Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Converting Laparoscopic Cancer Surgery to Open? Read These Tips Before You Code

This Ob-gyn case study will show you how to properly convert your coding.

If your ob-gyn converts a laparoscopic to an open procedure, your coding for endometrial cancer surgeries can drastically transform. Follow these three steps to ward against denials.

Review This Op Note

Preoperative diagnosis: Adenocarcinoma of the endometrium.

Postoperative diagnosis: Same as above, but greater than 50 percent myometrial invasion, pathology pending.

Operation performed: Laparoscopic assisted transvaginal hysterectomy (LAVH) with bilateral salpingooophorectomy, laparotomy with pelvic and periaortic node dissection, partial omentectomy, pelvic washings.

Procedure: Exam of the pelvic organs revealed an 8-week-size uterus. The right and left ovaries appear to be within normal limits. The ob-gyn found no evidence of excrescences or signs of metastatic disease in the lower pelvis along the bowel or serosa, nor did he discover evidence of metastatic disease in the upper abdomen, liver and dome of the diaphragm. He then performed a dissection.

He removed the uterus vaginally with the assistance of the laparoscope, and the pathologist was present to open the organ and render an opinion.

The pathologist saw an enlarged, fungating, relatively superficial lesion of the endometrium. Up in the patient's right fundal area, however, the pathologist saw an invasion of the myometrium at least two-thirds of the way through. Given this finding, the ob-gyn decided to perform an open pelvic node dissection. He removed the laparoscope and made a new incision to enter the peritoneum.

He obtained pelvic washings from the right cul-de-sac and pelvic area. He then performed a partial omentectomy with the aid of multiple Kelly clamps.

The ob-gyn did a pelvic node dissection, first on the right side identifying the ureter evenly. He carried down the dissection to include the internal and external iliac lymph nodes. He performed the same procedure on the left side. The dissection took place below the bifurcation of the aorta. The ob-gyn obtained tissue in the periaortic lymphatic chain area.

Step 1: Decipher the LAVH Approach

The first thing you must do is decide whether your ob-gyn used two different surgical approaches -- laparoscopic and abdominal.

Keep in mind: "Laparoscopic" means that the ob-gyn made several small incisions through which he can pass a fiber-optic scope and any required instruments to complete the surgery, says **Arlene J. Smith, CPC,** insurance, coding and billing specialist for Tacoma Women's Specialists in Washington. "Laparotomy," on the other hand, means that the ob-gyn made an incision into the abdominal wall.

Result: The ob-gyn did not complete the procedure via laparoscopy but, rather, performed an additional procedure abdominally separate from the laparoscopic surgery.

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But you've got a problem. If you search for the laparoscopic-assisted transvaginal hysterectomy code, you won't find a code that includes the nodes. This means that your only coding option for the hysterectomy is to report

58552 (Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube[s] and/or ovary[s]). You'll deal with the "dissection" of the nodes (or lymphadenectomy) in Step 3.

Avoid this pitfall: Because the ob-gyn did not convert the hysterectomy to an open procedure, you should not code the LAVH using 58200 (Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube[s], with or without removal of ovary[s]).

Code 58200 represents removing the uterus as well as neighboring areas (the parametrium and uterosacral ligaments) and includes a partial vaginectomy. Ob-gyns perform this procedure when the endometrial cancer has spread to the cervix or parametrium. In the case above, the ob-gyn performed the entire hysterectomy with the aid of a laparoscope and then found he had to do an additional procedure to take care of the more invasive cancer he found. He did not convert to an open procedure, so using 58200 is out.

Now that you've got the code for the LAVH, turn your attention to the omentectomy.

Step 2: Clarify the Lymphadenectomy

Your next challenge is to handle the "dissection" or lymph node sampling. The problem is you don't know whether the procedure was limited or complete. The dictation is not clear.

You have to ask your ob-gyn to clarify. To choose the correct code, you must know whether your ob-gyn performed a limited or complete pelvic lymphadenectomy.

For example, suppose "the ob-gyn heard from the pathologist about a greater-than-50-percent myometrial invasion, and instead of stopping, the ob-gyn opened the patient and did the lymphadenectomy," says **Harry Stuber, MD,** an independent gynecologist in Cookeville, Tenn. In that case, you have two options: either 38562 (Limited lymphadenectomy for staging [separate procedure]; pelvic and paraaortic) or 38770 (Pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes [separate procedure]), depending on whether it was a limited or complete pelvic lymphadenectomy.

Option 1: If the ob-gyn says that he performed a limited lymphadenectomy, you will use 38562. This code does include the peri-aortic lymph nodes. Keep in mind: The term "peri-aortic" is the same as the term "para-aortic" used in CPT.

You may have to append modifier 59 (Distinct procedural service) because this is a "separate procedure," and some payers will try to bundle it with other procedures, but the Correct Coding Initiative (CCI) does not bundle this code with an LAVH. So modifier 59 does not seem to be necessary at this stage of your coding.

Option 2: If the ob-gyn did a complete pelvic lymphadenectomy, the code changes to 38770. Notice that this code does not include the peri-aortic lymph node sampling. This was additional work for the ob-gyn, but you have the option of adding modifier 22 (Increased procedural services) to this code.

Keep in mind: While 38564 (Limited lymphadenectomy for staging [separate procedure]; retroperitoneal [aortic and/or splenic]) does represent a peri-aortic sampling, reporting this code in addition is not an option because CCI permanently bundles 38564 into 38770 and does not permit the use of modifier 59.

You would also add a modifier 50 (Bilateral procedure) because the procedure note describes the ob-gyn performing the lymphadenectomy on both sides, and CPT guidelines instruct you to use this modifier under this circumstance. And although 38770 is a CPT "separate procedure," you should not consider it bundled into the LAVH. Therefore, you do not need modifier 59. Your coding would then be 38770-50-22.

Note: You should avoid 38572 (Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and periaortic ymph node sampling [biopsy], single or multiple) because the ob-gyn did not perform the lymph node dissection procedure via laparoscopy but performed an additional procedure abdominally without the use of the laparoscope. But this code

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includes both a pelvic lymphadenectomy and peri-aortic sampling and is a bilateral code. That means you would not add modifier 50 if this code were appropriate to report.

Step 3: Tone Down Your Omentectomy Code

Unlike the LAVH, your challenge for the omentectomy may be to modify an existing code to reflect the ob-gyn's "partial" work.

According to the op note, the ob-gyn performed a partial open omentectomy. Although you have a code for the omentectomy (49255, Omentectomy, epiploectomy, resection of omentum [separate procedure]), you do nothave a code for a partial one. Under this circumstance, you need to append modifier 52 (Reduced services).

Coding separately for the omentectomy for this surgical case, however, may not be that straightforward. This is because your coding options change depending on which lymphadenectomy code you will be reporting. You may know that an omentectomy is not bundled with an LAVH or a complete lymphadenectomy, but you should consider it bundled when your ob-gyn performs a limited lymphadenectomy. In this latter case, you cannot append modifier 59 to bypass the edit, so your only option would be to add a modifier 22 (Increased procedural services) to code 38562 to account for the additional work. In other words, if you bill 38770, you can bill 49255-52; if you bill a limited lymphadenectomy, you would bill 38562-22.

Pull Everything Together

Now that you've tackled these three challenges, you can report these codes together on your claim.

Remember: Your diagnosis code should be 182.0 (Malignant neoplasm of body of uterus; corpus uteri, except isthmus) for all three procedures. Caution: You don't need to indicate V64.41 (Laparoscopic surgical procedure converted to open procedure) in this case because the ob-gyn completed the laparoscopic procedure before moving on to another approach for the other procedures.

Therefore, your claim should look like this:

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