



Operative Report – Nervous System

PREOPERATIVE DIAGNOSIS: Cervical spondylosis, C5-6, C6-7.

POSTOPERATIVE DIAGNOSIS: Same.

NAME OF PROCEDURE: Anterior cervical discectomy and fusion C5-6, C6-7, placement of interbody cage, placement of demineralized bone matrix (DBM), anterior placement of vertical in-line plate (VIP), fluoroscopic guidance and microscopic dissection.

SURGEON: Neurosurgeon, MD

ASSISTANT: Assistant, RNP

ANESTHESIA: General.

ESTIMATED BLOOD LOSS: Less than 75mL.

COMPLICATIONS: None.

INDICATIONS: This is a patient who presents with progressive neck and bilateral arm symptoms, noted to have cervical spondylosis, worse at C5-6, C6-7. The risks and benefits of surgery including bleeding, infection, neurologic deficit, nonunion, progressive spondylosis and lack of improvement were all discussed, understood and wished to proceed.

DESCRIPTION OF PROCEDURE: The patient was brought to the Operating Room and placed in supine position. Preoperative antibiotics were given. The patient was prepped and draped in standard fashion. Incision was made approximately at the level of the cricoid. Blunt dissection was used to expose the anterior portion of the spine with the carotid moved laterally and trachea and esophagus moved medially. We then confirmed we were at the correct levels with fluoroscopy. The distracting pins were placed in the body of C5, into the body of C7. Portions of the disks were excised. An interbody cage was then placed after meticulous hemostasis was performed with DBM in place, and then we placed a VIP plate into the body of 5, 6 and 7. Excellent purchase was obtained. Fluoroscopy showed excellent placement both the cage and plate. Meticulous hemostasis was obtained. The fascia was closed with 3-0, subcuticular 3-0 and Dermabond on skin. The patient tolerated procedure well and went to Recovery in good condition.

ICD-10-CM code(s):

M47.812 Spondylosis without myelopathy or radiculopathy, cervical region

ICD-10-PCS code(s):

0RG20A0 Fusion of 2 or more Cervical Vertebral Joints with Interbody Fusion Device, Anterior Approach, Anterior Column, Open Approach

0RB30ZZ Excision cervical vertebral disc, open approach (C5-6)

BR10ZZZ Fluoroscopy of cervical spine, no mention of contrast being utilized.

Rationale: Per AHA *Coding Clinic for ICD-10-CM/PCS, Q2, 2014* the excision is reported separately. AHA has also clarified the phrase “different body sites” in Multiple Procedure Guideline B3.2b refers to distinct body parts, not different locations within the same body part <AHA *Coding Clinic, Q4, 2014*>.

Per the ICD-10-PCS Device Key, an interbody fusion (spine) cage is considered an interbody fusion device.

If an interbody fusion device is used to render the joint immobile (alone or containing other material like bone graft), the procedure is coded with the device value Interbody Fusion Device <ICD-10-PCS Guidelines, B3.10c>

The fixation (rods, plates screws) are included in the fusion root operation and no additional code is assigned. <AHA, *Coding Clinic for ICD-10-CM/PCS, Q3, 2014*>