The kidneys felt healthy and viable. I placed another stay suture halfway through the anastomosis, I placed a 4.5 French x 20 cm double-J stent over. I opened up the posterior sheath of the anterior abdominal wall fascia and once this. Because of Vicryl suture in a running simple fashion. I injected local anesthetic, approximately 14 ml of 0.25% Marcaine and 0.5% lidocaine went ahead and closed all 3 layers; transverse abdominis, internal oblique, and external oblique separately. All this was done by 3-0. The lap counts and instrument counts were correct and I began closure. I took the patient out of flexion and kidney rest down and bleeding, the ureter had a nice watertight closure and no tension, and the repair was in a dependent portion of the renal pelvis. All all the stay sutures and let the repair fall back into the retroperitoneal space. Upon visualization, there was no evidence of active bleeding. I removed clear urine was obtained after the incision. I spatulated the ureter along the medial aspect for approximately 7–8 mm. This gave a healthy spatulation to the ureter, which was viable and pink. I transected off sharply the rest of the ureteropelvic junction region and sent this off for pathologic analysis. Clear urine was obtained from the renal pelvis. It did decompress nicely, so at this point, I followed the lower pole of the kidney and identified medially the structure consistent with a much distended renal pelvis. This extended inferiorly, anteriorly and medially. The large size of the renal pelvis distorted the anatomy to a significant extent. Once the renal pelvis was verified, I inserted a 25-gauge needle and syringe into the structure and obtained clear urine. I aspirated out approximately 30 ml that decompressed the renal pelvis. I placed a stay suture in the renal pelvis and was able to mobilize the anterior aspect of the renal pelvis and freed it up, and immediately visualize the ureteropelvic junction region that was inferior in its location to this distended renal pelvis. It clearly looked dysplastic with a kink, as well as having an hourglass deformity associated to the ureteropelvic junction region. The kidneys felt healthy and viable. I placed another stay suture directly in the lateral position of the renal pelvis and mobilized from the distal ureter for approximately 3 cm. At all points, there was good blood supply to the renal pelvis and the ureter was nicely perfused. There was no evidence of crossing vasculature across the ureter that could have caused the partially UPJ obstruction. I placed a stay suture in the adventitia of the ureter, approximately 2-3 cm distal to the ureteropelvic junction region. I transected the ureter 1 cm distal to the narrowing region with presumed obstruction. Clear urine was obtained after the incision. I spatulated the ureter along the medial aspect for approximately 7–8 mm. This gave a healthy spatulation to the ureter, which was viable and pink. I transected off sharply the rest of the ureteropelvic junction region and sent this off for pathologic analysis. Clear urine was obtained from the renal pelvis. It did decompress nicely, and I did not feel that a reduction pyeloplasty was necessary. I placed an S French feeding tube down into the ureter. I proceeded with the anastomosis of the renal pelvis to the ureter. I placed interrupted 6-0 PDS sutures circumferentially, giving a watertight closure of the ureter to the renal pelvis. Approximately 5–7 mm of the renal pelvis remained after the entire ureteral coverage and I closed this defect with a running 6-0 POS. Halfway through the anastomosis, I placed a 4.5 French x 20 cm double-J stent over a guide wire without difficulty. This was confirmed in correct placement with the curl in the bladder via instilling dilute methylene blue through a Foley catheter, and obtained retrograde flow through the ureteral stent and visualization proximally. Once this was complete, I utilized copious amounts of sterile irrigation, confirming that there were no areas of active bleeding. I removed all the stay sutures and let the repair fall back into the retroperitoneal space. Upon visualization, there was no evidence of active bleeding, the ureter had a nice watertight closure and no tension, and the repair was in a dependent portion of the renal pelvis. All the lap counts and instrument counts were correct and I began closure. I took the patient out of flexion and kidney rest down and went ahead and closed all 3 layers; transverse abdominis, internal oblique, and external oblique separately. All this was done by 3-0 Vicryl suture in a running simple fashion. I injected local anesthetic, approximately 14 ml of 0.25% Marcaine and 0.5% lidocaine.
as local incisional block, both in the fascia and the skin levels. The subcutaneous tissue was closed with running 4-0 chromic suture. The skin was closed with a running 5-0 Monocryl in a subcuticular type fashion. This gave excellent cosmesis. A drain was not left in place. Final dressing was Mastisol with Steri-Strips, Telfa and Tegaderm. The patient was then allowed to rise from anesthesia, was extubated, and transferred to the PACU in good condition. No complications for this case.

Postoperative diagnosis is right ureteropelvic junction obstruction.
Planned procedures are right open pyeloplasty and stent placement. Verify procedures in the body of the operative report.
The hydronephrosis is due to the obstruction.
Re-confirmation of the right-sided ureteropelvic junction obstruction.
This identifies the approach as open.
This identifies the deformity as a congenital defect—dysplastic, hourglass deformity of ureteropelvic junction
Confirmation that a complicated pyeloplasty was performed.
A double-J stent is placed.
Local anesthetic injected to help control postoperative pain.

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

CPT® Code: 50405-RT
ICD-10-CM Code: Q62.39

Rationales:
CPT®: The surgery performed was pyeloplasty with stent placement. This was considered a dysplastic segment of ureter at the ureteropelvic junction. Look in the CPT® Index for Repair/Kidney/Renal Pelvis 50400–50405. This was a congenital defect; therefore, 50405 Pyeloplasty (Foley Y-Pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephroscopy, nephrostomy, pyelostomy, or ureteral splinting; complicated (congenital kidney abnormality, secondary pyeloplasty, solitary kidney, calycoplasty) is correct. The placement of the double J stent (50605) is included in the procedure. The purpose is to keep the ureter open during healing process. Modifier RT is appended to indicate the right side. Local anesthetic is injected to help control postoperative pain. Local by the surgeon is included in the procedure and not reported separately.

ICD-10-CM: The reason for the surgery was ureteropelvic junction obstruction due to an hourglass deformity and dysplastic ureter. This is a congenital conditional. Look in the Alphabetic Index for Obstruction/ureter (functional) (pelvic junction)/congenital refers you to Q62.39. Hydronephrosis is not reported, because it is a symptom of an obstructed ureteropelvic junction. See Guideline I.B.4.