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## Documentation Dissection

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**PREOPERATIVE DIAGNOSIS:** Recurrent right acoustic neuroma.

**POSTOPERATIVE DIAGNOSIS:** Recurrent right acoustic neuroma <sup>[1]</sup>.

**PROCEDURES:**

1. Right translabyrinthine craniotomy for resection of acoustic neuroma; posterior cranial fossa approach <sup>[2]</sup>.
2. Intraoperative facial nerve monitoring; microsurgical technique <sup>[2]</sup>.
3. Harvest of abdominal fat graft through separate incision <sup>[2]</sup>.
4. Cranioplasty (less than 5 cm) <sup>[2]</sup>.

**ATTENDING:** Smith, M.D. <sup>[3]</sup>

**CO-SURGEON:** Jones, M.D. - For translabyrinthine exposure and fat graft harvest <sup>[3]</sup>.

**ANESTHESIA:** General endotracheal.

**ESTIMATED BLOOD LOSS;** Less than 15 mL for the neurosurgical portion.

**SPECIMENS:** Tumor for permanent pathology <sup>[4]</sup>.

**DRAINS:** None.

**COMPLICATIONS:** None.

**INDICATIONS:** This patient underwent a previous middle fossa resection of a small acoustic neuroma at two years following her original surgery. A follow-up MRI scan showed evidence of a recurrent lesion <sup>[5]</sup>. She also had some residual vestibular problems. On this basis, a variety of treatment options were discussed including conservative therapy, stereotactic radiation, and reoperation for microsurgical resection. After contemplating the alternatives, she elected to proceed with surgery.

**PROCEDURE IN BRIEF:** After extensive preoperative counseling, informed consent was obtained. The patient was brought to the operating room, intubated, placed under general anesthesia, and positioned in the supine position for access to the right postauricular area. A preoperative dose of antibiotics was administered and a standard surgical time-out was performed wherein the patient was identified, and the surgical site and procedure were confirmed. Dr. and his team initiated the procedure with a transtemporal approach to the posterior cranial fossa making a retroauricular incision and translabyrinthine exposure at the porus acusticus <sup>[6]</sup>. At the completion of this portion of the procedure, I was asked to resume. I employed the operating microscope for magnification and illumination <sup>[7]</sup>. Liberal facial nerve monitoring was used throughout <sup>[8]</sup>. The dura was opened. The proximal aspect of the eighth nerve complex was identified. The neuroma was removed and divided and an en bloc gross total specimen was submitted for permanent pathology <sup>[9]</sup>. Hemostasis was achieved. The facial nerve stimulated at the low setting at the brainstem origin showed robust impulses <sup>[10]</sup>. The arachnoid space was irrigated copiously. The dura was reapproximated using 4-0 braided Nurolon <sup>[11]</sup>. A segment of the fat harvested previously <sup>[11]</sup> was tucked through the residual dural defect after placement of a pledget of Gelfoam soaked in Decadron against the facial nerve. Alternating layers of fat and Surgicel were then used to obliterate the remainder of the mastoidectomy defect. A Synthes resorbable plate was then fashioned to the appropriate dimension and used as the cranioplasty, which was approximately 4 cm. It was secured at the periphery using 4-mm titanium screws <sup>[12]</sup>. The wound was irrigated copiously and then Dr. and his team resumed and conducted a layered closure. For specific details of their aspect to the procedure, please refer to their separately dictated note. At the completion of the procedure, all final needle and sponge counts were correct. There were no apparent complications.

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<sup>[1]</sup> Postoperative diagnosis is recurrent right acoustic neuroma.

<sup>[2]</sup> Planned procedures.

<sup>[3]</sup> Two surgeons at this operative session; each performing separate procedures.

- <sup>[4]</sup> Confirms the tumor was removed and sent to Pathology.
- <sup>[5]</sup> Re-confirmation of recurrent acoustic neuroma.
- <sup>[6]</sup> Approach identified to the posterior cranial fossa.
- <sup>[7]</sup> Confirmation of the use of an operating microscope.
- <sup>[8]</sup> Identifies the facial nerve monitoring.
- <sup>[9]</sup> The vestibular (acoustic) nerve intradural mass was excised and sent to Pathology.
- <sup>[10]</sup> Post tumor removal nerve testing is performed.
- <sup>[11]</sup> Confirmation of the fat harvested.
- <sup>[12]</sup> Confirmation of the cranioplasty.

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

**CPT® Codes:** 61616, 69990

**ICD-10-CM Code:** D33.3

**Rationales:**

**CPT®:** This is surgery at the skull base, which includes separate procedures for the approach, the definitive procedure, and the repair/reconstruction. The approach to the posterior cranial fossa was performed by another surgeon. This surgeon performed the definitive procedure and closure. To report the definitive procedure, in the CPT® Index, look for Skull Base Surgery/Posterior Cranial Fossa/Intradural referring you to 61616. A Synthes plate was used for the cranioplasty, which was 4 cm. The Sythes plate is used for the cranioplasty and is included in the procedure 61616. Note that the codes under the heading Repair and/or Reconstruction are for secondary repair of the dura for a leak following skull base surgery or repair with a local or regionalized vascularized pedical flap and are not reported for this operative procedure. Dr. Smith employs the surgical microscope for magnification and illumination. The use of the operating microscope is reported with 69990, and is not considered inherent in the procedure based on CPT® guidelines and may be reported separately. For a list of procedure codes, which include the operating microscope, refer to the guidelines associated with 69990. Facial nerve monitoring was performed. This is considered part of the definitive procedure and not reported separately.

**ICD-10-CM:** In the ICD-10-CM Alphabetic Index look for Neuroma/acoustic (nerve), which refers you to D33.3. Verify the code in the Tabular List.