Ordering Physician: Karen Smith, MD

Procedures: Surgical pathology procedure performed by a pathologist at a different location than the performing laboratory.

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 to the laboratory for slide preparation and subsequent interpretation and report by the pathologist providing consultative services to the laboratory.

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 prepared by the outside laboratory. 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 to the laboratory for both HPV testing and probe studies for the 3q26 and 5p15 genes.

The performing laboratory prepares the slides and performs HPV testing for the high-risk probes, 16 and 18, and prepared additional slide for FISH studies for probes 3q26 and 5p15. The laboratory sends the slides /images to the consultative pathologist for review and the interpretation and report of the FISH probes. The consulting pathologist reviewed the cells stained with the probes and issues an interpretation and report to the referring laboratory. The pathologist reports that the probes 3q26 and 5p15 are not present in this patient's cervical Pap smear specimen.

The laboratory sends the referring physician the patient's Pap smear results and FISH studies which include the pathologist's interpretation and report.

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[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: 88367-26, 88373-26

ICD-10-CM Codes: 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. Because the pathologist provided the review, interpretation and report for these procedures, and the outside laboratory performed the technical component, you will amend modifier 26 to these procedure codes to report the professional component.

ICD-10-CM: Look in the ICD-10-CM Alphabetic Index for Abnormal, abnormality, abnormalities/Papanicolaou (smear)/cervix referring you to R87.619. Verify code in the Tabular List.

Case 3

Requesting Provider: CI, MD

Surgical Pathology Report: Collected: Received: 3/4/2011, 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]

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[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 Index, *see* 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 Table, look for Neoplasm, neoplastic/tongue/base (dorsal surface)/Malignant Primary column. You are referred to 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 4

Clinical Indications: The patient is a 28 y.o. female for routine lab tests part of her yearly physical exam.

Collected: 04/14/XX 13:29 **Patient number:** xxxxxxxxxxx **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%)

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[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 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). This refers you to code Z00.00. Verify code selection in the Tabular List.

The results of the lab tests are normal.

Case 5

Requested by R Simon, MD

Cytology [1] **Report:** Collected: 1/26/2011 Received: 1/27/2011, 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 I diabetes presents for elective kidney transplant. [2]

Cytologic Impression: Peritoneal dialysis drain fluid: No cytologically malignant cells are identified. [3]

Comment: 100 mls yellow fluid is received from which two Papanicolaou stained cytocentrifuged slides are made. Slides contain mesothelial cells with a spectrum of reactive changes and histiocytes. No malignant cells are identified.

---

[1] Report indicates type of procedure performed.

[2] Use clinical diagnostic information to assign ICD-10-CM codes because the findings are negative.

[3] Cytology is performed on the fluid obtained.

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

CPT® Code: 88104

ICD-10-CM Codes: E10.22, N18.6, Z99.2

Rationale: CPT® Code: The test performed is cytopathology on the peritoneal fluid. From the CPT® Index, look up Cytopathology/Fluids, Washings, Brushings/Smears. Review of the code descriptions verifies 88104 is the correct code.

ICD-10-CM Codes: The patient is diagnosed with type I 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. You are referred to E10.22. In the Tabular List there is an instructional note for E10.22, "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, "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 6

Requested by R Williams, MD

Surgical Pathology Report Collected: 2/1/2011 Received: 2/2/2011. 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. You are referred to T86.19. An additional code is selected to report the renal artery thrombosis. In the Alphabetic Index look for Thrombosis/renal (artery). You are referred to N28.0. Verify code selection in the Tabular List.

Case 7

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, R60.14

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 Alphabetic Index and is listed first. Fever (R50.9) is a symptom of the pneumonia and is not reported separately. Look for Hematuria in the Alphabetic Index and you are directed to R31.9. Look for Edema/generalized in the Alphabetic Index and you are referred to R60.1. Confirm code selection in the Tabular List.

Case 8

Requested by D Freeman, MD

Surgical Pathology Report: Collected: 4/20/2011 Received: 4/20/2011. 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 immunfluorescence is coded separately.

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

CPT® Codes: 88307 x 2, 88346, 88350 x 6

ICD-10-CM Code: T86.21

Rationale: CPT® Codes: Two tissue specimans 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, 7 antibodies are tested, so it is reported as 88346 for the intitial stain, and 88350 x 6 for each additional stain. Notice, in the 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. You are referred to T86.21. Verify code selection in the Tabular List.

Case 9

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.

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[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.8

Rationale: CPT® Code: In the CPT® Index, look up 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 - *see also* Tumor, neuroendocrine. Look for Tumor/neuroendocrine/specified NEC. You are referred to C7A.8. Note, neuroendocrine carcinoma is listed under final diagnosis. Verify code selection in the Tabular List.

Case 10

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: 88300, 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 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. 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. You are referred to L97.511. Verify code selection in the Tabular List.

Case 1

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 will have to 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: Quality

[6] HPI: Severity

[7] HPI: Modifying factors

[8] Past medical history

[9] Social history

[10] Family history

[11] Organ: Skin

[12] Diagnosis

[13] Elective surgery

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

CPT® Code: 99201

ICD-10-CM Code: D17.21, D17.22

Rationale: CPT® Codes: 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—minor surgery with identified risk factors).

ICD-10-CM Code: 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) and you are directed to 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.

Case 2

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 diagnosis are not coded.

[6] Punch biopsy performed.

What are the CPT® and ICD-10-CM codes 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. 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, 11100 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 kertoacanthoma, but neither is confirmed. For this case, the patient is coming in for a suspicious lesion on the skin of the left arm. Because there is no pathology report to indicate whether the lesion is malignant or benign, The diagnosis listed in the MDM identifies this is a suspicious neoplasm. It is coded as a Neoplasm/skin NOS/arm - *see also* Neoplasm, skin, limb NEC, upper; Neoplasm/skin/limb/upper/Unspecified Behavior (column) which guides you to code 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 guides you to code Z85.828. Verify code selection in the Tabular List.

Case 3

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, 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] EKG review.

[8] Possibly due to pulmonary hypertension, but not certain, so code separately.

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

CPT® Code: 99212

ICD-10-CM Codes: M79.89, I27.2

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 & EKG reviewed, risk moderate.)

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 and you are directed to M79.89. For the pulmonary hypertension, look in the Alphabetic Index for Hypertension/pulmonary (artery) (secondary) NEC and you are directed to I27.2. Verification of both codes in the Tabular List confirms code selection.

Case 4

Age: 33 YRS—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, 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 2 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 codes reported?

CPT® Code: 99395—for some insurance carriers, also code G0101 for the pelvic and breast exam.

ICD-10-CM Code: Z00.00, Z01.419, E03.9

Rationale: CPT® Codes: Subcategory—Preventive Medicine Services, established patient

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 we had 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) and you are directed to Z00.00. There is also a code for Examination/pelvic, which is 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) and you are referred to 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

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.

[9] 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 codes 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, and you are directed to *see also* tenosynovitis. Look for Tenosynovitis/infective/lower leg, you are directed to M65.16-. In the Tabular List, sixth character 2 is reported for the left leg. Next, look for Contraction(s), contracture, contracted/joint/knee and you are directed to M24.56-. In the Tabular List, sixth character 2 is reported for the left knee. The medial meniscal tear is only a possible diagnosis, so it should not be coded.

Case 6

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 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, total T-score is -0.8 compared to previous there has been a 7% reduction from 2005. [14]

Assessment:

1. Seronegetive 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. Osteoporosis and continued care for compression 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 10 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: Detailed Musculoskeletal.

[14] DEXA 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 codes reported?

CPT® Codes: 99213-25, 20612-F1, 77080, J1020

ICD-10-CM Codes: M06.041, M06.042, M71.30. M80.88XD

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—Detailed (3 organ systems, musculoskeletal is detailed)

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 and 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, 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, referring you to code 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. This is indexed under Cyst/synovial referring you to – *see also* Cyst, bursa. Look for Cyst/bursa, bursal NEC refers you to M71.30. The next diagnosis to report is osteoporosis. Look for Osteoporosis/age-related/with current pathologic fracture/vertebra referring you to code M80.08XD. The seventh character D is reported because this is not the initial encounter for the compression fracture and the assessment indicates continued care indicating aftercare.

Case 7

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 is arousable. [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 lateral ribcage 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 of 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 history of 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 II 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 codes reported?

CPT® Code: 99309

ICD-10-CM Code: S20.211A, M25.11, R03.0, F03.90, I48.91, E11.9

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)

ICD-10-CM Codes:

1. Rib Contusion causing pain. In the Alphabetic Index, look for Contusion/chest (wall) – *see* Contusion, thorax. Look for Contusion/thorax (wall)/front and you are referred to 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 seventh character.

2. Shoulder pain. Look in the Alphabetic Index for Pain(s)/joint/shoulder and you are referred to M25.51-. Turn to the Tabular List to complete the code. Complete code is 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, and you are referred to R03.0. It is coded because there was a medication change and the blood pressure will be monitored.

4. Dementia is coded because it is being followed and the home meds will be continued. Look in the Alphabetic Index for Dementia and you are referred to F03.90.

5. Patient has history of atrial fibrillation, currently controlled with telemetry monitor. Look in the Alphabetic Index for Fibrillation/atrial or auricular (established) and you are referred to I48.91.

6. Blood glucose is reviewed for Type II DM. Look in the Alphabetic Index for Diabetes, diabetic/type 2 which refers you to E11.9.

Case 8

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, metform 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 2. 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. O_2 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, CO_2 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 ad 20 mg KCl per L to IV fluid. [37] Get a general surgery consult for cholelethiasis. Will check studies, fecal white blood cells, C. dif 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.

[6] HPI: Severity.

[7] ROS: GI.

[8] HPI: Severity.

[9] HPI: Associated Sign & Symptom.

[10] ROS: GI.

[11] ROS: Respiratory.

|12| PFSH: Personal History.

|13| PFSH: Social History.

|14| PFSH: Family History.

|15| ROS: Constitutional.

|16| ROS: ENT.

|17| ROS: Eyes.

|18| ROS: Respiratory.

|19| ROS: Cardiovascular.

|20| ROS: GI.

|21| ROS: Neurologic.

|22| ROS: Psychiatric.

|23| Integumentary.

|24| ROS: GU.

|25| Exam: Constitutional.

|26| Exam: Head, including face.

|27| Exam: Mouth (ENMT).

|28| Exam: Eye.

|29 Exam: Neck.

|30| Exam: Respiratory.

|31| Exam: Cardiovascular.

|32| Exam: Gastrointestinal.

|33| Exam: GU (CVA tenderness is check for signs of kidney infection).

|34| Exam: Cardiovascular.

|35| Labs reviewed.

|36| Ultrasound and CT reviewed.

|37| IV Hydration with additives.

|38| Ordered additional lab.

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

CPT® Code: 99222

ICD-10-CM Codes: R11.2, N30.90, E87.5, E87.1, K80.20, E11.9, 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)

ICD-10-CM Codes:

1. Nausea, vomiting, diarrhea, likely gastroenteritis (gastroenteritis is only a possible diagnosis, nausea and vomiting are symptoms, but the cause is undetermined, so it is coded). Look in Alphabetic Index for Nausea/with vomiting — R11.2, and for Diarrhea R19.7.
2. Cystitis—Look in the Alphabetic Index for Cystitis. There are no other descriptors, use N30.90.
3. Hyperkalemia—Look in the Alphabetic Index for Hyperkalemia, use E87.5.
4. Hyponatremia—Look in the Alphabetic Index for Hyponatremia, use E87.1.
5. Cholelithiasis—Look in the Alphabetic Index for Cholelithiasis – *see* Calculus, gallbladder. Look for Calculus/ gallbladder, use K80.20.
6. Diabetes mellitus type 2—look in the Alphabetic Index for Diabetes, diabetic/type, use E11.9.
7. Hypertension— Look in the Alphabetic Index for Hypertension, use I10.

Verify code selection in the Tabular List.

Case 9

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, 02 sat 96% on room air. Accu-cheks, 113, 132, 96, 98. [5]

General: No apparent distress, oriented x 3, pleasant English-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. [8]

Laboratory Data: Shows C Dif toxin negative. Sodium 129, potassium 3.4, chloride 96, CO_2 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 codes reported?

CPT® Code: 99232

ICD-10-CM Codes: K80.20, N30.90, H10.9, E87.1, E87.6, E11.9

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)

ICD-10-CM Codes:

1. Cholelithiasis—In the Alphabetic Index look for Cholelithiasis – *see* Calculus, gallbladder; Calculus/gallbladder K80.20.
2. Cystitis—Look in the Alphabetic Index for Cystitis. There are no other descriptors, use N30.90.
3. Conjunctivitis—Look in the Alphabetic Index for Conjunctivitis, use H10.9.
4. Hyponatremia—Look in the Alphabetic Index for Hyponatremia, use E87.1.
5. Hypokalemia—Look in the Alphabetic Index for Hypokalemia, use E87.6.
6. Diabetes mellitus type 2—Look in the Alphabetic Index for Diabetes, diabetic/type 2, use E11.9
7. Hypertension— Look in the Alphabetic Index for Hypertension, use I10.

Verify code selection in the Tabular List.

Case 10

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. General 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]

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[1] This indicates the provider is discharging the patient. Review the note to make sure discharge services where 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 codes reported?

CPT® Code: 99238

ICD-10-CM Codes: K80.20, N30.90, H10.9, E87.1, E11.9, I10

Rationale: CPT® Code: This is a discharge summary from a hospital. Discharge services are coded based on time. There is no time documented in the medical record, so the lowest time is selected. 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 or not.

ICD-10-CM Codes:

1. Cholelithiasis—In the Alphabetic Index look for Cholelithiasis – *see* Calculus, gallbladder; Calculus/gallbladder, use K80.20.
2. Cystitis—Look in the Alphabetic Index for Cystitis. There are no other descriptors, use N30.90.
3. Conjunctivitis—Look in the Alphabetic Index for Conjunctivitis, use H10.9.
4. Hyponatremia—Look in the Alphabetic Index for Hyponatremia, use E87.1.
5. Diabetes mellitus type 2—Look in the Alphabetic Index for Diabetes, diabetic/type 2, use E11.9.
6. Hypertension— Look in the Alphabetic Index for Hypertension, use I10.

Verify code selection in the Tabular List.

Case 1

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. 1 dog, 1 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.

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[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 is reported 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. From the Alphabetic Index, look for Examination/child (over 28 days old)/with abnormal findings. You are referred to Z00.121. According to the Official Coding Guidelines (Section 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) referring you to F90.9. Next, look for Wart you are referred to B07.9. Then, look for Urine/frequency. You are referred to R35.0. Varicella vaccination was administered. Look for Vaccination (prophylactic)/encounter referring you to Z23. Verify all codes in the Tabular List for accuracy.

Case 2

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, inspirometer 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.

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[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 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 Alphabetic Index for Asthma, asthmatic and you are directed to J45.909. The asthma is not stated as having status asthmaticus or acute exacerbation. Verify code selection in the Tabular List.

Case 3

Performed in the office

Pre-procedure Diagnosis: Gastroesophageal reflux disease (GERD), Heartburn

Post-procedure Diagnosis: GERD [1]

Procedure: Esophageal pH monitoring with Bravo pH Capsule [2]

Pt 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.

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[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 and you are directed to code range 91034–91038. The test is performed for 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 Alphabetic Index by looking for GERD (gastroesophageal reflux disease) or by looking for Disease, diseased/gastroesophageal reflux (GERD) (K21.9). Verification code selection in the Tabular List.

Case 4

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 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 SpO_2 during the non-supplemented sleep period was 73%. CPAP was then applied at 5 cm H2, and sequentially titrated to a final pressure of 18 cm H_2O. The Apnea-hypopnea index (AHI) changed from 60 events/hr to 4 events/hr. SpO_2 increased to 90%.

The sleep study with and without CPAP shows severe obstructive sleep apnea with improvement with CPAP settings at 18 cm H20. Based on the improved SpO_2 levels with CPAP, it is recommended this patient use a BIPAP machine during sleep hours due to obstructive sleep apnea events.

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[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 Alphabetic Index, look for Apnea, apneic/sleep/obstructive G47.33. Verification of the code in the Tabular List confirms code selection.

Case 5

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, 93350–93552. 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 and you are directed to *see also* Hypertrophy/cardiac. Hypertrophy/cardiac refers you to I35.7. Then look for Insufficiency, insufficient/aortic (valve) and you are directed to I35.1. Verification in the Tabular List confirms code selection.

Case 6

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

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[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, I87.2

Rationale: CPT® Code: In the CPT Index, look for Duplex Scan/Venous Studies/Extremities and you are referred to 93970–93971. Duplex scan for bilateral lower extremities is coded with 93970.

ICD-10-CM Codes: Look in the Alphabetic Index for Varicose vein and you are directed to *see* Varix; Both legs have the condition. Look for Varix/leg/right/with inflammation referring you to I83.11. Then, look for Varix/leg/left/with inflammation referring you to I83.12. Venous insufficiency is found under Insufficiency, insufficient/venous (I87.2). Leg pain due to the varicose veins is included in codes I83.11 and I83.12 because when looking for Varix/leg/right/with pain you are referred to code I83.11, which is the same code for inflammation. Verify code selection in the Tabular List.

Case 7

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]

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[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 Alphabetic Index, look for Apnea, apneic/sleep/with sleep and you are directed to G47.30. Verify code selection in the Tabular List.

Case 8

Pre-procedure Diagnosis: Epilepsy with history of seizures, VNS Implant

Post-procedure Diagnosis: Epilepsy with history of seizures, VNS Implant [1]

Procedure: Vagal Nerve Stimulator Analysis

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

_____

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

CPT® Code: 95970

ICD-10-CM Codes: G40.909, Z96.89

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, 95979. The vagus nerve is a cranial nerve. The correct code is 95970 for without reprogramming.

ICD-10-CM Codes: In the Alphabetic Index, look for Epilepsy referring you to G40.909. This patient has a VNS implant, which is a neurologic device. In the Alphabetic Index look for Status (post) which directs you to *see also* Presence (of); Presence (of)/implanted device/specified NEC or Presence (of)/device/implanted/specified refers you to Z96.89. Verify code selection in the Tabular List.

Case 9

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 ketatosis 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.

_____

[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: 96567, 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, and 96567. 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 codebook in the Table of Drugs under Levulan® Kerastick®.

ICD-10-CM Code: In the Alphabetic Index, look for Keratosis. Without any further description, use code L57.0. Verify code selection in the Tabular List.

Case 10

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 Alphabetic Index for Aneurysm/abdominal (aorta) and you are directed to I71.4. Verification in the Tabular List confirms code selection.