Documentation Dissection

PREOPERATIVE DIAGNOSIS: Right inguinal hernia.

POSTOPERATIVE DIAGNOSIS: Same [1].

PROCEDURE: Right inguinal hernia repair with mesh.

ASSISTANT: None.

ANESTHESIA: General.

DRAINS: None.

SPECIMEN: None.

BLOOD LOSS: Minimal.

COMPLICATIONS: None.

INDICATIONS FOR FROCEDURE: The 25-year-old [2] patient presents with a right groin bulge and findings consistent with a right inguinal hernia. He is brought to the operating room for repair.

DESCRIPTION OF PROCEDURE: After the risks, benefits, alternatives, potential complications were explained in detail to the patient, consent was given. The patient was identified, brought to the operative suite and placed supine in the bed.

After adequate anesthesia was obtained, the patient's abdomen and right groin were prepped with chlorhexidine and draped in normal fashion. A right inguinal incision was made with a knife [3]. The subcutaneous tissue was dissected down to the external oblique aponeurosis which was incised sharply. A muscle splitting incision was carried down to the preperitoneal space. Epigastric vessels were retracted anterolaterally, cord structures were identified and retracted anteromedially where the epigastric cord structures were identified and retracted laterally, using careful dissection, a hernia sac was identified and dissected free from the cord structures. This was an indirect hernia [4]. The inguinal floor was completely cleared. A small oval Kugel mesh was then placed in the preperitoneal space to cover the hernia defect and potential hernia defects [5]. This was secured to the transversalis fascia with interrupted 2-0 Vicryl suture. The muscle was allowed to reapproximate and external oblique aponeurosis closed with a running 2-0 Vicryl suture. The skin was closed with subcuticular 4-0 Monocryl.

Dressing, Steri-Strips and gauze were applied. The patient tolerated the procedure well. There were no complications. All counts reported as correct. Transferred to the recovery area stable.

---

[1] Specific type and laterality of hernia identified.

[2] Age of patient is needed to select correct CPT® code.

[3] Indicates open procedure performed.

[4] Identifies specific detail of hernia for diagnosis coding.

[5] Mesh used in repair; however, it is content of the procedure and not separately reportable.

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

CPT® Code: 49505

ICD-10-CM Code: K40.90

Rationales:

CPT®: An inguinal hernia occurs in the area between the abdomen and thigh. Some intra-abdominal organs may partially push through a weak spot in the inguinal canal. Inguinal hernia repairs are identified by type of hernia, clinical presentation (reducible, incarcerated or strangulated), initial or recurrent, and the age of the patient. The repair is coded as 49505 since the documentation indicates this is a right inguinal hernia without mention of incarceration/strangulation. Mesh is used in the repair; however, it is included in the procedure and not separately reported with 49568 (Implantation of mesh-this code is only used with incisional or ventral hernia repair codes). In CPT Index locate Repair/Hernia/Inguinal 49491–49525. Code 49505 identifies Repair initial inguinal hernia, ages 5 years or older.

ICD-10-CM: In the ICD-10-CM Alphabetic Index locate Hernia/Inguinal/Unilateral, K40.90.

Verification in the Tabular Index verifies a unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent. A subentry of this code is Inguinal Hernia, NOS.