Complex Laparoscopic Surgery for Severe Endometriosis

Guidance for clinical coders

April 2019

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1. 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 NHS Digital – Terminology and Classifications Delivery Service responsible for national clinical coding standards.

1.1 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. **It is only relevant to consultant episodes where complex laparoscopic surgery for severe endometriosis has been performed**.

This guidance is compliant with, and does not replace, the clinical coding standards provided by the Terminology and Classification Delivery Service as documented in the following reference books (available for download from the Main Publications page on Delen):

National Clinical Coding Standards – ICD-10

National Clinical Coding Standards – OPCS-4

1.2 Background

1.2.1 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

1.2.2 Terminology and Classifications Delivery Service

NHS Digital is responsible for the release of the clinical classifications ICD-10[1] and OPCS-4[2] and their associated support and products.

The Terminology and Classifications Delivery Service is the definitive source of clinical coding standards and guidance for clinical use of the classifications ICD-10 and OPCS-4.

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

https://digital.nhs.uk/services/terminology-and-classifications/clinical-classifications

2. 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

2.1 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

[1] World Health Organisation - International Statistical Classification of Diseases and Health Related Problems – Tenth Revision (ICD-10)

[2] UK - OPCS Classification of Interventions and Procedures (OPCS-4)

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

See **DGCS.3 Co-morbidities**.

3. Clinical Coding Standards

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

Clinical coders follow the four-step coding process which is key to the correct use of the ICD-10 and OPCS-4 Alphabetical Index and Tabular List, ensuring 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.

4. 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

5. 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.

In some circumstances, complete excision of the disease may require two separate procedures a few weeks apart. This may be for a number of clinical or logistical reasons.

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
- laparoscopic excision of endometriosis from pelvic nerves (e.g. sacral nerve roots, sciatic nerve etc)

5.1 Gastrointestinal

5.1.1 Shave excision

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**).

5.1.2 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. The procedure is a less invasive alternative to segmental resection (see section 5.1.3.2 Segmental bowel resection).

Disc resection is coded in OPCS-4 as an excision of a lesion of the section of the intestine upon which the disc resection was performed followed by code **Y75.2 Laparoscopic approach to abdominal cavity NEC** where applicable (see **PGCS1: Endoscopic and minimal access operations that do not have a specific code**).

5.1.3 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 determine from the medical record, operation note or responsible consultant whether an anastomosis was performed and if so, how.

5.1.3.1 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 during an excision for endometriosis (see section **5.1.3.2**).

However, where an ileostomy is not present within the code description and one has been performed, an additional code from OPCS-4 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**).

5.1.3.2 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 exteriorisation 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**).

5.2 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 classification to classify cystoscopic procedures within the bladder (for example **M42 Endoscopic extirpation of lesion of bladder**). In contrast, a procedure performed laparoscopically on the bladder should be coded using the code classifying the open procedure, followed by a code from category **Y75 Minimal access to abdominal cavity** to classify the minimal access approach (see **PGCS1: Endoscopic and minimal access operations that do not have a specific code**).

5.2.1 Ureters

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.

5.2.1.1 With or without ureterolysis

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**).

A code from category **Z94 Laterality of operation** must be assigned, where this information is available (see **PCSZ2: Laterality of operation (Z94)**).

5.3 Deep infiltrating endometriosis

This can occur in a variety of sites such as bladder, pelvic sidewalls, ovaries, pelvic brim, bowel surface and diaphragm. Deep infiltration endometriosis may also involve the rectovaginal septum (“Rectovaginal endometriosis”) and is separately described below. For information on bladder and bowel surface see sections **5.1 Gastrointestinal** and **5.2 Bladder**.

5.3.1 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 **5.2.2 Ureters**.

5.3.2 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 on the POD are classified at OPCS-4 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 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 exact method of destruction used.

Laparoscopic treatment of endometriosis may be preceded by examination of the abdomen and its contents. Where this proceeds to a therapeutic procedure on an examined organ(s), only the therapeutic procedure(s) is coded, see **PGCS2: Diagnostic versus therapeutic procedures**.

5.3.3 Ovaries

Laparoscopic adnexal surgery is minimally invasive surgery 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 code **N80.1 Endometriosis of ovary**.

A code from OPCS-4 category **Z94 Laterality of operation** must be also be assigned following the code classifying the intervention where this information is available (see **PCSZ2: Laterality of operation (Z94)**).

5.3.4 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 instead.

5.3.5 Other sites

Other site affected by deep infiltrating endometriosis are:

- Diaphragm
- Sciatic nerve
- Sacral nerve roots

6. 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 four step coding process.

7. 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 Terminology and Classifications Delivery 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 peritoneal endometriosis and left sided 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

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

Z94.3 Left sided operation

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

8. 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 Terminology and Classifications Delivery Service. They are available to download from the Main Publications page on Delen

National Clinical Coding Standards ICD-10 reference book (2019)

DGCS.3: Co-morbidities	Page 30
DCS.XIV.9: Endometriosis (N80)	Page 131

National Clinical Coding Standards OPCS-4 reference book (2019)

PRule 2: Single procedure analysis and multiple coding	Page 16
PRule 7: Subsidiary Chapters Y and Z	Page 21
PGCS1: Endoscopic and minimal access operations that do not have a specific code	Page 27
PGCS2: Diagnostic versus therapeutic procedures	Page 29
PGCS4: Failed percutaneous and minimal access procedures converted to open	Page 31
PGCS10: Coding endoscopic procedures	Page 34
PCSM2: Insertion and change of ureteric stents	Page 78
PChSY1: Use of codes in Chapter Y	Page 147
PCSY2: Insertion of adhesion barrier (Y36.8)	Page 149
PCSY6: Approach to organ (Y46-Y52 and Y74-Y76)	Page 150
PCSZ2: Laterality of operation (Z94)	Page 159

Coding Clinic

The Coding Clinic can be downloaded from the Main Publications page on Delen.

9. Summary of Changes

Location of change	Description of change
Throughout	Organisational details updated to reflect rebranding to NHS Digital and Terminology and Classifications Delivery Service Sections updated throughout to reflect new headings OPCS-4.7 updated to OPCS-4
5. Surgical treatment for severe endometriosis	Text deleted: ~~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 Gonadotropin Releasing Hormone agonist medication lasting 12 weeks.~~ • ~~Stage 2 is to remove all adhesions and excise the endometriosis.~~ Text added to the fourth paragraph: In some circumstances, complete excision of the disease may require two separate procedures a few weeks apart. This may be for a number of clinical or logistical reasons. Text added to the bullet point list: • laparoscopic excision of endometriosis from pelvic nerves (e.g. sacral nerve roots, sciatic nerve etc)
5.1 Gastrointestinal	New heading created to incorporate types of gastrointestinal surgery. Subheadings now included under 5.1 Gastrointestinal: 5.1.1 Shave excision replaces ~~5.2.3 Rectum~~ 5.1.2 Disc resection 5.1.3 Segmental bowel resection 5.1.3.1 With or without ileostomy 5.1.3.2 With or without colostomy

5.2 Bladder	New heading created to incorporate types of bladder. Subheadings now included under 5.2 Bladder: 5.2.1 Ureters 5.2.2.1 With or without ureterolysis
5.3 Deep infiltrating endometriosis	Subheadings now included under 5.3 Deep infiltrating endometriosis: 5.3.1 Uterosacral ligaments 5.3.2 Peritoneum 5.3.4 Ovaries 5.3.4 Recto-vaginal septum New subheading and text added: **5.3.8 Other sites** Other site affected by deep infiltrating endometriosis are: • Diaphragm • Sciatic nerve • Sacral nerve roots
5.3.2 Peritoneum	Text deleted from final paragraph: ~~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.~~ Text added to final paragraph: Where this proceeds to a therapeutic procedure on an examined organ(s), only the therapeutic procedure(s) is coded, see **PGCS2: Diagnostic versus therapeutic procedures**.
7 Coded Examples	Example text amended:

	Laparoscopic excision ~~left~~ of peritoneal ~~side wall~~ endometriosis and left sided ureterolysis Example codes amended: *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** **Z94.3 Left sided operation** **M25.3 Ureterolysis** **Y75.2 Laparoscopic approach to abdominal cavity NEC** **Z94.3 Left sided operation** Example codes amended: *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~~**