Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Reader Question: Drain Removal Could Warrant Modifier

Question: Surgeon A performed a posterolateral fusion, laminectomy, and pedicle screw insertion. Then two days later Surgeon B removed the remainder of the drain that was left after Surgeon A removed it.

Procedure done: Opening of the wound and inspection of the wound, removal of the retained drain and reclosure.

Below is the procedure note:

"After satisfactory induction of general endotracheal anesthesia and preoperative preparation, the inferior part of incision was opened. We took out the Monocryl and the 2-0 Vicryl and then the Prolene in the fascia and opened the wound up to a small extent. The drain, seen on the right side of the wound, was removed. Since the drain was torn, we imaged the remainder of the wound to ensure there wasn't any remaining fragment. No such fragments were located. We then thoroughly irrigated the wound. Further, we closed the drain with the Prolene that was tied to other Prolene stitch, 2-0 Vicryl and Monocryl, tied to the remaining Monocryl stitch. Dry sterile dressing was applied to the wound."

How can we report this condition?

Answer: This would be considered a complication of the original procedure, since the drain should be removable without reopening the wound. Since there is no specific code for removal of a postoperative drain with subsequent surgery, one may consider reporting this with unlisted code 22899 (Unlisted procedure, spine) appended with the 78 (Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period) modifier.