
Documentation Dissection

PREOPERATIVE DIAGNOSIS: Left-sided neuroblastoma.

POSTOPERATIVE DIAGNOSIS: Left-sided neuroblastoma ^[1].

PROCEDURE PERFORMED: Exploratory laparotomy with resection of left-sided neuroblastoma and repair of left ureteral injury ^[2].

ANESTHESIA: General endotracheal anesthesia ^[3].

SPECIMEN: Tumor to Pathology.

ESTIMATED BLOOD LOSS: about 15 ML.

DRAINED PLACED: A 7 French Jackson-Pratt in the left abdomen as well as a 10 French Replogle nasogastric tube and a 6 French Foley catheter.

INDICATIONS: The patient is a 5-month-old male who had been diagnosed with a neuroblastoma which was encasing the left kidney, ureter, and vessels ^[4]. He has received 4 cycles of chemotherapy ^[5] and now is prepared for resection of his tumor which is 2.7 cm ^[6].

FINDINGS: Left-sided infiltrating retroperitoneal mass encasing the ureter adjacent to the renal pelvis. The majority of the tumor was resected ^[7].

COMPLICATIONS: Transection of the left ureter intraoperatively ^[8].

DESCRIPTION OF PROCEDURE: The patient was brought to the Operating Room where general anesthesia was induced without incident. He received a dose of IV antibiotic and was prepped and draped in the standard sterile fashion. A bump was placed to elevate the left side. A 15-blade scalpel was used to make a left transverse incision ^[9] at the site of his previous biopsy scar. It was extended significantly. Bovie electrocautery was used to dissect the subcutaneous tissue, fascia and muscle until the peritoneum was identified and opened. The white line of Toldt was opened and the left colon was retracted medially to allow for exposure of the left kidney and the adjacent tumor which was medial to it. The tumor appeared firm and calcified particularly the medial portion. The left renal vein was identified and the tumor was carefully skeletonized from it. A small rim of tumor was left behind along the vein as the scarring was so extensive that no adequate plane could be identified between the vessel and the tumor. We attempted to dissect the tumor away from the renal pelvis and worked both superiorly, laterally and posteriorly until we were able to have better purchase of the tumor. We identified a tubular structure we presumed to be the ureter and followed it along inferiorly adjacent to the kidney in an attempt to outline the edges of the tumor. During our inferior dissection of the tumor, however, we noted that we had inadvertently transected the ureter completely ^[10]. We were able to identify both the proximal and distal edges of the transected ureter and made sure that we dissected them free from tumor on both sides maintaining an adequate blood supply. We placed a 5 French feeding tube both distally and proximally and repaired the transected ureter primarily with interrupted 6-0 Monocryl stitches with the knots on the outside ^[11]. We removed the feeding tube stents prior to tying down the last knot. We then completed the dissection of the remaining part of the tumor which we removed in approximately 3 pieces. We left a rim of tumor along the renal vein and at the edge of the pelvis of the kidney as we could not identify any plane between tumor and these structures. Overall, the vast majority of the tumor, approximately 85–90% was resected and sent off as specimen ^[12]. We placed clips supermedially, inferiorly, and laterally and placed an additional clip adjacent to the site of the ureter repair on the long lateral margin. We confirmed hemostasis. We closed the abdominal wall in 2 layers for the muscle with running 3-0 Vicryl stitches. We closed the skin with a running 5-0 Monocryl subcuticular stitch. Local anesthetic was injected and Steri-Strips were applied. The Jackson-Pratt drain was fixed to the skin with 3-0 nylon stitch. A 6 French Foley catheter was placed sterilely at the end of the case ^[13]. The patient tolerated the procedure and was taken to PICU with stable vital signs. Instrument, needle, and sponge counts were correct at the end of the case.

A specimen was sent for frozen section and revealed calcifications with a small amount of what appeared to be a viable tumor.

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- 11 Postoperative Diagnosis.
 - 12 Procedure performed. Check the body of the operative report to confirm.
 - 13 General Anesthesia.
 - 14 Indication and medical necessity for procedure.
 - 15 History of Chemotherapy.
 - 16 Tumor size is 2.7 cm.
 - 17 Location of mass—tumor resected.
 - 18 Complication noted.
 - 19 Open procedure—transverse incision is horizontal just above the umbilicus.
 - 20 Intra-operative complication.
 - 21 Repair of transected left ureter. This is not reported, because the surgeon created the need for the repair.
 - 22 Specimen sent to Pathology.
 - 23 Drains and catheters are not separately billed.

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

CPT® Code: 49203

ICD-10-CM Codes: C48.1, N99.72

Rationales:

CPT®: Look in the CPT® Index for Excision/Tumor/Retroperitoneal 49203–49205. This tumor was 2.7 cm; therefore, the correct code is 49203 for the excision of a retroperitoneal tumor of 5 cm or less.

ICD-10-CM: In the Alphabetic Index look for Neuroblastoma/specified site—see Neoplasm, malignant, by site. Look in the Table of Neoplasms for Neoplasm/retroperitoneal (space) (tissue)/Malignant Primary/C48.0. Check the Tabular List. C48.0 lists Malignant neoplasm of retroperitoneum. C48.1 Malignant neoplasm of specified parts of peritoneum is more specific because this neoplasm involved the left retroperitoneum adjacent to the left renal pelvis and encasing the left ureter

Next, the intraoperative complications will need to be listed. In the ICD-10-CM Alphabetic Index look for Complication/intraoperative/puncture or laceration/genitourinary organ or structure/during procedure on other organ leading to N99.72. Tabular List confirms N99.72 is correct. The procedure performed was on the digestive system.