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Ask the Editor

Question:
A 3-week-old male, who was diagnosed with transposition of the great arteries with pulmonary stenosis, presents for right modified Blalock-Taussig shunt procedure to augment pulmonary blood flow. At surgery, the aorta and pulmonary artery were separated with electrocautery and the branch pulmonary arteries were mobilized. The innominate artery was mobilized, an arteriotomy was made and the proximal anastomosis was created with a Gore-Tex graft. A longitudinal arteriotomy was performed and the distal anastomosis of the shunt created to the right pulmonary artery using Prolene suture. What is the appropriate ICD-10-PCS code for modified Blalock-Taussig shunt procedure?

Answer:
For the modified Blalock-Taussig shunt procedure assign the following ICD-10-PCS code:

021W0JQ  Bypass thoracic aorta to right pulmonary artery with synthetic substitute, open approach

Question:
A 55-year-old female was admitted with enlarging right temporal horn and right cavity near the lateral ventricle. She had been previously diagnosed with pilocytic astrocytoma and has a long neurosurgical history, status post intraventricular tumor resection, endoscopic membrane lysis, and ventricular peritoneal shunt placement. The patient was admitted for trapped right temporal horn and was also diagnosed with recurrent astrocytoma, hydrocephalus, and encephalopathy. She had re-resection of the tumor. Would it be appropriate to assign a separate diagnosis code for the trapped temporal horn, or is it considered integral to the patient’s condition?
Answer:
Assign code C71.9, Malignant neoplasm of brain, unspecified, as the principal diagnosis for the astrocytoma. Assign also code G91.4, Hydrocephalus in diseases classified elsewhere. Do not assign a unique code for the trapped temporal horn. Entrapment of the temporal horn is a form of focal hydrocephalus caused in this case by the brain tumor, and is therefore represented by the code for the astrocytoma.

Question:
A 68-year-old male presents to our facility with symptoms of malaise, fatigue and fever. The patient was diagnosed with systemic inflammatory response syndrome (SIRS). However, he did not have sepsis. The provider listed “SIRS secondary to pneumonia,” in his diagnostic statement. My particular encoder is directing me to the sepsis code. ICD-10-CM does not seem to have a code for SIRS due to infectious process. How should we report SIRS due to pneumonia?

Answer:
Assign only code J18.9, Pneumonia unspecified organism. When sepsis is not present, no other code is required. The ICD-10-CM does not provide a separate code or index entry for SIRS due to an infectious process. If the health record documentation appears to meet the criteria for sepsis, the provider should be queried for clarification. Encoders are tools that may assist coders; however the codes must be validated and supported by the health record documentation.

Question:
When coding encounters for treatment of conditions due to war, such as combat fatigue or post-traumatic stress disorder (PTSD), can we also assign a code from category Y36, Operations of war, to show the cause of these conditions?
Answer:
Yes, it is appropriate to assign a code from category Y36.-, Operations of war, to describe the external cause of the condition. Coders should be as specific as possible. As stated in the ICD-10-CM Official Coding Guidelines, an external cause code may be used with any code in the range of A00.0-T88.9, Z00-Z99 of the classification that is a health condition due to an external cause. The guidelines also state that although external cause codes are most applicable to injuries, they are also valid for use with such diagnoses as infections or diseases due to an external source, and other health conditions.

Question:
Previous Coding Clinic advice has supported the assignment of a more specific fracture code in ICD-9-CM and ICD-10-CM based on findings in imaging reports when a physician has documented a diagnosis of fracture. Does this advice hold true for other conditions that may be further specified based on imaging reports? For example, if a patient is diagnosed with a cerebral infarction or hemorrhagic stroke, can the imaging results be used to identify the specific vessel associated with these conditions?

Answer:
It is appropriate to utilize imaging reports to provide greater specificity of the anatomic site as documented by the physician. Therefore, if a patient is diagnosed with a cerebral infarction or hemorrhagic stroke, it would be appropriate to utilize the imaging report to determine the location of the stroke or infarction.

Question:
When coding the placement of an infusion device such as a peripherally inserted central catheter (PICC line), the code assignment for the body part is based on the site in which the device ended up (end placement). For coding purposes, can imaging reports be used to determine the end placement of the device?
Answer:
When the provider’s documentation does not specify the end placement of the infusion device, the imaging report may be used to identify the body part.

Question:
A 55-year-old woman presents to the hospital with a five-day history of abdominal pain, fever and chills. An exploratory laparotomy was performed which revealed a perforated appendix. The entire appendix was gangrenous down to the base, which was extremely thin-walled and friable. Therefore, the surgeon performed an ileocecectomy, which included the entire cecum, the terminal ileum and the appendix. Is it appropriate to assign separate codes for resections of the appendix and the cecum along with excision of the terminal ileum?

Answer:
An ileocecectomy is a surgery performed to remove the cecum (first part of the large intestine) and the ileum (end part of the small intestine). A complete resection of the cecum always includes part of the terminal ileum (ileocecal valve); the appendix is removed as well. No separate or distinct surgery is carried out to remove the ileum and appendix. Do not separately code the excision of adjacent structures that are an inherent part of the procedure to resect an entire body part. Assign the following ICD-10-PCS code for the ileocecectomy.

0DTH0ZZ    Resection of cecum, open approach

Question:
A 69-year-old patient, who was diagnosed with volvulus of the right colon, underwent right colectomy. Would separate codes be assigned for the resection of the cecum with appendix and excision of the transverse colon? What is the correct ICD-10-PCS procedure code assignment for the right colectomy?
Answer:
Although there is not universal agreement as to the anatomical definition of the right colon, the surgeon documented, “resection of the right colon,” in the operative report so it should be coded as such. Do not separately code the excision of adjacent structures that are an inherent part of the procedure to resect an entire body part. Assign the ICD-10-PCS code as follows:

0DTF0ZZ  Resection of right large intestine, open approach

Question:
A patient, status post right hemi-craniectomy, underwent a right hemi-cranioplasty to repair the cranial defect. In the process, two small dural rents were noted and repaired primarily. The cranial implant was secured in place. The area was irrigated, a head wrap was placed and the patient was transferred in stable condition. What would be the appropriate root operation for the right hemi-cranioplasty; replacement or supplement? Additionally, would the dural repair be coded separately?

Answer:
In this case, the correct root operation is “Replacement,” since the intent of the procedure is to replace the skull that was previously removed. The root operation “Replacement” is defined as putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part. It is appropriate to assign a separate code for repair of the dural rents, since the repair was not inherent to the surgery.

Assign the following ICD-10-PCS codes for the hemi-cranioplasty and repair of the dura, respectively:

0NR00JZ  Replacement of skull with synthetic substitute, open approach
Repair dura mater, open approach

**Question:**
Our facility is unclear regarding the coding of coronary artery bypass grafting (CABG) using the left internal mammary artery (LIMA). We are specifically debating whether the LIMA is considered a free graft or a pedicle graft, and if harvesting of the LIMA is also coded. If the LIMA graft remains attached, would only the bypass be coded with 6th character “Z” for no device?

**Answer:**
Based on the documentation for this case, the LIMA was used as pedicle graft and was not excised from the patient. Therefore, a separate code should not be reported for harvesting/excision of the left internal mammary artery. Assign the following ICD-10-PCS code for the CABG utilizing the left internal mammary artery:

02100Z9 Bypass, coronary artery, one site, from, left internal mammary, open approach

**Question:**
Please provide clarification for coding the harvest of the saphenous vein for coronary artery bypass grafting (CABG). In the operative note, the physician documents harvest of left saphenous vein from the leg with no further specificity. Is there any guidance when the documentation does not state upper/greater, or lower/lesser saphenous vein?

**Answer:**
ICD-10-PCS does not have an “unspecified” or “not otherwise specified” designation for procedures performed on the saphenous vein. If the documentation does not specify which saphenous vein was harvested, query the physician for clarification so that the appropriate body part may be reported. Facilities may also work with providers to develop facility-specific coding guidelines, which will establish a default code based on common practice.
Question:
A patient with cervical spondylosis, grade 1 cervical spondylolisthesis, severe facet arthropathy, and disk herniation with cord compression underwent cervical posterior fusion, hemilaminotomy, discectomy and cervical interspinous ligamentoplasty. The ligamentoplasty was performed using FiberWire in-between the spinous processes to tighten and stabilize the cervical spine. What is the appropriate ICD-10-PCS code for the cervical interspinous ligamentoplasty?

Answer:
The interspinous ligamentoplasty (ILP) was done to treat the degenerative conditions of the cervical vertebra by stabilizing and reinforcing the vertebral column. In ILP surgery, the interspinous and supraspinatus ligaments are augmented, restricting flexion movement in spinal segments. Since the surgical objective is distinct, it is not considered an integral part of the spinal fusion. In this case, the FiberWire polyethylene suture material, was used to stabilize and support the spinal column, and would not be classified as a device. The root operation “Supplement” is not appropriate. Although the body part key defaults to trunk for interspinous ligament, head and neck is more suitable for the cervical spine.

For the interspinous ligamentoplasty, assign the following ICD-10-PCS code:

0MQ00ZZ Repair head and neck bursa and ligament, open approach

Question:
A patient with adenoid cystic carcinoma underwent resection of the parotid tail with sacrifice of the marginal mandibular branch of the facial nerve, resection of the parapharyngeal space, and bilateral radical resection of level I lymph nodes.
The *ICD-10-PCS Reference Manual*, page 39, states “when an entire lymph node chain is cut out, the appropriate root operation is resection. When a lymph node(s) is cut out, the root operation is excision.” What is the correct ICD-10-PCS code assignment for radical resection of the level I lymph nodes?

**Answer:**

If a chain of lymph nodes is excised, it should be coded as resection. If a partial removal of the lymph node chain is done, it is coded as excision. 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. However, a radical resection of an organ does not necessarily imply the removal of adjacent nodes, it only implies that the entire organ was resected. A modified radical is also the removal of all nodes and is coded as resection. Radical procedures involve cutting out everything within a designated anatomic boundary. On the other hand, sampling of lymph nodes, such as sentinel nodes would be coded as excision.

Each level is considered a chain, and the surgeon removed the entire level I lymph nodes in this case. Assign the following ICD-10-PCS codes:

- **07T10ZZ** Resection of right neck lymphatic, open approach
- **07T20ZZ** Resection of left neck lymphatic, open approach

**Question:**

A patient diagnosed with right lung cancer and chronic obstructive pulmonary disease underwent flexible fiberoptic bronchoscopy, video-assisted thoracoscopic right lobectomy and removal of lymph nodes from the right paratracheal stations 2, 4R, 7, 9, and 10R. What is the correct ICD-10-PCS code assignment for the removal of the lymph nodes from the right paratracheal stations 2, 4R, 7, 9, and 10R?
Answer:
In this case, the surgeon removed some paratracheal lymph node positions and left other positions intact. Individual lymph nodes were removed, rather than a mass of lymph nodes. This implies excision (selective removal of lymph nodes), rather resection. Therefore the appropriate root operation is “Excision.” Some examples of terms indicating lymph node excision are “sampling”, “biopsy”, “sentinel node”, and “isolated nodes”. However, documentation specifying the intent to remove a chain of lymph nodes is coded as “Resection.” Assign the following ICD-10-PCS code for the excision of lymph nodes from the right paratracheal stations 2, 4R, 7, 9, and 10R:

07B74ZX   Excision of thorax lymphatic, percutaneous endoscopic approach, diagnostic

The body Part Key of ICD-10-PCS, directs the coder to “use lymphatic, thorax,” for paratracheal lymph node.

Question:
A patient presented with bile duct stones. The provider attempted to flush the stones from the duct by giving the patient Glucagon. Is the administration of Glucagon coded?

Answer:
No, the administration of Glucagon would not be coded. ICD-10-PCS provides codes for a great number of procedures, including some minor procedures which may not always be reported in an inpatient setting. As stated in the ICD-10-PCS Reference Manual, page 122, “Many different substances are typically put in or on the body in the course of an inpatient hospital stay, both during surgical procedures and at the bedside. Only those which meet Uniform Hospital Discharge Data Set (UHDDS) rules and facility coding guidelines are coded separately.”
Question:
A 33-year-old patient was admitted for vaginal delivery. Following delivery, the provider used Lidocaine to infiltrate skin tags on the left labia majora, and then excised the lesions. What is the correct ICD-10-PCS code for the excision of lesions on the labia majora?

Answer:
The Body Part Key of ICD-10-PCS directs the coder to “Vulva” for the labia majora. Assign the following ICD-10-PCS code:

0UBMXZZ Excision of vulva, external approach

Question:
The patient is a 34-year-old female, who is 21 weeks gestation, and currently diagnosed with twin-twin transfusion syndrome. The patient underwent selective fetoscopic laser photocoagulation and laser microseptostomy. At surgery, the fetoscope was inserted; amniotic fluid was aspirated; and a laser successfully photocoagulated all seven vascular connections. The provider then performed a laser microseptostomy in the inter-twin membrane. What are the appropriate ICD-10-PCS codes for selective fetoscopic laser photocoagulation and laser microseptostomy for twin-twin transfusion syndrome?

Answer:
Assign the following ICD-10-PCS codes:

10Q04ZY Repair other body system in products of conception, percutaneous endoscopic approach (for the fetoscopic laser photocoagulation)
10904ZC Drainage of amniotic fluid, therapeutic from products of conception, percutaneous endoscopic approach (for the laser microseptostomy)

Twin-twin transfusion syndrome occurs only in identical twins, who are monochorionic, and usually diamniotic. In most instances, the single placenta contains blood vessel connections between the twins. In approximately 15% to 20% of monochorionic, diamniotic twins, the blood flow through these connections is unbalanced, leading to twin-twin transfusion syndrome. The smaller twin (donor twin) does not receive sufficient blood, and the amount of amniotic fluid is inadequate. The larger twin (recipient twin) receives excessive blood, and has large amounts of amniotic fluid. In fetoscopic laser photocoagulation a telescope is used to visualize the vessels responsible for the condition. The laser is then used to coagulate, or seal off the problematic vessels. A laser microseptostomy creates small holes in the membranes that divide the twins, allowing fluid to pass through to equalize the amniotic fluid for each fetus.

Question: What are the appropriate procedure code assignments for an orthotopic liver allotransplant with end to side cavoplasty and choledochostomy?

Answer: For an orthotopic liver allotransplant, assign the following ICD-10-PCS code:

0FY00Z0 Transplantation of liver, allogeneic, open approach

The majority of liver transplants are performed via an orthotopic technique in which the native liver is resected and the new liver is placed in the same position. The resection of the liver involves the
division of all ligaments attached to the liver in addition to the common bile duct, hepatic artery, portal vein and the hepatic vein. In most cases, the retrohepatic portion of the inferior vena cava is removed along with the liver. Implantation of the new (donor) liver involves the anastomoses of the portal vein, inferior vena cava and hepatic artery. After the new liver has resumed blood flow, the bile duct anastomosis is created, either to the native bile duct or to the small intestine. Therefore, the anastomoses are considered components of the surgery and should not be reported separately. Do not assign unique codes for the end to side cavoplasty or the choledochostomy.

Furthermore, the ICD-10-PCS Official Guidelines for Coding and Reporting, B3.1b, state, “Components of a procedure specified in the root operation definition and explanation are not coded separately. Procedural steps necessary to reach the operative site and close the operative site, including anastomosis of a tubular body part, are also not coded separately.”

**Question:**
The patient, an 85-year-old male, presented with nonhealing ulcerations of the anterior ankle area and heel, which required further debridement and the application of TheraSkin®. The surgeon performed an excisional debridement that included tendon. TheraSkin® was then applied over the wound and stapled. What is the appropriate ICD-10-PCS code assignment for the application of TheraSkin®? Would a code for the excisional debridement be reported separately?

**Answer:**
In this instance, the excisional debridement is coded separately, because the graft was applied only at the skin level, and the debridement included tendon (deeper layer). The ICD-10-PCS Official Guidelines for Coding and Reporting B3.5 state, “If
the root operations Excision, Repair or Inspection are performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded.” Example: Excisional debridement that includes skin and subcutaneous tissue and muscle is coded to the muscle body part.” Assign the following ICD-10-PC codes:

**0HRNXXK3** Replacement of left foot skin with nonautologous tissue substitute, full thickness, external approach

**0LBT0ZZ** Excision of left ankle tendon, open approach

The qualifier “full thickness” is the default value for bio-engineered skin substitutes except where they are specifically designated as partial thickness.

**Question:**
A patient with known pseudocyst of the pancreas is admitted for endoscopic retrograde cholangiopancreatography (ERCP) and pseudocyst drainage. Multiple balloon sweeps were made of the common bile duct and a 10 French x 7 plastic biliary stent was successfully deployed across the papilla. Then the pancreatic pseudocyst was punctured and aspirated, and a tube placed for continued drainage from the pancreatic pseudocyst to the stomach using ultrasound guidance. What are the appropriate ICD-10-PCS procedure code assignments?

**Answer:**
The aspiration and puncture of the pancreatic pseudocyst is captured by the drainage code. Therefore no separate code is assigned for puncturing and aspirating the pseudocyst. Assign the following ICD-10-PCS codes:

**0F798DZ** Dilation of common bile duct with intraluminal device, via natural or artificial opening endoscopic
Drainage of pancreas with drainage device, percutaneous endoscopic approach

If desired, assign also code BF47ZZZ, Ultrasonography of pancreas, for the ultrasound guidance.

**Question:**
A patient underwent a complete left nephroureterectomy. The kidney and proximal ureter were removed via “hand-assisted” laparoscopy and the distal ureter was removed from the bladder via an incision. What is the appropriate ICD-10-PCS code assignment for a left nephroureterectomy when two planned approaches are used to completely remove the ureter?

**Answer:**
The left kidney and proximal ureter were excised using a “hand port” laparoscopic-assisted approach. At surgery, an 8-cm incision was made to gain access to the distal ureter site. This is considered an open approach. For the left nephroureterectomy assign the following ICD-10-PCS procedure codes:

- **0TT10ZZ** Resection of left kidney, open approach
- **0TT70ZZ** Resection of left ureter, open approach

**Question:**
A 4-month-old boy with a large conoventricular ventricular septal defect (VSD) with mild aortic override and mild anterior deviation of the conal septum was admitted for surgical repair. The surgeon accomplished a repair of Tetralogy of Fallot. At surgery, cardiopulmonary bypass was established; the ligamentum was ligated; the thymus was resected; the right ventricle outflow tract (RVOT) was divided and widened; and closure of VSD was done with a Gore-tex® patch. What is the correct ICD-10-CM diagnosis code assignment for obstruc-
tion of the right ventricular outflow tract (RVOT) muscle bundles? What are the correct ICD-10-PCS procedure code assignments?

**Answer:**
Assign code Q21.3, Tetralogy of Fallot, as the principal diagnosis. No separate diagnosis code is assigned for the obstruction of the right ventricular outflow tract muscle bundles, since the obstruction is a component of the Tetralogy of Fallot.

The ICD-10-PCS code assignments for the surgery to correct tetralogy of Fallot may be different for each case, since the repair can be performed at various stages. Therefore assign the ICD-10-PCS code(s) describing what was being done during that surgical episode. For this particular case, assign the following ICD-10-PCS codes:

- **02NK0ZZ** Release of right ventricle, open approach (for the widening of the right ventricular outflow tract).
- **02UM0JZ** Supplement ventricular septum, with synthetic substitute, open approach (for the closure of the ventricular septal defect with Gore-tex® patch)
- **07TM0ZZ** Resection of thymus, open approach
- **5A1221Z** Performance of cardiac output, continuous (for the cardiopulmonary bypass)

**Question:**
In ICD-10-CM’s Tabular List, Chapter 15, Pregnancy, childbirth and the puerperium (O00-O9A), there is an instructional note that states “Use additional code from category Z3A, Weeks of gestation, to identify the specific week of the pregnancy.” This note applies to all of the codes in the obstetric chapter. However, this information may
not be documented or relevant in cases of molar pregnancy or trophoblastic disease, since these are not viable pregnancies, and it is not possible for a normal baby to form. The *Official Guidelines for Coding and Reporting 2014*, page 92, states, “Codes in category Z3A, Weeks of gestation, may be assigned to provide additional information about the pregnancy.” Is it appropriate to assign code Z3A.00 Weeks of gestation of pregnancy, not specified, for these cases?

**Answer:**
Codes in category Z3A, Weeks of gestation are not applicable, and should not be assigned if the pregnancy is outside of the uterus or otherwise nonviable (categories O00-O02). The National Center for Health Statistics (NCHS) will be considering a future ICD-10-CM/PCS Coordination and Maintenance Committee (C&M) proposal to revise the conflicting note in the Tabular List.

**Question:**
The patient is a 78-year-old man who presents with a nonhealing wound over his right lower leg. The patient underwent excisional debridement of right Achilles tendon and first stage coverage of the right lower extremity nonhealing wound with elevation of reverse sural fasciocutaneous pedicle flap. How should a reverse sural flap be coded in ICD-10-PCS?

**Answer:**
The root operation for the reverse sural pedicle flap is “Transfer.” The excisional debridement of the tendon is coded separately, because it was performed on deeper layers than the flap graft, which involved only the skin and subcutaneous tissue. Assign the following ICD-10-PCS codes:

0JXN0ZC Transfer right lower leg subcutaneous tissue and fascia with skin, subcutaneous tissue and fascia, open approach (for the reverse sural flap)
**Question:**
The patient, who has ventricular tachycardia (VT), was admitted for ventricular tachycardia ablation. The ablation was performed percutaneously and Impella® 2.5 support was used. What are the code assignments for this procedure and is the Impella assistance coded separately?

**Answer:**
The cardiac conduction system includes the sinoatrial node, the AV node, the bundle of HIS and all other specialized pathways in the atria and ventricles that govern the stimulation of the heart’s pumping action. The cardiac conduction system is the site of any arrhythmogenic focus treated by an ablation procedure, and such procedures are coded to the conduction mechanism body part value. Assign the following ICD-10-PCS codes:

- **02583ZZ** Destruction of conduction mechanism, percutaneous approach
- **5A0221D** Assistance with cardiac output using Impeller pump, continuous

**Question:**
The patient has a previously placed Baclofen pump, which has reached the end of its service life. He underwent open removal and replacement of the Baclofen medication pump. During the procedure, the surgeon made an incision in the abdomen and dissected free the existing pump. An incision was made over the existing scar on the patient’s back and the existing catheter was removed. Attention was then turned to the new catheter, which was percutaneously inserted into the lower back, through the spinal canal and threaded into the intrathecal space. A subcutaneous tunnel was then created to the abdominal incision and the remaining tubing passed...
through this incision. The new pump was brought to the operating field and connected. The pump was placed into the existing subcutaneous pocket. What are the appropriate ICD-10-PCS code assignments for replacement of a Baclofen pump and catheter? Also, what would be the appropriate ICD-10-CM diagnosis code assignment for end of life of a Baclofen pump?

**Answer:**
Assign code Z45.49, Encounter for adjustment and management of other implanted nervous system device, as the principal diagnosis. The new pump was placed in the abdomen in the existing subcutaneous pocket, via an open incision that was used to remove the old pump. The new catheter was inserted percutaneously in the lower back through the spinal canal. Assign the following ICD-10-PCS codes:

- **0JH80VZ** Insertion of infusion pump into abdomen subcutaneous tissue and fascia, open approach
- **00HU33Z** Insertion of infusion device into spinal canal, percutaneous approach
- **0JPT0VZ** Removal of infusion pump from trunk subcutaneous tissue and fascia, open approach
- **00PU03Z** Removal of infusion device from spinal canal, open approach

**Question:**
The patient is a 74-year-old male who had 100% occlusion of the circumflex artery and occlusion of the right coronary artery with tight ostial stenosis of the left anterior descending artery. The patient was placed on cardiopulmonary bypass, and had coronary artery bypass grafting of the left internal mammary to the left anterior descending artery; greater saphenous vein graft to the diagonal branch; saphenous vein graft to the posterior descending ar-
tery; and modified left atrial MAZE procedure using AtriCure® radiofrequency ablation with left atrial appendage exclusion using an AtriClip® device. The vein graft was harvested from the right and left greater saphenous vein via a percutaneous endoscopic approach. How is the surgery coded?

**Answer:**
Assign the following ICD-10-PCS codes for the procedures performed:

- **02100Z9** Bypass coronary artery, one site from left internal mammary, open approach
- **021109W** Bypass coronary artery, two sites from aorta with autologous venous tissue, open approach
- **02570ZK** Destruction of left atrial appendage, open approach
- **02L70CK** Occlusion of left atrial appendage with extraluminal device, open approach
- **06BP4ZZ** Excision of right greater saphenous vein, percutaneous endoscopic approach
- **06BQ4ZZ** Excision of left greater saphenous vein, percutaneous endoscopic approach
- **5A1221Z** Performance of cardiac output, continuous

**Question:**
The patient presented with a mass of the right superficial parotid gland and underwent right superficial parotidectomy. What is the appropriate root operation for right superficial parotidectomy ("Resection" or "Excision")?
Answer:
Assign the root operation “Excision,” since only the superficial lobe was removed, leaving behind the deep lobe. The body part value is parotid gland. The root operation “Resection” should only be assigned when the entire parotid gland (superficial and deep lobes) is removed. Assign the following ICD-10-PCS code:

0CB80ZZ Excision of right parotid gland, open approach

Question:
The patient presented with a large pituitary macroadenoma with suprasellar extension. He underwent transsphenoidal removal of pituitary tumor with placement of fat graft. There does not appear to be an ICD-10-PCS procedure code describing the placement of the fat graft used to seal the sphenoid sinus (bilaterally) and sella at the conclusion of surgery. Would the placement of the fat graft be coded separately? How should this case be coded?

Answer:
Assign code D35.2, Benign neoplasm of pituitary gland, as the principal diagnosis. The fat graft was applied to the sphenoid sinus to fill and seal the space left after the tumor was excised. The appropriate root operation for the placement of the fat graft is “Repair,” since none of the other root operations available for the sphenoid sinus applies in this case. Furthermore, the fat graft was harvested from the abdomen (separate donor site). The ICD-10-PCS Official Guidelines for Coding and Reporting (B3.9) state, “If an autograft is obtained from a different body part in order to complete the objective of the procedure, a separate procedure is coded.” For the procedures, assign ICD-10-PCS codes as follows:

0GB00ZZ Excision of pituitary gland, open approach (for the removal of pituitary tumor)
09QW0ZZ  Repair right sphenoid sinus, open approach (for the placement of the fat graft to seal the sphenoid sinus and sella)

09QX0ZZ  Repair left sphenoid sinus, open approach (for the placement of the fat graft to seal the sphenoid sinus and sella)

0JB80ZZ  Excision of abdomen subcutaneous tissue and fascia, open approach (for the harvesting of the fat graft)

**Question:**
The patient is a 20-year-old male with maxillary hypoplasia. He underwent a Le Fort 1 osteotomy with extraction (open) of impacted teeth, insertion of internal fixation device, and placement of a custom surgical splint. Would the root operation be reposi-

**Answer:**
Assign code M26.02, Maxillary hypoplasia, as the principal diagnosis. The root operation is “Reposition.” The cutting of the maxillary bone in order to move it is included in the definition of the root operation “Reposition.” The ICD-10-PCS Official Definitions define reposition as “Moving to its normal location, or other suitable location, all or a portion of a body part. The body part is moved to a new location from an abnormal location, or from a normal location where it is not functioning correctly. The body part may or may not be cut out or off to be moved to the new location.” Assign the following ICD-10-PCS procedure codes:

0NSS04Z  Reposition left maxilla with internal fixation device, open approach

0NSR04Z  Reposition right maxilla with internal fixation device, open approach
**Question:**
A 5-week-old baby, who is diagnosed with lipomyelomeningocele and tethered cord, presents for untethering of the cord, excision of the lipoma, which involved the lumbosacral portion of the spinal cord, and microdissection of the spinal cord. At surgery, the area above the lipoma was dissected, and a S1 laminoplasty was performed. After freeing up the dural edges, the lipoma was dissected. Dural patch graft was sewn in using Durepair® to cover the wide opening at the site in which the lipoma was removed. What are the appropriate ICD-10-PCS codes for this procedure?

**Answer:**
For the procedures, assign the following ICD-10-PCS codes:

- **00NY0ZZ**  
  Release lumbar spinal cord, open approach (for the release of tethered cord)

- **0QQ10ZZ**  
  Repair sacrum, open approach (for the S1 laminoplasty)

- **00BY0ZZ**  
  Excision of lumbar spinal cord, open approach (for the excision of the lipoma)

- **00UT0KZ**  
  Supplement spinal meninges with nonautologous tissue substitute, open approach (for the dural patch graft with Durepair®)
Question:
The patient underwent wide local excision of the right soft palate with placement of a maxillary surgical obturator due to mucoepidermoid carcinoma. The malignant lesion was excised via Bovie cautery, and a surgical obturator was secured with screws. What is the appropriate approach for the excision of the soft palate, (external or open)? Also, should the surgical obturator be assigned to the root operation “Supplement?”

Answer:
In this case, the external approach is coded since the surgery was performed directly on the soft palate. The Bovie cautery was used as a cutting tool to excise the lesion, not as a means of destroying tissue (i.e., cauterization). The surgeon removed the soft palate, placed synthetic material to create a new covering between the mouth and the nose, and used screws to attach the obturator to the roof of the mouth. This is captured with the root operation “Replacement.” Per the ICD-10-PCS Official Definitions, “Replacement” is defined as putting in or on biological or synthetic material that takes the place and/or function of all or a portion of a body part. Assign ICD-10-PCS as follows:

0CR3XJZ   Replacement of soft palate with synthetic substitute, external approach, for the placement of palatal obturator

Question:
The patient was admitted due to occlusion of his transjugular intrahepatic portosystemic shunt (TIPS) at the portal end. Basket and balloon clot macerations were performed with successful removal of the clots at the medial and lateral TIPS. The lateral TIPS was relined by advancing a stent across the TIPS, extending it by 1 cm, followed by balloon dilatation. Final splenic-portography showed the TIPS shunt to be widely open. What are the appropriate ICD-10-PCS code assignments for this procedure?
Answer:
This is a procedure that is performed on a device. The root operation “Revision” is defined as correcting, to the extent possible, a portion of a malfunctioning or the position of a displaced device. Assign the following ICD-10-PCS code:

06WY3DZ Revision of intraluminal device in lower vein, percutaneous approach

The removal of clots from a stent system of the veins of the liver is classified to the “lower veins” body system. The *ICD-10-PCS Official Guidelines for Coding and Reporting* (B2.1b), state, “Where the general body part values “upper” and “lower” are provided as an option in the Upper Arteries, Lower Arteries, Upper Veins, Lower Veins, Muscles and Tendons body systems, “upper” or “lower “specifies body parts located above or below the diaphragm respectively.” The liver is located below the level of the diaphragm.

Question:
A 60-year-old patient with cirrhosis and hepatocellular carcinoma underwent multiple coil embolizations of the gastroduodenal artery, and chemoembolization of the 4 B arterial branch segments off the right hepatic artery with a mixture of mitomycin, doxorubicin, and lipiodol, followed by particle embolization with 100-300 microspheres. What are the correct ICD-10-PCS codes for the coil embolizations of the gastroduodenal artery, and chemoembolization of the hepatic artery, followed by embolization with microspheres?

Answer:
The Body Part Key of ICD-10-PCS instructs the coder to “use hepatic artery,” for gastroduodenal artery, and the Device Key of ICD-10-PCS instructs the coder that intraluminal device “includes embolization coil(s).” Embolization microspheres are likewise coded as intraluminal device when used to occlude a tubular body part.
The embolization procedure is coded twice, because the gastroduodenal and hepatic arteries are different body sites and are both included in the hepatic artery body part value. According to multiple procedures guideline B3.2b, multiple procedures are coded if:

The same root operation is repeated at different body sites that are included in the same body part value.

Assign the following ICD-10-PCS codes:

04L33DZ  Occlusion of hepatic artery with intraluminal device, percutaneous approach

04L33DZ  Occlusion of hepatic artery with intraluminal device, percutaneous approach

3E06305  Introduction of other antineoplastic into central artery, percutaneous approach

In sections of the ICD-10-PCS containing values that distinguish central vessels from peripheral vessels, the coding convention below can be applied to determine whether the procedure site is a central vessel or a peripheral vessel for coding purposes. The vessels specified below are coded to the central artery/vein body part value:

Coronary Artery
Coronary Vein
Pulmonary Trunk
Pulmonary Artery
Pulmonary Vein
Inferior Vena Cava
Superior Vena Cava
Thoracic Aorta

All other vessels are coded to the peripheral artery/vein body part value(s).
**Question:**
A 57-year-old female presented with a symptomatic midline diaphragm (paraesophageal) hernia and intractable gastroesophageal reflux. She underwent laparoscopic diaphragmatic hernia repair and Nissen fundoplication. During surgery, the hernia sac was separated from the diaphragm and the redundant sac was excised. The fundus of the stomach was brought around the esophagus and a loose Nissen fundoplication was performed. What are the correct ICD-10-PCS codes for laparoscopic paraesophageal hernia repair with Nissen fundoplication?

**Answer:**
When the diaphragmatic hernia is described as midline, assign codes for both right and left diaphragm repair, otherwise code to the side that was operated on. Assign the following ICD-10-PCS codes:

- **0DV44ZZ** Restriction of esophagogastric junction, percutaneous endoscopic approach (Nissen fundoplication)
- **0BQR4ZZ** Repair right diaphragm, percutaneous endoscopic approach (laparoscopic right diaphragm hernia repair)
- **0BQS4ZZ** Repair left diaphragm, percutaneous endoscopic approach (laparoscopic left diaphragm hernia repair)

**Question:**
A 33-year-old male patient with loop ileostomy, status post proctocolectomy and ileoanal J-pouch anastomosis for ulcerative colitis, presents for closure of the loop ileostomy. A parastomal hernia was also noted during the preoperative exam. At surgery, a parastomal incision was made. The ileostomy was dissected free, the parastomal hernia sac was dissected away from the ileum, and the ileostomy was closed. A side-to-side functional
end-to-end anastomosis was created. The parastomal hernia sac was then dissected free. What are the correct ICD-10-PCS codes for the ileostomy takedown, and repair of the parastomal hernia?

**Answer:**
The ileostomy takedown is coded as “Excision” because part of the ileum is removed, and the anastomosis is considered inherent to the surgery and not coded separately. The *ICD-10-PCS Official Guidelines for Coding and Reporting* state “Procedural steps necessary to reach the operative site and close the operative site, including anastomosis of a tubular body part, are also not coded separately.” Assign the following ICD-10-PCS codes:

- **0DBB0ZZ** Excision of ileum, open approach (for the ileostomy takedown)
- **0WQF0ZZ** Repair abdominal wall, open approach (for parastomal hernia repair and stoma closure)

**Question:**
A patient diagnosed with hypoplastic left heart syndrome, status post Norwood procedure and bidirectional Glenn procedure, presents for Fontan completion stage II. The intent of the procedure is to connect the inferior vena cava with the right pulmonary artery via a prosthetic conduit. What is the appropriate ICD-10-PCS code for this procedure?

**Answer:**
Although there are various methods to complete the Fontan procedure, ultimately the procedure is performed for blood flow to bypass the right ventricle and the blood to pass from the right atrium to the pulmonary artery. For the Fontan completion stage II procedure, assign ICD-10-PCS code as follows:

- **02160JQ** Bypass right atrium to right pulmonary artery with synthetic substitute, open approach
Question:
We are not sure how to report replacement of right ventricle (RV) to pulmonary artery (PA) conduit. In the examples we provided, the patient’s existing right ventricle to pulmonary artery conduit, along with the previously placed graft material, is resected and replaced with new graft material. Would this be considered removal and replacement of a device? Or should we just report a code for the new bypass procedure?

Answer:
Assign only a code for the new bypass. The removal of a previous conduit is not considered removal of a device. Assign the ICD-10-PCS code as follows:

021K0JQ  Bypass right ventricle to right pulmonary artery with synthetic substitute, open approach

Question:
_Coding Clinic_, First Quarter 2013, pages 29-30, advised to assign code 0RG40A0, for interbody fusion of C7 and T1 with placement of Vectra Synthes plate and screws. Third Quarter 2013, pages 25-26, advised to assign codes 0SG0071 and 0SG00AJ for a 360-degree interbody and autologous bone graft spinal fusion with placement of pedicle screws. Some coders disagree with this advice and feel that the plates and screws used during spinal fusion should be coded separately, since different root operations are utilized. The procedure appears to meet guideline B3.2c (multiple root operations with distinct objectives are performed on the same body part). Please clarify whether a separate code is assigned for internal fixation/instrumentation (rods, screws, plates, etc.) used with spinal fusion.

Answer:
ICD-10-PCS general guideline B3.1b, clarifies that components of a procedure specified in the root operation definition and explanation are not coded
separately. The explanation in the root operation for fusion states “that body part is joined together by fixation device, bone graft, or other means.” Therefore, the fixation (rods, plates, screws) is included in the fusion root operation, and no additional code is assigned.

**Question:**
A patient with a corneal ulcer with necrosis and descemetocele was seen for amniotic membrane transplantation to the left eye. Necrotic tissue on the cornea was debrided to access site, and a piece of amniotic membrane was cut to size, positioned and glued onto the cornea. Sutures were placed to secure the graft. What are the appropriate ICD-10-PCS procedure code assignments for the amniotic membrane transplant?

**Answer:**
During surgery, part of the cornea’s outer layer was removed and amniotic membrane was transplanted. The amniotic membrane was placed to augment the cornea during healing, so the root operation is “Supplement.” In this case, the debridement was part of the preparation for the amniotic membrane transplantation and should not be separately coded.” Guideline B3.1b states: Procedural steps necessary to reach the operative site and close the operative site are not coded separately. Assign ICD-10-PCS code as follows:

08U9XKZ Supplement left cornea with nonautologous tissue substitute, external approach

**Question:**
The patient, who is status post-surgical aortic valve replacement, underwent closure of an aortic paravalvular leak in the hybrid catheterization lab. The provider documented that a guide catheter was used to locate the paravalvular defect, and a glide wire was traversed across the paravalvular leak. Using transesophageal echocardiography, an Amplatzer®
vascular plug (AVP) was deployed with reduction in the paravalvular leak. A second AVP device was placed across the smaller defect.

ICD-10-PCS table 02W, Revision, heart and great vessels, appears to be the correct table, with “aortic valve” assigned as the body part (4th character). However, “percutaneous” is not an option for the approach (5th character). Code 02UF3JZ, Supplement aortic valve with synthetic substitute, percutaneous approach, also appears to be an option. What is the correct ICD-10-PCS code assignment for closure of a perivalvular leak using Amplatzer® device?

**Answer:**
The previously placed aortic valve is malfunctioning, because a leak has developed along the perimeter of the valve where it is attached. This procedure is performed to correct a portion of a malfunctioning or displaced device, and so the root operation is Revision. Because the “Aortic Valve” body part is not currently available in the tables for a percutaneous Revision procedure, assign the following ICD-10-PCS code:

02WA3JZ Revision of synthetic substitute in heart, percutaneous approach

**Question:**
The provider documented Whipple pyloric sparing pancreaticoduodenectomy, pancreaticojejunostomy and hepaticojejunostomy. What is the appropriate ICD-10-PCS procedure code assignment for the Whipple pyloric sparing pancreaticoduodenectomy procedure?

**Answer:**
In the pylorus-sparing Whipple, the pylorus section of stomach is not removed. This surgery is a variation of the standard Whipple procedure, and the preservation of the stomach and proximal duodenum sustains the function of the gastric reservoir,
allowing normal gastric emptying. In a conventional Whipple, the head of the pancreas, the duodenum, and a portion of the stomach are removed as well as the gallbladder and a portion of the bile duct. The remaining stomach, bile duct and pancreas are then reconnecte

to the digestive tract. The anastomoses (e.g., pancreaticojejunostomy and hepaticojejunostomy) are inherent to the procedure and included in the code assignment. Assign the following ICD-10-PCS codes for the Whipple pyloric sparing pancreaticoduodenectomy:

0FBG0ZZ  Excision of pancreas, open approach

0DB90ZZ  Excision of duodenum, open approach

Question:
The patient, who has a history of closed left distal radius fracture, was noted to have decreased sensation in the median distribution. During surgery, a complete distal release of the transverse carpal ligament, as well as the distal antebrachial fascia was performed under direct visualization, both for release of left carpal tunnel. Then an open reduction of the left distal radius fracture with plate and locking screws was performed. Finally, the scapholunate interosseous ligament was tested and found to be unstable. K-wires (internal fixation) were placed in the intercarpal scapholunate joint, longitudinal traction was placed and scapholunate interosseous alignment was restored. What are the ICD-10-PCS code assignments for this surgery?

Answer:
The objective of the carpal tunnel release is to release the median nerve. The K-wire fixation and longitudinal traction were performed to restore the correct alignment of the intercarpal scapholunate joint. For the procedures, assign the following ICD-10-PCS codes:
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01N50ZZ</td>
<td>Release median nerve, open approach</td>
</tr>
<tr>
<td>0PSJ04Z</td>
<td>Reposition left radius with internal fixation device, open approach</td>
</tr>
<tr>
<td>0RSR04Z</td>
<td>Reposition left carpal joint with internal fixation device, open approach</td>
</tr>
</tbody>
</table>
Correction Notices

Retained Laparotomy Sponge during Cesarean Delivery

On page 14 of the First Quarter 2014 issue Coding Clinic for ICD-9-CM, advice was provided regarding the coding of a retained laparotomy sponge during Cesarean delivery. Upon further review of the case and the submitted operative report, the patient had remained in the operative room following emergent cesarean section when the patient was reopened to remove a retained laparotomy sponge. Therefore, do not assign code 998.4, Foreign body accidentally left during a procedure, as the sponge was retrieved before surgery ended. This advice is consistent with advice previously published in Coding Clinic, First Quarter 2013, page 90.

The National Quality Forum’s Serious Reportable Events in Healthcare—2011 Update, provides the following implementation guideline for unintended retention of a foreign object in a patient after surgery or other invasive procedure:

This event is intended to capture:

• occurrences of unintended retention of objects at any point after the surgery/procedure ends regardless of setting (post anesthesia recovery unit, surgical suite, emergency department, patient bedside) and regardless of whether the object is to be removed after discovery;

• unintentionally retained objects (including such things as wound packing material, sponges, catheter tips, trocars, guide wires) in all applicable settings.
The report also provides the following definition: “Surgery ends after all incisions or procedural access routes have been closed in their entirety, device(s) such as probes or instruments have been removed, and, if relevant, final surgical counts confirming accuracy of counts and resolving any discrepancies have concluded and the patient has been taken from the operating/procedure room.”

**Lumbar Interbody Fusion of Two Vertebral Levels**

_Coding Clinic, Second Quarter 2014, pages 6-7, contained an error. Code 0SG007J was assigned for a lumbar interbody fusion of L3-L4 and L4-L5. However this code assignment describes only one vertebral level and two vertebral levels were fused. Assign the following ICD-10-PCS code for the fusion of two vertebral levels:

**0SG107J** Fusion of two or more lumbar vertebral with autologous tissue substitute, posterior approach, anterior column, approach