Documentation Dissection

Preoperative Diagnosis: Left patella fracture.

Postoperative Diagnosis: Left patella fracture [1].

Procedure Performed: Left patella open reduction, internal fixation [2].

Estimated Blood Loss/Transfusion: Blood loss 30 cc.

Drains: None.

Findings: Comminuted patella fracture [3].

Implants Used: Two 0.062 K-wires and one 18 gauge wire [4].

Anesthesia Type: General [5].

Intravenous Fluids: 400 cc crystalloid.

Indications for Procedure: The patient is a 60-year-old female status post fall with injury to the left lower extremity [6]. The patient was found to have a left patella fracture with no functions of her extensor mechanism. The patient was deemed to be an operative candidate. Risks and benefits of operative and nonoperative treatment were discussed with the patient and informed consent was obtained prior to surgery. Risks including pain, bleeding, infection, scar, fever, failure of surgery, need for more surgery were discussed with the patient. Again, full informed consent was obtained prior to surgical procedure.

Procedure in Detail: The patient was seen, marked and identified by the orthopedic surgery service in the preoperative holding area. The patient was taken back to the operating room, placed on the operating room table in supine position [7]. Time-out was performed when the patient entered the room. The patient received 1 g of Ancef preoperatively. The patient underwent general endotracheal anesthesia with no complications. At this time, the patient's left lower extremity was prepped and draped in normal sterile fashion including pre-prep with chlorhexidine and alcohol. A tourniquet was placed to the patient's left upper thigh with a bump under her hip. At this time, using a standard anterior approach to the knee, an incision was made from the superior polo of the patella down to the tibial tuberosity. Incision was taken through the skin, subcutaneous tissue down to the level of the paratenon. Flaps were elevated both medially and laterally over the paratenon level. A large defect of the patella was seen at this time with a fracture hematoma [8]. The fracture hematoma was thoroughly irrigated with normal saline to remove all fracture debris. Once this was done, obvious fracture of the patella was identified. At this time, a Weber clamp was taken to reduce the fracture to a near anatomic position [9]. Two 0.062 K-wires were placed in antegrade fashion across the patella fracture holding the fracture in place provisionally [10]. With this done, C-arm imaging was brought in to ensure adequate reduction of the fracture [11], an 18 gauge stainless steel wire was taken and placed under the 2 K-wires using a 14 gauge Angiocath. Once the wires were passed under the wires, they were placed across the patella fracture in a tension band technique using a figure-of-eight. It was tensioned to the appropriate strength once wrapped around the patella fracture. The wire was then cut to the appropriate length. C-arm imaging was brought in again to ensure adequate reduction. The K-wires were then brought back to the appropriate level, bent and tamped down, again in to the appropriate length on the patella. Once this was done, the patient's wound was sterilely irrigated with normal saline. Subcutaneous tissue was closed using a 2-0 Vicryl stitch. Skin was closed using a 2-0 nylon stitch. The wounds were cleaned and dressed with Xeroform, 4 x 4s, ABDs. The patient was placed in a knee immobilizer locked in extension. The patient was awoken from general endotracheal anesthesia with no complications, taken to the postoperative holding area doing well.

Specimens Removed: None.

Disposition: The patient tolerated surgery well, extubated and transferred to the recovery room in good condition [12].

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[1] Postoperative diagnosis and medical necessity for procedure.

[2] Procedure performed.

[3] Description of fracture.

[4] Fixation devices.

[5] Anesthesia.

[6] External cause of the injury.

[7] Positioning of the patient.

[8] The incision supports an open procedure.

[9] Displacement of the bones.

[10] Internal fixation of the fracture.

[11] Verification of the reduction of the fracture.

[12] Postoperative status of the patient.

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

CPT® Code: 27524-LT

ICD-10-CM Codes: S82.042A, W19.XXXA

Rationales:

CPT®: In the CPT® Index look for Fracture/Patella/Open Treatment 27524. Review in the musculoskeletal section shows 27524 is for open treatment of a patellar fracture. This code includes the internal fixation and soft tissue repair. Modifier LT is appended for the left leg.

ICD-10-CM: The code will be in the Category S82 for a fracture of the lower leg. Documentation of the left lower leg, and findings to support a comminuted displaced fracture. In the ICD-10-CM Alphabetic Index look for Fracture, traumatic/patella/comminuted (displaced) directing you to S82.04-. In the Tabular List, 6th character 2 is reported for the left leg. 7th character A is reported for initial encounter, or active treatment. ICD-10-CM guidelines instruct to use initial encounter for surgical intervention. S82.042A is correct.

A second code is used for the external cause, documented as a fall. In the External Cause of Injuries Index look for Fall leading to W19. In the Tabular List, 7th character A is required and XXX placeholders are required to keep the 7th character in the 7th position. W19.XXXA is correct.