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### How to Dissect An Operative Report

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### Disclaimer

Information contained in this text is based on CPT®, ICD-9-CM and HCPCS rules and regulations. However, application of the information in this text does not guarantee claims payment. Payers' interpretation may vary from those found in this text. Please note that the law, applicable regulations, payer' instructions, interpretations, enforcement, etc., may change at any time. Therefore, it is crucial to stay current with all local and national regulations and policies.

# Three Main Reasons to Dissect an Operative Report

- 1. To ensure coding accuracy
- 2. For auditing purposes
- 3. For educational purposes

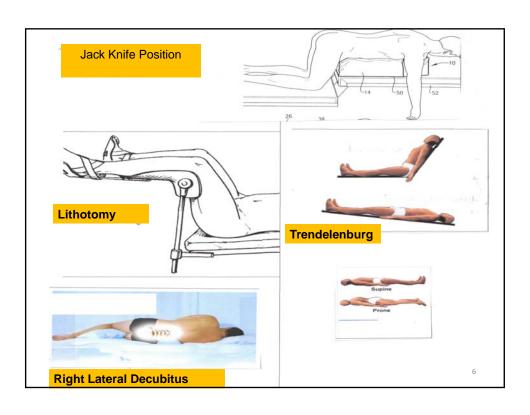
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### **Helpful Tools**

- Having access to the actual operative report, not just a billing sheet where the physician selects the codes.
- Having medical terminology/anatomy experience, or access to the material via diagrams or the internet or a good terminology book
- Having the current year CPT®, ICD-9, and HCPCS books

### **Helpful Tools**

- Access to the National Correct Coding Initiative Edits (NCCI)
- Access to the fee schedules (RVU)
- Diagram or knowledge of surgical positions (see next page)



### Coding from an Operative Report

### The Surgical Package:

- 1. Local Infiltration, metacarpal/metatarsal/digital block
- 2. Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure
- 3. Writing orders
- 4. Evaluating patient in the Post-Anesthesia recovery area
- 5. Immediate post-operative care

### Coding from an Operative Report

### Standards of Medical/Surgical Practice:

- 1. Cleansing/shaving/prepping skin
- 2. Surgical approach, incision, lysis of simple adhesions
- 3. Insertion and removal of drains, suction devices, dressings, pumps into same site
- 4. Surgical closure
- 5. Pre-op, intra-op, post-op documentation (photos, drawings, dictation, transcription)

The Preoperative Diagnosis

Why is the patient here today?

Not necessarily the reason
for all the procedures. This is
why the patient has now
presented for is the
"planned procedure."

## Coding from an Operative Report The parts of an operative report

The Postoperative Diagnosis

Why were the procedures performed?
What was discovered during the operation?
Where was the work performed?

The Operation

Title of the Procedure

Brief description of what procedures were performed This should be a total listing, whether or not the item can be coded/billed

DO NOT CODE FROM THIS

DESCRIPTION!

# Coding from an Operative Report The parts of an operative report

- 1. Who did the work?
- 2. Assistants?
- 3. Co-Assistants?
- 4. Co-Surgeons?
- 5. Team?

**Surgeons** 

#### Type

- Anesthesia
- General
- Regional
- Moderate Sedation

## Coding from an Operative Report The parts of an operative report

- What disease/injury/condition created the need for the surgery?
- Indications
- Is there any indication that there is an existing global period?
- Are there indications that this may be a more difficult procedure?

- The procedure clearly outlined
- Any complications or misadventures noted

### Procedure Note

- · Any unsuspected findings
- All unusual findings and additional work

## Coding from an Operative Report The parts of an operative report

- · Patient position
- Approach

### Procedure Note

- Anatomic site
- Depth
- Findings

### Procedure Note

- Excisions
- Biopsies
- Lesions
- Foreign Bodies

### Coding from an Operative Report The parts of an operative report

### Procedure Note

- Anastomoses
- Tubes placed-drainage/feeding
- Hardware used as part of repair
- Grafts

### Procedure Note

- Closure(s)
- Therapy line placements
- Amount of blood loss
- Patient's status

### Most Commonly Used Surgical Modifiers

- 22 Increased Procedural Service
- 50 Bilateral Procedure
- 51 Multiple Procedures
- 59 Distinct Procedural Service
- 58 Staged or Related Procedure
- 78 Unplanned Return to the Operating Room
- 79 Unrelated Procedure
- 53 Discontinued Procedure
- 26 Professional Component

0.9

# Coding For Abdominal Procedures

Hernias
Gallbladders
Colectomies

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#1

Ventral hernia repair with mesh

**PROCEDURE**: Ventral hernia repair with mesh

**SURGEON:** Dr. Meranda Bailey

**SPECIMEN:** Sac contents

PRE OP DX: Ventral hernia and possible right inguinal hernia

**POST OP DX**: Ventral hernia

**DRAINS**: none

**COMPLICATIONS**: none

**IMPLANT**: Large Bard Ventralex mesh

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### Ventral hernia repair with mesh

#### **INDICATIONS:**

Ms Breeden is a 79 <u>yr old woman with an upper midline ventral hernia which caused quite a bit of bulging and some pain.</u> It was suggested that she <u>undergo a laparoscopic ventral hernia repair</u>, and <u>also then a laparoscopic exploration and evaluation of the right groin with repair of any hernias identified in that area.</u>

### Ventral hernia repair with mesh

Note #1

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### Ventral hernia repair with mesh

- Codes: 49652 Lap Ventral Hernia(includes mesh)
- Rationale: This was a Laparoscopic procedure. We did not code separate for the mesh (49568) because it is included in the code per CPT guidelines. We did not code for the groin exploration due to the fact there is not a sufficient code, and there was no hernia found. This was diagnostic.

### #2

Repair of incarcerated umbilical hernia with mesh reinforcement. Laparoscopic placement of peritoneal dialysis catheter

Repair of incarcerated umbilical hernia with mesh reinforcement. Laparoscopic placement of peritoneal dialysis catheter

PRE OP DX: Renal failure and umbilical hernia with

incarceration

POST OP DX: Renal failure and umbilical hernia with

incarceration

**SURGEON**: Dr. Alex Carev **ANESTHESIA**: General

INDICATIONS: A 63 yr old female who needs dialysis access

and also has an incarcerated umbilical hernia with

preperitoneal fat and omentum.

Repair of incarcerated umbilical hernia with mesh reinforcement. Laparoscopic placement of peritoneal dialysis catheter.

Note #2

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Repair of incarcerated umbilical hernia with mesh reinforcement. Laparoscopic placement of peritoneal dialysis catheter

**49587** - Umbilical incarcerated hernia repair

49324 - Lap Peritoneal Catheter

**Rationale:** The Umbilical hernia was an open incarcerated procedure. This was listed first due to the allowed amounts being higher. The PD catheter was performed laparoscopically.

#3

Anterior repair with Ethicon Prolene Hernia System, size medium and large mesh

Anterior repair with Ethicon Prolene Hernia System, size medium and large mesh

PRE OP DX: Incisional and umbilical hernias

POST OP DX: Same as above

**SURGEON:** Dr Meranda Bailey

**ANESTHESIA:** General

**COMPLICATIONS:** There were no complications

**ESTIMATED BLOOD LOSS:** Minimal

### Anterior repair with Ethicon Prolene Hernia System, size medium and large mesh

#### **INTRAOPERATIVE FINDINGS:**

At the umbilicus, there was a small, approximately 1.5cm umbilical hernia with a secondary defect in the fascia just to the right inferior aspect of the wound and it was about 0.5cm Small, approximately 1 cm to 1.2 cm subxiphoid defect with incarcerated preperitoneal fat.

<u>INDICATIONS FOR PROCEDURE</u>: A 55 yr old Caucasian woman with a progressively <u>enlarging and symptomatic incisional hernia</u> at a subxiphoid trocar site. She also has a <u>small umbilical hernia</u>.

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### Anterior repair with Ethicon Prolene Hernia System, size medium and large mesh

Note #3

### Anterior repair with Ethicon Prolene Hernia System, size medium and large mesh

Codes: 49561 - Incarcerated hernia repair

49568 – Insertion of mesh

49587 - Incarcerated umbilical hernia repair

**Rationale:** Both hernias were performed through an open incision. Both hernia's were incarcerated. The mesh is coded to go along with the 49561 code only. The 49561 was first due to the fact that it carried a higher allowed amount.

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#4

Left scrotal exploration, partial omentectomy, repair of sigmoid colon serosal tear, left inguinal hernia repair, epigastric and umbilical hernia repairs with mesh

Left scrotal exploration, partial omentectomy, repair of sigmoid colon serosal tear, left inguinal hernia repair, epigastric and umbilical hernia repairs with mesh

**SURGEON:** Dr. Arizona Robbins

PRE OP DX: Left hydrocele and possible hernia and

supraumbilical hernia

POST OP DX: Incarcerated left inguinal hernia, umbilical

hernia, and supraumbilical hernia

**COMPLICATIONS:** There was a serosal tear in the sigmoid

colon, it was not full thickness

**ANESTHESIA:** General

**ESTIMATED BLOOD LOSS: Minimal** 

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Left scrotal exploration, partial omentectomy, repair of sigmoid colon serosal tear, left inguinal hernia repair, epigastric and umbilical hernia repairs with mesh

Note #4

Left scrotal exploration, partial omentectomy, repair of sigmoid colon serosal tear, left inguinal hernia repair, epigastric and umbilical hernia repairs with mesh

Codes: 49507-(LT) Incarcerated Inguinal Hernia Repair
49587 – Incarcerated Umbilical Hernia Repair

**Rationale:** Even though, a 44604 and 49255 were performed, they were bundled according to CCI Edit. Both hernia's were incarcerated. The mesh is not billable with either of the selected codes.

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#5

INCISIONAL HERNIA REPAIR WITH MESH AND BILATERAL RECTUS MUSCLE FLAP TRANSFER

### INCISIONAL HERNIA REPAIR WITH MESH AND BILATERAL RECTUS MUSCLE FLAP TRANSFER

**Pre-op Dx:** Multiple Incisional hernias

Post-op Dx: Multiple Incisional hernias

Surgeon: Dr Webber

Anesthesia: General

**Complications:** none

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### INCISIONAL HERNIA REPAIR WITH MESH AND BILATERAL RECTUS MUSCLE FLAP TRANSFER

Note #5

### INCISIONAL HERNIA REPAIR WITH MESH AND BILATERAL RECTUS MUSCLE FLAP TRANSFER

CODES: 15734 - Muscle Flap; Trunk

15734 - 59

49561 - Repair Incisional hernia; incarcerated

49568 - Insertion of mesh

**RATIONALE:** This was coded as an incarcerated incisional hernia with insertion of mesh. This patient also had to have a bilateral muscle flap. Due to the fact the code 15734 is not modifier 50 approved, we had to use modifier 59 appended to the second code of 15734.

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#6

### **Example of Modifier 22**

Subtotal Colectomy w/end colostomy, take down of splenic flexure. Extensive Lysis of Adhesions

### **Example of Modifier 22**

Subtotal Colectomy w/end colostomy, take down of splenic flexure. Extensive Lysis of Adhesions.

**Date of Surgery:** 10/18/11

**Surgeon:** Dr Lexie Gray

Preoperative Diagnosis: Lower GI Bleed

Postoperative Diagnosis: Lower GI Bleed

**Anesthesia:** General

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Indications: This 68 yr old female with multiple medical problems who presented with lower GI bleed. She has been hypotensive, has received prior to surgery, 6 units of packed Red blood cells. She is now on pressor support. She had a lower endoscopy with finding of Diverticulosis. The patient did have a bleeding scan on 10/16/11, which did not show a source of bleeding. She continues to be critically ill with obvious ongoing GI blood loss, as noted on exam; continued pressor support dependence. I have advised urgent subtotal colectomy with colostomy.

The patient <u>does have <u>multiple comorbidities</u> including <u>morbid obesity</u>, COPD, for which she is dependent on home oxygen, hysterectomy for endometrial cancer, bilateral mastectomies for breast cancer, coronary artery disease, chronic atrial fibrillation, obstructive sleep apnea and Hypertension.</u>

# Subtotal Colectomy w/end colostomy, take down of splenic flexure. Extensive Lysis of Adhesions

### Note #6

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# Subtotal Colectomy w/end colostomy, take down of splenic flexure. Extensive Lysis of Adhesions

Codes: 44143-22 - Hartmann type Colectomy 44139 - Mobilization of Splenic Flexure

**Rationale:** Used a modifier 22 due to the extensive lysis of adhesions and because of the patient's body habitus. Mobilization of the splenic flexure is also billable.

See next slide for the "kiss letter" that was used because of the modifier 22 usage.

Patient: Lucille Ball
Date of Surgery: 10/18/11
Subject: Modifier 22

To whom it may concern:

We are adding a modifier 22 to code 44143 due to this very difficult case. The patient had extreme co-morbidities such as morbid obesity, COPD, hypotension and GI Bleed. This added a great deal of risk and difficulty to this case, as well as the extensive lysis of adhesions that took over an hour to perform. The physician also spent close to 2 hours on standby in the angio suite prior to the surgery.

We are asking for an additional 30% reimbursement to this very difficult and risky case.

Please see attached operative report.

Thank You,

The office of Dr Lexy Gray

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### **More Examples of Kiss Letters**

Code: 47562 - 22 - Lap Cholecystecomy

**Kiss Letter:** To whom it may concern, we are billing this procedure with a modifier 22 due to the patient's body habitus and excessive BMI that made it quite difficult to dissect the gallbladder from the liver bed. This part of the procedure took 2 hours to perform. The size of the patient and the size of the gallbladder made this procedure extremely difficult during the case. Please also note that the patient was hypotensive during the case.

We are asking for an additional 30% reimbursement.

### **Example of Kiss Letter**

Code: 49565-22 - Recurrent Incisional

Hernia

To whom it may concern, we are adding a modifier 22 to code 49565 due to the extensive lysis of adhesions that took 2 ½ hours to perform. This caused a great deal of time, risk, and difficulty.

We are asking for an additional 25% reimbursement.

Please see attached operative report.

5:

#7

Laparotomy, gastrotomy, enterotomy and removal of foreign body from stomach and proximal jejunum

# Laparotomy, gastrotomy, enterotomy and removal of foreign body from stomach and proximal jejunum

Pre-Op Dx: Ingested foreign bodiesPost-Op Dx: Ingested foreign bodies

**Surgeon:** Meranda Bailey

Anesthesia: General

**INDICATIONS:** This 47 yr old woman with a history of multiple episodes of ingestion of foreign bodies, some requiring surgical procedures to remove them. She again has ingested a large amount of foreign material.

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Laparotomy, gastrotomy, enterotomy and removal of foreign body from stomach and proximal jejunum

**Note #7** 

Laparotomy, gastrotomy, enterotomy and removal of foreign body from stomach and proximal jejunum

CODES: 44020 – Enterotomy, small intestine for exploration or foreign body removal

**43500** - Gastrotomy, with exploration or foreign body material.

**RATIONALE:** We billed for the foreign body removal of the stomach and for the jejunum.

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# Colonoscopies Hemorrhoidectomies

#8

**Colonoscopy** 

**Procedure: Colonoscopy** 

**SURGEON**: Dr McDreamy

**PRE OP DX:** Diverticulitis **POST OP DX:** Diverticulitis

**ANESTHESIA:** Five mg of Versed Iv and 50 mcg fentanyl IV **INDICATIONS:** This is an 86 yr old white male who previously had undergone a Hartmann's procedure for diverticulitis. He now is presenting for a colonoscopy prior to a Hartmann's reversal. After discussing risks and benefits of colonoscopy, informed consent was obtained.

### **Colonoscopy**

### Note #8

### **Colonoscopy**

Codes: 44388 - Colonoscopy through Stoma

**Rationale:** The physician was just checking the rectal area through the scope to make sure the area was cleaned. He then performed a complete colonscopy through the stoma.

#9

Colonoscopy, Diagnostic

PROCEDURE PERFORMED: COLONOSCOPY

**SURGEON:** Dr. House

PRE OP DX: Rectal Bleeding

**POST OP DX:** Hemorrhoids

**ANESTHESIA:** Five mg of Versed IV and 100 mg of fentanyl IV **INDICATIONS:** This is a 41 year old female who presented as an outpatient with complaints of rectal bleeding. She did on exam, have some internal hemorrhoids; however, she has a family history significant for colon cancer and so now presents for colonoscopy. After discussing risks and benefits informed consent was obtained.

### **COLONOSCOPY**

Note #9

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### **COLONOSCOPY**

**Codes:** 45378-53 - Colonoscopy; diagnostic past the splenic flexure.

**Rationale:** Modifier 53 was used here because the procedure was aborted. The scope was not advanced

#### **Example of "Kiss Letter"**

To whom it may concern,

We are adding a modifier 53 due to the fact that the scope was not advanced past the splenic flexure because of the tortuous colon and the patient's tolerance.

# 10

#### **FLEXIBLE SIGMOIDOSCOPY**

PROCEDURE PERFORMED: FLEXIBLE SIGMOIDOSCOPY

**SURGEON:** Dr Addison Montgomery

PRE OP DX: Diverticulitis

**POST OP DX:** Diverticlitis

ANESTHESIA: Versed Iv 3 mg and fentanyl IV 75 mcg.

**INDICATIONS FOR OPERATION**: This is a 57 yr old female who was in the hospital with focally perforated diverticulitis. She now is approximately 6 weeks out from this episode <u>and is ready to undergo elective colonoscopy prior to sigmoid resection</u>. Risks and benefits of the procedure were discussed with the patient and she agreed to proceed.

### **FLEXIBLE SIGMOIDOSCOPY**

Note # 10

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### **FLEXIBLE SIGMOIDOSCOPY**

Codes: 45378-53 - Colonoscopy; diagnostic

Rationale:

This procedure was intended to be colonoscopy.

However, due to poor bowel prep, the procedure had to be aborted.

This is coded as a colonoscopy with a modifier 53 due to the fact that the scope did not get past the splenic flexure.

### # 11

### **External Hemorrhoidectomy**

**PROCEDURE:** External Hemorrhoidectomy

**SURGEON**: Dr Derek Sheppard **PRE OP DX**: External Hemorrhoids **POST OP DX**: External Hemorrhoids

**Anesthesia:**General **SPECIMENS:** Hemorrhoids

**INDICATIONS FOR OPERATION**: This is a 47 yr old female who has had a <u>history of discomfort with external hemorrhoids</u> and additionally with <u>some intermittent bleeding</u>. She recently underwent a colonoscopy which was normal and her only complaint now is an external hemorrhoid. After discussing risks and benefits of hemorrhoidectomy, she agreed to proceed.

### **External Hemorrhoidectomy**

Note #11

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Codes: 46320 – Excision of Thrombosed hemorroid, external

**Rationale:** This ended up being an excision of an external bleeding thrombosed hemorroid.

#### **External Hemorrhoidectomy**

Codes: 46320 – Excision of Thrombosed hemorroid, external

**Rationale:** This ended up being an excision of an external bleeding thrombosed hemorrhoid.

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# BREAST PROCEDURES

Left simple mastectomy with intraoperative lymphatic mapping and left axillary sentinel node dissection.

Procedure: Left simple mastectomy with intraoperative lymphatic mapping and left axillary sentinel node dissection.

12/14/11

**Surgeon:** Dr Addison Montgomery

**Preop Dx:** Ductal carcinoma in situ left breast **Postop Dx:** Ductal carcinoma in situ left breast

**Indications:** The patient is a 76 yr old woman who presents with path confirmed ductal carcinoma of the left breast. She wishes to proceed with planned left mastectomy without reconstruction and with sentinel node biopsy, possible completion axillary node dissection. I have discussed the operative technique in detail. All questions were answered.

Left simple mastectomy with intraoperative lymphatic mapping and left axillary sentinel node dissection.

Note # 12

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Left simple mastectomy with intraoperative lymphatic mapping and left axillary sentinel node dissection.

Codes: 19303-LT - Total/Simple Mastectomy
38525-LT - Excision Axillary Node
38900 - Mapping of Sentinel Node

**Rationale:** This was coded as simple (Total) mastectomy. The 38525 is coded for the sentinel node excision. The 38900 is for the mapping of the node.

#### **MAMMOTOME BREAST BIOPSY**

PROCEDURE: MAMMOTOME BREAST BIOPSY

Pre-op Dx: Mass, right breast

Post-op Dx: Mass, right breast

**Surgeon:** Dr Addison Montgomery

Anesthesia: Local

PROCEDURE: MAMMOTOME BREAST BIOPSY

Note #13

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#### **MAMMOTOME BREAST BIOPSY**

CODES: 19103 – RT – Percutaneous automated vacuum assisted biopsy device; using imaging guidance

19295 – Image guided placement, metallic localization clip, percutaneous

76942 - Ultrasonic guidance for needle placement (biopsy, aspiration, localization device)

### EXISION OF SKIN CANCERS, LIPOMAS AND MELANOMAS

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# 14

EXCISION 3CM LIPOMA, PERINEUM

OPERATIVE PROCEDURE: EXCISION 3CM LIPOMA, PERINEUM

PRE OP DX: Left peroneal massPOST OP DX: Left peroneal mass

**ANESTHESIA:** MAC **COMPLICATIONS:** 

**ESTIMATED BLOOD LOSS:** minimal

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### EXCISION 3CM LIPOMA, PERINEUM

Note # 14

### EXCISION 3CM LIPOMA, PERINEUM

**CPT Code:** 27043 – Excision tumor,

Soft tissue of Pelvic area; subcutaneous, 3cm or

greater

Rationale: This code was selected

due to the size (3cm), the location (perineum) and the fact that is was dissected down to the

subcutaneous tissue.

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# 15

EXCISION TUMOR RIGHT ARM WITH LAYERED CLOSURE

PROCEDURE: EXCISION TUMOR RIGHT ARM WITH LAYERED CLOSURE

Pre-op Dx: Tumor right arm

Post-op Dx: Squaumous cell right arm

**Surgeon:** Dr Addison Montgomery

Anesthesia: MAC

**Findings:** Frozen section of this 3 x 3cm lesion was performed and confirmed a squamous cell cancer.

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### EXCISION TUMOR RIGHT ARM WITH LAYERED CLOSURE

Note # 15

## EXCISION TUMOR RIGHT ARM WITH LAYERED CLOSURE

#### **CPT CODES:**

13121 – Repair complex, arm; 2.6cm - 7.5cm 13122 - each additional 5 cm or less 11606 – Excision Malignant Lesion, arm; over 4 cm

**RATIONALE:** This was coded as a malignant lesion. Because of the layered closure and creating flaps by undermining the subcutaneous tissue, this was coded as a complex repair.

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#### #16

Wide excision of left upper back melanoma. Complex layered closure measuring 18 cm.
Intraoperative lymphatic mapping with left axillary sentinel lymph node biopsy.

PROCEDURES: Wide excision of left upper back melanoma. Complex layered closure measuring 18 cm. Intraoperative lymphatic mapping with left axillary sentinel lymph node biopsy.

Pre-op Dx: Path confirmed 5 mm melanoma of left

upper back.

Post-op Dx: Same

Surgeon: Meranda Bailey

who presents with path confirmed melanoma of the upper back. He has no other evidence of disease. I have discussed the operative technique in detail with the patient and family and they wish to proceed.

Wide excision of left upper back melanoma. Complex layered closure measuring 18 cm.
Intraoperative lymphatic mapping with left axillary sentinel lymph node biopsy

Note # 16

Wide excision of left upper back melanoma. Complex layered closure measuring 18 cm.

Intraoperative lymphatic mapping with left axillary sentinel lymph node biopsy

CODES: 38525- LT - Excision of Deep Axillary Node

38900 - Lymphatic Mapping

11606 - Excision Malignant Lesion over 4cm

13101 - Repair, Complex; Trunk 2.6 to 7.5cm

13102 x 3 - each additional 5 cm or less

**RATIONALE:** This patient had a sentinel node bx performed in the left axilla. The patient's melanoma was over 4 cm once you added the margins. We coded for the complex closure according to the incision size of 18 cm.

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# 17

Wide Excision and Closure of Flank Lipoma

**Procedure: Wide Excision and Closure of Flank Lipoma** 

Pre-op Dx: Lipoma

Post-Op Dx: Right Flank Lipoma

Anesthesia: MAC

Findings at Surgery: 8 cm lipoma

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#### Wide Excision and Closure of Flank Lipoma

Note # 17

#### Wide Excision and Closure of Flank Lipoma

Codes: 21933 – Excision tumor, soft tissue of back or flank; subfacial, 5cm or greater

Rationale: This was coded by the location (flank), the size (8 cm), and the depth (subfascial).

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# VASCULAR PROCEDURES

## Port-A-Cath insertion, subclavian approach

PROCEDURE: Port-A-Cath insertion, subclavian approach

**SURGEON:** Dr Meridith Grey

ANESTHESIA: Local 1% lidocaine and IV sedation

**INDICATIONS:** Eighty-four year old male who has lung cancer

and needs a port for chemotherapy

## Port-A-Cath insertion, subclavian approach

Note # 18

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## Port-A-Cath insertion, subclavian approach

Codes: 36561 - Insertion of tunneled catheter
77001(26) - Fluoroscopic guidance for central
venous access

Rationale: This was a tunneled catheter w/port on an adult. The 77001 is for the S&I of the Port-a-Cath. The modifier 26 was used due to the fact that the physician performed this at the hospital.

Right Popliteal to dorsalis pedis bypass
 with nonreversed Ipsilateral
 translocated greater saphenous vein

 Amputation of a portion of the great
 toe, right foot

PROCEDURE: 1) Right Popliteal to dorsalis pedis bypass with nonreversed Ipsilateral translocated greater saphenous vein 2) Amputation of a portion of the great toe, right foot

**PRE OP DX:** PVD, right lower extremity, with an infection of right great toe with tissue loss.

POST OP DX: Same as above

**SURGEON:** Dr. McDreamy

ANESTHESIA: General, sciatic block

**COMPICATIONS:** None

**INDICATIONS:** The patient is <u>a 68 yr old woman with</u> <u>diabetes mellitus and pvd</u> with trifurcation occlusion of her right leg. She had <u>a chronic ulcer of her right great toe</u> and also more recently infection in the nail bed of the great toe which resulted in exposure of the distal tuft of her bone. It was felt that revascularization and amputation of the distal great toe would be indicated. The benefits, risks, complications and alternatives were explained and she agreed to proceed.

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1) Right Popliteal to dorsalis pedis bypass with nonreversed Ipsilateral translocated greater saphenous vein 2) Amputation of a portion of the great toe, right foot

Note # 19

1) Right Popliteal to dorsalis pedis bypass with nonreversed Ipsilateral translocated greater saphenous vein 2) Amputation of a portion of the great toe, right foot

Codes: 35571-RT – Popliteal and other distal vessels 28825-T5 – Amputation, toe; interphalangeal joint

Rationale: This was a bypass graft using vein. The saphenous vein is included in the work of the procedure. It is always important to list the modifier for the side of the body that is being operated on. The toe amputation was down to the interphalangeal joint. The T5 modifier indicates which toe is being amputated.

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## Coding from an Operative Report Putting it all Together

- Use a copy
- · Highlight any unknown terminology and look it up
- Identify all actions
- · Look up codes
- Apply coding rules
- CCI
- MFS
- Use modifiers as needed

