

# Complex Laparoscopic Surgery for Severe Endometriosis

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**Guidance for clinical coders**

**April 2015**

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## Introduction

The British Society for Gynaecological Endoscopy (BSGE) accredited Endometriosis Centres are at the forefront of providing complex surgery for patients with severe endometriosis; defined as deeply infiltrating endometriosis or recto-vaginal endometriosis.

The BSGE is committed to collecting complete data, including quality of life data, to establish the outcome of surgery and publish robust evidence for patients and doctors. It is therefore crucial that the patient's condition and treatment are recorded and coded accurately to yield complete and comparable data to support the management and monitoring of services and to demonstrate the benefits to patients, clinicians, policy makers and the wider public.

This clinical coding guidance is the result of collaborative work between the BSGE and the Health and Social Care Information Centre (HSCIC) – Clinical Classifications Service responsible for national clinical coding standards.

## Purpose

This guidance has been prepared for clinical coders to support accurate clinical coding of complex laparoscopic surgery for severe endometriosis undertaken in accredited Endometriosis Centres to ensure high quality and comparable coded information.

**The guidance is compliant with, and does not replace, the clinical coding standards provided by the Clinical Classifications Service and as documented in the following reference books:**

National Clinical Coding Standards – ICD-10

National Clinical Coding Standards – OPCS-4

## Background

### British Society for Gynaecological Endoscopy

The BSGE (<http://www.bsge.org.uk/index.php>) exists to improve standards, promote training and encourage the exchange of information in minimal access surgery techniques for women with gynaecological problems.

Whilst minor or moderate endometriosis can be managed in all gynaecology departments, laparoscopic surgery for deeply infiltrating endometriosis and recto-vaginal endometriosis is considered to be a specialist service due to its complexity and higher risk of morbidity. The BSGE established criteria for centres carrying out such work and accredits departments that reach its standards.

Commissioners of healthcare in England have designated the surgical treatment for severe endometriosis a specialist service. It is commissioned by the specialist commissioners rather than local commissioning consortia.

NHS England have published the specification for the service and endorsed the BSGE Endometriosis Centre model and only plan to commission services from centres that meet the BSGE accreditation criteria. See specification at <http://www.england.nhs.uk/wp-content/uploads/2014/04/e10-comp-gynae-endom-0414.pdf>

## Clinical Classifications Service

The HSCIC Clinical Classifications Service is responsible for the clinical classifications – ICD-10<sup>1</sup> and OPCS-4<sup>2</sup> - release and associated support and products.

The service is the definitive source of clinical coding standards and guidance for clinical classifications ICD-10 and OPCS-4.

The HSCIC is the designated UK World Health Organisation – Family of International Classifications (WHO-FIC) Collaborating Centre.

<http://systems.hscic.gov.uk/data/clinicalcoding>

## Generic Medical Record Keeping Standards

Complete and accurate medical records are important because they are the primary source of information for all healthcare professionals and form the basis of a discharge summary to inform the patient's GP of the diagnosis and treatment provided in hospital. The medical record is used by a clinical coder to extract and translate the complaint, diagnosis and treatment into classification codes.

The clinical coder is dependent on all relevant clinical information being available in the medical record and attributed to the relevant consultant episode at the time of coding. National clinical coding standards cannot provide direction to compensate for deficiencies in the source documentation. We encourage close two way collaboration between clinical coders and clinicians; this ensures that coders have accurate information with which to code, and that clinicians can have confidence in the quality of their coded data.

Information about generic medical record keeping standards can be found at:

<https://www.rcplondon.ac.uk/projects/healthcare-record-standards>

## Comorbidities

Any relevant comorbidity that co-exists at the time of the consultant episode or develops during the hospital provider spell must be recorded in the medical record by the responsible consultant to enable coding of that information.

For the purposes of coding, co-morbidity is defined as:

- any condition which co-exists in conjunction with another disease(s) that is currently being treated at the time of admission or develops subsequently and,
- that affects the management of the patient's current consultant episode

Conditions that relate to an earlier episode but do not have a bearing on the current episode should not be coded.

## Clinical Coding Standards

The final selection of codes is dependent on the information provided in the medical record and compliance with classification rules, such as sequencing, and coding standards.

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<sup>1</sup> World Health Organisation - International Statistical Classification of Diseases and Health Related Problems – Tenth Revision (ICD-10)

<sup>2</sup> UK - OPCS Classification of Interventions and Procedures (OPCS-4)

Clinical coders follow the 4 step coding process which is key to the correct use of the classifications alphabetical index and tabular list and accurate coding of the diagnosis or intervention.

The Appendix - Clinical Coding Standards highlights pertinent standards (correct at the time of publication) that should be referenced by the clinical coder.

The procedures detailed in this document may be performed in combination. Sequencing of the codes assigned would be dependent upon the main procedure performed.

## Endometriosis

Endometriosis is a condition where endometrial tissue is found in locations in the body other than within the uterus. Endometriotic tissue may be located on the surface of organs and on the peritoneum. It may infiltrate deeper into the structures or may form cysts within the ovaries.

Endometriotic tissue is responsive to hormonal changes and may cause pain during menstruation, leading to inflammation and scarring. The scarring can cause adhesions, distorting normal anatomy, causing pelvic pain, pain during bowel movement and during sexual intercourse, as well as potentially leading to difficulty in becoming pregnant.

<http://www.nhs.uk/Conditions/Endometriosis/Pages/Introduction.aspx>

## Surgical Treatment for Severe Endometriosis

All women with severe endometriosis who require surgery will have a nationally standardised treatment pathway to provide patient centred specialist care, improving their quality of life.

The aim of the surgical treatment is to remove all endometriosis and relieve symptoms of the disease, whilst incurring the lowest possible morbidity.

Admission can be arranged according to local protocols but usually on the day of surgery. However, some patients will require surgery in two stages 12 weeks apart. In this case:

- Stage 1 is to drain adherent endometriomas and where appropriate strip out the cyst lining, followed by treatment with Gonadotrophin Releasing Hormone agonist medication lasting 12 weeks.
- Stage 2 is to remove all adhesions and excise the endometriosis.

The specific complex laparoscopic surgical procedures which will be undertaken within an Endometriosis Centre include:

- First stage drainage and stripping of endometriomas and staging of endometriosis
- Laparoscopic excision of pelvic sidewall endometriosis
- laparoscopic excision of recto-vaginal endometriosis
- laparoscopic excision of recto-vaginal endometriosis + skinning of rectal surface
- laparoscopic excision of recto-vaginal endometriosis + disc resection of bowel
- laparoscopic excision of recto-vaginal endometriosis + low anterior resection
- laparoscopic excision of recto-vaginal endometriosis + low anterior resection + ileostomy
- laparoscopic excision of recto-vaginal endometriosis + low anterior resection + colostomy

- laparoscopic excision of ureteric endometriosis +/- Ureteric re-implantation/re-anastomosis
- laparoscopic partial bladder cystectomy for endometriosis
- Laparoscopic excision of diaphragmatic endometriosis
- Laparoscopic excision of other bowel endometriosis

## Deeply infiltrating endometriosis

This can occur in a variety of sites such as bladder, pelvic sidewalls, ovaries, pelvic brim, bowel surface and diaphragm.

### Bladder

Endometriosis may occur either superficially on the surface of the bladder, or within the bladder. The freeing of adhesions between the bladder and other intraabdominal organs is coded according to how it is described by the responsible consultant. Freeing of adhesions to the bladder may involve excision of endometriosis from the bladder, or even partial cystectomy.

Nodules on the exterior surface of the bladder may be destroyed or excised. Endometriosis that has infiltrated the bladder may necessitate opening of the bladder.

Care must be taken when coding procedures performed upon the bladder using minimal access techniques. Specific categories exist within the OPCS-4.7 classification to classify cystoscopic procedures upon the bladder (for example **M42 Endoscopic extirpation of lesion of bladder**). In contrast, a procedure performed laparoscopically upon the bladder should be coded using the code classifying the open procedure, followed by a code from category **Y75** to classify the minimal access approach (see **PGCS1: Endoscopic and minimal access operations that do not have a specific code**).

### Ovaries

Laparoscopic adnexal surgery is minimally invasive procedure performed on the ovary, fallopian tube, or ovarian cysts.

Endometriosis may infiltrate the ovaries and form an endometrioma. This term does not have an entry in the ICD-10 Alphabetical Index (Vol. 3); however, the BSGE has confirmed that within the United Kingdom the term endometrioma refers to endometriosis of the ovary. This condition is coded to ICD-10: **N80.1 Endometriosis of ovary**.

As the ovaries are paired organs, a code from OPCS-4.7 category **Z94 Laterality of operation** must be also be assigned following a code (classifying the intervention) where this information is available (see **PCSZ2: Laterality of operation (Z94)**).

### Bowel

#### Disc resection

Disc resection of the bowel involves removal of the endometriotic nodule infiltrating the bowel, followed by excision of a full thickness disc of tissue; this opening is then repaired. The procedure is a less invasive alternative to segmental resection (see section **Segmental bowel resection**).

Code disc resection to excision of a lesion of the section of the intestine upon which the disc resection was performed followed by **Y75.2 Laparoscopic approach to abdominal cavity NEC** where applicable (see **PGCS1: Endoscopic and minimal access operations that do not have a specific code**).

## Segmental bowel resection

Segmental resection of the bowel is the most invasive procedure performed for endometriosis of the bowel. This procedure will commonly be performed in conjunction with a colorectal surgeon.

Segmental bowel resection is coded according to the segment of bowel resected. In addition, coders need to be aware of whether an anastomosis was performed and if so, how; see also sections **With or Without Ileostomy** and **With or Without Colostomy**.

## Peritoneum

Endometriosis may be found anywhere within the peritoneum. It can range from isolated spots, which may be ablated, to large endometriotic nodules requiring excision and potentially involving other organs which may also need treatment.

Accurate coding of procedures involving the peritoneum is dependent on the responsible consultant recording the site(s) of the endometriosis and the procedure(s) performed upon the organ(s)/structure(s).

The pouch of Douglas (POD) is the most distal part of the peritoneum and is a common site of endometriosis. Procedures upon the POD are classified at OPCS-4.7 category **P31 Operations on pouch of Douglas** rather than within Chapter T Soft Tissue.

When coding laparoscopic destruction of a lesion of the peritoneum, the OPCS-4.7 code **T42.2 Endoscopic destruction of lesion of peritoneum** is assigned; an additional code from Chapter Y Subsidiary Classification of Methods of Operation may be further assigned to specify the method of destruction used.

Laparoscopic treatment of endometriosis may be preceded by examination of the abdomen and its contents. Care must be taken when coding these procedures; if a therapeutic procedure was performed upon a single organ, e.g. the uterus, and at the same time a full diagnostic laparoscopy was performed it would still be appropriate to assign the code **T43.9 Unspecified diagnostic endoscopic examination of peritoneum** in addition to the code for the therapeutic procedure, to classify that a full diagnostic laparoscopic examination was performed.

## Recto-vaginal endometriosis

This involves the recto-vaginal septum area: recto-vaginal septum, vagina, uterosacral ligaments and rectum.

### Recto-vaginal septum

The recto-vaginal septum may be affected by endometriosis. Treatment may involve adhesiolysis and excision of scar tissue, destruction of either vaginal or rectal lesions or partial excision of either organ.



Recto-vaginal endometriosis, involving the pararectal space, is commonly treated at Endometriosis Centres. It is not possible to specifically code the opening or inspection of the pararectal space using OPCS-4 codes, the procedures and the individual sites upon which they are performed would be coded.

## Uterosacral ligaments

Procedures on the uterosacral ligaments are classified at **Q54.8 Other specified operations on other ligament of uterus**. Add codes from Chapter Y Subsidiary Classification of Methods of Operation, for example **Y13.1 Cauterisation of lesion of organ NOC** to classify diathermy of a lesion.

The ureters pass laterally to the uterosacral ligaments, and therefore may be involved in endometriosis of the uterosacral ligaments. See section **With or Without Ureterolysis**.

## Rectum

Shave excision of rectal endometriosis involves the removal of a superficial layer of the rectal tissue.

This procedure is coded at **H34.1 Open excision of lesion of rectum** followed by **Y75.2 Laparoscopic approach to abdominal cavity NEC** where applicable (see **PGCS1: Endoscopic and minimal access operations that do not have a specific code**).

## With or Without Ureterolysis

The ureters arise from the renal pelvis and descend through the abdomen, into the pelvis and insert into the bladder. Their course brings them close to a number of other structures in the pelvis, and due to this, endometriosis or endometriotic nodules of other structures may become involved and adhere to the ureters as well.

The most common procedure performed upon the ureters is ureterolysis; the freeing of the ureters from adhesions or endometriotic tissue. When this is performed, it must be coded to **M25.3 Ureterolysis** followed by **Y75.2 Laparoscopic approach to abdominal cavity NEC** where applicable (see **PGCS1: Endoscopic and minimal access operations that do not have a specific code**).

To protect the ureters, stents may be inserted. Generally these are removed at a later date. In this case, an appropriate code from Chapter M Urinary would be assigned to classify the stent insertion (see **PCSM2: Insertion and change of ureteric stents**).

As the ureters are paired organs, a code from category **Z94 Laterality of operation** must be assigned, where this information is available (see **PCSZ2: Laterality of operation (Z94)**).

## With or Without Ileostomy

A number of codes within Chapter H Lower Digestive Tract include ileostomy within the code description. One of these codes may be assigned if a bowel resection with ileostomy is



performed in the course of an excision for endometriosis (see section **Segmental bowel resection**).

However, where an ileostomy is not present within the code description and one has been performed, an additional code from OPCS-4.7 category **G74 Creation of artificial opening into ileum** is assigned, followed by **Y75.2 Laparoscopic approach to abdominal cavity NEC** where applicable (see **PGCS1: Endoscopic and minimal access operations that do not have a specific code**).

## With or Without Colostomy

A number of codes within Chapter H Lower Digestive Tract instruct the coder to use a secondary code to classify the exteriorization of the bowel.

If the medical record specifies that a colostomy was performed it is appropriate to code the colostomy, followed by **Y75.2 Laparoscopic approach to abdominal cavity NEC** where applicable (see **PGCS1: Endoscopic and minimal access operations that do not have a specific code**).

## Surgery on Distant Organs

Where endometriosis has spread to distant organs, for example the caecum, and this has been treated, it should be coded according to the 4 step coding process.

## Coded Examples

The majority of complex laparoscopic surgical procedures undertaken within an Endometriosis Centre, as listed in Section 5, can be indexed in OPCS-4 and coded according to the rules and conventions of the classification such as the diagnostic versus therapeutic rule.

The following are examples to illustrate this guidance or are examples received by the Clinical Classifications Service.

Sequencing in the examples provided below is not definitive, and may change dependent on the specific case information and/or clarification from the responsible consultant.

*Laparoscopic diathermy of endometriosis of peritoneum*

**T42.2 Endoscopic destruction of lesion of peritoneum**

**Y13.1 Cauterisation of lesion of organ NOC**

*Laparoscopic cauterisation of endometriosis of pouch of Douglas*

**P31.8 Other specified operations on pouch of Douglas**

**Y75.2 Laparoscopic approach to abdominal cavity NEC**

**Y13.1 Cauterisation of lesion of organ NOC**

*Laparoscopic excision of left peritoneal side wall endometriosis and unilateral ureterolysis*

**T42.1 Endoscopic resection of lesion of peritoneum**

**M25.3 Ureterolysis**

**Y75.2 Laparoscopic approach to abdominal cavity NEC**

**Z94.3 Left sided operation**

*Full diagnostic laparoscopy identified right sided endometrioma, which was drained and stripped via a laparoscope*

**Q49.1 Endoscopic extirpation of lesion of ovary NEC**

**Z94.2 Right sided operation**

**T43.9 Unspecified diagnostic endoscopic examination of peritoneum**

*Laparoscopic excision of left uterosacral ligament endometriotic nodule and freeing of left ureter*

**Q54.8 Other specified operations on other ligament of uterus**

**Y75.2 Laparoscopic approach to abdominal cavity NEC**

**Y06.9 Unspecified excision of lesion of organ NOC**

**M25.3 Ureterolysis**

**Y75.2 Laparoscopic approach to abdominal cavity NEC**

**Z94.3 Left sided operation**

*Partial excision of bladder for endometriosis, converted from laparoscopic to open access due to adhesions*

**M35.9 Unspecified partial excision of bladder**

**Y71.4 Failed minimal access approach converted to open**

*Laparoscopic excision of endometriosis of the rectovaginal septum (confirmed to be excision of lesions of both the vagina and the rectum) with bilateral ureterolysis*

**H34.1 Open excision of lesion of rectum**

**Y75.2 Laparoscopic approach to abdominal cavity NEC**

**P20.1 Excision of lesion of vagina**

**Y75.2 Laparoscopic approach to abdominal cavity NEC**

**M25.3 Ureterolysis**

**Y75.2 Laparoscopic approach to abdominal cavity NEC**

**Z94.1 Bilateral operation**

*Laparoscopic excision of rectovaginal endometriosis by anterior resection of the rectum with anastomosis and creation of a defunctioning ileostomy, resection of vaginal endometriosis and bilateral ureterolysis*

**H33.4 Anterior resection of rectum and anastomosis NEC**

**Y75.2 Laparoscopic approach to abdominal cavity NEC**

**G74.2 Creation of temporary ileostomy**

**Y75.2 Laparoscopic approach to abdominal cavity NEC**

**P20.1 Excision of lesion of vagina**

**Y75.2 Laparoscopic approach to abdominal cavity NEC**

**M25.3 Ureterolysis**

**Y75.2 Laparoscopic approach to abdominal cavity NEC**

**Z94.1 Bilateral operation.**

## Appendix: Sources of Clinical Coding Standards

The National Clinical Coding Standards reference books (ICD-10 and OPCS-4) and the Coding Clinic are the definitive source of national standards published by the Clinical Classifications Service. They are available at <https://isd.hscic.gov.uk/trud3/user/guest/group/61/home>.

### National Clinical Coding Standards ICD-10 - reference book

DCS.XIV.9: Endometriosis (N80)	Page 130
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### National Clinical Coding Standards OPCS-4 reference book

PRule 2: Single procedure analysis and multiple coding	Page 15
PRule 7: Subsidiary Chapters Y and Z	Page 19
PGCS1: Endoscopic and minimal access operations that do not have a specific code	Page 24
PGCS2: Diagnostic versus therapeutic procedures	Page 26
PGCS4: Failed percutaneous and minimal; access procedures converted to open	Page 27
PGCS10: Coding endoscopic procedures	Page 30
PCSM2: Insertion and change of ureteric stents	Page 66
PChSY1: Use of codes in Chapter Y	Page 119
PCSY2: Insertion of adhesion barrier (Y36.8)	Page 120
PCSY6: Approach to organ (Y46-Y52 and Y74-Y76)	Page 121
PCSZ2: Laterality of operation (Z94)	Page 127

### Coding Clinic

The Coding Clinic can be found at:

<http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/publications/codingclinic>