**PREOPERATIVE DIAGNOSIS:** Biliary dyskinesia.

**POSTOPERATIVE DIAGNOSIS:** Biliary dyskinesia.

**PROCEDURE PERFORMED:** Laparoscopic cholecystectomy.

**ANESTHESIA:** General endotracheal anesthesia with 30 mL of 0.25% Marcaine with epinephrine for local anesthesia.

**ESTIMATED BLOOD LOSS:** Less than 30 mL.

**COMPLICATIONS:** None.

**INDICATIONS FOR PROCEDURE:** The patient is a 23-year-old woman who presented to General Surgery Clinic with complaints of periodic right upper quadrant pain. This was initially evaluated with an ultrasound that demonstrated no stones. This was followed up by HIDA scan, which demonstrated an ejection fraction of 18%. After careful discussion about the indications for surgery, the possibilities of no improvement in her symptoms following surgery, and risks of surgery including bleeding, infection, injury to the cystic duct, or injury to the common bile duct or bile leak were all discussed with the patient's. Questions were answered and consent was signed and placed in the chart.

**OPERATIVE FINDINGS:** The gallbladder was very minimally inflamed. It did not contain any obvious stones.

**DESCRIPTION OF PROCEDURE:** The patient was brought to the operating room and placed supine on the operating room table. Bilateral lower extremity sequential compression devices were placed. General endotracheal anesthesia was induced. A surgical time-out was held. The patient's abdomen was prepped with ChloraPrep and draped in standard surgical fashion. Then, few milliliters of local anesthesia was infiltrated just below her umbilicus. The Veress needle was used to access the intra-abdominal cavity. A saline drop test was used to confirm intra-abdominal placement. It did take three passes of the Veress needle to be within the intra-abdominal cavity. The abdomen was then insufflated to 15 mmHg pressure. A 5 mm port was then inserted. The camera was then inserted into the abdomen and the abdomen inspected for any evidence of injury from Veress needle or port placement, no injury was seen. The patient was then placed into reverse Trendelenburg and right-side up position to aid with visualization. Two 5 mm ports were placed in the right upper quadrant using local anesthesia and under direct visualization. An 11 mm port was placed in the epigastric area to the right of the falciform ligament using local anesthesia and under direct visualization. The gallbladder was then grasped at the dome of the gallbladder and retracted up over the liver. The infundibulum of the bladder was retracted out laterally. The cystic triangle was identified. The fat in the area of the cystic triangle was bluntly dissected down using the Maryland dissector. This quickly freed up a critical view. The cystic duct was seen to be entering directly into the gallbladder. Between this was empty space, where we could visualize the liver posteriorly. The cystic artery was then seen as a separate structure going directly onto the body of the gallbladder. Again, we could see liver posteriorly to the cystic artery. Both the artery and the duct were clipped twice proximally and once distally and cut between clips. Hook electrocautery was then used to take the gallbladder off of the liver bed. Complete hemostasis was achieved using Bovie electrocautery. A small hole was made into the gallbladder with a little bit of spillage of bile. There were no stones. All of the bile was suctioned up and irrigated out at the end of the case. Once the gallbladder was fully excised, it was placed into an EndoCatch bag and removed from the abdomen. We then carefully irrigated out our area of dissection and suctioned up all of our irrigation fluid. The liver bed was examined and no bleeding was seen. The cystic duct stump and cystic artery stump were examined and seemed to be intact. We then removed our 11 mm port and used the inlet device to place a 2-0 Vicryl to close the fascial defect. The abdomen was then desufflated and the 5 mm ports removed. The skin was then closed with 4-0 Monocryl. Steri-Strips and a sterile dry dressing were applied. The patient was then awakened from anesthesia and extubated and brought to the recovery room in stable condition. She tolerated the procedure well and there were no complications. All counts were correct at the end of the case.

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| 1 | Diagnosis to report. |
| 2 | Indication of the procedure to be performed. |
| 3 | Procedure is performed laparoscopically. |
Removal of gallbladder

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

**CPT® Code:** 47562

**ICD-10-CM Code:** K82.8

**Rationales:**

**CPT®:** Cholecystectomy was performed laparoscopically. Look in the CPT® Index for Cholecystectomy/Laparoscopic directing you to code range 47562–47564. In reviewing the codes in the numeric section, code 47562 is the correct code to report for only performing the cholecystectomy.

**ICD-10-CM:** The postoperative diagnosis is biliary dyskinesia which are spasms of the gallbladder of ducts that impair filling or emptying. Look in the ICD-10-CM Alphabetic Index for Dyskinesia/biliary (cystic duct or gallbladder) K82.8. Verification in the Tabular List confirms the code is reported to the highest specificity and is for Other specified diseases of gallbladder with the inclusion term Dyskinesia of cystic duct or gallbladder listed.