OPERATIVE REPORT

OPERATIVE DATE: [Date]

PREOPERATIVE DIAGNOSIS: Esophageal cancer.

POSTOPERATIVE DIAGNOSIS: Esophageal cancer.

OPERATIVE PROCEDURE PERFORMED:

1. Fluoroscopic guidance for placement of central venous wire and line.
2. Placement of right internal jugular central line.

FINDINGS: This is a very pleasant 66-year-old lady referred from Oncology for placement of a tunneled central line for ongoing therapy for esophageal cancer. Preoperatively, the patient was informed of the risks of bleeding, infection, scarring, re-operation for complications, pneumothorax, hemothorax, and other mechanical complications from line placement. She is also aware of the possibility of premature removal due to clotting or infection. After full informed consent, she was brought to the operating room.

OPERATIVE PROCEDURE: The patient was brought to room and placed in the supine position. A time-out procedure was performed. She then received sedatives and narcotics from anesthesia and I used 1% Xylocaine mixed with 0.5% Marcaine as a local in all operative sites. The right neck and chest were first prepped and draped in sterile fashion and local was placed. A standard right internal jugular venipuncture was performed and a wire was passed into the central circulation using fluoroscopic guidance. A counter-incision was made on the chest wall. The catheter was tunneled between the two sites using a tendon passer. The catheter was then cut to an appropriate length and passed into central circulation using a dilator split away sheath technique. Fluoroscopy was again brought over the field to document the passage of the catheter from the right chest wall through the subcutaneous tissues into the right internal jugular vein down through the central circulation to the superior vena cava right atrial junction. Due to the catheter/device terminating in the superior vena cava right atrial junction, the documentation supports a central venous access procedure. The catheter was irrigated with 1 mL of heparinized saline 100 units/mL. The catheter was anchored using 3-0 Vicryl. There were no intraoperative complications, no transfusions, and no specimens.

Diagnosis is esophageal cancer for which they are placing a tunneled central line to receive ongoing chemotherapy treatment. Findings document patient is 66 years of age.

Fluoroscopic guidance was used to perform a standard right internal jugular venipuncture and a wire passed into the central circulation.

The catheter was tunneled.

Fluoroscopic guidance was used to document the passage of the catheter from the right chest wall through the subcutaneous tissues into the right internal jugular vein down through the central circulation to the superior vena cava right atrial junction. Due to the catheter/device terminating in the superior vena cava right atrial junction, the documentation supports a central venous access procedure.

The catheter was irrigated and closed.

The venipuncture site was closed.
What are the CPT® and ICD-10-CM codes reported?

**CPT® Codes:** 36558-RT, 77001-26

**ICD-10-CM Code:** C15.9

**Rationales:**

**CPT®:** The venous access device was centrally inserted via the right internal jugular using fluoroscopic guidance. The catheter was tunneled. Fluoroscopy was again used to document the passage of the catheter from the right chest wall through the subcutaneous tissues into the right internal jugular vein down through the central circulation to the superior vena cava right atrial junction.

Based on our identified key elements a code selection will be made from the Insertion of Central Venous Access Device subcategory. The note documents a tunneled catheter. Look in the CPT® Index for Central Venous Catheter Placement/Insertion/ Central/Tunneled without Port or Pump 36557–36558, 36565. The findings indicate the patient is 66 years of age which narrows the code selection down to one option, 36558 *Insertion of tunneled centrally inserted central venous access catheter, without subcutaneous port or pump; age 5 years or older.*

In this case, the provider performed a procedure via the right internal jugular. Modifier RT may be applied to CPT 36558 to specify the side of the body the procedure was performed.

Referring to the chapter specific guidelines for Central Venous Access Procedures you will find when imaging is used for these procedures, either for gaining access to the venous entry site or for manipulating the catheter into final central position, use 76937, 77001.

The operative note documents fluoroscopic guidance which supports a code selection of 77001. Since fluoroscopic guidance is not included in the descriptor for 36558, the add-on code 77001 is reported.

In this case, the provider performed a procedure that contained both a professional and technical component. Per Appendix A in the CPT® codebook, when the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the procedure code. Additional examples of modifier 26 can be found in the Introduction section of the CPT® codebook.

**ICD-10-CM:** The postoperative diagnosis documents esophageal cancer. First, look for Cancer in the ICD-10-CM Alphabetic Index. The Alphabetic Index refers you to *see also* Neoplasm, by site, malignant. In the ICD-10-CM Table of Neoplasms, look for Neoplasm/esophagus/Malignant Primary column C15.9. Verify in the Tabular List C15.9 *Malignant neoplasm of esophagus, unspecified.* Do not report Z51.11 *Encounter for antineoplastic chemotherapy,* because the purpose of the encounter is not chemotherapy.