Society of Gynecologic Oncology

SGO Coding and Reimbursement

Questions and Answers by Category

Bringing together the best in gynecologic cancer care.

Disclaimer: Answers to incoming questions are provided by the members of the Society of Gynecologic Oncology (SGO) Coding and Reimbursement subcommittee and represent their opinion based upon the current and usual practices in the field. Every effort is made to ensure the accuracy of the information provided. However, the information neither replaces information in Medicare regulations, the CPT-4 code book, or the ICD-10 CM code book; nor does it constitute legal advice. Responses to questions are intended only as a guide and are not a substitute for specific accounting or legal opinions. SGO expressly disclaims all responsibility and liability arising from use of, or reliance upon this information as a reference source, and assumes no responsibility or liability for any claims that may result directly or indirectly from use of this information, including, but not limited to, claims of Medicare or insurance fraud.

TABLE OF CONTENTS

OVARIAN CANCER OR MASSES

How do you code for ovarian cancer with cancers in both ovaries?

ICD-10 requires you to code to the greatest degree of specificity. If you have bilateral ovarian cancer, you should use BOTH the right ovarian cancer (C56.1) and the left ovarian cancer (C56.2) codes. The unspecified code (C56.9) might be appropriate for a patient diagnosed on biopsy if it is impossible to determine a site of origin.

Is it always necessary to identify the sites of advanced ovarian or fallopian tube cancer in ICD-10?

Yes, it is required for ICD-10 to identify the primary site of the tumor as well as sites of metastatic disease. Cancer codes for sites of metastatic disease are designated as "secondary cancer". For example, a stage 4 ovarian cancer may be coded using 3 codes: C56.1 (malignant neoplasm of the right ovary), C78.6 (secondary malignancy of the peritoneum and retroperitoneum, and J91.0 (malignant pleural effusion).

How do you code for borderline ovarian tumors or tumors of low malignant potential? Should histology types (i.e., mucinous) be included in the coding?

Borderline ovarian tumors are "low malignant potential" not "no malignant potential". There is therefore controversy about which code set to use.

The options are:

D39.1	Neoplasm of uncertain behavior of ovary
D39.10	Neoplasm of uncertain behavior of unspecified ovary
D39.11	Neoplasm of uncertain behavior of right ovary
D39.12	Neoplasm of uncertain behavior of left ovary
C56	Malignant neoplasm of ovary
C56.1	Malignant neoplasm of right ovary
C56.2	Malignant neoplasm of left ovary
C56.9	Malignant neoplasm of unspecified ovary

When using CPT codes that are designated for use for ovarian malignancies, e.g., 58950 (resection of ovarian malignancy with BSO and omentectomy) a cancer code should be used.

Histological types such as mucinous tumors are not included in ICD-10 codes. However, they are included in the ICD-Oncology codes. By and large, these are not needed for medical coding, but are important for tumor registries.

Is there a corresponding laparoscopic code for codes 58952 (Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with radical dissection for debulking (i.e., radical excision or destruction, intra-abdominal or retroperitoneal tumors) and 44955 (Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)?

For a laparoscopic BSO with staging (for a patient with prior hysterectomy, for instance), you can use the CPT code 38573 (Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling, peritoneal washings, peritoneal biopsy(ies), omentectomy, and diaphragmatic washings, including diaphragmatic and other serosal biopsy(ies), when performed) with a -22 modifier. That would be billed with the laparoscopic BSO CPT code 58661 with the -59 modifier for a second surgery. With any -22 modifier, you would need to have an operative note and letter requesting increased reimbursement with the rationale, in this case the extra time and effort for "debulking".

For a laparoscopic appendectomy at the time of another procedure, the coding choice is code 44970 (laparoscopic surgical appendectomy). You will need to append modifier 59 to this code to indicate it is separate and distinct from the other surgery. The operative report documentation should clearly describe the procedure and the reason for performing it. You should also append a distinct ICD code, such as C78.5, secondary malignant neoplasm of the large bowel.

How do I code for a laparoscopic omentectomy done at the time of a laparoscopic BSO and pelvic and para-aortic lymph node dissection for a borderline tumor?

In 2018, the CPT code 38573 (Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling, peritoneal washings, peritoneal biopsy(ies), omentectomy, and diaphragmatic washings, including diaphragmatic and other serosal biopsy(ies), when performed.) was created to address situation where a Gyn Onc is asked to perform staging where another surgeon has performed the laparoscopic BSO ± hysterectomy.

This code specifically excludes hysterectomy codes. If you perform a laparoscopic hysterectomy, BSO, debulking, the proper CPT code would be 58575 (Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking), with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed).

What is the most appropriate way to code laparoscopy with laparoscopic right salpingo-oophorectomy, left ovarian cystectomy, omentectomy and ovarian cancer peritoneal staging biopsies?

Use code 38573 (Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling, peritoneal washings, peritoneal biopsy(ies), omentectomy, and diaphragmatic washings, including diaphragmatic and other serosal biopsy(ies), when performed.) with a -52 modifier if not all of the components were performed. In addition, you can use laparoscopic BSO CPT code 58661 with the -59 modifier for a second surgery

How do you report a radical hysterectomy and bso without nodes; rectosigmoid resection; infragastric omentectomy; and optimal debulking on a patient with ovarian cancer?

The best approach is to report code 58953 (Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking) plus the appropriate colectomy code (e.g., 44145) or other more appropriate code. If there was also a takedown of the splenic flexure, then you would also report code +44139 (Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy). Code +44139 is not subject to multiple procedure reduction since it is an add-on code.

How do you code for a resection of a left ovarian CA; radical dissection and tumor reduction of pelvic tumor involving the rectosigmoid, mesentery and left pelvic retroperitoneal spaces; omentectomy; and pelvic and paraaortic lymphadenectomy on a patient with Stage III malignant germ cell tumor? The uterus and right ovary and tube were preserved.

You can use 58954 (Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy) with modifier 52. The 52 modifier indicates a “reduced service” since the hysterectomy component was not performed. Not all payers recognize modifier 52 so that the full allowable amount may be reimbursed for the procedure. You can choose to decrease your fee as you deem appropriate. The appropriate colectomy code (e.g., 44145) should also be added to this procedure with a 59 modifier for multiple procedures.

How do you code for ovarian cancer staging for early disease? We perform a TAH/BSO, pelvic and para-aortic dissection, omentectomy, and biopsies?

The codes for ovarian cancer procedures are in the 58943-58958 for open procedures. The options for the above would be to code 58951 (Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy). If radical dissection for debulking is done, then you would report code 58954 (Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy). Codes 58953-58956 can be used for cancer at all sites including the uterus. Although the selection of codes for treatment of gyn malignancy is fairly robust, there may be those occasions when the procedure actually performed is varied slightly from the available codes. In these instances, you can consider appending either a 52 (reduced services) or 22 (increased services) modifier to the basic procedure.

What code is best to use for an interval ovarian debulking surgery with TAH-BSO extensive pelvic dissection? There was no omentectomy or lymphadenectomy. Is it best to use 58150-22 (increased procedural services) or 58953? If I used 58953, would it be necessary to put a 52 reduced services modifier on it?

If there was described debulking of peritoneal implants, whether or not they turned out to be viable malignancy, use a debulking code- i.e., 58953. In the context of extensive debulking without omentectomy, it is reasonable to not reduce it with a 52. If there was just lysis of adhesions without debulking, then 58150-22 or 58956-52.

Would 58957 be the appropriate code for "total pelvic peritonectomy, other sites peritonectomy and diaphragmatic stripping" in ovarian cancer surgery?

Those procedures are included as "debulking". 58957 is a code that is used for resection of recurrent gynecologic cancer. If you are doing a primary debulking then you should use 58952-58954 depending on what else is done.

Can I use 49205 for removing a large (>10cm) ovarian mass through a laparotomy incision?

49205 is not to be used in this circumstance. The procedure described is an oophorectomy and the code 58720 is the same regardless of the size of the ovary. If there is excessive work required it should be documented in the operative report and a modifier 22 may be added. The 4920X codes are used when managing masses not involving the uterus, cervix, fallopian tube or ovary.

Is it appropriate to append the 22 modifier to code 58210 when a total omentectomy is performed? Our practice has been unsuccessful in getting additional reimbursement from either Medicare or the commercial payers.

One of the problems lies in the fact that Medicare's CCI bundles an omentectomy into code 58210 and will not allow it to be paid even with a modifier. Therefore, they may not be willing to pay additionally for the omentectomy even though the code does not include a total omentectomy. A number of other payers also use the CCI as part of the claims review process. You might try having the surgeon dictate a general letter indicating the need for the total omentectomy and the work involved including the additional time and risk. The letter should clearly indicate that the procedure is not a partial omentectomy. Another coding alternative might be code 58954 but this includes a debulking and assumes there is intra-abdominal disease.

What is the difference between codes 58950-58952 and codes 58953 and 58954?

The series 58950-58952 can only be used with ICD10 codes for ovarian, tubal or primary peritoneal malignancy. 58953-58954 may be used with any diagnosis. All describe various combinations of procedures commonly performed for advanced gynecologic cancers.

Is code 58720 bundled into code 49203?

Medicare's Correct Coding Initiative (CCI) bundles 58720 into the payment for 49203 and does not allow it to be reported even with a modifier.

Can one report a radical debulking code (58952-58954) when there is no tumor outside the ovary?

No. Debulking codes are designed for when there is tumor outside of the ovary/fallopian tube/endometrium. If there is only staging performed, then the more appropriate codes are 58943 or 58950-58951.

What code is reported when a TAH/BSO/Omentectomy/Staging is performed for LMP or borderline tumor?

Code 58956 includes a TAH/BSO with total omentectomy. If this is the only staging performed, then this would be appropriate. A more likely choice would be code 58951, which includes a TAH/BSO, omentectomy, and P&P nodes.

How do I code for HIPEC for ovarian cancer?

There is no specific CPT code for intraoperative intraperitoneal heated chemotherapy administration. This procedure may be performed at the same surgical session following removal of all gross tumors from the abdominal cavity. Prior to completion of the surgical procedure, a warmed chemotherapy solution is administered directly into

the abdominal cavity, allowed to dwell, and then drained while the patient is under general anesthesia. If the instillation of the hyperthermic chemotherapy solution is a planned, integral part of the surgical procedure, it may be reported with code 96549 (unlisted chemotherapy procedure), or alternatively with modifier -22 on the primary surgical code as the hyperthermic chemotherapy solution administration adds time to the surgical time and requires physician/operating suite staff work above and beyond that of the surgical procedure. CPT code 96446 is intended to report intraperitoneal chemotherapy administered through a permanently placed intraperitoneal catheter so is not appropriate for HIPEC.

POST-OP ISSUES

Can you bill for inpatient and outpatient E/M services provided after surgery if the patient is seen for a post-operative complication such as a wound infection? Is a modifier required?

The CPT global surgical package includes all routine postoperative visits but payment rules vary depending on insurance carrier. The global package for Medicare includes the treatment of all complications managed outside the operating/procedure room. If a complication requires a return to the OR that can be reported with the appropriate surgical code, appending modifier 78 (unplanned procedure during the global period). For non-Medicare payers, you can report any additional E/M services above routine care for services related to the surgery, such as care for wound infections. If visits for conditions unrelated to surgery are provided in the global period, these can be reported by appending modifier 24. Modifier 24 is used for E/M services provided in the global period that are "unrelated" (e.g., a UTI or breast lump) or otherwise not part of routine postop care.

CHEMOTHERAPY

What is the best diagnosis code to use for patients that are seen in the office, by their physician, prior to receiving chemotherapy at the hospital outpatient center? Is it correct to use Z51.11 with their E/M code when seen in the office?

The ICD-10 code for an evaluation prior to chemotherapy is Z01.818 (encounter for examinations prior to antineoplastic chemotherapy). Z51.11 is attached to the billing for the administration of chemotherapy so would not be used by the provider when the patient is going to a hospital-owned infusion center.

How do I bill for an office visit on the day of chemotherapy? What if the patient is still in the global period after surgery?

Office visits on the day of chemo should be reported using the appropriate E/M code (usually 99214-99215) with modifier -24 if during the global period. To indicate the reason for the visit use code Z01.818 (encounter for other preprocedural examination including encounter for examinations prior to antineoplastic chemotherapy), as well as codes for the primary cancer and sites of metastatic disease. If you are also going to be reporting the chemotherapy administration you can add Z51.11 (encounter for chemotherapy) and modifier -25 (E/M visit on day of procedure - the chemo administration is the procedure).

Can a gyn oncologist bill for chemotherapy counseling if that counseling falls within the global period following a surgical procedure?

Yes. Use the relevant E/M code with the 24 modifier for distinct E/M service during the global period. Also, you must use an ICD-10 code for counseling, such as Z71.89 (other specific counseling).

How do you bill for intraperitoneal (IP) chemotherapy?

96446 refers to chemotherapy administration into the peritoneal cavity via indwelling port or catheter. It is not time based. This single code covers all infusions into the peritoneal cavity for that day and does not include peritoneocentesis.

What ICD code do you use for laboratory testing done on a day prior to chemotherapy administration?

You should always report the ICD code that most accurately reflects the reason for the service being provided. In your example, that would be the most specific code for the disease or the presenting sign or symptom. For example, if the patient has a neutropenia, D70.1 would be reported followed by the cancer diagnosis. In the absence of a sign or symptom, then the cancer diagnosis should be primary.

What code should be used to bill a port flush by a nurse in the absence of any other service?

If the patient is seen only for a port flush, code 96523 should be used. If you use a de-clotting or thrombolytic agent, you should use code 36550. Also remember to use the J-code for the specific thrombolytic agent used. The diagnosis code should be the patient's primary cancer and Z45.2 (encounter for adjustment and management of vascular access device).

When administering chemotherapy in an office setting, what are the requirements for the presence of the billing physician?

The billing provider must be "in the suite" as per Medicare rules. The interpretation of "in the suite" can vary, but should generally mean under the same roof and immediately available if needed. For example, the provider could be seeing patients in the same office suite where chemo is being administered, but could not be performing surgery in one part of an outpatient facility while supervising chemo in another part of the facility.

Is it sufficient for a Physician Assistant to be onsite in a clinic during a chemo infusion, or must a physician be physically onsite?

Non-physician providers can supervise chemo administration if allowed under state law and the insurance carrier rules for supervision. Rules may differ for NP's and PA's.

The physicians are currently on the hospital floor when the chemo is being administered by the nursing staff at the hospital and want to start billing for chemo administration. I was asked to look into billing and I have not been able to find anything that would allow us to bill at a hospital if the nursing staff is employed by a different employer than the providers. Can you please clarify under what conditions providers can bill for chemo in a hospital setting?

Chemo administration codes require that the staff are your employees and are giving the chemo in your facility. If the doctor sees the patient at the hospital on the day of the chemo, they could bill the appropriate E&M code but could not bill for the administration (i.e., 96365-96379 or 96401-96549). Chemotherapy administration codes reimburse primarily for the overhead/personnel costs of the infusion center. You can only bill for chemotherapy administration if you own the facility. If it is a hospital–based infusion center, you cannot collect for chemo administration. However, the amount of physician work associated with most chemo admin codes is only about 0.5 RVUs. You can charge for E&M codes if they are separately identifiable services. You then must document what was done and show medical justification for the visit. It should not be duplicative of clinic visits.

OFFICE EVALUATION & MANAGEMENT NOTE QUESTIONS

Can the nurse or office staff document the History of Present Illness (HPI)?

The Documentation Guidelines for Evaluation and Management Services state that the Review of Systems (ROS) and the Past, Family, Social History (PFSH) can be recorded by ancillary staff or on a form completed by the patient. It does not specifically indicate that the History of Present Illness (HPI) can be recorded by staff. It is generally felt that the content of the HPI requires the expertise of a physician or Qualified Healthcare Provider (QHP) to appropriately address the patient's presenting problem. If the physician is noting changes, additions, or agreement with the HPI then this may be seen as adequate in the event of a payer audit. The physician should be encouraged to make the necessary additions or changes as he/she interviews the patient.

How long can you use the cancer diagnosis (C56.1-9) for a patient once they have completed treatment?
Historically the primary cancer codes were used until the patient had been in remission for 5 years. However recent guidelines state that when the primary has been previously excised or eradicated from its site, there is no further treatment directed to that site, and there is no evidence of any existing primary malignancy at that site, it is appropriate to use the personal history code. Both are recognized for patients who are on surveillance. For patients on treatment, including maintenance, the primary cancer code should be used.

When deciding on the level of Medical Decision-Making complexity, can the MDM be a high level if the physician discusses high risk surgery with many other options but the patient declines the surgery?
Yes, you would code it as if the surgery was elected. The point is not what the patient ultimately decided, but the work done by the physician. Of course, the option for surgery (and thus need for counseling) must be medically appropriate. The medical decision was performed and the patient made a decision based on it.

Do we need to add the acquired absence of organ (Z90.710) to each visit?
It is not necessary on a routine basis unless it is clinically relevant to a particular encounter.

How do I code a cancer patient visit who comes once a year after treatment for surveillance? Is it a "Well Woman visit "or is it a "Follow-up "visit?
If a patient has a history of cancer you could bill an E&M visit using the appropriate ICD-10 codes for the personal history of cancer (for example Z85.41 for cervix) and for medical surveillance following completed treatment Z08. Some carriers will cover E&M visits but not well woman visits or vice versa.

CMS and Medicare guidelines allow for an Annual Wellness Visit once a year (G0438 initial and G0439 established) but only allow a "Cervical or vaginal cancer screening; pelvic and clinical breast examination" (G0101) every 2 years for most women. These are CPT billing codes used instead of an E&M code for the visit. They are reported with an ICD-10 for general gynecology visit (Z01.419). More information may be found on the ACOG and CMS websites.

EXTENT, BOWEL OR PLASTIC

How do you code for placement of a matrix or some protective covering in the pelvis during a pelvic exenteration?
Placement of matrix material in the pelvis to prevent bowel obstruction would be considered an inherent part of the procedure, and should not be billed separately. Therefore, you should report only code 58240 for the pelvic exenteration. An exception would be placement of an omental pedicle j-flap in the pelvis which is CPT code 49905+ and is an add on code to the primary procedure code of the pelvic exenteration.

Would it be appropriate to code construction of the vagina (57292) with pelvic exenteration (58240) or is the construction of the vagina bundled into the exenteration code?
Vaginal reconstruction with a skin graft is not included in the pelvic exenteration code (58240) and can be coded separately with CPT 57292. If muscle, myocutaneous, or fasciocutaneous tissue is used to reconstruct the vagina, then CPT code 15734 should be used.

How would you code a total pelvic exenteration if a colorectal surgeon performs the colon resection?
The CPT code for total pelvic exenteration is 58240. Colon resection and reanastomosis (44140) is bundled into the TPE code, so you cannot bill both together. The best way to code this is as co-surgeons. To do that both you and the colorectal surgeon bill 58240-62.

How do you code for a Hartmann procedure done in conjunction with a radical hysterectomy?
The Hartmann procedure is reported with code 44143. The 51 modifier (multiple procedure) should be appended to code 44143 as it has fewer RVUs than the radical hysterectomy (58210).

How do you code for an ileo-jejunal bypass anastamosis and drainage of small bowel fistula with malecot drain?

When you perform an internal bypass, the best CPT code would be 44130, enteroenterostomy with or without cutaneous enterostomy. The fistula drainage with placement of a drain would not be separately reported as it would be considered part of the primary procedure.

Can you code for an appendectomy if the reason it is being taken is to avoid possible appendiceal mucinous lesions?

Incidental appendectomy cannot be billed separately at the time of another intra-abdominal surgery. However, if there is disease of the appendix (i.e., tumor metastatic to the appendix or involvement with endometriosis), appendectomy maybe performed and billed with CPT +44955. This code is an add-on code to the primary procedure performed.

How should you code for an ileotransverse entero-colostomy without a bowel resection?

When you perform an internal bypass, the best CPT code would be 44130, enteroenterostomy with or without cutaneous enterostomy.

RADIATION

How do you code for the insertion of a Smit/cervical sleeve?

There is no code for Smit sleeve insertion. The most appropriate way to code this procedure is to use the 57155 (insertion of tandem and ovoids) code with a -52 modifier to reflect reduced work for the procedure

How do you code for placement of Heyman's capsules?

Report code 58346 (Insertion of Heyman capsules for clinical brachytherapy).

How do you code for placement of tandem/ovoids for brachytherapy?

Gyn oncologists should use code 57155 (insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy). Use modifier 76 (repeat procedure by the same physician) for subsequent treatments. Radiation oncologists will bill for insertion of radioactive elements using separate codes.

How do you bill for insertion of vaginal applicator device in High Dose Rate (HDR) brachytherapy?

Code 57156: insertion of a vaginal after-loading apparatus for clinical brachytherapy

How does one bill for placement of fiducial markers/seed markers at the time of placement of a cervical/Smit sleeve for brachytherapy?

Use 57800, add -22 modifier. This will require a copy of the procedure note to obtain additional reimbursement.

Is there a laparoscopic code for the open procedure code 58825 (Transposition, ovary(s))?

There is no corresponding laparoscopic code to 58825. You can report code 58679 (unlisted laparoscopy procedure, oviduct, ovary). If an unlisted procedure code is reported, the claim should be filed manually (paper claim) with a copy of the operative note and a brief explanation of the procedure and reason for the unlisted code. Alternatively, you might report code 58660 (Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure) to justify any manipulation of the ovary. The lysis of adhesions must be well documented. As a point of information, the RVUs for codes 58825 and 58860 are very similar.

CERVICAL CANCER OR EUA

How do you code for a radical parametrectomy?
Use a code for partial/total vaginectomy with removal of paravaginal tissue with or without nodes (codes 57107-57112)

How should you code for EUA/cystoscopy/proctoscopy for staging of cervical cancer?
EUA-57410. Cystoscopy (52000) and proctoscopy (45300) have separate procedure codes and are frequently not reimbursed when used with 57410 for a diagnosis of cervical cancer. However, if there is a separate diagnosis specific for cystoscopy or proctoscopy, (hematuria, melena, dysuria, constipation) you may use code(s) 52000 and/or 45300 linked with code 57410 using the 59 modifier.

What code do you use to charge for a Trucut needle biopsy of the pelvic soft tissue performed along with an exam under anesthesia?
Report code 20206 (Deep biopsy using percutaneous needle).

How do I code a robotic parametrectomy with lymph node dissection?
Use laparoscopic radical hysterectomy code (58548) with a -52 modifier for reduced work. You will have to provide documentation to explain.

How do you code for a radical abdominal hysterectomy and an ovarian suspension?
You should report code 58210 (Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)) and 58825 (Transposition, ovary(s)).

How do you code for a radical hysterectomy when there was not a node dissection performed because the patient had pre-op radiation?
Report code 58210 with the reduced service modifier 52.

How do you code for a laparoscopic (robotic assisted) trachelectomy, BSO, and lymphadenectomy?
58548 with a reduced services modifier -52.

How would you code sentinel LN injection, mapping and resection with laparoscopic radical hysterectomy? 58548 includes PPA LND
55848 -52 reduced services if only the sentinel nodes were removed 38900 -50 intraoperative injection of dye for sentinel node identification. (Use modifier 50 for bilateral injections)

GENETICS

Can you use a *BRCA-1* mutation as a diagnosis?
There is no specific code for *BRCA-1* mutations. You can use genetic susceptibility codes such as: V84.01-genetic susceptibility to breast cancer or V84.02-genetic susceptibility to ovarian cancer

Can one code for genetic assessment? What ICD10 codes can you use for genetic counselling?
You can use other specified counseling Z71.89, encounter for nonprocreative genetic counseling Z71.83, and the family history code if applicable (e.g., family history of ovarian cancer Z80.41).

ENDOMETRIAL CANCER

What is the code for laparoscopic or robotic endometrial cancer surgery with hysterectomy and BSO with pelvic and para-aortic lymphadenectomy?

You would code the hysterectomy (58571 or 58573) and lymph nodes separately (38572-51) If the uterus was > 250gm then 58573 should be used, and laparoscopic pelvic lymph node resection only is 38571, and with para-aortic nodes is 38572.

Sentinel node mapping would use 38900 -50 for bilateral injection of dye and 38570 for node biopsy. If full node dissection needs to be done because of non-mapping or some other reason you can still bill the 38900-50 if the injection was done

How do you code for a laparotomy with pelvic and para-aortic lymphadenectomy and omentectomy for endometrial cancer when a TAH/BSO was done by the Ob/Gyn?

When 2 surgeons perform procedures that are all included in one code, they should both use that code and split as co-surgeons. In this case each would bill 58210 for TAHBSO with pelvic and para-aortic lymphadenectomy with modifier 62 for 2 surgeons. Omentectomy without pathology is generally not reimbursed.

What is the correct way to code a TAH/BSO with omentectomy and full staging for a diagnosis of papillary serous endometrial carcinoma?

If there is no gross metastatic disease then use 58210 for TAHBSO, pelvic and paraaortic nodes. Omentectomy without metastatic disease is generally not reimbursed. If there is gross disease in the omentum then could bill 59854 (TAHBSO, pelvic and paraaortic nodes, omentectomy and debulking) as this code is for any malignancy.

How do you code for IUD placement for endometrial hyperplasia or cancer?

58300 is the CPT. The ICD10 code is Z30.430. The patient's diagnosis code may or may not make a difference to the insurer since this is an off-label use. If they are reproductive age you could present this also as contraception device.

How do you code for laparoscopic/robotic sentinel lymph node biopsy(ies) in endometrial and cervical carcinoma?

The code depends on dye injected. For non-radioactive dye use 38900, with modifier 50 if bilateral mapping is performed. In addition, bill the appropriate laparoscopic lymph node sampling or lymphadenectomy code depending on the extent and location of the dissection. If lymph node dissection is done because of non-mapping or other indications such as lymph adenectomy then the 38900-50 can still be billed with the lymphadenectomy codes.

How do you determine the difference between node sampling, biopsy, dissection and lymphadenectomy?

"Node dissection" and "lymphadenectomy" are often used interchangeably and usually this means that the entire nodal bundles are removed rather than a few isolated nodes. Remember not to unbundle; if nodes are removed at the time of open hysterectomy they will be coded together. The following apply when the node procedures are not already bundled into the code:

For open procedures, options are:

38562 Limited lymphadenectomy for staging; pelvic and para-aortic. This would be appropriate for a situation in which only a few selected nodes were removed without performing a full lymphadenectomy. i.e., sentinel lymph node(s) or isolated enlarged lymph nodes.

38770 Pelvic lymphadenectomy including external iliac and obturator nodes. If bilateral use modifier 50.

38780 Retroperitoneal lymphadenectomy, extensive. Includes pelvic and paraaortic and infrarenal nodes

For laparoscopic procedures:

38570 Retroperitoneal lymph node sampling. (This would apply to a situation where only a few isolated nodes are removed. i.e., sentinel lymph node(s) or isolated enlarged node(s)

38571 Total pelvic lymphadenectomy

38572 Total pelvic lymphadenectomy with paraaortic node sampling

What code would you report for the removal of 2 large pelvic nodes at the time of a TAH/BSO on a patient with post-menopausal bleeding? The nodes were benign.

58200 is the code for TAHBSO with PA and Pelvic node sampling. The number of nodes and pathology report do not impact the use of this code.

Is CPT 38900 still a billable service for the work performed when there are no sentinel nodes identified for biopsy? The patient had a total laparoscopic hysterectomy, bilateral salpingo-oorphorectomy in addition for endometrioid endometrial adenocarcinoma.

Lymph node mapping (38900) must be added on to a code for removal of nodes, whether sentinel nodes or full lymphadenectomy. If no nodes are removed then 38900 may not be billed.

Is there a certain percentage of myometrial invasion of endometrial cancer that would warrant the use of C54.8 as opposed to C54.1 endometrial cancer? If we have ovarian cancer of the same type in both ovaries, should we use C56.1 along with C56.2 or should we use a single code such as C57.8?

Code for primary site of origin: if it is an endometrial cancer with myometrial invasion the site of origin is the endometrium (C54.1). If there are metastases to the ovaries use the code for secondary malignancy of the ovaries C79.60. If one or both ovaries contain a separate primary then use the primary ovarian cancer codes for right ovarian cancer (C56.1), left ovarian cancer (C56.2) or both if bilateral.

VULVA

How do you code for bilateral inguinal sentinel lymph node removal performed at the time of radical vulvectomy?

Billing depends on the dye that was injected and the procedures performed. The identification of the sentinel nodes with non-radioactive dye is reported using code 38900 (Intraoperative identification (e.g., mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed) with the 50 modifier for bilateral procedures. If the mapping is successful then use 38531 (biopsy/excision of inguinofemoral node(s) with modifier 50 if bilateral, as well as the code for complete (56633) or partial (56630) radical vulvectomy. If lymphadenectomy is required, then you can still use the mapping code (38900-50) but you should use the code that bundles radical vulvectomy with unilateral or bilateral lymphadenectomy (see codes 56631 - 56637).

How do you code for a partial urethrectomy done en bloc with a radical vulvectomy for vulvar cancer?

It would be reasonable to report code 53210 (Urethrectomy, total, including cystostomy; female) for the partial urethrectomy with the reduced services modifier 52. Code 53210 is not bundled into the vulvectomy codes (CPT 56620-56625 for simple vulvectomy, 56630-56637 for radical vulvectomy). If partial vaginectomy was performed add the appropriate code from 57106-57111.

How do you code for a skinning vulvectomy? Is it better to report code 56620 or a code from the integumentary section of CPT?

In general, it is better to be more specific for coding purposes. Codes 56620 and 56625 are specifically meant for vulvar procedures and should be used instead of integumentary codes. The 80% rule applies. If you remove >80% of the total vulva, it is considered “Vulvectomy, simple complete” (56625). If <80% is removed, it is considered “Vulvectomy, simple partial (56620). Skin graft codes (CPT 14xxx-15xxx) can be billed in addition to vulvectomy codes if performed.

What is the most appropriate code for extramammary vulvar Paget's disease?

D07.1 is the ICD 10 code for vulvar carcinoma in situ. The code does not specify the histologic type (squamous vs adeno). This is the most appropriate code for vulvar Paget's disease i.e., adenocarcinoma in situ of the vulva. If there is invasion then the appropriate codes would be from the C51 series (Vulvar carcinoma, again without distinction for histologic subtype). There are 5 codes to choose from depending on the anatomic location of the primary tumor.

What is the code for scalpel excision and cauterization of a 2 cm condyloma growing out of the distal urethra?

You should report a code from the 11420-6 f=group (Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia;). Code selection is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margins required equals the excised diameter). For a 2 cm lesion the excised diameter is likely to be greater than 2 cm and so would most likely be code 11423 (excised diameter 2.1 to 3.0 cm).

Nuclear medicine injects the vulva preop with technetium sulfur colloid. A lymphoscintigram is done. They bill for both the injection and the imaging. The patient comes up to the OR. I inject the vulvar malignancy with blue dye -4 subdermal injections at 12,3,6,9. I have been using 38900. Can I bill for 4 injections or just one?

38900 is the CPT code for "intraoperative identification (e.g., mapping) of sentinel node(s) includes injection of non-radioactive dye, when performed. This means it can be billed twice using the -50 modifier if both right and left groin sentinel nodes are mapped. The code is not solely for the intratumoral injection, but for the mapping as well.

MIS SURGERY SPECIFIC

Is it permissible to report an open procedure code when there is not a corresponding laparoscopic code?

CPT guidelines indicate that it is not appropriate to report an open procedure code for a procedure performed laparoscopically. An unlisted code be reported when there is not a specific CPT code for the service provided. You will need to send in a special report or cover letter as well as the operative report to describe the need for the unlisted code.

Could you comment on the use of the S2900 code as an additional code for robotic surgery?

The "S" codes are HCPSC codes created by CMS and not CPT codes developed by the AMA. The recognition and utilization of these codes vary according to the payer. You would report code S2900 as a secondary code when you perform a surgery using robotics if required by your payers. It is not necessary to append a modifier. You should apply some incremental charge to the code for the work associated with the robotic approach that is different from the basic surgery you report. Reimbursement will vary by payer. CMS has made the decision not to have a modifier or specific codes for robotic surgery thereby restricting any additional payment for this technique.

Regarding billing for a gelport robotic assisted salpingo-oophorectomy; as this type of equipment requires a larger incision than other types of laparoscopy, can this procedure be billed as "open" vs "laparoscopic" CPT code?

The distinction between "open" and "laparoscopic" or "robotic" surgery is by what method the major portions of the procedure are done. In this case, if the adnexa is detached by robotic surgery but then an incision made to remove the specimen, the surgery is still "robotic". The op-report should dictate the billing. Robotics is not billed any different than laparoscopy. Based on the fact that a robotic USO was done, it is recommended to submit a 58661 with a 22 modifier and submit the op report with it. It is not recommended to code this as an open procedure.

What code should be used to report a vaginal incision or episiotomy to deliver the uterus during laparoscopic/robotic hysterectomy?

This is bundled into the procedure and not separately billable, however you can add modifier -22 for increased work. Be sure to document the increased work in your operative note.

Is the 22-modifier appropriate if you convert from a laparoscopic to an open procedure with diagnosis code V64.41 (Laparoscopic surgical procedure converted to open procedure)? Does the operative report need to indicate additional time or just state that the procedure was converted?

No, you would only bill for the open procedure code. The 22 modifier is appended when the work to perform the procedure was substantially greater than that typically required. The conversion from laparoscopic to an open procedure might be an instance in which the 22 modifier is appended, but the documentation will need to reflect "substantial" additional work as specified in CPT. CPT also states that the reason for the additional work such be documented. It lists increased intensity, time, technical difficulty, severity of patient's condition, and physical and mental effort as reasons for additional work. (See modifier 22 descriptor in Appendix A). The note does not specifically need to indicate additional time if any of the above reasons for the additional work is documented.

What is the difference between codes 58552 (Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)) and 58571 (Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s))?

Codes 58550-58554 describe laparoscopically assisted vaginal hysterectomy which includes a laparoscopic detachment of ovarian vessels and skeletonization of the uterine attachments prior to performing the remainder of the surgery vaginally (colpotomy, division of parametria, closure of cuff). Codes 58570-58573 describe services in which the entire procedure is performed laparoscopically with or without robotics. In all of these procedures the specimen is removed via the vagina. The site of specimen delivery does not determine the code used.

Can you report a cystoscopy at the time of a pelvic procedure to make sure there is no injury to the ureters?

A cystoscopy performed routinely at the time of a surgical procedure is not separately reportable. When procedures are done to "check" one's work, it is considered inherent in the procedure. If there is a separate indication, the ICD code can be appended to support a clinical need for the service, for example the presence of hematuria.

We have a provider that has started performing ureterolysis for retroperitoneal fibrosis. We know that CPT code 50715 is specific for this procedure/diagnosis our physician is performing the procedure laparoscopically and not open. Would you suggest reporting the ureterolysis with an unlisted or appending modifier 22 to the "main" laparoscopic procedure code?

CPT 50715 (ureterolysis for retroperitoneal fibrosis) describes an open procedure performed for a distinct diagnosis that's also known as Ormond's disease. The disease is characterized by excess fibrous tissue that develops in the retroperitoneal space behind the stomach and intestine. It is not meant to be used for ureterolysis performed due to post-inflammatory changes or postoperative adhesions. There is no analogous code for a laparoscopic approach and you should append modifier -22 to the main laparoscopic procedure. The increased work required should be clearly documented and quantified in the operative note.

Is there any decent code for the Robotic resection of presacral mass?

49215 is a laparotomy code for excision of a presacral mass. There is no corresponding laparoscopic code. Options include 49321 (laparoscopy with biopsy) and a 22 modifier with explanation of the extra work involved OR use of the unlisted code 49329 (unlisted laparoscopic procedure abdomen, peritoneum, omentum) with a letter recommending 49215 as the code most closely describing your procedure.

Is it appropriate to code 49321 when an omental biopsy is done during a laparoscopic hysterectomy, such as 58571?

If the omentum is removed without pathology it is generally not reimbursed. However, a biopsy of the omentum could be separately captured as CPT 49321 with modifier 59 if it was performed for a distinct diagnosis such as metastatic disease. The -59 modifier and separate diagnosis are required since 58571 and 49321 are bundled and trying to code both without it will run afoul of the CCI edits.

OB OR BACKUP MYOMA SURGICAL ASSIST

Is it possible to bill for 99360 as "backup" for surgeries?

When standby care is requested, both the requesting physician and providing physician must document the need for standby care. The standby doctor must not provide care to other patients during the standby period. This code is not used to report time spent proctoring another individual. It is also not used if the period of standby ends with the performance of a procedure subject to a surgical package by the individual who was on standby. This may not be reimbursed by carriers. Documentation such as noted below might be useful.

I was requested by [DOCTOR'S NAME] to be on standby for [PROCEDURE/INDICATION] performed on [PATIENT'S NAME] on [DATE]. I arrived at the operating room at [ARRIVAL TIME] and departed at [DEPARTURE TIME]. –

The patient was very adamant about not having a hysterectomy so our provider reconstructed the uterus and with the multiple myomas the surgery took 5 hours. Is there a code to reflect the additional time?

When a case exceeds the usual time/effort, the op note should reflect that and modifier 22 should be used. Case times vary, and there is not a code to denote "extra-long operative time". When using the 22 modifier, it is important to document fully why the work that was done above and beyond the normal scope. Simply stating it took longer will not justify additional payment.

Am I able to code 58558 and 58561 together or are these CPT codes bundled? The physician performed the D&C as well as polyp removal and hysteroscopic resection of myoma.

According to CCI these are bundled codes and may not be billed together. 58558: (Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D&C) is included when performed with 58561: (Laparoscopic/Hysteroscopic Procedures on the Corpus Uteri). A 59 modifier will not break the bundling. When a major surgery is performed laparoscopically/ endoscopically the minor procedure in that same site with the same entry and in the same session is considered an integral part of that major procedure and is not separately billable.

Is there specific documentation required in the op note to allow a nurse practitioner to bill for first assisting in the OR?

Surgeon should document assistant in the operative report. Assistant does not need to sign the operative report. For an assistant to bill in a teaching hospital it must be documented that no qualified resident was available or what exceptional medical circumstances existed to require the assistant. The assistant needs to bill the same surgical code as the surgeon, with either modifier -80 (Assistant Surgeon) or modifier AS (PA, NP or Clinical Nurse Specialist assistant in OR). Check with your regional carriers to determine which modifiers they recognize.

Society of Gynecologic Oncology

MISSION

To promote and ensure the highest quality of comprehensive clinical care through excellence in education and research in gynecologic cancers.

VISION

To eradicate gynecologic cancers.

SGO.ORG