General Surgery Review: Decoding Operative Reports

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Enjoin, General Surgery Review: Decoding Operative Reports

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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Identify the intent of various general surgery procedures
  - Recognize basic anatomy and operative steps inherent to general surgery procedures
  - Identify common PCS issues within various general surgery procedures

Roux-en-Y Gastric Bypass

- Intent/indications for procedure:
  - Weight loss
  - Gastric or duodenal pathology: Mass, perforation, obstruction
- Pertinent anatomy:
  - Stomach
  - Duodenum
  - Jejunum
Roux-en-Y Gastric Bypass

- Procedural steps:
  - Gastric/duodenal resection or creation of gastric pouch
  - Division of the jejunum
  - Creation of the gastrojejunal bypass
  - Creation of the jejunojunal bypass

- PCS codes:
  - 0D164ZA, Bypass stomach to jejunum
  - 0D1A4ZA, Bypass jejunum to jejunum
  - 0DB64ZZ, Excision stomach, non-diagnostic*

*Not always performed

Roux-en-Y Gastric Bypass

- Associated procedures:
  - Dilation of gastrojejunostomy stricture
    - Use Dilation of both stomach and jejunum (per Coding Clinic, Fourth Quarter 2014, p. 40)
  - Control of bleeding of marginal ulcer
    - Use Control root operation (per Coding Clinic, Fourth Quarter 2016, p. 99)
  - Reversal of gastric bypass
  - Gastro-gastrostomy
Roux-en-Y Gastric Bypass

- Common PCS issues:
  - Keep in mind that not every Roux-en-Y is the same. For example, if the Roux-en-Y bypass is done for bariatric weight loss purposes, an “Excision” of stomach is not done but might be performed in other situations.
  - Both bypasses (stomach to jejunum, jejunum to jejunum) are coded for a Roux-en-Y; however, not all gastric bypasses have the “Roux” limb, in which case the jejunum to jejunum bypass is not coded.
- Coding Clinic guidance:
  - No specific guidance for Roux-en-Y.
Low Anterior Resection

- Intent/indications for procedure:
  - Excision of rectal mass (most often rectal carcinoma)

- Pertinent anatomy:
  - Sigmoid colon
  - Rectum

Low Anterior Resection

- Procedural steps:
  - Mobilization of the splenic flexure
  - Division of the bowel proximally (sigmoid or recto-sigmoid junction or proximal rectum)
  - Takedown of the mesentery and mesorectum (including lymph nodes)
  - Division of the rectum distally (rectum or anorectal junction)
Low Anterior Resection

- PCS codes:
  - 00B02Z/00TP2Z, Excision/Resection of the rectum
  - 00B02Z, Excision of sigmoid
  - 00B02Z, Excision of rectum

- Common PCS issues:
  - More often than not, the rectum and sigmoid colon are both excised and not resected

- Coding Clinic guidance:
  - No specific guidance for low anterior resection

* Not always performed

Loop Ostomies

- Intent/indications:
  - Diverting fecal stream away from an obstruction and/or a newly formed anastomosis (Bypass)

- Pertinent anatomy:
  - Can be formed from any portion of the bowel from the jejunum down to the sigmoid colon

- Procedural steps:
  - Identify loop of bowel proximal to area of concern
  - Create a circular opening through the abdominal wall
  - Pull loop of bowel up through the abdominal wall opening
  - Partially open the bowel and mature the edges to create stoma

End Ostomies

- Intent/indications:
  - To divert the fecal stream entirely out of the abdomen (Bypass). May be temporary or permanent. Used in the setting of acute inflammation, perforation, and/or cancer.

- Pertinent anatomy:
  - End ostomies can be created from the ileum (ileostomy) or the large bowel (Hartmann's procedure).

- Procedural steps:
  - Divide the bowel proximal to the area of concern.
  - Create a circular opening through the abdominal wall.
  - Pull the proximal end of the divided bowel through the abdominal wall opening.
  - Open the end of the divided bowel and mature the edges to create stoma.
Loop Ostomies and End Ostomies

• PCS codes:
  - Both types of ostomies are considered "Bypass, cutaneous"
    - 0D1B0Z4, Bypass ileum to cutaneous, open approach
      - Note: Use "no device" for 6th character
    - 0D1M0Z4, Bypass desc colon to cutaneous, open approach
      - Note: Use "no device" for 6th character

• Associated procedures:
  - Ostomy takedown
  - Ostomy revision
  - Parastomal hernia repair

Ostomy Procedures

• Common PCS issues:
  - Ileostomy "takedown": 0D3B0Z2, Excision ileum, open
    - CC, Third Quarter 2016 states: The root operation for ileostomy takedown is "Excision", because part of the ileum is removed. The anastomosis is considered inherent to the surgery and not coded separately. Further, the root operation "Repair" would only be coded when a parastomal hernia is repaired.
  - Transverse or loop colostomy "reversal":
    - CC, Third Quarter 2016 states: "Excision" is the appropriate root operation for a transverse loop colostomy takedown. Occasionally, the divided portions of the colon are just sutured together without any removal, in which case "Repair" would be the appropriate root operation.
  - Closure of end stoma (Hartmann):
    - CC, Third Quarter 2016 states: After anastomosing (reconnecting) the two ends of the intestine, the bowel is returned to its proper anatomical location within the abdominal cavity. "Reposition" is the appropriate root operation.
  - Parastomal hernia repair: 0WQ10Z2, Repair abdominal wall, open
Lymphatic Procedures

Lymph Node Dissection

- Intent/indications:
  - Performed most frequently in the setting of malignancy (suspected or known)
  - Removal of lymph nodes may also occur in the setting of enlarged and/or painful lymph nodes
  - The intent of the procedure is to remove lymph node(s)
- Pertinent anatomy:
  - Lymph node chain(s)
- PCS codes:
  - Root operation of either Excision or Resection
  - Qualifier of either diagnostic or no qualifier
Lymph Node Dissection

- **Excision vs. Resection—rules of thumb**
  - If a few nodes are removed (1–3), this is most likely an Excision for diagnostic purposes
  - Most lymph node Excisions/Resections are diagnostic in purpose; however, note that a “Resection” does not have an option for the diagnostic 7th character
  - If the description/name of the procedure is a lymph node dissection, this is most likely a Resection (e.g., pelvic lymph node dissection, para-aortic lymph node dissection)
  - If the description/name of the procedure is a lymph node biopsy, this is an Excision
  - When in doubt—query (avoid using the term “removal of entire chain” in the query)

Lymph Node Dissection

- **Common PCS issues:**
  - Difficulty determining the extent of the procedure (Excision vs. Resection)
- **Coding Clinic guidance:**
  - CC, First Quarter 2014: Lymph node “aspiration” biopsy is an Excision (not a Drainage)
  - CC, Third Quarter 2014: If the intent is to remove all of the lymph nodes in an area, code as Resection. A radical resection implies removal of all of the lymph nodes. A modified radical resection is also the removal of all nodes and is coded as Resection.
  - CC, First Quarter 2016: Each lymph node level is considered a chain.
Tunneled Catheter

• Intent/indications:
  – Hemodialysis
  – Extended duration of antibiotics
  – Need for reliable IV access

• Pertinent anatomy:
  – Location of catheter tip (superior vena cava, cavo-atrial junction)
  – Exit site of the catheter (chest wall)

• Procedural steps:
  – Gain access to the venous system (subclavian vein, internal jugular vein, femoral vein)
  – Dilate the vein
  – Insert catheter tip into vein and advance to correct position (often achieved with use of fluoroscopy)
  – Tunnel the catheter end through the subcutaneous tissue and out of the exit site (or if implanting a port, connect the catheter end to the port after tunneling, and then implant the port into the subcutaneous tissue)
Port-a-Cath

![Port-a-Cath Image]

Vascular Catheters

- PCS codes:
  - **Insertion** (tunneled catheter/port), 2 codes required
    - O2HV33Z, Insertion of infusion device into superior vena cava, percutaneous
    - O1H63XXZ, Insertion of vascular access device into subQ tissue chest (approach may be either open or percutaneous)
  - **Removal** (tunneled catheter/port), 2 codes required
    - O2PY33Z, Removal of infusion device from SVC (great vessel)
    - O1PT0XXZ, Removal of vascular access device from subQ of trunk (approach may be either open or external)

Vascular Catheters

- Common PCS issues:
  - PICC lines: Only 1 code for percutaneous insertion of the catheter into either the atrium or SVC (regardless of entry point)
  - Central lines: Only 1 code for percutaneous insertion of the catheter into either the atrium or SVC (regardless of entry point)
  - Totally implantable VAD (port-a-cath): 2 codes required
    - Insertion of the line into atrium or SVC, perc approach
    - Insertion of port into chest subQ, open approach

- **Coding Clinic** guidance:
  - Many examples of vascular catheter coding in CC, Fourth Quarter 2015 and Second Quarter 2016
Skin Grafts and Flaps

• Intent/indications:
  – The intent of a grafting procedure or a flap procedure is to replace a tissue deficit
  – Typically done in the setting of non-healing wounds, burns, or traumas/procedures that leave a large tissue deficit
  – Flaps are also used in the correction of congenital anomalies such as cleft lip

• Pertinent anatomy:
  – Components of the graft/flap: Skin, subQ, fascia, and/or muscle
  – Vascular supply of the graft/flap

Skin Graft and Rotational Flap

• Procedural steps (skin graft):
  – Debride/clean wound bed as needed
  – Harvest graft from donor site (full thickness or split thickness) or prepare non-autologous graft
  – Apply graft to wound bed and secure (suture, staple, wound vac)

• Procedural steps (rotational flap):
  – Excise lesion/clean wound bed as needed
  – Excise edges of flap, leaving at least one edge intact
  – Mobilize flap
  – Rotate flap onto wound bed and secure
  – Close flap bed
Skin Grafts and Flaps

- PCS codes:
  - Skin grafts and free flaps are coded to the root operation Replacement
    - Advancement flaps, rotational flaps, and pedicle flaps are coded to the root operation Transfer
  - Common PCS issues:
    - Breast TRAM flap can be either a free flap or pedicled flap
      - If free flap, use Replacement root operation with 7th qualifier TRAM
      - If pedicled flap, use Transfer root operation with 7th qualifier TRAM
  - Coding Clinic guidance:
    - CC, Fourth Quarter 2008 states: The TRAM procedure can be performed as either a pedicled flap or a free flap.
    - CC, Second Quarter 2014 states: While the main index term for reconstruction alone references the root operations Repair, Replacement, and Supplement, the root operation Transfer is the appropriate root operation for a TRAM flap reconstruction.

Thank you. Questions?
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