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Answers and Rationale

Preoperative diagnosis:
Hemoptysis\(^1\)

Postoperative diagnosis:
Same

Procedure performed:
Fiberoptic bronchoscopy with endobronchial and transbronchial biopsies

Procedure description:
The patient was brought to the endoscopy suite and was sedated using IV Versed. It should be noted that the patient has some tendency toward obstructive apnea while in the supine position.\(^4\) The fiberoptic scope was introduced via the right naris and passed into the hypopharynx. The vocal cords, false cords, arytenoid region, hypopharyngeal region, and the epiglottis were examined and found to be unremarkable. The trachea was inspected and found to be normal. The right bronchial tree was examined. The right upper lobe had three normal segments examined. The right middle lobe had two segments, the medial one was stenotic. A very small amount of increased mucus was present in this area. The right lower lobe was also inspected revealing no abnormality. The left upper lobe and lower lobe were inspected to the subsegmental level, revealing no abnormalities.

Using fluoroscopy, a brush was placed into the medial portion area of the right middle lobe. Biopsies were taken from this region. Additional endobronchial biopsies were taken from the area near the stenotic orifice of the right middle lobe and its associated carina.\(^3\) The scope was removed, and fluoroscopy ensured that there was no pneumothorax. The patient tolerated the procedure well.

Diagnosis Codes
R04.2  Hemoptysis\(^1\)
R06.81  Apnea, not elsewhere classified\(^2\)

Rationale for Diagnosis Codes
The pre- and postoperative diagnosis is hemoptysis. Because there is no definitive diagnosis documented, a code from the signs and symptoms chapter is used. The physician also documents that the patient has obstructive apnea but does not specify “sleep” apnea. Therefore the default code for apnea—not a code from category G47—is assigned.

Procedure Codes
0BBD8ZX  Excision of Right Middle Lung Lobe, Via Natural or Artificial Opening, Endoscopic, Diagnostic\(^3\)

Rationale for Procedure Codes
The tissue removed was from the right middle lung lobe, making the appropriate body part character value D. As only a portion of the lung tissue was removed and not the entire lobe, the root operation is Excision. Biopsies are often considered excisions under ICD-10-PCS. A procedure involving inserting an endoscope via a natural orifice is reported using the approach character value of 8. It is important to note that the qualifier character value (X) should indicate that a biopsy is considered a diagnostic procedure. It is important to note that the inspection of the lungs (bronchoscopy) is not reported separately as it is included in the overall objective of the biopsy.

MS-DRG
168  Other Respiratory System O.R. Procedures without CC/MCC  RW 1.2791
MDC 3 Diseases and Disorders of the Ear, Nose, Mouth and Throat

**OPERATIVE REPORT MDC 3—#1**

**Preoperative diagnosis:**
1. Suspected supraglottic cancer to left anterior neck
2. Lymphadenopathy

**Postoperative diagnosis:**
1. Supraglottic cancer to left anterior neck

**Procedure description:**
1. Microdirect laryngoscopy with biopsy
2. Tru-Cut needle biopsy of left anterior neck lymph node

**Indications:**
The patient initially presented with persistent dysphagia and hoarseness and recently discovered a left anterior neck mass. He has been a heavy smoker for the past 30+ years and carries a diagnosis of long-standing COPD.

**Procedure performed:**
The patient was brought into the operating room and identified, and general endotracheal anesthesia was induced. The patient was then steriley prepped and draped in the usual manner. A vallecula laryngoscope was then carefully inserted in the oral cavity and the tongue retracted anteriorly. The lingual mobile tongue was without evidence of lesions, and there was no evidence of lesions in the oral cavity. The tongue base was normal appearing. The vallecula was then examined and noted to be without evidence of obvious lesions. The area of epiglottic folds and arytenoid regions were noted to be markedly edematous. There was noted to be greater fullness of the left tip of the epiglottis on the lingual surface as well as the left arytenoid. There was no obvious friability of the mucosa. The true vocal cords were visualized and noted to be of normal appearance. Photo documentation with 5 mm rigid telescope was then performed. The vallecula scope was then placed into suspension, and multiple biopsies were taken of the vallecula and the tip of the epiglottis, the left area epiglottic fold, and laryngeal surface of the epiglottis. Hemostasis was obtained with adrenaline-soaked pledgets. No further evidence of bleeding was noted. The vallecula scope was removed, and the patient tolerated the procedure well.

Next, the left neck was steriley prepped with Betadine. A Tru-Cut needle biopsy was then carried out through the skin and subcutaneous tissue to a palpable left anterior neck mass just below the hyoid bone. This lymph node was greater than a centimeter in size and firm to palpation. Multiple passes with the Tru-Cut needle were then performed, and this tissue was sent for pathologic examination. Hemostasis was obtained with a pressure type dressing on the anterior neck. The patient was then safely awakened from general anesthesia and transferred to the recovery room in stable condition.

**Operative report addendum:**
Pathology report (gross & microscopic) was viewed by myself (surgeon) and indicated supraglottic squamous cell carcinoma; the Tru-Cut biopsies of the neck lymph node also involved metastatic disease of the same tumor.

Code all relevant ICD-10-CM diagnosis and ICD-10-PCS procedure codes in accordance with official guidelines and coding conventions.

**Diagnosis Codes:**

**Procedure Codes:**

**MS-DRG:**
Answers and Rationale

Preoperative diagnosis:
1. Suspected supraglottic cancer to left anterior neck
2. Lymphadenopathy

Postoperative diagnosis:
1. Supraglottic cancer to left anterior neck

Procedure description:
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Operative report addendum:
Pathology report (gross & microscopic) was viewed by myself (surgeon) and indicated supraglottic squamous cell carcinoma; the Tru-Cut biopsies of the neck lymph node also involved metastatic disease of the same tumor.

Diagnosis Codes
C32.1 Malignant neoplasm of supraglottis
C77.0 Secondary and unspecified malignant neoplasm of lymph nodes of head, face and neck
F17.210 Nicotine dependence, cigarettes, uncomplicated
J44.9 Chronic obstructive pulmonary disease, unspecified

Rationale for Diagnosis Codes
The postoperative diagnosis and the operative report addendum confirm the malignant neoplasm of the supraglottis. The addendum also documents that the mass excised from the neck was a lymph node affected by metastatic carcinoma. The indications section indicates that the patient has been dependent on cigarettes for more than 30 years and also carries a diagnosis of COPD. The “code also” note under category C32 directs that an additional code should be reported for any nicotine dependence.

Procedure Codes
0CBR8ZX Excision of Epiglottis, Via Natural or Artificial Opening Endoscopic, Diagnostic
07B20ZX Excision of Left Neck Lymphatic, Open Approach, Diagnostic