Case 1

Operative Report

Preoperative diagnosis: Transitional cell carcinoma in the bladder 1.

Postoperative diagnosis: Transitional cell carcinoma in the bladder

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 was performed. A 1 cm tumor was noted on the posterior bladder wall. The tumor was resected without complications. 3. 4.

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.

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.

5. A bilateral retrograde pyelogram was performed which showed no filling defects or irregularities.

Bilateral Retrograde Pyelogram

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

CPT® codes: 52234, 74420-26

ICD-9-CM code: 188.4

RATIONALE: CPT® codes: A Cystoscopy, excision of a 1 cm bladder tumor, bilateral retrograde pyelogram and cytology were performed. In the CPT® Index, see 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-9-CM code: In the ICD-9-CM Index to Diseases, see Carcinoma/transitional cell. The /3 morphology code indicates this is malignancy of a primary site. The operative note states, "a 1 cm tumor was on the posterior bladder wall." Look at the Neoplasm Table and locate bladder/wall/posterior referring you to code 188.4.

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 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. 2.

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. 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. 3.

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

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.

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

CPT® codes: 52240

ICD-9-CM codes: 188.0, 188.5, 185

RATIONALE: CPT® codes: The patient is having a large bladder tumor removed by excision through a cystoscope. In the CPT® Index, go to Bladder/Excision/Tumor (52234–52240).

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-9-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 will be reported instead because the cancer has been proven by the pathology report. In the ICD-9-CM Neoplasm Table, look up Neoplasm/bladder/trigone/Malignant/Primary (column), which guides you to 188.0 Neoplasm/bladder/neck/Malignant/Primary (column) (188.5), and finally Neoplasm/prostate/Malignant/Primary (column) (185). The sites are reported as primary because there is no indication that these sites are secondary or metastasized from a primary site.

Case 3

Operative Note

Preoperative diagnosis: Ta grade 3 transitional cell carcinoma (TCC) bladder CA in January 2010 1.

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 poster 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 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. 3.

Plan: We will schedule the patient for a bladder biopsy at the next-available date. 4.

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-9-CM codes reported?

CPT® codes: 52000

ICD-9-CM codes: 596.9, V10.51

RATIONALE: CPT® codes: This procedure note is very straight-forward. A diagnostic cystoscopy (only examining the urethra, bladder, and ureteric openings in the bladder) was performed. In the CPT® Index, look up Cystoscopy (52000).

ICD-9-CM codes: Because there were findings of new bladder lesions, you will report the bladder lesion as your diagnosis. In the Index to Diseases, look up, Lesion/bladder (596.9). This is an unspecified code, but because the note clearly states "lesion," you will report 596.9. Do not report a bladder cancer code because that diagnosis has yet to be proven.

Patient had bladder cancer in January. In the Index to Diseases, look up History/malignant neoplasm (of)/bladder (V10.51).

Case 4

Operative Note

Preoperative diagnosis: Desire for circumcision

1. **Postoperative diagnosis:** Desire for circumcision

Procedure: Circumcision

Anesthesia: General

2. **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 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%
3. Marcaine plain.

4. Two circumferential incisions 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.

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-9-CM codes reported?

CPT® code: 54161

ICD-9-CM code: V50.2

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-9-CM code: In the Index to Diseases, see Circumcision/in the absence of medical indication. Verify 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-9-CM codes reported for this procedure?

CPT® code: 50610-RT

ICD-9-CM code: 592.1

RATIONALE: CPT® code: In the CPT® Index, look up 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-9-CM code: In the Index to Diseases, look up Calculus/ureter, which guides you to 592.1.

Case 6

Operative Report

Preoperative diagnosis: Prostate Cancer

1. **Postoperative diagnosis**: Prostate Cancer

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.

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.

We made a midline infraumbilical incision and dissected down to the rectus fascia. We then transected the rectus fascia between the bellies of the rectus muscle and dissected
2. into the retropubic space. We placed a Bookwalter retractor to aid in visualization and to
3. protect the surrounding structures. We did bilateral pelvic lymph node dissection, taking care to avoid the obturator nerves bilaterally. The node packets were sent off the field for permanent section and frozen section. We 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. We sewed some back bleeding sutures over the prostate and we placed a right angle again behind the dorsal venous complex and then transected it with a long handled blade. We carefully inspected the dorsal venous complex for any bleeding and no bleeding was noted. We then placed a right angle clamp behind the urethra and transected the anterior aspect of the urethra, exposing the Foley catheter. We 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. We then 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. We then clipped and cut the lateral pedicles to free the prostate up to the level of the bladder neck. We then transected Denonvilliers' fascia and identified the bilateral vas deferens, which were clipped and cut

accordingly. We also dissected the seminal vesicles leaving the tips of the seminal vesicles in place in the hopes of improving his continence.

Once this was complete, we dissected the prostate free from the bladder neck using electrocautery. Once we had opened the anterior aspect of the bladder, we were 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, we turned our attention to recapitulating the bladder neck. We everted the bladder mucosa with 4-0 Monocryl and then closed the bladder neck in a tennis racquet closure using 2-0 Vicryl. We 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. We then 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. We then cinched down these anastomotic sutures and tied them off. We 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. We stitched the drain in place with a 2-0 silk. We 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.

4.

4. Radically removing the entire prostate.

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

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

CPT® code: 55845

ICD-9-CM code: 185

RATIONALE: CPT® code: In the index, look up 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.

ICD-9-CM code: In the Neoplasm Table, look up Neoplasm/prostate/Malignant/Primary (column) (185).

Case 7

Operative Note

Preoperative diagnosis: Left renal calculus

1. **Postoperative diagnosis:** Left renal calculus

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. 2. We then resumed at 60 slowly working up to 120, for a total of 1800 shocks on the lower pole, which completely disappeared. 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.

1. Diagnosis to report if no further positive findings are found in the operative note.
2. Lithotripsy.

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

CPT® code: 50590-LT

ICD-9-CM code: 592.0

RATIONALE: CPT® code: Shock waves are used to pulverize the kidney stone. In the index, look up 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-9-CM code: In the Index to Diseases look for Calculus/kidney (592.0).

Case 8

Operative Note

Preoperative diagnosis: Prostate cancer

Postoperative diagnosis: Prostate cancer 1.

Procedure: Ultrasound guidance 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. He had an excellent appearance and ultrasound. 2. 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-9-CM codes reported?

CPT® code: 55876

ICD-9-CM code: 185

RATIONALE: CPT® code: The CPT® Index does not list "fiducial" or "marker" to identify this code; however, CPT® does list "Placement." In reading through the "Placement" codes, you find "Interstitial Device" with "prostate" (55876). An interstitial device is used to administer radiation therapy. 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-9-CM code: The diagnosis is stated several times as prostate cancer. Go to the Neoplasm Table in the Index to Diseases and look for Prostate. Use the code from the Malignant/Primary column, 185. Verify 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
2. Undescended testes

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.

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 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 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. There did not appear to be any abdominal contents within the hernia sac. It was then twisted and suture ligated at the base. 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 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 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. 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. 8.

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.

8. Fixation of the left undescended testicle.

9. Surgical circumcision being performed.

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

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

ICD-9-CM codes: 752.51, 550.92, V50.2

RATIONALE: CPT® codes: Three procedures were performed: Bilateral orchiopexy, bilateral hernia repair, and circumcision. In the index, look for Orchiopexy. The codes are listed by the type of anatomical incision made. CPT® 54640 is the appropriate code. 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 54640 and 49505 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 49505 and 54161 to indicate additional procedures performed in the same surgical session by the same surgeon.

ICD-9-CM codes: In the Index to Diseases, look up Undescended/testis (752.51). In the Index to Diseases, look up Hernia/inguinal (550.9X). Your fifth digit will be "2." In the Index to Diseases, look up Circumcision guides you to V50.2.

Case 10

Operative Note

Preoperative diagnosis:

1. Intrinsic sphincter deficiency
2. Incontinence

Postoperative diagnosis:

1. Intrinsic sphincter deficiency
2. Incontinence

1. Diagnoses to report if no further positive findings are found in the operative note.
2. This is a symptom of the ISD, will not be reported as an ICD-9-CM code diagnosis.
3. Indication that the procedure will be performed through a scope entering the urethra.
4. Injection of the synthetic material into the urethra and bladder neck, helping to prevent urinary 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 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 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.

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

CPT® code: 51715

ICD-9-CM code: 599.82, 788.30

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-9-CM code: In the Index to Diseases, look to Deficiency/intrinsic (urethral) sphincter (ISD), which guides you to 599.82. There is a note under 599.8 to "Use additional code to identify urinary incontinence…" 788.30 is used to identify the urinary incontinence.