



Operative Note – Musculoskeletal System

PREOPERATIVE DIAGNOSIS: Degenerative joint disease, left knee.

POSTOPERATIVE DIAGNOSIS: Degenerative joint disease, left knee.

NAME OF PROCEDURE: Left total knee arthroplasty.

COMPONENTS USED: DePuy PFC Sigma posterior stabilized rotating platform, size 5 femoral component, size 4 tibial tray, 10-mm posterior stabilized rotating platform insert, 38-mm patellar button, antibiotic cement.

INTRAVENOUS FLUIDS: 2500 mL crystalloid.

ESTIMATED BLOOD LOSS: 100 mL.

COMPLICATIONS: None.

SPONGE AND NEEDLE COUNTS: Correct.

TOURNIQUET TIME: 71 minutes.

ANESTHESIA: General endotracheal anesthesia.

INDICATIONS FOR PROCEDURE: The patient is a 58-year-old gentleman who presents with longstanding pain in his left knee. The pain is worse with walking, standing and activities of daily living.

DESCRIPTION OF PROCEDURE: The patient was brought to the surgical suite. Appropriate IV access was placed. The patient was then taken to the OR and placed supine on the OR table. He was placed under excellent general tracheal anesthesia. He received 2 grams of IV Ancef. A well-padded tourniquet was placed on the left upper thigh. The left lower extremity was sterilely prepped and draped in usual manner. The limb was exsanguinated with an Esmarch bandage. Tourniquet was inflated to 300

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mmHg. Standard midline incision was made for a medial parapatellar approach to the knee. A knife was used to dissect through skin and subcutaneous tissues. Deep soft tissue flaps were developed. The standard medial parapatellar arthrotomy was performed. The knee was brought into full extension. Tricompartmental arthrosis was noted. The patella was everted. The patella was taken down to a thickness of 15 mm using a freehand technique. Lug holes were drilled and hubcap was applied. The patella was subluxed throughout the remainder of the case. Excellent exposure was obtained of the femur. IM drill was used to enter the femoral canal. The canal was lavaged and suctioned to lessen the chance of fat emboli. The distal femoral cut was then made at 5 degrees of valgus, taking 10 mm from distal femur. Excellent cut was obtained. We turned our attention to the tibia. Excellent exposure was obtained. Using the extramedullary guide, the tibia was cut perpendicular to its long axis, taking 10 mm from the less involved lateral side. Excellent cut was obtained. The knee was then brought in full extension. The tibia sized to size 4. Drop rod was placed confirming excellent alignment of tibial cut. We found we had a 10-mm spacer block fit nicely in the knee in full extension and had good balance. The knee was then flexed. Using a posterior reference technique, the femur was sized to size 4. Using a reduction balance technique, a size 5 Ranawat block was pinned in place so to give ourselves a 10-mm flexion gap, which was well balanced. Anterior and posterior cuts were then performed, being careful not to notch the femur. We checked our flexion space and found it also to be 10-mm size and well balanced. The femoral cuts were then completed including box and chamfer cuts. The tibial tray was drilled and punched in proper rotation. Trial reduction was then performed with a size 4 tibia, size 5 femur, 38-mm patellar button and a 10-mm insert. The knee came out in full extension, flexed fully and the patella tracked centrally with no liftoff or tilt. At this point, the trial components were removed. All bony surfaces were copiously pulse lavaged with sterile saline and dried. We then cemented in sequence using antibiotic cement to the size 4 tibia, the size 5 femur and the 38-mm patellar button. The 10-mm rotating platform polyethylene insert was placed. The knee was brought in full extension while the cement fully cured. Once the cement was fully cured, we made sure all loose cement debris was removed. The tourniquet was released. Tourniquet time was 71 minutes. Hemostasis was achieved. A deep drain was placed. The knee was then placed in slight flexion for wound closure with interrupted 0 Vicryl on the arthrotomy layer, interrupted 2-0 Vicryl in deep and superficial subcutaneous tissues and staples to approximate the wound edges. Sterile compressive dressing was applied. The patient tolerated the procedure well. There were no complications. He was awoken from anesthesia, extubated, transferred to hospital bed and taken to recovery in excellent condition. I was present for all key components of the case.

Answer:

ICD-10-CM

M17.12 – (Osteoarthritis of left knee, primary)

Rationale: Symptoms (pain in left knee) integral to a definitive diagnosis should not be coded separately.

ICD-10-PCS

0SRD0J9 – (Replacement, left knee joint, open, synthetic substitute, cemented).

Rationale: The arthrotomy would not be separately reported because procedures performed to gain access to perform a root operation are not separately reported. In addition, the resection of the knee for a joint replacement is not separately reported considering it is an integral part of the procedure. <PCS Guideline B3.1b.>

The closure of the operative site is not coded separately. <PCS Guidelines, B3.1b.>

When the coder cannot determine from the medical record documentation whether a cemented or uncemented prosthesis was placed, use “Z” No qualifier. Assign qualifier “A” Uncemented when the medical record documentation supports the use of a noncemented prosthesis. <AHA, *Coding Clinic for ICD-10*, Q3, 2016>