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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Report Female UI Surgical Procedures Easier With These Tips

If MD does a combined vaginal and abdominal approach to perform a suburethral sling operation, report this.

The causes of female urinary incontinence are many, so you may be overwhelmed by treatment coding options. But if you can correctly decipher both the treatment and the cause, you'll easily choose the best code every time. Here's how.

From both a clinical and coding perspective, it helps to think of incontinence procedures in categories. Your physician can choose from the following surgical options for incontinence:

1. Retropubic suspension
2. Needle procedures
3. Slings

Remember, you also have minimally invasive laparoscopic options.

In all of these options, your ob-gyn's documentation is key. Here are the terms to highlight.

1. Report 51840, 51841 for Retropubic Urethropexy

Your physician may choose a retropubic suspension to treat a female patient with urinary incontinence.

If the operative report states that the sole surgical approach was abdominal and the physician performed either a Marshall-Marchetti-Krantz (MMK) or Burch procedure, you can immediately narrow your search to two codes: 51840 (Anterior vesicourethropexy, or urethropexy [e.g., Marshall-Marchetti-Krantz, Burch]; simple) and 51841 (...complicated [e.g., secondary repair]). During an MMK procedure, the surgeon places sutures into the vaginal wall at the level of the urethra or bladder neck and anchors them to the pubic bone. For a Burch sling procedure, the surgeon would anchor the sutures to the Coopers ligament.

How to choose: Your physicians' documentation is the key to choosing 51840 or 51841. You can consider a retropubic suspension procedure to be complicated in the following situations:

- If it is a secondary repair following a previous surgery
- If there is extensive bleeding during surgery
- If the patient has adhesions from a previous surgery
- If the patient has vaginal prolapsed
- If the procedure takes an excessive amount of time to complete
- If the patient is obese
- If the surgeon encounters aberrant anatomy.

Tip: A good way to double-check your code selection is to determine whether the patient's diagnosis correlates to procedures 51840 and 51841. Possible diagnoses for MMK and Burch procedures include stress incontinence (625.6), vaginal prolapse (618.x), and mixed incontinence (788.33).

ICD-10: When your diagnosis system changes, you will report the following equivalents:

- Code 625.6 will become N39.3 (Stress incontinence [female] [male]).
- Codes for vaginal prolapses (618.x) will become N81.0 (Urethrocele) or N81.1_ (Cystocele).
- Code 788.33 will become N39.46 (Mixed incontinence).

2. Don't Let 51845 Needle You

Another surgical method your physician may opt for is needle suspension. Physicians don't use these procedures as often as they used to because they haven't worked well, but as there may be some physicians who do use them, you need to know how to approach coding for them.

If your physician does perform a Stamey, Raz, Gittes or modified Pereyra needle procedure, however, you should report 51845 (Abdomino-vaginal vesical neck suspension, with or without endoscopic control [e.g., Stamey, Raz, modified Pereyra]) or 57289 (Pereyra procedure, including anterior colporrhaphy) for a Pereyra procedure. Physicians perform these procedures using either an abdominal or a combined abdominal-vaginal approach.

3. 57288 Is Your Answer for Slings

Physicians often perform sling procedures on female patients with incontinence. Although several types of sling procedures exist, you only have one code to use: 57288 (Sling operation for stress incontinence [e.g., fascia or synthetic]).

Do this: If your physician uses a combined vaginal and abdominal approach to perform a suburethral sling operation, you should report 57288. During this procedure, the surgeon places fascia or other materials at the urethrovesical junction to encircle and suspend the urethra. The surgeon then pulls the ends of the sling toward the symphysis pubis and fastens them to the rectus abdominus sheath.

In addition to the combined approach, you should use 57288 when your surgeon treats incontinence with tension-free transvaginal tape (TVT). In this case, the surgeon places the TVT sling, providing new support to tissue with less morbidity than traditional sling procedures. This procedure has become a popular option because it is less invasive for the patient. Other sling procedures may include TOT, Monarc subfascial hammock, Precision Tack Transvaginal Anchor System, a percutaneous pubovaginal sling, to name a few.

The bottom line: No matter what type of sling your physician uses, report 57288, even though the code descriptor may not specifically mention the type of sling he used. Note: For a sling revision or removal, use 57287 (Removal or revision of sling for stress incontinence [e.g., fascia or synthetic]).

Bonus: 51990, 51992 Are Your Laparoscopy Options

Some physicians decide to treat urinary incontinence with laparoscopic approaches. If you see in the operative report that your physician performed a laparoscopic procedure, turn to 51990 (Laparoscopy, surgical; urethral suspension for stress incontinence) and 51992 (...sling operation for stress incontinence [e.g., fascia or synthetic]).

Take your pick: If your physician laparoscopically places sutures into the vaginal wall at the level of the urethra or bladder neck and anchors them to Coopers ligament, choose 51990. You should report 51992 when he laparoscopically places the sutures from a sling under the mid-urethra to the rectus abdominus sheath.

Note: Physicians don't use laparoscopic approaches as commonly today as they used to. Laparoscopic treatments for incontinence became less popular when TVT and other midurethral slings took off.

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