

cpt 2009

Changes

An insider's view

Reprint

Abdomen, Peritoneum, and Omentum

REPAIR

Hernioplasty, Herniorrhaphy, Herniotomy

- + ▲ 49568** Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)



Rationale

Add-on code 49568 was revised, adding the word “open” to the descriptor. This was done to accommodate development of the codes used to identify laparoscopic provision of hernia repair (the addition of the word “open” to this code specifically identifies this code as an open procedure and restricts use of this code for laparoscopic procedures). The new codes used to identify laparoscopic provision of hernia repair specifically include language that identifies use of those codes for laparoscopic hernia procedures.

LAPAROSCOPY

- 49652** Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible
 - ▶(Do not report 49652 in conjunction with 44180, 49568)◀
- 49653** incarcerated or strangulated
 - ▶(Do not report 49653 in conjunction with 44180, 49568)◀

- **49654** Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible
▶(Do not report 49654 in conjunction with 44180, 49568)◀
- **49655** incarcerated or strangulated
▶(Do not report 49655 in conjunction with 44180, 49568)◀
- **49656** Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible
▶(Do not report 49656 in conjunction with 44180, 49568)◀
- **49657** incarcerated or strangulated
▶(Do not report 49657 in conjunction with 44180, 49568)◀



Rationale

Codes 49652-49657 were added to report laparoscopic repairs performed for hernias. Parenthetical notes have been added following codes 49656 and 49657 to restrict use of these codes with open procedures for mesh insertion and lysis of adhesions. Instead, the laparoscopic provision of the previously noted laparoscopic services includes mesh insertion and adhesiolysis when performed. As is true with many other surgical procedures, diagnostic laparoscopy, which includes collection of specimens and brushings or washings, is also inherently included as part of the surgical services included in these new codes. For other hernia repairs performed laparoscopically, the unlisted code 49659 should continue to be used. In addition, a parenthetical note has been added to restrict use of these codes with open mesh placement.



Clinical Example (49652)

A 35-year-old obese man presents with a new abdominal wall bulge first noted after exercise, which has been increasing in size over the last few months. It is occasionally painful, with tender edges. The hernia is reducible on examination. He is referred for a laparoscopic repair.

Description of Procedure (49652)

If hernia contents are present, they are manually reduced. Pneumoperitoneum is induced by insertion of a needle, bladeless optical trocar, open insertion of the first port (described below), or other appropriate technique.

Starting at a distance from the hernia location, for open insertion the first skin incision is made and carried through the subcutaneous tissues. Hemostasis is obtained. The fascia is exposed and incised, and the peritoneum is opened carefully under direct vision, avoiding underlying bowel, omentum, or adhesions. The first trocar is inserted and secured with stay sutures as needed. The abdomen is then insufflated while physiologic changes are monitored. The appropriate camera is inserted, and a preliminary visual exploration of the abdominal cavity is made before subsequent cannulae are placed. With the camera viewing placement of each port, typically two more are positioned to allow two-handed surgical technique while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of

instruments inserted through the other ports, viewing where possible the liver, small bowel, colon, stomach, spleen, and pelvic organs. At any stage in this initial process, adhesions may require sharp and/or blunt lysis to allow adequate exposure.

The hernia defect is identified and, if necessary, its contents are reduced. An appropriate margin around the defect to accommodate overlapping mesh is cleared by lysing adhesions or mobilizing structures such as the falciform ligament. Hemostasis is secured before continuing, and intestine that has been handled or freed by adhesiolysis is carefully checked to confirm that it is intact. Sites on the abdominal wall are selected for the transfascial fixation sutures if used. The size of the defect is measured and an appropriate-sized mesh patch is selected. The mesh is rolled and introduced through the largest available cannula or abdominal puncture and, once inside, is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points is intended to achieve adequate overlap of flat-lying mesh beyond the edge of the defect, and prevent both movement of the mesh and protrusion of intestine, omentum, or other abdominal structures between the mesh and the abdominal wall. A second or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect may be inserted according to surgeon preference. The mesh is inspected for gaps, large ripples, and other defects, with and without insufflation, and corrected as needed.

The secondary cannulae are removed, carbon dioxide is allowed to escape from the abdomen, and the fascial defects of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed, the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate a dead space. The skin incisions are closed according to surgeon preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.



Clinical Example (49653)

A 50-year-old woman with no past surgical history presents with a large abdominal wall mass. She reports that it has been slowly increasing in size over the last 3-4 years. It would initially go away when she laid down but has been nonreducible for the last year. It is increasingly tender and often painful. She has occasional nausea but no vomiting associated with it. On examination she is afebrile with normal vital signs. She has a chronically incarcerated ventral hernia and is referred for a laparoscopic repair.

Description of Procedure (49653)

An attempt is made to reduce the hernia contents manually. Pneumoperitoneum is induced by insertion of a needle, bladeless optical trocar, open insertion of the first port (described below), or other appropriate technique.

Starting at a distance from the hernia location, for open insertion the first skin incision is made and carried through the subcutaneous tissues. Hemostasis is obtained. The fascia is exposed and incised and the peritoneum opened carefully under direct vision, avoiding underlying bowel, omentum, or adhesions. The first trocar is inserted and secured with the stay sutures as needed. The abdomen is then insufflated while physiologic changes are monitored. The appropriate camera is inserted, and a preliminary visual exploration of the abdominal cavity is made before subsequent cannulae are placed. With the camera viewing placement of each port, typically two more are positioned to allow two-handed surgical technique while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of instruments inserted through the other ports, viewing where possible the liver, small bowel, colon, stomach, spleen, and pelvic organs. At any stage in this initial process, adhesions may require sharp and/or blunt lysis to allow adequate exposure.

The hernia defect is identified and, if necessary, its contents are reduced by a combination of external pressure, careful traction with the laparoscopic instruments, and judicious adhesiolysis as necessary. An appropriate margin around the defect to accommodate overlapping mesh is cleared by lysing adhesions or mobilizing structures such as the falciform ligament. Hemostasis is secured before continuing, and intestine that has been reduced, handled, or freed by adhesiolysis is carefully checked to confirm that it is intact. Devitalized tissue such as fat or omentum is excised and removed. Sites on the abdominal wall are selected for the transfascial fixation sutures if used. The size of the defect is measured and an appropriately sized mesh patch is selected. The mesh is rolled and introduced through the largest available cannula or abdominal puncture and, once inside, is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points are intended to achieve adequate overlap of flat-lying mesh beyond the edge of the defect, and prevent both movement of the mesh and protrusion of intestine, omentum, or other abdominal structures between the mesh and the abdominal wall. A second or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect may be inserted according to surgeon preference. The mesh is inspected for gaps, large ripples, and other defects, with and without insufflation, and corrected as needed.

The secondary cannulae are removed, carbon dioxide is allowed to escape from the abdomen, and the fascial defects of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed, the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate dead space. The skin incisions are closed according to surgeon preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.



Clinical Example (49654)

A 60-year-old man with a prior laparotomy for a colectomy has developed a bulge in the midline incision. The defect has been increasing in size during follow-up. He has symptoms of pain and local tenderness. He has had no history of incarceration or bowel obstruction. On examination, he is found to have a reducible incisional hernia. He is referred for laparoscopic repair.

Description of Procedure (49654)

If hernia contents are present, they are gently reduced. Pneumoperitoneum is induced by open insertion of the first port (described below) or other appropriate technique.

Starting at a distance from the hernia location for open insertion, the first skin incision is made and carried through the subcutaneous tissues. Hemostasis is obtained. The fascia is exposed and incised, and the peritoneum is opened carefully under direct vision, avoiding underlying bowel, omentum, or adhesions. The first trocar is inserted and secured with the stay sutures as needed. The abdomen is then insufflated while physiologic changes are monitored. The appropriate camera is inserted, and a preliminary visual exploration of the abdominal cavity to identify the pattern of adhesions is made before subsequent cannulae are placed. The camera views placement of each port. Typically, two more cameras are positioned to allow two-handed surgical technique while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of instruments inserted through the other ports, viewing where possible the liver, small bowel, colon, stomach, spleen, and pelvic organs. At any stage in this initial process, adhesions may require sharp and/or blunt lysis to allow adequate exposure. There are several defects adjacent to each other containing suture loops from the first wound closure. Adhesions to the abdominal wall between loops of bowel, and between bowel and other structures, are meticulously lysed to free the entire anterior abdominal fascia.

The hernia defects are identified and, if necessary, their contents reduced. An appropriate margin around the ensemble of defects to accommodate overlapping mesh is cleared by lysing adhesions or mobilizing structures such as the falciform ligament. Hemostasis is secured before continuing, and intestine that has been handled or freed by adhesiolysis is carefully checked to confirm that it is intact. Sites on the abdominal wall are selected for the transfascial fixation sutures, if used. The distribution of the defects is measured and an appropriate-sized mesh patch is selected. The mesh is rolled and introduced through the largest available cannula or abdominal puncture and, once inside, is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points are intended to achieve adequate overlap of flat-lying mesh beyond the edge of the defect, and prevent both movement of the mesh and protrusion of intestine, omentum, or other abdominal structures between the mesh and the abdominal wall. A second

or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect may be inserted according to the surgeon's preference. The mesh is inspected for gaps, large ripples, and other defects, with and without insufflation, and corrected as needed.

The secondary cannulae are removed; carbon dioxide is allowed to escape from the abdomen and the fascial defects of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed, the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate dead space. The skin incisions are closed according to surgeon preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.



Clinical Example (49655)

A 54-year-old man has a surgical history of a partial gastrectomy for ulcer disease. He has developed an incisional hernia in the midline incision. During the past few months, it has become chronically protuberant. He reports increasing pain and discomfort associated with it. He has had episodes of worsening distention and occasionally vomiting with the episodes of pain. He is not able to reduce the hernia even when lying down. He is referred for laparoscopic repair.

Description of Procedure (49655)

If hernia contents are present, they are gently reduced, if possible. Pneumoperitoneum is induced by open insertion of the first port (described below) or other appropriate technique.

Starting at a distance from the hernia location for open insertion, the first skin incision is made and carried through the subcutaneous tissues. Hemostasis is obtained. The fascia is exposed and incised, and the peritoneum is opened carefully under direct vision, avoiding underlying bowel, omentum, or adhesions. The first trocar is inserted and secured with the stay sutures as needed. The abdomen is then insufflated while physiologic changes are monitored. The appropriate camera is inserted and a preliminary visual exploration of the abdominal cavity to identify the pattern of adhesions is made before subsequent cannulae are placed. There are many adhesions to the anterior abdominal wall involving the small and large intestine. The hernia contains both omentum and multiple loops of small bowel. The small bowel entering the hernia appears chronically dilated; the loops leaving it are flat and decompressed. The camera views placement of each port; typically two more cameras are positioned to allow two-handed surgical technique while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of instruments inserted through the other ports, viewing where possible the liver, small bowel, colon, stomach, spleen, and pelvic organs. At any stage in this initial process, adhesions may require sharp and/or blunt lysis to allow adequate exposure.

The hernia defect or defects are identified and, if necessary, the contents are reduced. Adhesions to the hernia(s), to the abdominal wall, between loops of bowel, and between bowel and other structures are slowly and meticulously lysed to free the entire anterior abdominal fascia. An appropriate margin around the

defect(s) to accommodate overlapping mesh is cleared by lysing adhesions or mobilizing structures such as the falciform ligament or adjacent colon. Hemostasis is secured before continuing, and intestine that has been handled or freed by adhesiolysis is carefully checked to confirm that it is intact. Sites on the abdominal wall are selected for the transfascial fixation sutures, if used. The size/distribution of the defects is measured and an appropriate-sized mesh patch is selected. The mesh is rolled and introduced through the largest available cannula or abdominal puncture and, once inside, is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points are intended to achieve adequate overlap of flat-lying mesh beyond the edge of the defect and prevent both movement of the mesh and protrusion of intestine, omentum, or other abdominal structures between the mesh and the abdominal wall. A second or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect(s) may be inserted according to surgeon preference. The mesh is inspected for gaps, large ripples, and other defects, with and without insufflation, and corrected as needed.

The secondary cannulae are removed; carbon dioxide is allowed to escape from the abdomen and the fascial defects of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed, the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate dead space. The skin incisions are closed according to surgeon preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.



Clinical Example (49656)

A 65-year-old woman has a surgical history of an open cholecystectomy 20 years ago. She developed an incisional hernia. She underwent a surgical repair of that hernia 10 years ago because of increasing size and symptoms. That repair was performed as laparotomy with implantation of a synthetic mesh as an inlay for closure. The patient has developed a recurrence of the hernia with new defects of varying sizes at multiple points around the margins of the inlay mesh. She has symptoms of pain and tenderness at the sites. She is referred for laparoscopic repair of a recurrent incisional hernia.

Description of Procedure (49656)

If hernia contents are present, they are gently reduced. Pneumoperitoneum is induced by open insertion of the first port (described below) or other appropriate technique.

Starting at a distance from the hernia location for open insertion, the first skin incision is made and carried through the subcutaneous tissues. Hemostasis is obtained. The fascia is exposed and incised, and the peritoneum is opened carefully under direct vision, avoiding underlying bowel, omentum, or adhesions. The first trocar is inserted and secured with the stay sutures as needed. The abdomen

is then insufflated while physiologic changes are monitored. The appropriate camera is inserted, and a preliminary visual exploration of the abdominal cavity to identify the pattern of adhesions is made before subsequent cannulae are placed. Extensive adhesions of varying thickness and vascularity are found to the anterior abdominal wall and especially to the mesh inlay. These involve the omentum, stomach, and small and large intestine. The camera views placement of each port; typically two more cameras are positioned to allow two-handed surgical technique while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of instruments inserted through the other ports, viewing where possible the liver, small bowel, colon, stomach, spleen, and pelvic organs. At any stage in this initial process, adhesions may require sharp and/or blunt lysis to allow adequate exposure.

The hernia defects are identified and, if necessary, the contents are reduced. Adhesions to the hernias, to the abdominal wall, between loops of bowel, and between bowel and other structures are meticulously lysed to free the entire anterior abdominal fascia. An appropriate margin around the defects to accommodate overlapping mesh is cleared by lysing adhesions or mobilizing structures such as the falciform ligament or adjacent colon. Hemostasis is secured before continuing, and intestine that has been handled or freed by adhesiolysis is carefully checked to confirm that it is intact. Sites on the abdominal wall are selected for the transfascial fixation sutures, if used. The size of the defect is measured and an appropriate-sized mesh patch is selected. The mesh is rolled and introduced through the largest available cannula or abdominal puncture and, once inside, is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points are intended to achieve adequate overlap of flat-lying mesh beyond the edge of the defect, and prevent both movement of the mesh and protrusion of intestine, omentum, or other abdominal structures between the mesh and the abdominal wall. A second or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect may be inserted according to surgeon preference. The mesh is inspected for gaps, large ripples, and other defects, with and without insufflation, and corrected as needed.

The secondary cannulae are removed; carbon dioxide is allowed to escape from the abdomen and the fascial defects of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed, the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate dead space. The skin incisions are closed according to surgeon preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.



Clinical Example (49657)

A 60-year-old man presents with an irreducible mass in the midline of the abdomen. He has a history of a laparotomy for repair of a perforated gastric ulcer in the distant past. He had an incisional hernia from that operation that was repaired electively with a mesh 5 years ago. He developed a recurrence from that repair that was being observed. During the last few months, it has been slowly increasing in size. It is now irreducible and tender. He is referred for laparoscopic repair of an incarcerated, recurrent incisional hernia.

Description of Procedure (49657)

If hernia contents are present, they are gently reduced if possible. Pneumoperitoneum is induced by open insertion of the first port (described below) or other appropriate technique.

Starting at a distance from the hernia location for open insertion, the first skin incision is made and carried through the subcutaneous tissues. Hemostasis is obtained. The fascia is exposed and incised, and the peritoneum is opened carefully under direct vision, avoiding underlying bowel, omentum, or adhesions. The first trocar is inserted and secured with the stay sutures as needed. The abdomen is then insufflated while physiologic changes are monitored. The appropriate camera is inserted, and a preliminary visual exploration of the abdominal cavity to identify the pattern of adhesions is made before subsequent cannulae are placed. The camera views placement of each port; typically two more cameras are positioned to allow two-handed surgical technique while remaining at a distance from the hernia. A thorough visual examination of the abdominal cavity is then undertaken with the aid of instruments inserted through the other ports, viewing where possible the liver, small bowel, colon, stomach, spleen, and pelvic organs.

There are many adhesions to the anterior abdominal wall from the small and large intestine. The hernia contains multiple loops of small bowel with adhesions from the intestine to the prior mesh inlay. There are also adhesions from the omentum and colon to the exposed areas of mesh. Careful adhesiolysis proceeds very slowly to fully expose the hernia defect and the incarcerated contents. The viscera are gently reduced with a combination of intra-abdominal traction and extra-abdominal pressure. The area of recurrence is dissected free, and all the intra-abdominal adhesions are taken down to allow for deployment of a new mesh. After all the contents are reduced, the entire small and large bowel is carefully inspected to assess for any injury. Hemostasis is secured before continuing, and intestine that has been handled or freed by adhesiolysis is carefully checked to confirm that it is intact. Sites on the abdominal wall are selected for the transfascial fixation sutures, if used. The size of the defect is measured and an appropriate-sized mesh patch is selected. The mesh is rolled and introduced through the largest available cannula or abdominal puncture and, once inside, is unfurled and positioned with the correct surface facing the abdominal wall. The entire periphery of the mesh is secured at appropriate intervals to the abdominal wall with a combination of any or all of the following: tacks, staples, transfascial or intracorporeal stitches, or other permanent fixation devices. A fourth or subsequent port may be necessary to permit access of instrumentation for fixation of an inaccessible corner of the mesh. The number and position of these fixation points are intended to achieve

adequate overlap of flat-lying mesh beyond the edge of the defect and prevent both movement of the mesh and protrusion of intestine, omentum, or other abdominal structures between the mesh and the abdominal wall. A second or subsequent concentric inner ring of fixation points between the outer ring and the edge of the defect may be inserted according to surgeon preference. The mesh is inspected for gaps, large ripples, and other defects, with and without insufflation, and corrected as needed.

The secondary cannulae are removed; carbon dioxide is allowed to escape from the abdomen and the fascial defects of all port punctures are repaired as appropriate. Local anesthetic is injected once again to all trocar sites and transfascial fixation points. If needed, the subcutaneous tissues of the larger punctures are approximated with interrupted sutures to eliminate dead space. The skin incisions are closed according to the surgeon's preference. Sponge, needle, and instrument counts are obtained and confirmed prior to closure.

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