Getting Through the Operative Report without Crying

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Today’s Objectives and Goals

- Dissect 4 operative reports
  - Hip replacement revision
  - Cerebral angiography
  - Cardioverter defibrillator replacement/upgrade
  - Spinal fusion
- Demystify these tough operative reports
  - Explain the procedures
  - Give clues for code assignment
- Assign PCS codes to operative reports
Have you ever opened an op report and felt like this?

You're not alone!

What You Need to Know About Op Reports and ICD-10-PCS

- You can’t rely on report headers
  - But they can include critical information for coding
  - Read the whole report – read all the words
- You will probably only use 10-20% of the op report
- There is no such thing as bundling in ICD-10-PCS...
  - ...but there is such a thing as a procedure integral to another
Where do you turn?

• The coding guidelines are your first stop for coding advice
  ▫ When to code multiple procedures
  ▫ Guidelines related to specific body parts
  ▫ Approach questions
• Don’t forget the Reference Manual!
  ▫ Character meanings and definitions
    • Root operations
    • Approaches
  ▫ Coding scenario examples
• Coding Clinic
  ▫ Over 3 years of coding advice on ICD-10-CM/PCS

Case 1: The Procedure

**OPERATION:** Left total hip arthroplasty, acetabular component.

**DIAGNOSIS:** Failed left total hip arthroplasty secondary to osteolysis and polyethylene wear.

**Initial Impression:** body part will be hip joint, acetabular
Case 1: The Meat of the Report
The hip was dislocated posteriorly and the head was removed. The stem was noted to have excessive anteversion. The acetabulum was exposed and there was noted to be significant polyethylene wear. The explant was then used to remove acetabular component. There was noted to be some osteolysis posteriorly involving the ischium. This required placement of a larger shell. We ultimately reamed up to a size 57 and impacted a 58 mm shell. The shell was positioned about 40° of abduction. Care was taken not to put too much anteversion on the shell based upon the excessive anteversion on the femoral side. The shell was then stabilized with multiple screws all of which had good purchase. We then trialed and were happy with a +4 liner. This was impacted.

Case 1: More Meat
On the femoral side we used a +5 femoral head. With this we had good stability and adequate restoration of her leg lengths. The definitive head was placed after the taper was cleaned and impacted. The hip was reduced and then the rotators repaired. A deep drain was then placed.
Case 1: The Stuff You May Have Missed

**IMPLANTS USED:**
Depuy multi holed gription, cementless acetabular shell. Size 58 mm. We used a +4 neutral acetabular insert. A 36 mm +5 femoral head.

Initial Conclusion: Wrong!

Case 1: The Codes

- **0SRBOJA**, Replacement of Left Hip Joint with Synthetic Substitute, Uncemented, Open Approach
- **0SPBOJZ**, Removal of Synthetic Substitute from Left Hip Joint, Open Approach

Notes
- *Coding Clinic, 2nd Quarter 2015* states replacement of femoral head without stem codes to hip replacement
- In this case, would not code acetabular liner since it is integral to a total hip replacement
- Guideline B6.1b: drains are integral to the procedure and not coded separately
Case 2: The Procedure Header

PROCEDURE: Three-vessel cerebral angiogram, right common femoral artery runoff; Angio-Seal closure, right common femoral arteriotomy.

Indication: 65-year-old male with acute left hemiparesis with high NIHSS of 13. He was transferred for acute stroke intervention. He did not receive IV-tPA at prior hospital because of severe hypertension.

Initial Thoughts:
- Does my facility code angiograms?
- The patient hasn’t received tPA

Case 2: The Meat of the Report

The right common carotid artery was first selected. Based off a roadmap, the right ICA was selected. Then intracranial AP, lateral and Caldwell right oblique images were performed. These images did not demonstrate any occlusion in the right anterior circulation. Then the catheter was retracted into the right common carotid artery. Cervical AP and lateral images were performed.
Case 2: More Meat

Next the posterior circulation was investigated to ascertain whether this was a posterior circulation stroke given the finding of ataxia on NIH stroke scale performed at the outside hospital. Then the catheter was retracted into the left subclavian artery. Roadmap was obtained. Using roadmapping, the left vertebral artery was selected. Intracranial AP and lateral were obtained. Next the catheter was retracted to the proximal left subclavian. Cervical vertebral artery images were taken. Next the catheter was retracted into the left common carotid artery. Cervical AP and lateral images were obtained. Then intracranial AP, lateral and Caldwell left oblique images were performed. Next the catheter was retracted to the right brachiocephalic artery. Using the roadmap, the right subclavian artery was selected. Then the proximal cervical vertebral artery image was obtained.

Case 2: Quick Anatomy Tutorial

- Intent of this procedure:
  - View the carotid artery distribution
    - Cervical (neck)
    - Anterior cerebral
  - View the vertebral artery distribution
    - Cervical
    - Posterior cerebral
Case 2: The Interpretation

Confirmation of areas imaged
1. Right common/internal carotid artery. Intracranially the internal carotid artery...
2. Left subclavian/vertebral artery. The left vertebral artery is seen to give rise to the posterior inferior cerebellar artery intracranially...
3. Left common/internal carotid artery. Intracranially the internal carotid artery...
4. Right vertebral artery
5. Right common femoral artery runoff

Case 2: Additional Notes about Interpretation

- Subclavian artery imaging is integral to vertebral imaging
- Right common femoral artery runoff has no documented indication and was likely done to check for vascular closure placement
Case 2: Medications and Contrast

Medications: Ancef 3 grams IV was administered at the commencement of the procedure. Fentanyl 50 mcg and Versed 0.5 mg were administered for conscious sedation under cardiopulmonary monitoring, by the angiography team. He was started on alteplase infusion 90 milligram total with 10% as a bolus after BP achieved within appropriate parameters. Labetalol 20 mg IV x1 at the commencement of the procedure and IV Cleviprex titrated infusion were administered during the procedure for blood pressure control to maintain at less than or equal to 180/105.

Contrast Visipaque approximately 136 cc.

Case 2: The Codes

- **3E03317**, Introduction of Other Thrombolytic into Peripheral Vein, Percutaneous Approach
- **B318YZZ**, Fluoroscopy of Bilateral Internal Carotid Arteries using Other Contrast
- **B31GYZZ**, Fluoroscopy of Bilateral Vertebral Arteries using Other Contrast
- **B31RYYZZ**, Fluoroscopy of Intracranial Arteries using Other Contrast
Case 2: Additional Notes about the Codes

- The most distal artery in the anterior distribution is internal carotid
- The most distal artery in the posterior circulation is vertebral carotid
- Intracranial arteries were imaged from the carotid and vertebral distributions
- The femoral angiogram is integral to the procedure and not coded separately
- Visipaque contrast is an iso-osmolar contrast medium, which is coded as “Other Contrast”

Case 3: The Procedure Header

PROCEDURES PERFORMED:
1. Implantation of a new left ventricular lead.
2. Implantation of a new right ventricular defibrillating lead.
3. Implantable cardioverter-defibrillator pocket revision.
4. Implantable cardioverter defibrillator generator change.
5. Defibrillation threshold testing.

DIAGNOSES:
1. Class II to III systolic heart failure.
2. Left IVCD with QRS duration exceeding 130 ms.
3. Ischemic cardiomyopathy with a severely reduced ejection fraction.
4. Recalled Fidelis defibrillating lead in place.
5. ICD at elective replacement interval.
Case 3: Clues and Key Points

- Device type is defibrillator, not pacemaker
  - This is a very big deal!
- There is a left ventricular lead
  - This is a cardiac resynchronization (CRT) device

BIG CLUE: Lead placement in left ventricle/coronary sinus is not a conventional device!

Case 3: Indications for the Procedure

The patient is a 72-year-old man with ischemic cardiomyopathy related to a large lateral infarction several years ago. He has been followed by Dr K. primarily since implantation of a dual-chamber defibrillator for protection from sudden cardiac death. The device reached end of life last month. His left ventricular function was reevaluated with an echo and his ejection fraction remains quite poor in the 20s. His QRS duration is 140 ms, therefore he was felt to be a candidate for upgrading his dual-chamber device to a CRT-D (cardiac resynchronization therapy/defibrillator). He had a Medtronic 6949 Fidelis lead and Dr. K. recommended replacing the lead at the time of his generator change. He will also receive a new LV lead.
Case 3: The Meat of the Report

Device was removed from the pocket and disconnected from the leads and the leads were carefully freed from adhesions. We then performed an axillary puncture over the 1st rib. Leads were placed under fluoroscopy. The new right ventricular lead is a single coil Medtronic 6935. We found a suitable septal position and extended to helix. R wave was 10 to 12. Electrogram was wide and subsequently narrowed down. Impedance started at 800, came down to 650. Threshold started at 0.8 and came down to 0.6. There was no phrenic stimulation at 10. We sutured the lead in place.

Case 3: More Meat

We cannulated the coronary sinus with an extended hook delivery system and a Glidewire. We performed several venograms of the coronary sinus. There was only 1 mid lateral branch that was small and tortuous. There was a large posterolateral branch. First, we targeted the mid lateral branch. With some difficulties, we were able to advance the wire into the vessel, but we were not able to follow it with the lead. We then targeted the posterolateral branch. We placed a St. Jude quadripolar lead into the branch in the position that we accepted, placing between electrodes 4 and RV coil, had an impedance of 600, there was no phrenic stimulation at 10, and pacing threshold was between 1 and 1.5 V.
Case 3: Even More Meat

We then removed the LV lead delivery system using a slitter. We adjusted the amount of redundancy on the lead, and sutured it in place. To accommodate the antibiotic pouch, we enlarged the pocket in inferior and medial directions and achieved hemostasis after doing so.

Case 3: But Wait… There’s More!

We then capped all 3 portions of the Fidelis lead. We reused the chronic right atrial lead. We reconnected the chronic right atrial lead and the new right ventricular lead and the new left ventricular lead to the device. We plugged the SVC port. We placed the device in the antibiotic pouch and then in the pocket and proceeded with DFT testing. Additional sedation was administered by anesthesia. Ventricular fibrillation was induced. With ventricular sensitivity programmed to the least sensitive setting, it was promptly recognized. A 24 joule shock was delivered in B TO AX configuration. Shock impedance was 80 ohms, which is expected for the single-core lead configuration. Duration of the 1st and the 2nd phases of the shock were 5.5 and 3 ms respectively.
Case 3: The Codes

- **0JH609Z**, Insert CRT Defib Pulse Gen in Chest Subcu/Fascia, Open
- **02HK3KZ**, Insertion of Defibrillator Lead into Right Ventricle, Percutaneous Approach
- **02H43KZ**, Insertion of Defibrillator Lead into Coronary Vein, Percutaneous Approach
- **0JPT0PZ**, Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
- Optional
  - **3E0102A**, Introduction of Anti-Infective Envelope into Subcutaneous Tissue, Open Approach
  - **4B02XTZ**, Measurement of Cardiac Defibrillator, External Approach

Case 4: The Procedure Header

**PREOPERATIVE DIAGNOSIS:**
Lumbar spinal stenosis, spondylolisthesis, and scoliosis L3-S1.

**POSTOPERATIVE DIAGNOSIS:**
Lumbar spinal stenosis, spondylolisthesis, and scoliosis L3-S1.

**OPERATION PERFORMED:**
L3-S1 lumbar laminectomy, decompression of cauda equina, posterior spinal fusion, segmental instrumentation, and local bone grafting.

This procedure involves 2 lumbar joints (L3-4 & L4-5) and 1 lumbosacral joint.
Case 4: The Meat of the Report

**SUMMARY OF OPERATION:** After adequate general anesthesia was obtained, the patient was positioned prone on the operating table. We prepped and draped the back in the usual sterile fashion.

The facet joint capsules were stripped at L3-4, L4-5, and L5-S1. The osteophytes were removed as well. We stripped the interspinous ligaments at L3, L4, and L5. Next, we used a half-inch osteotome, Leksell rongeurs, and Kerrison rongeurs to open our laminectomy. We removed the entire lamina of L3, L4, and L5. We found very severe stenosis, especially on the right side at L3-4 and L4-5.

Case 4: More Meat

We thoroughly irrigated out the entire incision with sterile saline. Next, we used the Synthes Universal Spine System and placed 7 x 45 mm screws at L3, L4, L5, and sacrum. On the left side, I was able to use the standard landmarks of the base of the transverse process and junction with the superior facet. On the right side, the anatomy was significantly distorted because of the degenerative scoliosis. I was able to place screws at L3, L4, and S1 using the standard landmarks.

At L5, I had to use radiographic guidance in order to localize the pedicle. After the screws were placed, AP and lateral C-arm images were obtained which showed an acceptable position of all screws.
Case 4: The Rest of it

Finally, we cut and contoured 2 pieces of rod from the Universal Spine System and attached these to the screws on each side. All attachments were torque-tightened appropriately. We decorticated the transverse processes and sacral ala.

This is the fusion.

Our bone graft, which was saved from the laminectomy, was morselized using the bone mill, and it was placed posterolaterally from L3 down to the sacrum on each side.

Case 4: The Codes

- **0SG1071**, Fusion 2-4 lumbar joints with autologous tissue substitute, posterior approach posterior column, open approach
- **0SG3071**, Fusion lumbosacral joint with autologous tissue substitute, posterior approach posterior column, open approach

Notes
- 2 lumbar joints (L3-4 and L4-5)
- 1 lumbosacral joint fused
- Laminectomy is integral
- Pedicle screw fixation is integral
Summary of Tips and Tricks

- Organize your charts by topic/type
  - Immerse yourself and improve productivity at the same time
- Don’t know the procedure? Google it!
  - Anatomy, surgical tools and techniques, etc.
  - Images, videos, and descriptions
  - It’s okay if you have to google almost every word (at first)!
- Read all the words!
- Just for grins and giggles, look it up in Coding Clinic to see if there is published advice

Questions?
Thank You!

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Resources


• American Hospital Association. Coding Clinic for ICD-10-CM and ICD-10-PCS. http://www.ahacentraloffice.org/codes/products.shtml#CCICD10