PREOPERATIVE DIAGNOSIS: Bilateral vesicoureteral reflux with bilateral duplicated ureter.

POSTOPERATIVE DIAGNOSIS: Bilateral vesicoureteral reflux with bilateral duplicated ureter.

PROCEDURE PERFORMED: Bilateral cross-trigonal common sheath ureteral reimplantation.

DRAINS: Left lower pole ureteral catheter and Marcaine catheter.

HISTORY: The patient is a 10-year-old female who has had vesicoureteral reflux bilaterally. The patient has been on prophylactic antibiotics and has largely been infection free; however, going over the risks and benefits of surgical correction prior to reaching pregnancy age, the patient and her family elected to proceed with surgical reimplantation.

DESCRIPTION OF PROCEDURE: Appropriate consent was obtained. The patient was brought back to operating suite and underwent general endotracheal anesthesia. She was prepped and draped in normal sterile fashion. An appropriate timeout was performed. Performed a 4 cm Pfannenstiel incision, and dissected down through subcutaneous fat and fascia to reach the external abdominal oblique fascia. We then incised this with Ganz scissors and placed Allis clamps superiorly and posteriorly to dissect up the midline to free up the fascia off the rectus abdominis muscles. We then entered into the midline into the perivesical space and swept the peritoneum off the bladder, grabbed the bladder with Allis clamps and brought it out through our incision. We then entered the bladder anteriorly posteriorly with Bovie electrocautery and obtained urine for specimen. Urine was clear and did not appear to be infected. Once we had incised the bladder, we placed a figure-of-eight stitch with 3-0 Vicryl at the base of the bladder for retraction. We then placed 3 lap-pads at the dome of the bladder for retraction and inserted a Bookwalter retractor and inspected the trigone. Upon inspection, we identified that she had complete bilateral duplicated collecting systems. We cannulated each ureteral orifice with feeding tubes. The lower pole ureters were large and cannulated with 5 French feeding tubes. The upper pole ureter was cannulated with 3.5 French feeding tubes. Each of these feeding tubes were anchored in place with 4-0 chromic. Due to the fact that the ureteral orifices appeared greater than 1 cm apart, we initially attempted to dissect out the left lower pole ureter as a single sheath and exclude the upper pole ureter. However, as we attempted to dissect this out, it became difficult to separate it from the upper pole ureter and a small injury was made to the lower pole ureter. At this time, it was decided to dissect them both out as a common sheath. This was performed on the right side and then on the left side. Once we had adequate mobilization for reimplantation, we closed the old detrusor hiatus with 3-0 Vicryl simple interrupted sutures. We then made new submucosal tunnels for the ureter with tenotomy scissors. The left ureter was tunneled inferiorly to that of the right. We brought the left ureter through the new submucosal tunnel, we identified the lower pole ureter and its injury. We sutured the right upper pole and lower pole ureters to the new hiatus with 4-0 chromic sutures laterally and then matured its orifice separately with 5-0 chromic sutures. We then sutured the left upper and lower pole ureters to the bladder anchoring with 2 anchoring 4-0 chromic stitches. A stent was in the left lower pole ureter due to the injury, although we did check the orifice and the feeding tube did slide very easily in and out. The rest of the orifices were checked and they accepted feeding tube easily without any difficulty and therefore all stents were pulled from those ureters. We closed up all bladder epithelial defect with 5-0 running chromic sutures. The bladder was then closed in 2 layers with 3-0 Vicryl. The left lower pole ureteral stent was brought out through the detrusor and through the fascia on the right side of the body. The rectus abdominis was reaproximated with 3-0 Vicryl and the fascia was closed with 2-0 Vicryl. Subcutaneous fat and fascia closed with 4-0 Vicryl and a Marcaine catheter was placed in subcutaneous tissue and the skin was closed with 5-0 Monocryl. The Marcaine catheter and the left ureteral stent were sutured to the skin with 4-0 Ethilon, and the wound was dressed appropriately. The patient was awakened from anesthesia and transferred to the PACU in stable condition.

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[1] Diagnosis #1—Bilateral vesicoureteral reflux.
[4] The indication for surgery was elective surgery to repair the duplicate ureter.
Open procedure.

The surgeon cut an opening into the bladder.

Patient had duplicated collecting systems. This means there were two ureters attached to each kidney. In order to code this scenario correctly, we will need to keep track of where each ureter is sutured.

The two lower pole ureters (LP-left and LP-right) had feeding tubes inserted.

Upper pole ureters (UP-left and UP-right).

Intraoperative complication.

Bilateral procedure.

The surgeon closed the old ureter opening into the bladder with sutures.

Cross trigonal reimplantation.

Stent placed n the left lower pole since there was an injury.

The openings to the ureters were patent.

The surgeon sutured the bladder incision closed.

The injured ureter with a stent still inserted was brought out to the right side of the body and sutured in place. This is not normally done in the procedure. The surgeon wanted to monitor the injured ureter.

The abdominal wall was sutured closed.

Placed for pain control.

What are the CPT® and ICD-10-CM codes reported?

**CPT® Code:** 50782-50

**ICD-10-CM Codes:** N13.71, N99.71, Q62.5

**Rationales:**

**CPT®:** This operative note is for a bilateral cross trigonal common sheath ureteral reimplantation. Ureteral reimplantation means that the ureters are going to be dissected from the bladder and “reimplanted” in a different area and is considered a repair. Looking for Reimplantation/ureters leads to 51565, also referred to as ureteroneocystostomy. 51565 does not include duplicate ureters. In the CPT® Index look for Repair/Ureter/Anastomosis with a code range of 50740–50825. Ureteroneocystotomy has a code range of 50780–50785, 50830, 51565. 50780 is used for a single ureter to the bladder. 50782 would be correct for anastomosis of duplicated ureter to bladder. For a bilateral procedure instructional note states to use Modifier 50.

**ICD-10-CM:** The first postoperative diagnosis is listed as vesicoureteral reflux. In the ICD-10-CM Alphabetic Index, look for reflux/vesicoureteral N13.7-. The next choices will depend on whether the patient has any kidney disease or abnormality (nephropathy) or has a hydroureter. In the history, the physician states that the patient is relatively symptom free. He further explains that this is an elective surgery to correct duplicate anatomy. He does not mention kidney disease or hydroureter. The indication for surgery is the duplicate ureters.

After reflux, vesicoureteral, select “without nephropathy” because no kidney disease was mentioned in the report. Report N13.71, Reflux, vesicoureteral without nephropathy. The words with scarring are in parentheses. The guidelines state that words in parentheses are nonessential modifiers. The code can be reported if this term is not mentioned in the diagnosis.
During the procedure a small injury occurred when dissecting the ureter. Look in the ICD-10-CM Alphabetic Index for Complication/Intraoperative/puncture or laceration/genitourinary organ or structure/during a procedure on the genitourinary system N99.71.

Next look for bilateral ureters. This is a congenital malformation. In the ICD-10-CM Alphabetical Index, look for malformation/ureter/duplication. This leads to Q62.5. Verify in the Tabular Index.