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Op Report #1-5

Preoperative diagnosis: Infected mesh from previous incisional hernia repair
Postoperative diagnosis: Same
Operation: Debridement of abdominal necrotized soft tissue with removal of mesh
Anesthesia: MAC with local supplementation
Informed Consent: The risks and benefits of the procedure were explained to the patient. The patient elected to proceed with the procedure.
Procedure: The patient was placed on the operation table in the supine position. The abdomen was prepped and draped in a routine manner. Local anesthetic was infiltrated into the site of the previous incision of the lower abdomen.
A transverse incision was made through the old scar and carried down to the mesh.
Adhesions were lysed from the mesh using blunt and sharp dissection. Necrotized tissue was débrided and the mesh was excised from the muscle attachments.
The wound was thoroughly irrigated with antibiotic solution. Final exploration revealed no remaining necrotized tissue.
Subcutaneous tissue was closed with running 3-0 Vicryl and the skin was closed with running subcuticular 4-0 Monocryl. Estimated blood loss was less than 5 cc's.
A dressing was applied and the patient was released to the recovery room in satisfactory condition. Follow up in the office in 7 days.

ICD-9-CM DIAGNOSES
Postoperative
998.59 Infection and inflammatory reaction due to other internal prosthetic device, implant, and graft
686.8 Other specified local infections of skin and subcutaneous tissue

ICD-9-CM OPERATIONS/PROCEDURES
86.22 Excisional débridement of wound, infection, or burn
86.05 Incision with removal of foreign body from skin and subcutaneous tissue

CPT PROCEDURES
11005 Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure
11008 Removal of prosthetic material or mesh, abdominal wall for infection (e.g., for chronic or recurrent mesh infection or necrotizing soft tissue infection)
(List separately in addition to code for primary procedure) Do not add a modifier to 11008.

Debridement: Removal of dead tissue or foreign matter from a wound

CODES FOR OP REPORT
1. Dissection and débridement of adhesions, part of 11005
2. Débridement of necrotized tissue specified in 11005
3. Excision of mesh described in 11008

Debridement with Removal of Foreign Material

Codes
11010 Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin and subcutaneous tissues
11011 skin, subcutaneous tissue, muscle fascia, and muscle
11012 skin, subcutaneous tissue, muscle fascia, muscle, and bone

These codes only report débridement of open fractures and dislocations. They should not be used to report minor débridement or the normal care that would be taken with an open fracture, such as minor excision of the wound edges (skin margin) necessary to close the defect. These codes are used when foreign material (e.g., particulate matter, dirt, or gravel) is embedded into the tissue and around or at the fracture site and requires meticulous débridement.

It is important to note that two of these codes (11011–11012) are used to report sites that usually are listed in the Musculoskeletal System 20005-29999 series of codes.

Issues
• Use these codes to report débridement of the skin and other sites when an open fracture or dislocation is present. If an open fracture or dislocation is not present, use a code from the 11042–11047 series.
• Open fractures often require some débridement of the skin, subcutaneous tissue, muscle, and/or bone. Use these codes only when significant débridement of tissue is necessary.
• When an open fracture or dislocation débridement code is reported, the diagnosis must correspond to an open fracture.

CCI Edits (Version 16.3)
11010*
11011*
11012*

*The CCI edits associated with the above codes are too numerous to list here. Please consult Medicare’s Correct Coding Initiative for the complete list.
Op Report #1–6

Preoperative Diagnosis: Compound fracture of the right hand, fifth finger, distal phalanx with deep, oblique laceration, dorsal aspect, possible tendon injury. Laceration, right distal phalanx, index finger

Postoperative Diagnosis: Compound fracture, distal phalanx, right fifth finger, with partial laceration of extensor tendon; Laceration, right distal phalanx, index finger

Operation: Debridement of compound fracture, right hand, distal phalanx, fifth finger, with repair of lacerated extensor tendon. Debridement and repair of laceration, distal phalanx, right index finger.

Anesthesia: Local

Blood Loss: Less than 5 cc's

Informed Consent: The risks and benefits of the procedure were explained to the patient. The patient elected to proceed with the procedure(s).

Approach and Surgical Procedure:
The patient was placed on the operating table in the supine position, and the left upper extremity was evaluated. Local anesthetic, a digital block was injected into the index, and fifth finger, by Dr. Smith using adequate quantities of 0.5% Marcaine and 2% Xylocaine. Wearing 3.5 magnification loupes I first took a culture to be sent for gram stain, and culture and sensitivity from the wounds on the right hand. Then the hand was meticulously prepped with Betadine and draped in the usual manner.

First I explored the oblique laceration of the distal aspect of the distal phalanx, fifth finger, medial side: The laceration was approximately 3 centimeters in length. The laceration was found to involve approximately two-thirds of the extensor tendon. I also noted a compound fracture of the distal phalanx.

I thoroughly debrided the wound which was very contaminated, taking time to ensure all particulate matter was removed. Then I irrigated the wound using copious quantities of antibiotic solutions of Kanamycin and Polymyxin. The fracture then was reduced.

Repair of the digitorium communis tendon was accomplished using interrupted 4-0 Vicryl suture.

I then turned my attention to a 1.0 cm ovoid laceration of the distal phalanx of the index finger. This laceration required only minimal debridement using normal saline. I then sutured the laceration using interrupted 4-0 PDS suture. The wounds were then cleaned and Neosporin ointment was applied to the wounds. An Adaptic dressing was applied and one inch Kling was used to hold the dressings in place. A splint was applied to the fifth finger, immobilizing the proximal interphalangeal joints in extension. More Kling was wrapped around the entire hand, and an ace bandage wrap was applied over the Kling. The patient was sent to the recovery room in stable condition.

Estimated blood loss during the procedure was less than 5 cc's.

Coding Points
1. The procedure performed meets the criteria for CPT code 11010-51. Note the wound was "very contaminated," and required time to ensure all particulate matter was removed. The procedure as it is listed in this operative report does not meet the criteria to qualify for a higher level code. The surgeon does not specify whether it was skin and subcutaneous tissue, soft tissue, or bone. Therefore the lowest level code is assigned. If there is other documentation in the medical record that does specify soft tissue, or bone was debrided, then a higher level code may be appropriate. Check the operative progress note or query the physician for further information.
2. CPT code 26765—treatment open distal phalanx fracture
3. CPT code 26418
4. CPT code 12001-59

I thoroughly debrided the wound which was very contaminated, taking time to ensure all particulate matter was removed.

The fracture then was reduced.

Repair of the digitorium communis tendon was accomplished using interrupted 4-0 Vicryl suture.

Next, I turned my attention to a 1.0 cm ovoid laceration of the distal phalanx of the index finger. This laceration required only minimal debridement using normal saline. I then sutured the laceration using interrupted 4-0 PDS suture.

The wounds were then cleaned and Neosporin ointment was applied to the wounds. An Adaptic dressing was applied and one inch Kling was used to hold the dressings in place. A splint was applied to the fifth finger, immobilizing the proximal interphalangeal joints in extension. More Kling was wrapped around the entire hand, and an ace bandage wrap was applied over the Kling. The patient was sent to the recovery room in stable condition.

Estimated blood loss during the procedure was less than 5 cc's.

ICD-9-CM DIAGNOSES
Postoperative
816.12 Open fracture of distal phalanx or phalanges of hand
883.2 Open wound of finger(s), with tendon involvement

ICD-9-CM OPERATIONS/PROCEDURES
82.45 Other suture of other tendon of hand
79.64 Debridement of open fracture of phalanges of hand
79.24 Open reduction of fracture of phalanges of hand without internal fixation
86.59 Closure of skin and subcutaneous tissue of other site

CPT PROCEDURES
26418 Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon
26765-51 Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each
11010-51 Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (e.g., excisional debridement); skin and subcutaneous tissues
12001-59 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

Report modifier 59 to indicate that this was a separate procedure, on a different finger, and should not be bundled into other services this date.
DEBRIDEMENT

Codes

11042 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
#11045 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
11043 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less
#11046 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
11044 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less
#11047 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

# Codes are resequenced in CPT

These codes are used to report debridement of subcutaneous tissue, muscle (soft tissue), fascia, and bone. Codes within this series go beyond the integumentary system and into the musculoskeletal system normally listed in the 20000 series.

Debridement is reportable with repair codes when contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is performed separately without immediate primary closure of the wound.

Wound debridement (11042–11047) should be reported by depth of tissue removed and by surface area of the wound treated. Services may be reported for injuries, infections, wounds, and chronic ulcers. For debridement of a single wound, report the depth of the deepest level of tissue removed. For multiple wounds, add the surface area of all wounds that are at the same depth. Do not combine wound size from different depths.

Issues

- Do not use these codes to report debridement of open fractures or dislocations. Debridement of open fractures are reported by codes 11010–11012.
- Do not use these code to report minor debridement or irrigation of the wound. Significant debridement of contaminated or devitalized tissue must be performed in order to assign a code from this series of codes.
- Do not use these codes to report debridement of skin. Debridement of epidermis and/or dermis only is reported by codes 97597 and 97598.

CCI Edits (Version 16.3)

11042 0183T, 0213T, 0216T, 0228T, 0230T, 10060, 11000, 11010-11011*, 11040-11041, 11100, 11719-11721, 15852, 17250, 20526, 20551-20553, 24300, 25259, 26340, 28289*, 29086, 29131, 29280, 29365-29425, 29445, 29515, 29540-29581, 29700, 29730, 35761, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 49000, 51701-51703, 62310-62319, 64400-64435, 64445-64450, 64479, 64493, 64505-64553, 64565, 69990, 72295, 76000-76001, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94600-94690, 94770, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96376, 97022, 97597-97598, 97602, 99148-99150, G0168
Chapter 11: Urinary, Male Genital and Female Genital Systems, and Maternity Care and Delivery (50010–59899)

INTRODUCTION
The CPT surgery section codes 50010–59899 include four subsection headings:

- Urinary System 50010–53899
- Male Genital System 54000–55899
- Female Genital System 56405–58999
- Maternity Care and Delivery 59000–59899

Selected areas of these subsections will be discussed.

URINARY SYSTEM
The urinary system consists of the two kidneys, two ureters, the bladder, and the urethra.

Kidneys
The kidneys are paired organs between the parietal peritoneum and the posterior abdominal wall (retroperitoneal). They are located in the area of the last thoracic vertebrae to the third lumbar vertebrae.

Think of the kidneys as the body’s blood filter. Items no longer needed are removed from the blood by the filter (kidneys) and eliminated in the form of urine. Elements the body needs are put back into the blood to be used by the cells and tissues of the body. Some of the blood the heart outputs with each cardiac cycle is sent to the kidneys to be filtered via two renal arteries (one to each kidney). In the kidneys the renal arteries drain into other small arteries, then into even smaller arterioles and capillary networks called glomerulus where filtration takes place. Once the blood has been filtered and cleaned in the kidneys, it goes through venous capillaries that change into small veins called venules. Venules drain into larger veins that finally drain into the renal veins. The renal veins return the blood that has been filtered to the heart via the inferior vena cava.

Ureters
Cup-like projections in each of the kidneys called the renal calyces drain the urine produced to two ureters (tubes), one from each kidney. Urine that has collected in the renal pelvis is transported via a process called peristalsis to a storage in the bladder.