Documentation Dissection

PREOPERATIVE DIAGNOSIS: Morbid obesity with comorbidities.

POSTOPERATIVE DIAGNOSIS: Morbid obesity with comorbidities [1].

PROCEDURE: Laparoscopic gastric sleeve resection [2].

ANESTHESIA: General.

DRAINS: None.

SPECIMEN: Portion of stomach to Pathology.

BLOOD LOSS: Minimal.

COMPLICATIONS: None.

INDICATIONS FOR PROCEDURE: The patient presents with morbid obesity and comorbidities having failed medical management and is brought to the operating suite for a gastric sleeve resection.

DESCRIPTION: After the risks, benefits, alternatives and potential complications were explained in detail to the patient, consent was given. Patient was identified, brought to the operative suite and placed supine on the bed. After adequate anesthesia was obtained, the patient's abdomen was prepped with chlorhexidine and draped in a normal fashion. A stab incision was made to the left of the umbilicus and a bladeless trocar was inserted intraperitoneally. Pneumoperitonuem was created with CO_2 insufflation to 15 mmHg with good-four quadrant tympany. Under direct vision with the laparoscope, a subxiphoid 5 mm, two right upper quadrant one 10 and one 15 mm and a left upper quadrant 5 mm stab incisions were made and trocars were inserted into the abdomen [3]. Via the subxiphoid incision, a Nathanson liver retractor was positioned to expose the hiatus. A point approximately 4 cm proximal to the pylorus was identified and we began taking down the gastroepiploic vessel and greater omentum from the greater curvature of the stomach from this point up to the angle of His. This was done using Harmonic scalpel dissection. A 42 French bougie was then passed along the lesser curvature of the stomach and a gastric sleeve resection was completed with successive firings of an Echelon stapler [4]. With the sleeve complete, the staple line was oversewn with a running 2-0 Vicryl suture. Any bleeding points on the staple line were controlled with clips. Hemostasis was assured throughout. With hemostasis assured, the liver retractor was removed. The resected portion of the stomach was placed in a laparoscopic bag and removed via the 15 mm trocar site [5]. The 15 mm trocar site fascia was closed with a 0-Vicryl suture. Pneumoperitonuem was allowed to desufflate and the trocars were removed. The skin of all incisions was closed with subcuticular 4-0 Monocryl. A dressing of Steri-Strips and gauze was applied. The patient tolerated the procedure well. There were no complications. All counts reported as correct, transferred to recovery area stable.

---

[1] Diagnosis is morbid obesity

[2] Procedure for gastric banding.

[3] Verification procedure is performed laparoscopically by placement of trocars into the peritoneal cavity.

[4] Documentation of sleeve gastrectomy performed

[5] Removal of resected portion of stomach that will be sent to pathology

---

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

CPT® Code: 43775

ICD-10-CM Code: E66.01

Rationale:

CPT®: The procedure is a laparoscopic longitudinal gastrectromy, also called sleeve gastrectomy. Gastric sleeve is a gastric restrictive procedure. Look in the CPT codebook for Laparascopy/Gastric Restrictive Procedures and you are directed to 43644-43645, 43770-43775. 43775 reports a sleeve gastrectomy.

ICD-10-CM: The postoperative diagnosis is morbid obesity. Look in the Alphabetic Index for Obesity/morbid E66.01. There is no indication of the reason for the morbid obesity so the default code is used, E66.01. In the Tabular List, category E66 has a note to report an additional code for the body mass index. This information is not in the operative report so this code cannot be reported.

In this case, the provider documents "morbid obesity with comorbidities;" if the specific comorbidities were documented in the operative note, the comorbidities are coded as additional diagnosis codes. If the specific comorbidities were documented in the operative note, we would code them as secondary diagnosis codes.