Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Engage These 3 Challenges for a Clean Endometrial Cancer Surgery Claim

You need to know whether your ob-gyn did a limited or complete lymphadenectomy.

If your ob-gyn treats a patient with endometrial cancer, you'll find that procedure codes specific to this complicated type of surgery are hard to come by.

Read the following op note and see what steps our experts recommend you take when you tackle these three challenges: deciding whether the ob-gyn converted a laparoscopic to an open procedure, finding a code for a partial omentectomy, and asking your ob-gyn questions about the lymphadenectomy.

First, Read Over 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 salpingo-oophorectomy, laparotomy with pelvic and periaortic node dissection, partial omentectomy, pelvic washings.

Procedure: Exam of the pelvic organs revealed an eight-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. So the ob-gyn performed a laparotomy and 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.

Coding Challenge 1: Consider the LAVH

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

Read the op note one more time. Keep in mind: "Laparoscopic" means that the ob-gyn used a scope-assisted technique with a small incision. "Laparotomy" means that the ob-gyn made an incision into the abdominal wall.

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

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 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 Coding Challenge 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 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.

Coding Challenge 2: Modify the Omentectomy

Unlike the LAVH, your main challenge for the omentectomy is 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 not have a code for a partial one.

Answer: You can still use 49255, but you'll have to use modifier 52 (Reduced services). And if your payer bundles the omentectomy when the ob-gyn also performs a hysterectomy, you should include modifier 59 (Distinct procedural service), so that your full code looks like this: 49255-59-52.

Coding Challenge 3: Examine the Lymphadenectomy

Your last 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.

Answer: 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 would have two options:

either 38562 (Limited lymphadenectomy for staging [separate procedure]; pelvic and para-aortic) 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 should append modifier 59 (Distinct procedural service) because this is a "separate procedure," and most payers will try to bundle these procedures into the LAVH. You should use this modifier to show that the lymphadenectomy was separate and distinct.

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 always have the option of adding modifier 22 (Increased procedural services) to this code.

You would use modifier 50 (Bilateral procedure) because the procedure notes describe how the ob-gyn performed the lymphadenectomy on both sides, and CPT® guidelines instruct you to use this modifier under this circumstance. Again, you should also use modifier 59 because this code represents a "separate procedure," and some payers will try to bundle it into the LAVH. Your code would then look like 38770-59-50-22.

Note: You should avoid 38572 (Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and periaortic lymph node sampling [biopsy], single or multiple) because the ob-gyn did not complete the procedure via laparoscopy but performed an additional procedure abdominally without the use of the laparoscope. Notice, however, that this code includes both a pelvic lymphadenectomy and peri-aortic sampling.

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:

Option 1:

- Dx: 182.0
- 58552
- 38562-59
- 49255-52

Option 2:

- Dx: 182.0
- 58552
- 38770-50-59-22
- 49255-52.