



Operative Report – Injuries

Date of Procedure: December 4, 2013

PREOPERATIVE DIAGNOSIS: Nondisplaced greater trochanteric fracture, right proximal femur

POSTOPERATIVE DIAGNOSIS: Same as above.

PROCEDURE PERFORMED:

Open reduction and internal fixation, right proximal femur, using a 200 mm length intramedullary nail (PFNA) with 100 mm hip compression screw. Biplanar C-arm fluoroscopy utilized.

NAME OF SURGEON: Orthopedic, MD

ANESTHESIA: Spinal

INDICATIONS: This is a 72-year-old female who tripped and fell in the kitchen at her apartment, injuring her right hip. She was brought to the Emergency Room where X-rays did not reveal a hip fracture, but subsequent MRI revealed a nondisplaced greater trochanteric fracture of her right proximal femur. She was awake and alert. Neurovascularly, the right leg was intact. She had no obvious shortening. Dorsalis pedis pulsations were intact. She had normal light touch sensation throughout her lower extremities. She denies any other areas of discomfort. Patient was cleared by Internist, MD medically. The procedure was discussed in detail with patient and family. All risks and benefits were noted. All questions were answered.

PROCEDURE: The patient was taken to the Operating Room and placed in a supine position. A spinal anesthetic is administered and after adequate anesthesia had been achieved, the patient was placed on a Chick fracture table. A closed reduction is then performed with satisfactory alignment under fluoroscopy of the right proximal femur. The right hip and leg undergoes standard prep and drape.

I palpated the greater trochanter and made a 5 cm incision proximal from the tip of the greater trochanter. I made a parallel incision of the fasciae of the gluteus medius and split the gluteus medius in line with the fibers. In AP view, the proximal femoral nail antirotation (PFNA) entry point is on the tip or slightly lateral to the tip of the greater trochanter. I made a small incision slightly lateral to the tip of the greater trochanter and inserted the 3.2 mm guidewire. The guidewire went into the medullary cavity to a depth of 15 mm, checked with fluoroscope, AP and lateral. I guided the cannulated drill bit through the protection sleeve over the guidewire and drilled as far as the stop on the protection sleeve. I removed the drill bit, the protection sleeve and the guidewire. I inserted the reaming rod and quickly determined that reaming was not needed because of the inferior bone quality. I carefully inserted the 200 mm PFNA manually using slight bidirectional turns of the insertion handle as far as possible into the femoral opening.

Attention was then directed to the insertion of the screw into the femoral head. I mounted the appropriate aiming arm for the 130 degree angle of the PFNA and fixed it firmly to the insertion handle. I made a stab incision in the area of the trocar tip. I advanced the sleeve assembly through the soft tissues in direction of the lateral cortex of the femur.

Lateral cortex was reached. Another 3.2 mm guidewire was inserted. Drill was inserted over guidewire. Direction and position verified under AP and lateral views. I measured for the correct screw length. The guidewire's position was subchondral so I subtracted 10 mm to ensure I would not hit head of femur. I pushed the cannulated drill bit over the 3.2 mm guidewire and drilled to the stop. The lateral cortex was opened. I inserted the sleeve assembly as far as the lateral cortex. I inserted the 100 mm screw over guidewire and through protection sleeve into the femoral head. Position checked with AP and lateral views. Sleeve assembly and guidewire were removed.

AP and lateral views indicated appropriate placement of PFNA and femoral hip screw. Satisfactory reduction of fracture was achieved. A ConstaVac drain was placed in the depth of the wound and brought out through a separate stab incision situated distally. The wound was copiously irrigated with normal saline and closed in layers. Skin was closed with staples. A Xeroform gauze, 4 x 4, ABD pad dressing was then applied to incision, and the patient was then carefully transferred from the fracture table onto a bed to the recovery room in a stable condition. The estimated blood loss during surgery was 150 cc. No blood transfusion was given during surgery. Needle and sponge counts were correct at the end of the procedure. No intraoperative complications were noted.

Answer:

ICD-10-CM

S72.114A – Nondisplaced fracture of the greater trochanter of right femur, initial care for closed fracture

W18.30xA – Fall on the same level, unspecified

Y92.030 – Place of occurrence, apartment, kitchen

ICD-10-PCS

0QS636Z

Rationale:

Fracture is documented as non-displaced necessitating open reduction with internal fixation. However, the operative report states a closed reduction was performed with internal fixation.

Nondisplaced fractures may necessitate reduction to re-approximate bones even if not out of alignment.

Per the response from the AHA, this reduction should be coded as 0QS636Z, Reposition, right upper femur with intramedullary internal fixation device, percutaneous approach since this was a closed reduction. The nail and guidewire were inserted percutaneously. However, it may still require a physician query for definitive clarification of procedure approach.

Per the ICD-10-PCS Body Part Key, the greater trochanter is considered the Upper Femur.

Reduction of a displaced fracture is coded to the root operation Reposition. <PCS Guidelines>

Temporary post-op wound drains are considered integral to the performance of a procedure and not coded as devices. <PCS Guidelines>