**Self-Assessment: Coding Outpatient Cases**

Your coding for PCI Memorial Hospital. Apply only hospital outpatient guidelines and modifiers. Assign ICD-9 diagnoses, ICD 9 procedure, and CPT codes.

**Case 1:**

**Preoperative diagnosis:** Chronic torn medial meniscus and DJD localized rt knee, rule-out loose body lateral compartment.

**Postoperative diagnosis:** Large flap tear, posterior horn, medial meniscus; chondral loose bodies, significant degenerative arthritis rt knee

**Operation:** Arthroscopy of the rt knee with partial medical menisectomy; arthroscopy of the right knee, with removal of chondral loose bodies.

**Procedure description:** This 47-yr-old male was taken to the operating room and placed in the supine position. General anesthesia was accomplished without complication. Evaluation under anesthesia of the rt knee showed it was stable with a negative Lachmann’s and firm end point. Negative anterior and posterior drawer stable to varus and valgus testing. A tourniquet was placed the mid-right thigh. The rt leg was prepped and draped free in the usual sterile manner. Tourniquet inflated to 325 mmHg. There were loose bodies throughout the medial compartment of the knee, which were flushed and removed. The patient had a large flap tear of the posterior horn of the medial meniscus that was unstable. He underwent a partial medial menisectomy with small basket forceps and small synovial resector removing the torn portion of the meniscus, leaving about a 2mm rim posterior and then saucerizing this to smooth margins anteriorly. The anterior cruciate ligament and posterior cruciate ligament were normal. The lateral compartment could not be entered because of significant arthritis medially. The knee joint was thoroughly irrigated and the portals closed and trocars removed. 3-0 nylon mattress sutures placed. Sterile dressing was applied. No complications occurred. The tourniquet was deflated after 20 minutes. The patient was taken to the recovery room.

**Case 2:**

**Preoperative diagnosis:** Left frontal lesion

**Postoperative diagnosis:** Left frontal lesion

**Operation:** Stereotactic biopsy of left frontal lesion

Indications for Procedure: The patient is 66-yr-old female transferred to the University neurosurgical service for outpatient treatment from Blank Memorial Hospital, where is an inpatient. She presents with neurologic deterioration, nausea, neck pain, and headache. A CT and magnetic scan revealed a left frontal mass. It was recommended that the patient undergo stereotactic biopsy. The risks and benefits of the procedure were explained to the patient and her family in detail, who requested the procedure be performed and the patient returned to Blank for further therapy.

**Procedure:** The patient was first taken to the CT suite, where a stereotactic halo was placed on the patient’s head with the four-pin system using local anesthesia. The stereotactic CT was then performed, and the patient was transported to the operative room. The patient was placed on the operating room table in the supine position. General endotracheal anesthesia was smoothly induced. The left frontal area was then clipped and shaved, and the area was then brought into the field and placed on the stereotactic ring. The localizing arm and the pointer were used to mark the left frontal area for skin incision. The area was then infused with 1 percent lidocaine with epinephrine, and a 2 cm skin incision was created in the left frontal region. The self-retaining was placed, and hemostasis was obtained. At this time, the patient began to express bradycardia. The physician decided to stop the procedure.