Case 1

Diagnoses: Stage III cystocele, stage II uterine prolapse.

Procedure: Pessary fitting.

Indications: A 75-year-old, gravida 2, para 2, female with pelvic organ prolapse. She had atrophic vaginitis so we had her use Premarin vaginal cream twice a week for 6 weeks. She is back for a pessary fitting today.

Findings: She has a third-degree cystocele, and now third-degree uterine prolapse. Her vaginal tissues are improved, although still atrophic, but much less thin than prior appointment. She has a stage I, rectocele.

Description of procedure: After her exam, I started with a #4 ring pessary with support. This was clearly not large enough and the cystocele was coming around it. I then went to a #5 ring pessary with support with the same problem. I went to the #6 ring pessary with support. It did not lodge behind her pubic bone very well, but it definitely reduced all of her prolapse. She mentioned earlier in the appointment that she could not void when she came in today. She has not tried reducing it. I am hopeful that the pessary may help with that. The #6 was comfortable for her. I stood her up and put her through some maneuvers and it stayed nicely in place. Then she went walking with it in for 10 or 15 minutes and went up and down the stairs. She definitely was able to void easily with that in. It was comfortable and she did not really notice it was in.

On recheck it still seemed like she had a little more room in the pelvis. I removed the #6 and went up to a #7 size. This seemed to reduce the prolapse a bit better, but was a little uncomfortable for her. We went back to the #6 ring pessary with support. She was able to remove it and place it with instruction in our clinic today.

Disposition: We have ordered the #6 ring pessary with support and it will be sent to her. After she gets the pessary, she will remove it once a week and leave it out over night. She will continue to use the Premarin vaginal cream twice a week. She will return to clinic after she has used the pessary for 2 or 3 weeks, so we can check her tissues. She is to report if she has vaginal discharge or bleeding, as she is at risk for getting ulceration from the pessary.

I answered all of her questions about her condition of pelvic organ prolapse and treatment with estrogen and pessary. She will call if she has any bleeding.

What are the CPT® and ICD-9-CM codes reported?

CPT® code: 57160
ICD-9-CM code: 618.3
RATIONALE: CPT® code: The procedure performed is a pessary fitting. From the CPT® Index, look up Pessary/insertion. You are referred to 57160. A review of the code description verifies 57160 is for fitting and insertion of pessary which is the correct code.

ICD-9-CM code: The patient is diagnosed with a cystocele and uterine prolapse. In the diagnosis, it is referred to as stage II; however, in the findings it is stage III prolapse. From the Index to Diseases, look up Cystocele/with uterine prolapse. There is an option for complete or incomplete. A stage III prolapse is considered a complete prolapse. You are referred to 618.3. Verify the code accuracy in the Tabular List.
Case 2

Diagnoses:
1. Complete procidentia
2. Recurrent urinary tract infections
3. Postmenopausal vaginal bleeding

Procedures:
1. Vaginal hysterectomy
2. Anterior and posterior colporrhaphy
3. Cystoscopy
4. Vaginal vault suspension

Specimens: Uterus and cervix.

Findings: A thick hypertrophic ulcerated cervix was noted. The adnexa were small and atrophic. Complete procidentia with cystocele and rectocele. Cystoscopy done after indigo carmine, at the end of the case, revealed bilateral strong ureteral jets.

Indications: Pt. with history of postmenopausal vaginal bleeding, anemia and recurrent urinary tract infections, although she denied any urinary incontinence. Her cervix was found to be ulcerated, erythematous and hypertrophic. Cervical biopsy was negative for neoplasia but the endometrial biopsy showed evidence of active endometritis. She desires surgical management of these problems.

Operation: The patient was taken to the operating room and placed in lithotomy position while awake. The patient has a history of bilateral knee replacements and cannot bend her legs so we did put her in lithotomy position using Yellofin stirrups, but kept her legs without any bend and positioned her while she was awake in a comfortable way. The patient was then placed under general anesthesia. An exam under anesthesia was done with findings of a complete procidentia with ulcerations posteriorly. The vagina and perineum was prepped in the usual sterile fashion. A tenaculum was then placed on the right and left lateral cervix. A circumferential incision was made at the cervicovaginal junction using Bovie cautery. The vesicovaginal fascia was then dissected anteriorly using a combination of sharp dissection with Metzenbaum scissors and blunt dissection.

Attention was then turned posteriorly. The posterior peritoneum was grasped with a half curve, identified a then incised using Mayo scissors. A weighted speculum was then placed in the posterior cul de sac. The uterosacral ligaments were identified and clamped bilaterally with Heaney clamps, and a transection suture using 0 Vicryl suture was placed at the tip of the clamp system in both the right and left side. The uterocervical ligaments were then tagged and held for use during the vaginal vault suspension.

Attention was then turned to the anterior peritoneum. A finger was placed in the posterior cul de sac around the uterine fundus distending the anterior vaginal epithelium and allowing the anterior peritoneum could be entered safely using Mayo scissors. The cardinal ligaments were clamped and cut bilaterally. The utero-ovarian were identified cut, suture-ligated, and then free tied bilaterally. The uterus was then removed from the vagina and sent to pathology. All pedicles were then inspected and were found to be hemostatic. We could not visualize the ovaries but were palpated and felt to be atrophic.
At this point, we began the vaginal vault suspension. There was some oozing from the patient’s left side near the vaginal cuff area. This was controlled with a figure-of-eight suture of 0 Polysorb. Other small areas along the cuff were touched with the Bovie, and hemostasis was very good at this point. The uterosacral ligament remnant was put under pressure to palpate the ligament through its course to near the ischial spine. The bladder was drained with a Foley. A long Allis clamp was placed on the uterosacral near the ischial spine by tugging gently on the remnant that was stretched out and using the more inferior fibers. A suture of 0 Polysorb was placed through the ligament with care to drive the needle from superior to inferior, to avoid the ureter. A second suture was placed slightly more distal with 0 Maxon and then more distal again a 0 Polysorb. These were all held while a similar procedure was repeated on the left side with palpation of the ligament and the ischial spine and taking the inferior fibers.

All of the sutures were held while the anterior and posterior repairs were made. The anterior vagina was then inspected and the cystocele identified. The vaginal wall was trimmed anteriorly. The posterior vagina was also inspected and excessive tissue was excised. At this point the vaginal cuff appeared hemostatic and was closed by first taking the 0 Polysorb, which is the distal uterosacral stitch and making an angle stitch to close the vagina. The anterior and posterior vaginal walls were closed as well as the pubocervical fascia anteriorly and the rectovaginal fascia posteriorly to get fascia to fascia closure. Once each of the angle stitches had been placed, they were held and not tied down yet. The 0 Maxon were then placed in a similar fashion through the anterior vaginal fascia and mucosa and the posterior fascia and mucosa. Lastly the 0 Prolene, which were the most superior stitches, were placed through the anterior posterior vaginal cuff, but these were taken slightly away from the cut edge so that the knots could be buried but again taking fascia and vaginal mucosa. Then a 0 Polysorb figure-of-eight suture was placed across the midline and vaginal mucosa so that we could completely bury the Prolene sutures at the end of the case. At this point, all of the sutures were tied except the Polysorb to close the mucosa in the midline. There appeared to be excellent vaginal support at this point.

The Foley catheter was removed. The 17-French cystoscope sheath was placed through the urethra. The 70 degree lens was used with sterile water infusing to inspect the bladder. There was moderate trabeculation of the bladder. There were no mucosal lesions to explain her infections. There were no stones, stitches or other lesions. A quarter of an ampule of indigo carmine had been given about 10 minutes earlier IV. Strong ureteral jets were observed from both sides, although the right side concentrated the dye faster than the left side by about 5 minutes. The bladder was drained and the urethra was inspected with the 0 degree lens and there were no urethral lesions. The bladder was drained and the Foley catheter replaced.

The last midline 0 Polysorb suture was closed over the midline to bury the Prolene. All the sutures were cut and the cuff had been irrigated with the cystoscopy fluid. A rectal exam was done, which did not yield any sutures. The vagina was then irrigated and was found to be hemostatic. A vaginal pack was then placed. The patient was awakened from general anesthesia and brought to the PACU in stable condition.
What are the CPT® and ICD-9-CM codes?

CPT® code: 58260, 57260-51, 57283-51, 52000-51

ICD-9-CM code: 618.3, 627.1, 599.0, 596.89

RATIONALE: CPT® code: A vaginal hysterectomy where the uterus is not weighed must be coded to the lesser weight, which is reported with 58260. From the CPT® Index, look at Hysterectomy/vaginal. The peritoneal approach to perform the vaginal colpopexy is reported with 57283. From the index, look for colpopexy/intraperitoneal. The provider also performed an anterior and posterior colporrhaphy which can be found in the CPT® Index under Colporrhaphy/anteriorposterior. The correct code is 57260. Code 52000 reports the cystoscopy. This would usually be bundled into the other procedures when it is performed only to verify that there is no damage to the bladder during the procedure but in this case the patient’s recurrent bladder infections (UTIs) support the separate medical necessity allowing the procedure to be billed. Modifier 51 is appended to all procedure codes except 58260 because multiple procedures are performed during the same operative session, in the same anatomical location via a shared access.

ICD-9-CM code: The patient is diagnosed with a cystocele and the uterine prolapse. From the Index to Diseases, look up Cystocele/with uterine prolapse. You have a choice between complete or incomplete. This is stated as complete. You are referred to 618.3. Verify the code accuracy in the Tabular List. Next, look for the code for postmenopausal vaginal bleeding. From the Index to Diseases, look up Bleeding/postmenopausal which is reported with 627.1. The patient is also diagnosed with a recurrent UTI which is found in the Index to Diseases under Infection/urinary (tract) and is reported with 599.0. The patient is diagnosed with trabeculation of the bladder which is found in the index under Trabeculation/bladder and is reported with 596.89. Verify code selection in the Tabular List.
Case 3

**Indications:** 21-year-old, G3, P1-0-2-1, found to have an abnormal cervical Pap test with possible LGSIL. She presents for follow up Pap and colposcopy.

**Exam:** Pubic hair is shaved. Negative inguinal adenopathy. The urethra, the introitus and anus grossly normal. Vagina is long, need extra long Pederson speculum. Cervix is posterior, parous. Uterus anteverted, normal size. Some tenderness of the adnexa to deep palpation. No cervical motion tenderness. Normal discharge. Pap test was performed.

**Colposcopic procedure:** Speculum was inserted for the colposcopy. An extra long, narrow Pederson speculum was required and the cervix was visualized. 3% acetic acid was placed and the T-zone is large and bleeds to touch. The 3% acetic acid was placed, and several aceto-white lesions were noted, particularly at the 12 and 11 o'clock positions. Lugol solution was placed, and there was no uptake at the 6 and 11 o'clock portions of the cervix. 4% topical lidocaine was placed without epinephrine, followed by 1 cc of 1% lidocaine also without epinephrine. **LEEP** biopsy was taken of the cervix without difficulty and this also cauterized the bleeding.

Instructions given to the patient that she must refrain from intercourse for at least 1 week. She is aware to call if any severe pain, bleeding that does not stop, foul odor, or fever. She is aware the results will take approximately 1–2 weeks and she will receive direct notification.

**What are the CPT® and ICD-9-CM codes?**

**CPT® code:** 57460

**ICD-9-CM code:** 795.00

**RATIONALE:** CPT® code: The provider performs a LEEP biopsy and Pap smear. From the CPT® Index, look up LEEP. You are referred to 57460. Review the code description to verify the code accuracy.

ICD-9-CM code: The indication for the procedure is an abnormal Pap smear. The provider documents possible LGSIL which is not coded because it has not been confirmed. Look in the Index to Diseases for Abnormal/Pap (smear)/cervix which is 795.00. Verify code selection in the Tabular List.
Case 4

Chief complaint: **Contraceptive placement of IUD**

**Indications:** Ms. Barrett is a 29-year-old, gravida 1, para 1-0-0-1 who is status post a normal spontaneous vaginal delivery of a male infant weighing 4086 grams. She has not had intercourse since delivery. She is interested in a Mirena IUD at this time.

**Procedure:** After obtaining consent, the patient is placed in the dorsal lithotomy position. A speculum was placed in the vagina to visualize the cervix. The cervix was cleaned 3 times with Betadine. Following this, a single-tooth tenaculum was placed on the anterior lip of the cervix. The uterus was sounded to approximately 6.5 cm. The Mirena IUD was then placed in the usual fashion and the strings cut to 2.5 cm. The lot number is TU003SL. The patient tolerated the procedure well, and hemostasis was noted at the tenaculum site after removal.

The patient tolerated the procedure well and was given instructions to return if she should have any difficulties.

**What are the CPT® and ICD-9-CM codes?**

**CPT® code:** 58300

**ICD-9-CM code:** V25.11

**RATIONALE:** CPT® Code: The provider inserts an IUD. To locate the code, look up Insertion/Intrauterine Device (IUD). Review of the code description verifies that 58300 is the correct code.

ICD-9-CM Code: To locate the code, look up Intrauterine contraceptive device/insertion. You are referred to V25.11. Verify the code accuracy in the Tabular List.
Case 5
ABC Hospital

**Indication:** A 30-year-old G0P0Ab0 with irregular periods and mild male factor. She is infertile and would like to start a clomid/iui cycle and requires hysterosalpingogram for evaluation.

**Procedure Note:** The patient was brought to the outpatient surgical suite. After written consent was obtained and written final verification, the cervix was visualized with a Pedersen speculum, anesthetized with Cetacaine spray and swabbed with 3 swabs of Betadine scrub and an endocervical prep.

A single-tooth tenaculum was placed on the anterior lip of the cervix without problems. An HSG catheter was introduced through the cervix. At this point the balloon was insufflated with 1 mL of normal saline within the cervix, speculum was then removed. Ethiodol contrast, approximately 8 ml, was insufflated under fluoroscopic guidance.

Under fluoroscopic guidance, the uterus shape was found to be normal. The tubes filled and spilled on the left. The right tube filled normally but no spill could be documented due to exuberant spill from the left. The patient was instructed to roll completely for two revolutions. An additional film was taken which showed normal dispersion.

**Plan:** Follow-up as scheduled.

**What are the CPT® and ICD-9-CM codes?**

**CPT® code:** 58340, 74740-26

**ICD-9-CM code:** 628.9

**RATIONALE:** CPT® Codes: The procedure performed is a hysterosalpingogram. To locate the code, look up Hysterosalpingography/Injection Procedure which refers you to 58340. When you review the code description there is a parenthetical statement which informs us to use code 74740 for the S&I of a hysterosalpingography. This procedure is performed in the outpatient hospital setting. Modifier 26 is appended to 74740 to report the professional component.

ICD-9-CM Codes: Indexing for the diagnosis code begins by looking in the Index to Diseases under Infertility/female. You are referred to 628.9. Verify the code in the Tabular List.
Case 6

Procedure performed: Amniocentesis.

Indications: The patient is a 28-year-old G4 P2103 at 36 2/7, here in the office today for amniocentesis for FLM secondary to Rh isoimmunization to D antigen. Following informed consent she elected to proceed with the amniocentesis.

Procedure: An ultrasound was carried out that revealed a single intrauterine gestation of 36+2 weeks in vertex presentation. A site for amniocentesis was identified in the left upper uterine segment, which did not transgress the placenta and an image was retained for the record. The amniocentesis site was steriley prepped and draped with a sterile towel and an alcohol based solution. Following this using direct ultrasound guidance a 22 gauge amniocentesis needle was sharply inserted in the amniotic fluid cavity. This returned clear amniotic fluid. 20 cc was easily aspirated and 10 cc sent for FLM and 10 cc held for possible OD450 if needed. The patient tolerated the procedure very well and fetal cardiac activity was seen following the procedure. The patient was sent for a follow-up NST. Rhogam is not indicated as the patient is already sensitized.

What are the CPT® and ICD-9-CM codes?

CPT® codes: 59000, 76946

ICD-9-CM codes: 656.13, V23.89

RATIONALE: CPT® Codes: The provider performs amniocentesis with ultrasound guidance in the office. To locate the code, look up Amniocentesis in the CPT® Index. You are referred to 59000. There is a parenthetical statement under code 59000, which instructs you to report code 76946 for radiologic S&I. This procedure was performed in the provider’s office so modifier 26 is not reported on the radiologic guidance code.

ICD-9-CM Codes: The indication for the amniocentesis is pregnancy complicated by Rh immunization. In the Index to Diseases, look up Pregnancy/complicated by/ Rh immunization which directs us to code 656.1. The episode of care is antepartum which is reported with 656.13. A patient with Rh isoimmunization is a high risk pregnancy patient. In the Index to Diseases, see Pregnancy/supervision/high-risk/specified problem NEC V23.89. Confirm code selection in the Tabular List.
Case 7

OB Delivery Note

Indications: 31 y/o G3P1 at 39 and 4/7 weeks admitted in labor. She has been followed in the OB clinic with 12 normal antenatal visits.

Stage I: Patient was admitted with a cervical exam of 3/c/-1. She slowly progressed to 5 cm dilation. She had SROM at 0330 which showed light meconium. She continued to labor and reached the end of stage I at 1000, a period of 10 hours. FHTs showed some periods of reactivity but responded to stimulation.

Stage II: Duration of Stage II (from pushing to delivery) was approximately 3 hours. A pediatric team was present. There was slight meconium staining present at delivery.

Presentation was OP with right shoulder anterior shoulder. There was no nuchal cord. The cord was clamped x2 and cut and the baby was handed to the pediatric team.

Gender: Male

Weight: 3772 grams. Apgars 8/9

Stage III: Placenta delivered spontaneously with gentle traction and fundal massage and was intact. Vagina and cervix examined for lacerations. Inspection revealed a small 2nd degree perineal laceration which was repaired with 3.0 Polysorb in the usual sterile fashion in layers. Another small lateral cutaneous tear was repaired with 3.0 polysorb and a figure of 8 stitch. Good hemostasis was noted.

Patient will return to clinic for follow up in 6 weeks.

What are the CPT® and ICD-9-CM codes?

CPT® code: 59400

ICD-9-CM code: 664.11, 656.81, V27.0

RATIONALE: CPT® Code: The stages indicate the patient is in labor and delivers vaginally. There is no mention of an incision made for a Cesarean delivery. Code 59400 represents routine obstetric care antepartum and postpartum and the vaginal delivery. To locate the code in CPT® Index, look up Vaginal Delivery/routine care.

ICD-9-CM Code: This is a complicated pregnancy by the 2nd degree perineal laceration and the meconium in the amniotic fluid. In the Index to Diseases, look up Delivery/complicated/laceration/perineum/second degree. You are referred to 664.11. Also documented is meconium in the amniotic fluid which is located under Delivery/complicated by/meconium which is reported with 656.81. According to ICD-9-CM Guidelines, Section I.C.11 b.5 “A V27.X “outcome of delivery” code must be included on every maternal record when a delivery has occurred.” In the Index to Diseases, look for Outcome of delivery/single/liveborn. A single live birth is V27.0.
Case 8  
Diagnosis: Intrauterine pregnancy at 20-5/7 weeks with multiple fetal anomalies.

Procedure: D&E  

Anesthesia: Moderate sedation.

Indications: The patient is a 29-year-old gravida 1 at 20-5/7 weeks with multiple fetal anomalies, who desires a termination of pregnancy. She has previously had dilators placed.

Description of procedure: The patient was brought to the operating room, and moderate sedation was administered. The patient then placed in the dorsal lithotomy position and was prepped and draped in usual sterile fashion. The dilators were removed. The patient’s cervix was dilated to 5–6 cm. There was a bulging bag that ruptured during vaginal prep. A speculum was attempted to be placed, but the fetus was already delivering into the vagina. The umbilical cord was severed at this time, and no fetal heart beat was noted on ultrasound. Ultrasound guidance was used for the entire procedure. Gentle traction was applied and the fetus delivered intact. There was no respiratory or cardiac effort noted. Bierer forceps were then used to remove the placenta intact. A speculum was placed, and an atraumatic tenaculum was placed on the anterior lip of the cervix and a standard D&C was then performed until the characteristically gritty texture was noted on the endometrium. There was a small amount of bleeding noted from the lower uterine segment; 20 units of Pitocin was added to the patient’s IV fluids and pressure was held against lower uterine segment for 5 minutes. At this time, hemostasis was noted to be excellent. The speculum was then removed, and the patient was taken out of the dorsal lithotomy position after her perineum was cleansed.

The patient’s anesthesia was discontinued and she was brought to the recovery room in stable condition. There were no complications to this procedure. The patient tolerated the procedure well.

Specimen(s): The products of conception were sent to pathology for cytogenetics and pathologic evaluation.

Plan: The patient will follow up in the outpatient clinic

What are the CPT® and ICD-9-CM codes?

CPT® code: 59841

ICD-9-CM code: 635.91, 655.93
RATIONALE: CPT® Code: The procedure performed is an induced abortion with dilation and evacuation due to the management of the mother caused by fetal abnormalities. From the CPT® Index, look up Abortion/induced/by dilation and evacuation.

ICD-9-CM Code: The encounter is for an induced legal abortion due to fetal abnormalities. From the Index to Diseases, look up Abortion/legal. You are directed to 635.9. The fifth digit of 1 indicates the abortion is “incomplete.” According to the Chapter 11 Guidelines (Section I.C. 11.k.1) for code categories 634–637: Fifth digit, assignment is based on the status of the patient at the beginning (or start) of the encounter. Fifth digit 1, incomplete, indicates that all of the products of conception have not been expelled from the uterus at the beginning of the procedure. Code 655.93 represents a known or suspected fetal abnormality affecting the management of the mother. Look in the Index to Diseases for Pregnancy/management affected by/fetal/abnormality (655.93). Chapter 11 guidelines (Section I.C.11.k.2) for code categories 640–648 and 651–659: Fifth digit 3 is assigned with codes from these categories when used with an abortion code because the other fifth digits will not apply.
Case 9

Anesthesia: General with LMA.

Preoperative diagnosis: Sterilization

Postoperative diagnosis: Sterilization

Procedure performed: Tubal ligation with bilateral Falope ring application

Counts: Needle, sponge and instrument counts were correct.

Intraoperative medications: 0.25% Marcaine with epinephrine.

Operative findings: The left ovary was mildly adhered to the side of the uterus. The right ovary appeared normal. Both tubes appeared normal. The upper abdomen appeared normal. There was a small subserosal fibroid approximately 1 to 1.5 cm on the left upper aspect of the uterus.

Description of procedure: After informed consent, Ms. Mathews was taken to operating suite #4 and a general anesthetic was administered. She was placed in the dorsal lithotomy position. She was sterilely prepped and draped in the usual manner. A sponge stick was placed vaginally. An infraumbilical incision was made and a non-bladed trocar and sheath were placed. Proper placement was confirmed with insufflation performed. A suprapubic incision was then made and the suprapubic trocar and sheath were placed under direct visualization. Findings were made as noted above and the right tube was ligated with the Falope ring, and then the left. Pictures were taken to document proper placement.

All instruments were removed and gas was allowed to escape. The sheaths were removed. Marcaine with epinephrine were placed again at the incision sites and they were closed with Monocryl in a subcuticular manner.

The patient was allowed to emerge from the anesthetic and was transferred to the Postanesthesia Care Unit in stable condition.

What are the CPT® and ICD-9-CM codes?

CPT® Code: 58671

ICD-9-CM Code: V25.2

RATIONALE: CPT® Code: The method of the tubal ligation is placement of Falope rings on the right and left tubes. The method dictates the proper code selection. In the CPT® Index, look up Fallopian tube/occlusion/endoscopy. You are referred to 58671.

ICD-9-CM Code: The indication for the procedure is sterilization. From the Index to Diseases, look up Admission/for/sterilization. You are referred to V25.2. Verify the code description in the Tabular List.
Case 10

Preoperative diagnosis: Severe cervical dysplasia

Postoperative diagnosis: Severe cervical dysplasia

Procedure performed: Cold knife conization.

Anesthesia: General.

Complications: None.

Estimated Blood Loss: 25 cc.

Fluids: 500 cc crystalloid.

Drains: Straight catheter x 1.

Indications: All risks, benefits, and alternatives of this procedure were discussed with the patient and informed consent was obtained.

Description of procedure: The patient was taken to the operating room where general anesthesia was obtained without difficulty. She was prepped and draped in the normal sterile fashion after being placed in the dorsal lithotomy position.

Attention was turned to the patient’s pelvis where a weighted speculum was placed inside the patient’s vagina. The anterior lip of the cervix was grasped with a single-tooth tenaculum and a paracervical block was performed using 10 units of Pitressin and 20 cc of normal saline. A #2-0 Vicryl stitch was used at the three o’clock and nine o’clock positions on the cervix to ligate the cervical branch of the uterine artery.

Procedure (continued): A #11 blade was then used to incise in a circumferential fashion. This incision was carried down to the cervix using a cone shape. The cervical biopsy was removed and marked at the twelve o’clock position using a silk suture.

The cervical bed was cauterized using the Bovie cautery with good hemostasis noted. The FloSeal was placed into the cervical bed and the cervical stitches were tied together in the midline. Good hemostasis was noted.

All instruments were removed from the patient’s vagina. All sponge, needle and instrument counts were correct x 2.

The patient was taken out of the dorsal lithotomy position and taken to the recovery room awake and in stable condition.

What are the CPT® and ICD-9-CM codes reported?

CPT® Code: 57520

ICD-9-CM Code: 233.1
RATIONALE: CPT® Code: The procedure performed is a conization of the cervix using a cold knife. In the CPT® Index, look up Conization/cervix. You are referred to 57461, 57520–57522. The approach and method will determine the proper code. The method is a cold knife which is reported with 57520.

ICD-9-CM Code: The indication for the procedure is severe cervical dysplasia. From the Index to Diseases, look up Dysplasia/cervix/severe. You are referred to 233.1. Verification of the code in the Tabular List confirms code selection.