

## Case 1

### Operative Report

**Preoperative diagnosis:** Comminuted left proximal humerus fracture

**Postoperative diagnosis:** Comminuted left proximal humerus fracture

**Operative procedure:** Open treatment of left proximal humerus.

**Anesthesia:** General.

**Implants:** DePuy Global fracture stem size 10 with a 48 x 15 humeral head.

**Indications:** The patient is a 66-year-old female who sustained a severely comminuted proximal humerus fracture. The risk and benefits of the surgical procedure were discussed. She stated understanding and desired to proceed.

**Description of procedure:** On the day of the procedure after obtaining informed consent, the patient was taken to the main operating room where she was prepped and draped in the usual sterile fashion in beach chair position after administering general anesthesia. Standard deltopectoral approach was used; the cephalic vein was taken laterally with the deltoid. Dissection carried out down to the fracture site. The fracture site was identified. The fragments were mobilized and the humeral head fragments removed. Once this was done, the stem was prepared up to a size 10. A trial reduction was carried out with the DePuy trial stem and implant head. This gave good range of motion with good stability. Sutures were placed in key positions for closure of the tuberosities down to the shaft including sutures through the shaft. The shaft was then prepared and cement was injected into the shaft. The implant was placed. Once the cement was hardened, the head was placed on Morse taper and then reduced. A bone graft was placed around the area where the tuberosities were being brought down. The tuberosities were then tied down with a suture previously positioned. This gave excellent closure and coverage of the significant motion at the repair sites. The wound was thoroughly irrigated. The skin was closed with Vicryl over a drain and also staples in the epidermis. A sterile dressing and sling was applied. The patient was taken to recovery in stable condition. No immediate complications.

1. Postoperative diagnosis is used for coding.
2. Working procedure until report is read.
3. General anesthesia is used.
4. This is an indication that a prosthesis was introduced to the joint.
5. This is confirmation of diagnosis. Keep in mind that the proximal end of the humerus is the shoulder area.
6. Indicates the approach.
7. This further explains the comminuted fracture.
8. This is explaining the placement of the prosthesis.
9. Bone grafts are common in prosthetic placement. It gives a matrix for new bone to grow on and further stabilize the prosthesis. These are not charged separately.

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

CPT® codes: 23616-LT

ICD-9-CM code: 812.00

**RATIONALE: CPT® code:** In the CPT® Index, look for Fracture/Humerus/Open Treatment and you are directed to code range 23615–23616. A humeral prosthetic treatment is performed to repair the fracture which is reported with 23616. Modifier LT should be appended to indicate it is the left humerus.

**ICD-9-CM code:** The diagnosis is listed as a comminuted left proximal humerus fracture. In the ICD-9-CM Index to Diseases, look for Fracture/humerus/proximal which directs you to Fracture/humerus/upper end. There is no mention of this being an open fracture, so default coding is closed. Verification of code 812.00 in the Tabular List confirms it is used for a fracture of the proximal end of the humerus.

## Case 2

**Preoperative diagnosis:** Painful L2 vertebral compression fracture.

**Postoperative diagnosis:** Painful L2 vertebral compression fracture. 1.

**Name of operation:** L2 kyphoplasty. 2.

### Findings preoperatively:

She had compression fractures at T 11 and L1, which underwent kyphoplasty and she initially had very good results, but then developed back pain once again. Repeat MRI a couple of weeks later showed that she had fresh high intensity signal changes in the body of L2 and some scalping of the superior end plate consistent with a compression fracture at L2. After some preoperative discussion and some patience to see if she would get better, she was admitted to the hospital for L2 kyphoplasty when she was not getting better. At surgery, L2 had some scalloping of the superior end plate. Most of the softness was in the back part of the vertebral body. 3.

### Procedure:

The patient was taken to the operating room and placed under general endotracheal anesthesia in a supine position. She was placed prone on the Jackson table and her back was prepped and draped in the usual sterile fashion. Using biplane image intensifiers, the skin incision sites were marked out. 0.5 Marcaine with epinephrine was injected. Initially on the left side, a Xyphon trocar was passed down to the superior lateral edge of the pedicle and then passed down through the pedicle and into the vertebral body—uneventfully in the usual fashion. The drill was then placed into the vertebral body and then the Kyphon bone tamp. In a similar fashion, the same thing was done on the other side. Balloons were then inflated uneventfully. The balloons were then deflated and removed and the cement when it was in the doughy state was then injected into the 2 sides in the usual fashion. 4.  
This was done carefully and sequentially to make sure that there were no cement extrusions and in fact there were none, there was a good fill to the edges of vertebral body up towards the superior end plate and across the midline. The bone filling devices were then removed and the trocars removed. Pressure was applied after which the skin was sutured with 4-0 nylon. Band-Aids were applied and she was taken to recovery in stable condition. 5.  
6.

1. Postoperative diagnosis is used for coding.
2. Working procedure.
3. Confirmation of diagnosis.
4. General anesthesia was used.
5. This is describing the approach to the defect. It is percutaneous using trocars.
6. This is describing how the area is prepped to be enlarged and receive the cement that is placed in a kyphoplasty procedure.

**Complications:** There were no complications.

**Blood loss:** Minimal blood loss.

**Counts:** Sponge and needle counts were correct.

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

CPT® code: 22524

ICD-9-CM code: 733.13

**RATIONALE: CPT® code:** In the CPT® Index, look for kyphoplasty and you are directed to the range of codes 22523–22525. The code selection is based on location. 22524 is the correct code for the lumbar spine. If the provider performed and documented radiologic supervision and interpretation, you would also report 77291 or 77292. It is not appropriate in this case because it was not documented.

**ICD-9-CM code:** In the ICD-9-CM Index to Diseases, look for fracture/vertebra/compression and you are directed to 733.13. Verification in the Tabular List confirms 733.13 is for a pathologic fracture of the vertebra. Compression fractures are considered pathological in nature; if there have been no visible injuries. If the pathological reason has been identified, such as osteoporosis, then that becomes the additional code. Our report does not mention that however, so the only code reported is 733.13.

### Case 3

**Preoperative diagnosis:** Comminuted intraarticular distal radial Colles' fracture left wrist.

**Postoperative diagnosis:** Comminuted intraarticular distal radial Colles' fracture left wrist. 1.

**Procedure:** Application uniplane external fixation and closed reduction of left distal radial fracture under fluoroscopy. 2.

**Anesthesia:** General endotracheal. 3.

#### Description of the procedure:

After induction of adequate general endotracheal anesthesia, the patient's left upper extremity was routinely prepped and draped into a sterile field. The extremity was elevated and exsanguinated with an Esmarch bandage. The tourniquet was inflated to 300 millimeters of mercury. We first placed two half pins distally over the dorsoradial aspect of the second metacarpal first placing first pin in freehand technique making an incision, spreading with hemostat, and then placing the half pin. The second pin was placed identically by using the pin guide. Similarly, we placed pins in the dorsoradial aspect of the distal third of the radius. We then connected these 2 pins with clamps and then under C-arm control we reduced the fracture. All pins are now attached to the external fixation. This fracture at both dorsal and volar comminution and intraarticular fractures and was significantly shortened and telescoped. We obtained the best reduction possible and then tightened down the clamps to the bars. The pin tracks were dressed with Xeroform and 2 x 2 gauze and volar 3 x 15 plaster splints were applied. The tourniquet was allowed to deflate during application of the dressing. Total tourniquet time was 14 minutes. There were no intraoperative complications. 4. 5. 6.

1. Postoperative diagnosis is used for coding.
2. This will assist in coding the procedure.
3. General anesthesia used.
4. External fixation.
5. Closed reduction under fluoroscopy.
6. Comminuted aspect.

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

CPT® codes: 25605-LT, 20690-51-LT

ICD-9-CM code: 813.41

**RATIONALE:** CPT® codes: This is a repair of a Colles' fracture. Looking in the index under Fracture/radius/Colles and you are directed to code range 25600–25605. Code 25605 is correct because a reduction (manipulation) was performed. The codes for Colles' fracture repair (25600–25605), do not include the external fixation. Look in the index for External Fixation/application and you are referred to code range 20690–20692. The codes are differentiated by the type of fixation. In this case, it was uniplane fixation, making 20690 the correct code to report. Modifier LT should be appended to indicate it is the left wrist. Fluoroscopy is included in the procedure.

ICD-9-CM code: Look in the ICD-9-CM Index to Diseases for fracture/Colles'. You are directed to ICD-9-CM code 813.41. Verification in the Tabular List verifies 813.41 is for a Colles' fracture.

## Case 4

### Operative report

**Preoperative diagnosis:** Dislocation of right elbow.

1. Postoperative diagnosis is used for coding.
2. Working procedure.
3. General anesthesia used.
4. Backs up diagnosis.
5. This indicates a closed method of reduction. There is no indication the skin was cut.
6. Indicates fluoroscopy.
7. Manipulation of the medial epicondyle.
8. This is showing the fracture, reduced and set. No indication that the skin was broken.

1. **Postoperative diagnosis:** Dislocation of right elbow with medial epicondyle fracture.
2. **Operative procedure:** Closed reduction of elbow dislocation with a closed reduction of medial epicondyle fracture.
3. **Anesthesia:** General.
4. **Indications:** This is a 12-year-old male who sustained a dislocation of his right elbow. The risks and benefits of surgical treatment were discussed with the family who stated understanding and desired to proceed.

**Description of procedure:** On the day of procedure after obtaining informed consent, the patient was taken to the main Operating Room where general anesthesia was induced. Once he was under adequate anesthesia the reduction maneuver was performed. The elbow was reduced and was stable. Through a full range of motion there was noted to be a slight crepitus on the medial elbow and it was felt some mobility in the medial epicondyle. Examination under C-arm imagery revealed a concentric reduction of the elbow but with mildly unstable medial epicondyle. When the elbow was held in the appropriate position the medial epicondyle was well reduced in acceptable position and it was elevated to treat this non-surgically and therefore a long arm splint was applied. The patient was awakened from anesthesia and taken to Recovery in stable condition with no immediate complications.

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

CPT® codes: 24565-RT, 24605-51-RT

ICD-9-CM codes: 812.43, 832.00

**RATIONALE:** CPT® codes: Look in the CPT® Index for Fracture/Humerus/Epicondyle/ Closed treatment and you are directed to code range 24560–24565. The code selection is based on whether manipulation is used. 24565 is the correct code for the repair of the epicondyle fracture.

The first procedure performed is the reduction of the dislocated elbow. Look in the CPT® Index for Dislocation/Elbow and you are directed to 24605–24615 and 24640. 24640 is for nursemaid's elbow. The code selection between codes 24605–24615 is based on whether anesthesia is used. In this case, general anesthesia was used, making 24605 the correct code choice. Typically the reduction of a dislocation would be included in the fracture repair. Modifier 51 is appended to show more than one procedure is performed. Modifier RT would also be used to indicate it was on the right elbow.

**ICD-9-CM codes:** The diagnosis is stated as dislocation of right elbow with medial epicondyle fracture. The fracture is a more severe diagnosis, so it will be coded first. The medial epicondyle is the bony protrusion on the inside of your elbow and is part

of the distal end of the humerus. Look in the ICD-9-CM Index for Fracture/humerus/condyle(s)/medial (internal epicondyle) and you are directed to 812.43. For the dislocation of the elbow, look in the index for Dislocation/elbow and you are directed to 832.00. Verification in the Tabular List confirms this diagnosis selection.

## Case 5

**Preoperative diagnosis:** Right long finger trigger finger  
Left shoulder impingement/subacromial bursitis.

**Postoperative diagnosis:** Right long finger trigger finger.  
Left shoulder impingement/subacromial bursitis.

1. Postoperative diagnosis is used for coding.

2. General anesthesia used.

3. Shoulder injection.

4. The A1 pulley is a flexor tendon pulley.

5. The release of the nerve.

1.

**Procedures:** Right long finger trigger release.  
Injection of the left shoulder with Xylocaine, Marcaine, and Celestone via anterior subacromial approach.

2.

**Anesthesia:** General.

**Complications:** None.

**Estimated blood loss:** Minimal.

**Replacement:** Crystalloids.

**Description of procedure:** The patient was taken to the operating room where he was given appropriate anesthesia. The right upper extremity was prepped and draped in the usual sterile fashion. While the draping was going on, the left shoulder was prepped with Betadine and using Xylocaine. Marcaine and Celestone, through an anterior subacromial approach; the left shoulder was injected with 1 cc of Xylocaine, 1 cc of Celestone and 1 cc

3.

of Marcaine. The patient tolerated the procedure well.

4.

Meanwhile, the right hand had been prepped and draped. It was exsanguinated with Esmarch and tourniquet inflated to 250 millimeters of mercury. I made an incision over the A1 pulley in the distal transverse palmar crease, about an inch in length. This was taken through skin and subcutaneous tissue. The A1 pulley was identified and released

5.

in its entirety. Care was taken to avoid injury to the neurovascular bundle. The wound was irrigated with antibiotic saline solution. The subcutaneous tissue was injected with Marcaine without epinephrine. The skin was closed with 4-0 Ethilon suture. Clean dressing was applied. The patient was awakened and taken to the recovery room in stable condition.

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

CPT® codes: 26055-F6, 20610-51-LT

ICD-9-CM codes: 727.03, 726.19

**RATIONALE:** CPT® codes: The most complicated procedure is the right long finger trigger release. Look in the CPT® Index for trigger finger repair and you are directed to 26055. Reading the descriptor, we see tendon sheath incision, (eg, Trigger finger). For the shoulder injection, look in the CPT® Index for injection/joint, you are directed to code range 20600-20610. The code selection is based on the joint. The shoulder is considered a major joint making 20610 the correct code. Modifier 51 should be appended to indicate multiple procedures. An F6 should be appended to the trigger finger release and an LT should be appended to the shoulder injection. The proce-



dures were performed under general anesthesia which is an indication this case was performed in a facility. The drugs are reported by the facility-not the physician.

ICD-9-CM codes: The diagnoses were stated as right long finger trigger finger and left shoulder impingement/subacromial bursitis. For the trigger finger, look in the ICD-9-CM Index for trigger finger and you are directed to 727.03 as the default (there is no mention of it being congenital). For the shoulder, look for bursitis/subacromial and you are directed to 726.19. There is no index for impingement of the shoulder. In the Tabular List, both codes are verified. Bursitis can be a cause of shoulder impingement (or rub).

## Case 6

**Preoperative diagnosis:** Painful hardware left foot.

1. Postoperative diagnosis is used for coding.

2. Stated procedure.

3. Confirmation of diagnosis.

4. Removal of hardware.

1. **Postoperative diagnosis:** Painful hardware left foot.

2. **Procedure performed:** Removal of hardware, left foot

**Anesthesia:** Sedation and local

**Drain:** None.

**Estimated blood loss:** Minimal.

**Indications for procedure:**

3. **The patient had the above-mentioned problems**, unresponsive to conservative treatment. We discussed the above-mentioned surgery, along with the potential risks and complications, and the patient understood and wished to proceed.

**Description of procedure:**

With the patient supine on the operating table after the successful induction of anesthesia, the left foot was prepped and draped in the usual sterile fashion, and then I injected 0.5% Marcaine into the area of the screw heads, both on the lateral side of the foot and then dorsal midfoot, about 5 mL each area. A small incision through the skin 0.5 cm, and blunt dissection down to the screw head. **The screw was removed with the screwdrivers.** They were irrigated and closed with simple 4-0 nylon sutures. A sterile compression dressing was applied. The patient was taken to the recovery room in satisfactory condition.

**Material sent to laboratory:** None.

**Complications:** None.

**Condition on discharge:** Satisfactory.

**Discharge diagnosis:** Painful hardware, left foot.

**Discharge plan:**

Discharge instructions were discussed with the patient. A copy of the instructions was given to the patient and a copy retained for the medical record. The following items were discussed: diet, activity, wound care medications if applicable, when to call the physician, and follow-up care.

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

CPT® code: 20680-LT

ICD-9-CM code: 996.78

**RATIONALE:** CPT® code: Look in the CPT® Index for removal/implantation and you are directed to code range 20670-20680. The code selection is based on whether the implant (hardware) is superficial or deep. In the description of 20680, you will see screws are considered deep. The correct code is 20680. Modifier LT should be appended to indicate it is the left foot.

ICD-9-CM code: The diagnosis is stated as painful hardware, left foot. In the ICD-9-CM Index, look for Complications/orthopedic device, implant, or graft or internal (fixation) (nail) (plate) (rod) NEC 996.78. Verify the code in the Tabular List. Under subcategory 996.7, Pain due to (presence of) any device, implant, and graft classifiable to 996.0-996.5 confirms we are in the correct subcategory.

## Case 7

### Procedure performed in office.

**Preoperative diagnosis:** Right-sided thoracic pain.

1. Postoperative diagnosis is used for coding.

2. Procedure performed.

3. Three muscles injected.

4. Secondary diagnosis for the visit.

5. This verifies the trigger points injected.

6. This is the amount and name of drug used.

1. **Postoperative diagnosis:** Right-sided thoracic pain.

2. **Operation:** Trigger point injection into the right-sided thoracic spine musculature, into the rhomboid major, rhomboid minor, and levator scapular muscles.

#### Procedure:

The patient was seated on the bed. He was explained the risks, including but not limited to bleeding, infection, nerve damage and no guarantee of symptom relief. The patient has metastatic lung cancer and has had a right lung resection. The patient agreed and the informed consent was signed.

4. The patient has metastatic lung cancer and has had a right lung resection. The patient agreed and the informed consent was signed.

I palpated for areas of maximal tenderness. Five spots were marked into the right-sided thoracic paraspinal musculature. I then cleaned off his back with chlorhexidine x2. Then a 25 gauge 1.5 inch needle on a 10 cc controlled syringe with Depo-Medrol, 40 mg/mL was used. After negative aspiration, 1 cc was injected into each point. A total of four points were injected. A total of 4 cc (160 mg) was used. The patient tolerated the procedure well. Band-Aids were not placed. The patient was not bleeding.

5. After negative aspiration, 1 cc was injected into each point. A total of four points were injected. A total of 4 cc (160 mg) was used. The patient tolerated the procedure well. Band-Aids were not placed. The patient was not bleeding.

We are also going to refill the patient's pain medication. He is seeing an oncologist and is getting Percocet 7.5/500. He takes four a day. That does provide him with pain relief. We are going to dispense to him today a three week supply. We are going to dispense #84. He is to return to the office in two weeks at which time we will get a urine for follow-up. Emphasized to the patient once again that he had to bring his pills to every appointment according to the opioid contract.

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

CPT® codes: 20553, J1030 x 4

ICD-9-CM codes: 724.1, 197.0

**RATIONALE:** CPT® codes: In the CPT® Index, look for Injection/Trigger Point(s). Under trigger point(s) you have a selection between One or Two Muscles and Three or More muscles. The documentation states 3 muscles were injected, directing us to 20553. Verification of 20553 confirms the code selection. The drug used for the procedure is billable also, looking in the HCPCS Level II codebook at the drug table for Depo-Medrol, we are directed to Methylprednisolone acetate, code J1030 each 40 mg. Verifying it in the tabular of the HCPCS Level II codebook, J1030 is billed with 4 units (40 mg x 4 = 160 mg).

ICD-9-CM codes: Look in the index for Pain/thoracic spine and you are directed to 724.1. The patient also has metastatic lung CA. Look at the Neoplasm Table and find lung. The code in the column for Malignant/Secondary is 197.0. There is no mention the pain is neoplasm related, so a code from category 338 is not reported.

## Case 8

### Operative report

**Preoperative diagnosis:** Plantar fasciitis left.

**Postoperative diagnosis:** Same as preoperative diagnosis. 1.

**Procedures:** Plantar fasciotomy left heel. 2.

For informed consent, the more common risks, benefits, and alternatives to the procedure were thoroughly discussed with the patient. An appropriate consent form was signed, indicating the patient understands the procedure and its possible complications.

This 61-year-old male was brought to the operating room and placed on the surgical table in a supine position. Following anesthesia, surgical site was prepped and draped in the normal sterile fashion. Attention was then directed to the left heel where, utilizing a 61 blade, a stab incision was made, taking care to identify and retract all vital structures. The incision was deepened to the medial band insertion of the fascia.

The fascia was then incised and avulsed from the calcaneus. The surgical site was then flushed with saline. 1 cc of Depo-Medrol was injected in the op site. Site was dressed with a light compressive dressing. Excellent capillary refill to all the digits was observed without excessive bleeding noted. 3.

**Hemostasis:** none

**Estimated blood loss:** minimal

**Injectables:** Agent used for local anesthesia was 5.0 cc and Marcaine 0.5% with epi

**Pathology:** No specimen sent.

**Dressings:** Applied Bacitracin ointment. Site was dressed with a light compressive dressing.

**Condition:** Patient tolerated procedure and anesthesia well. Vital signs stable. Vascular status intact to all digits. Patient recovered in the operating room.

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

CPT® code: 28008-LT

ICD-9-CM code: 728.71

**RATIONALE:** CPT® code: Looking in the index under fasciotomy/plantar, we are only given an endoscopic approach. This was not done with an endoscope. Looking under fasciotomy/foot we are directed to 28008. Reading the descriptor, it is indeed an incision into the foot. Modifier LT for the designation of the foot operated on. ICD-9-CM code: In the ICD-9-CM Index, look for fasciitis/plantar and you are directed to 728.71. Verification in the Tabular List confirms this is the correct code.

1. Postoperative diagnosis is used for coding. In this case, it is the same as the preoperative diagnosis.
2. Listed procedure.
3. Description of the fasciotomy.

## Case 9

**Anesthesia:** General anesthesia

**Preoperative diagnosis:** Left Achilles' tendon rupture.

1. Postoperative diagnosis is used for coding.

2. Stated procedure.

3. General anesthesia used.

4. Rupture of Achilles' tendon verified.

5. Repair of Achilles's tendon with sutures.

6. Short leg cast applied.

1. **Postoperative diagnosis:** Left Achilles' tendon rupture.

2. **Operation performed:** Open Left Achilles' tendon repair.

**Indications:** The patient is 25-year-old male who was playing basketball when he was hit by another player and felt a pop in the back of his ankle approximately two months ago. Examination reveals a positive Thompson test, but no plantar-flexion on squeezing the calf. There is a palpable defect in the Achilles' tendon. There is some swelling in this region and neurovascular examination is intact. Given these clinical findings the patient is taken to the operating room for the aforementioned procedure.

3. **Description of procedure:** Following induction of general anesthesia the patient was placed prone on the operating table and all bony prominences were well-padded. The patient received a dose of one gram of Ancef. Under tourniquet control of 250 mm Hg, a longitudinal incision was made followed by an opening up the paratenon of the Achilles' tendon. An obvious rupture was noted. The hematoma was evacuated and the ends were then debrided with a Metzenbaum scissors. Using a #2 FiberWire® this was placed in a Bunnell type fashion in both the proximal and distal portions of the Achilles' tendon. Another #2 Orthocord was then used and placed in a running fashion along the proximal and distal portions of the Achilles' tendon. A total of four sutures were used. These were then tied together to re-approximate the tendon with no significant tension on the repair.

A nice secure repair was noted. The ends of the repair were also further augmented with a 2-0 Vicryl suture. The wound was thoroughly irrigated with antibiotics irrigation solution. The fascial plane was closed with a 2-0 Vicryl suture followed by closing the skin with a 2-0 in subcuticular fashion. Approximately 10 cc of 0.5% Marcaine was injected for postoperative pain control. A routine dressing was applied to the extremity and it was then placed into a short leg cast with the foot slightly plantar-flexed. In addition, the anterior aspect of the cast was then univalved. The tourniquet was deflated for a total tourniquet time of 42 minutes.

The patient was then awakened in the operating room breathing spontaneously and taken to the recovery room in stable condition.

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

CPT® code: 27650-LT

ICD-9-CM codes: 845.09, E917.0, E007.6

**RATIONALE:** CPT® code: In the CPT® Index, look for Achilles Tendon/repair and you are directed to code range 27650–27654. This is a primary repair and no graft was used. 27650 is the correct code.

ICD-9-CM codes: In the ICD-9-CM Index, look for rupture/tendon/Achilles' and you are directed to 845.09. It is coded as traumatic because the diagnosis is a result of an

injury from the patient playing basketball. Verification in the Tabular List confirms 845.09 is for a sprain or strain of other specified part of the foot. E codes are reported to describe the circumstances. For the E code, go to the Index to External Causes of Injury and Poisoning, look for Hit, hitting/other person(s)/in sports and you are directed to code E917.0. The second E code is under Activity/basketball directing you to code E007.6. We do not have the location of the activity, so it is not reported.

## Case 10

**Preoperative diagnosis:** Right ankle triplane fracture

1. Postoperative diagnosis is used for coding.
2. Stated procedure.
3. General endotracheal anesthesia used.
4. Radiologic guidance used.
5. Confirms fracture and treatment were of the distal tibia.
6. Fracture reduced.
7. Internal fixation accomplished with screws.

1. **Postoperative diagnosis:** Right ankle triplane fracture

2. **Procedure:** Open reduction and internal fixation (ORIF) right ankle triplane fracture

3. **Anesthesia:** General endotracheal

**Complications:** None

**Specimen:** None

**Implant used:** Synthes 4.0 mm cannulated screws

### Indications for procedure:

The patient is a pleasant 15-year-old male who fell and sustained a right ankle triplane fracture. This was confirmed on both X-ray and CT scan. Explained to the patient are indications for ORIF as well as possible risks and complications which include but are not limited to infection, bleeding, stiffness, hardware pain, need for hardware removal, no guarantee of functional ambulatory result. The patient and the family understood and wished to proceed.

### Procedure in detail:

The patient was brought back to operating room and placed on an operating table, given a general anesthetic without any complications, given preoperative antibiotics per usual routine. He had right lower extremity prepped and draped in the usual sterile fashion with alcohol prep followed by routine Betadine prep.

4. Under X-ray guidance, a pointed reduction clamp was placed from the anterolateral
5. corner of the distal tibia to the medial side and reduced the triplane fracture. It was confirmed on both AP and lateral X-ray images that the gap was reduced. The patient then had guidewires taken from the Synthes 4.0 mm cannulated screw set, placed one from medial along the epiphysis on the anterior half of the epiphysis and parallel to the joint to catch the lateral aspect of the epiphysis. Then one screw was placed above the physis from anterior to posterior to capture that spike. Once wires were in appropriate position, length was measured, partially threaded 4.0 mm cancellous screws were selected so that all threads were across the fracture site. Appropriate length screws were placed, confirmed by X-ray to be in good position. Fracture was anatomically reduced, and ankle joint was anatomic. The patient had wounds copiously irrigated out. Closure was done with interrupted horizontal mattress 3-0 nylon suture. The patient had sterile compressive dressing, was placed into a 3-sided posterior mold splint, was extubated and brought to recovery room in stable condition. There were no complications. There were no specimens. Sponge and needle counts were equal at the end of the case.
- 6.
- 7.

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

CPT® codes: 27827-RT

ICD-9-CM code: 824.8



**RATIONALE: CPT® codes:** In the CPT® Index, look under Fracture/Tibia/Distal and you are directed to code range 27824–27828. This code range is for open treatment with internal fixation (ORIF). The treatment was of the distal tibia making 27827 the correct code selection.

**ICD-9-CM code:** The diagnosis is stated as a right ankle triplane fracture. A triplane ankle fracture refers to a fracture in the distal tibia in three planes. In the alphabetic index, look for Fracture/ankle, you are directed to 824.8. Verification of 824.8 confirms it codes to fracture of the ankle, unspecified. There is not a “not otherwise specified” code for a fracture of the ankle, so this would be correct.