Documentation Dissection

PREOPERATIVE DIAGNOSIS:

Left hip hematoma after hip revision.

POSTOPERATIVE DIAGNOSIS:

Left hip hematoma after hip revision [1].

PROCEDURE PERFORMED:

1. Left hip incision and drainage [2].
2. Hematoma evacuation and closure over drain [2].

SEDATION: General.

DESCRIPTION OF PROCEDURE: After establishment of general anesthetic, IV antibiotics were given. The patient was placed in the lateral decubitus fashion using a beanbag. The left lower extremity was prepped and draped in the normal sterile fashion. Following this, all staples were removed. The obvious hematoma involving the left hip [3] at the site of hip revision was opened with the previous incision. The hip joint area had a large hematoma. After evacuation of the hematoma by irrigation with pulsatile lavage, bacitracin solution was used followed by gentle debridement back to excellent fresh tissue with excellent color and bleeding response [4]. There was no necrosis, no obvious pus. Once the hematoma was evacuated, the overlying skin flaps already improved from a vascular standpoint with decreased ecchymosis and improved skin turgor. Therefore, palpation of the fascia and bursa was performed. There was mild tension. Therefore, the site was opened and then a hematoma was evacuated from the deep area [5]. The prosthesis appeared well. Cultures were taken in both the superficial and the deep fascia and sent for anaerobic-aerobic fungal culture. Following this, further irrigation with bacitracin was performed. At least 5 liters was performed in total and it should be noted that multiple times throughout the case suction tips, outer drapes and gloves were changed to improve the environment. Instruments were cleaned and multiple irrigations and debridement were performed sequentially. The wound was thoroughly irrigated [6]. The fascia was closed overlying a drain. The fascia was re-approximated with sutures and then large nylon sutures were used to re-approximate the fascia and dermis and epidermis to close down the potential space. Following this, a bulky dressing was applied, multiple ABDs and a compression hip spica dressing was placed followed by the patient's standard brace to decrease the risk of instability. The patient tolerated the procedure well. There were no apparent complications.

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[1] Postoperative diagnosis is left hip hematoma after hip revision.

[2] Procedures performed are incision and drainage of hematoma, with insertion of drain.

[3] Hematoma of the left hip is confirmed.

[4] Incision and drainage was performed on the hematoma.

[5] The anatomical site of the incision and drainage is identified as deep.

[6] The hip area was further irrigated.

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

CPT® Code: 26990-LT

ICD-10-CM Code: M96.830

Rationales:

CPT®: In the CPT® Index, locate Drainage/Joint/Hip, which refers to 26990, 27030. Code 26990 Incision and drainage, pelvis or hip joint area, deep abscess or hematoma is the correct code as it identifies the hematoma of the hip that is deep. Modifier LT is used as this was performed on the left hip.

ICD-10-CM: In the ICD-10-CM Alphabetic Index, locate Complication/surgical procedure/hematoma—postprocedural—*see* Complication/postprocedural/hemorrhage (hematoma of)/musculoskeletal structure/following orthopedic surgery, which refers to M96.830. Verify in the Tabular List that M96.830, Postprocedural hemorrhage and hematoma of a musculoskeletal structure following a musculoskeletal system procedure, is the correct code.

ICD-9-CM Application

What ICD-9-CM code(s) is/are reported?

ICD-9-CM Code: 998.12

Rationale: In the ICD-10-CM Alphabetic Index, locate Complication/surgical procedure/hematoma, which refers to 998.12. Code 998.12 Hematoma complicating a procedure, is the correct code.