Documentation Dissection

OPERATIVE REPORT

Pre-operative Diagnosis: Uncontrolled Glaucoma of the Left Eye

Post-operative Diagnosis: Uncontrolled Glaucoma of the Left Eye [1]

Operative Procedure: Trabeculectomy [2] with Mitomycin C of the Left Eye

The patient was given a retrobulbar block consisting of 50:50 mixture of 2% Lidocaine without Epinephrine, Marcaine, and 75 U Hyaluronidase in the holding area. Intermittent gentle pressure was applied to the eye for several minutes after the block.

There was noted to be excellent akinesia and anesthesia of the globe and lids. The patient was then brought into the operating room. After the eye was prepped, the patient was draped in the usual sterile fashion for ophthalmic surgery. The operating microscope was positioned over the eye. A lid speculum was placed between the lids of the eye. A 6-O nylon corneal retraction suture was placed through clear cornea superiorly and the globe retracted downward. A conjunctival incision was made superiorly 10mm posterior to the limbus using Westcott scissors parallel to the limbus. Tenons capsule was then entered at the same location of the conjunctival incision and this was dissected down to bare sclera. Several relaxing incisions in tenons capsule were made and the tenons and conjunctival insertion was identified at the limbus. Care was taken to avoid any conjunctival button hole. The insertion of tenons capsule and conjunctiva were cleaned with a #69 blade [3]. A triangular slceral flap was outlined using a#57 blade, and dissected anteriorly into clear cornea. The episcleral tissues were cauterized until there was good hemostasis [4]. Mitomycin C 0.5 mg per ML was then soaked in a small piece of Weck Cell sponge. This was applied under the conjunctival tenons flap and on the scleral flap area, avoiding the conjunctival incision. This was left in place for a duration of 2 minutes. The entire globe and conjunctival surface was then irrigated profusely with BSS for several minutes. A temporal clear corneal paracentesis incision was then made using a paracentesis blade. The anterior chamber was then entered under the base of the scleral flap using a #75 blade and an internal ostium was made. A partial thickness ring of trabecular meshwork was removed [5].

A superior iridectomy was then performed [6]. The scleral flap was repositioned and closed using three interrupted 10-O nylon sutures. BSS was irrigated through the paracentesis incision and an adequate amount of flow was noted through the internal ostium site. 8-0 vicryl was used to close Tenons. Conjunctiva was closed with running 9-0 vicryl suture. BSS was irrigated through the paracentesis incision and a bleb was raised superiorly.

Fluorescein was applied to the conjunctival surface and no wound leak was detected. The retraction suture and lid speculum was removed from the eye.

At the close of the case the bleb was elevated, the anterior chamber was formed and the pupil was round. The eye was patched and shielded and the patient the operating room in stable condition.

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[1] Postoperative diagnosis is used for coding.

[2] Indication of the procedure that will be performed.

[3] Creation of the conjunctival pocket.

[4] Scleral flap is created.

[5] Creation of a drainage opening into the anterior chamber and removal of part of the trabecular meshwork.

[6] Part of the iris was excised.

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

CPT® Code: 66170-LT

ICD-10-CM Code: H40.9

Rationales:

CPT®: In the CPT® Index look for Trabeculectomy ab Externo/in Absence of Previous Surgery. There is no mention of a previous surgery or scarring, so 66170 is reported with modifier LT to indicate that the surgery was performed on the left eye. A separate code is not reported for the iridectomy because the two options listed under Iridectomy/for Glaucoma are indicated in the code description as a separate procedure meaning these codes can only be reported if no related procedure was performed during the same operative session. The iridectomy is bundled in code 66170 and not reported separately.

ICD-10-CM: The postoperative diagnosis is listed as uncontrolled glaucoma of the left eye.

In the Alphabetic Index, look for Glaucoma. There isn't a subterm for uncontrolled and no specific type of glaucoma reporting the default code H40.9. A review of the code in the Tabular List shows no additional characters are required.