July 2022

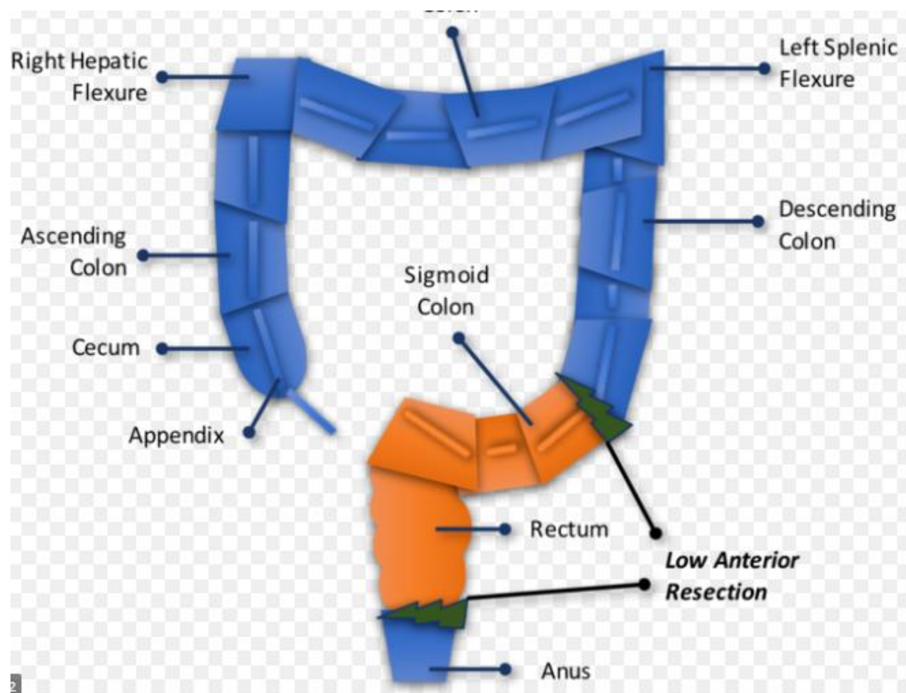
Topic: Lower Anterior Resection

Question: Do you know the main guidelines, definitions and Coding Clinic's which help direct correct coding for Lower Anterior Resections?

Answer: Now you do!

Lower Anterior Resection:

Low anterior resection (LAR) In LAR the surgeon removes the diseased portion of the rectum and the sigmoid colon. To reduce the risk, your surgeon may create a temporary ostomy (colostomy or Ileostomy) to divert fecal matter away from the newly created anastomosis.



Guidelines and Definitions to Remember when Coding LAR Procedures:

B3.11c "When both an Inspection procedure and another procedure are performed on the same body part during the same episode, if the Inspection procedure is performed using a different approach than the other procedure, the Inspection procedure is coded separately."

- **If Sigmoidoscopy performed to check the anastomosis during LAR – Sigmoidoscopy is Coded**

B5.2b, "Procedures performed using the percutaneous endoscopic approach, with incision or extension of an incision to assist in the removal of all or a portion of a body part or to anastomose a tubular body part to complete the procedure, **are coded to the approach value Percutaneous Endoscopic**."

- **When Robotic-assisted low anterior colon resection "with a small Pfannenstiel incision was made to divide, skeletonize and remove the specimen"- This is still Percutaneous Endoscopic Approach.**

B3.1b Components of a procedure specified in the root operation definition and explanation are not coded separately**. Procedural steps necessary to reach the operative site and close the operative site, including anastomosis of a tubular body part, are also not coded separately.**
Examples: Resection of a joint as part of a joint replacement procedure is included in the root operation definition of Replacement and is not coded separately. Laparotomy performed to reach the site of an open liver biopsy is not coded separately. **In a resection of sigmoid colon with anastomosis of descending colon to rectum, the anastomosis is not coded separately.**

- **LAR without an "ostomy"– No additional code for anastomosis**

Definitions:

- **Bypass:** is defined as altering the route of passage of the contents of a tubular body part. Bypass is coded when the objective of the procedure is to reroute the contents of a tubular body part.
  - **If "ostomy" created during the LAR, code the additional PCS "ostomy" code.**
- **Excision**: Root Operation-takes out some of a body part without replacement (some of a body part).
- **Resection:** Root operation -takes out all of a body part without replacement (all of a body part…no portion of the organ left behind).

Excision vs Resection?

LAR Excision VS Resection Tip? When the creation of the anastomosis during the LAR states it is connecting to the rectum this is evidence of remaining rectal tissue therefore is considered "excision" of rectum rather than "resection", per ICD-10-PCS definition.

1. Laparoscopic low anterior resection of the rectum with stapled side-to-end descending colon-to-rectal anastomosis at 5 cm from the anal verge

Evidence that the entire rectum was not resected (removed)

Coding Clinics to Consider on your Quest to Accurate LAR coding:

Robotic-assisted low anterior resection of colon

ICD-10-CM/PCS Coding Clinic, **First Quarter ICD-10 2022** Pages: 49-50 Effective with discharges: March 18, 2022

Question: A patient underwent robotic-assisted low anterior colon resection for treatment of cancer. At surgery, pneumoperitoneum was established; robotic ports were placed; and the splenic flexure was mobilized laparoscopically, followed by robotic excision. A Pfannenstiel incision was made; the sigmoid colon was pulled through the incision; and skeletonized extracorporeally. Anastomosis was then performed and inspected via proctoscope. What is the appropriate approach value for this procedure?

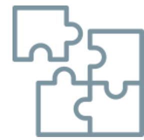
Answer: Assign the approach value "4, Percutaneous Endoscopic" for the robotic-assisted sigmoid colectomy with primary anastomosis. In this case, surgery was performed laparoscopically; towards the end of the procedure, a small Pfannenstiel incision was made to divide, skeletonize and remove the specimen. According to the ICD-10-PCS guideline B5.2b, "Procedures performed using the percutaneous endoscopic approach, **with incision or extension of an incision to assist in the removal of all or a portion of a body part or to anastomose a tubular body part to complete the procedure, are coded to the approach value Percutaneous Endoscopic**."

Low anterior resection with sigmoidoscopy

ICD-10-CM/PCS Coding Clinic, **Second Quarter ICD-10 2017** Pages: 15-16 Effective with discharges: May 17, 2017

Question: The patient underwent open low anterior resection, takedown and repair of a chronically incarcerated ventral incisional hernia. During the procedure, an anastomosis was performed utilizing the left colon and the remainder of the proximal sigmoid at the level of the pelvic brim**. After completion of the operative procedures, the surgeon performed a limited rigid sigmoidoscopy** to the level of the anastomosis to test for anastomotic leaks. There were no leaks identified. Is it appropriate to assign a separate code for the rigid sigmoidoscopy performed to check the anastomosis?

Answer: Yes. In this case, after completion of the definitive operation, the surgeon inspected the anastomosis to check for occult leaks, which could not be seen from outside inspection. **The sigmoidoscopy is not inherent to the low anterior resection procedure.** The



inspection was not done to achieve the objective of the procedure**, the anastomosis had already been completed, and the sigmoidoscopy was a separate procedure.** Assign the following ICD-10-PCS code:

0DJD 8ZZ Inspection of lower intestinal tract, via natural or artificial opening endoscopic, for the rigid sigmoidoscopy performed to check the anastomosis

The ICD-10-PCS Official Guidelines for Coding and Reporting B3.11c state: "When both an Inspection procedure and another procedure are performed on the same body part during the same episode, if the Inspection procedure is performed using a different approach than the other procedure, the Inspection procedure is coded separately."

Colostomy creation following lower anterior resection of rectum

ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2014 Pages: 41-42 Effective with discharges: December 31, 2014

Question: The above patient also had colostomy creation at the same time that the lower anterior resection of the rectum was performed. Should the colostomy be coded?

Answer: **Yes, creation of the colostomy should be separately coded**. In this case the sigmoid colon was bypassed to skin and is appropriately coded to the root operation "Bypass." Assign the ICD-10-PCS code as follows:

0D1N0Z4 Bypass sigmoid colon to cutaneous, open approach

In ICD-10-PCS, the root operation "Bypass," is defined as altering the route of passage of the contents of a tubular body part. Bypass is coded when the objective of the procedure is to reroute the contents of a tubular body part. The range of "Bypass" procedures includes normal routes such as those made in coronary artery bypass procedures, and abnormal routes such as those made in colostomy formation procedures.

Happy Coding!

References

AHA Coding Clinics:

Colostomy creation following lower anterior resection of rectum
ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2014 Pages: 41-42 Effective with discharges: December 31, 2014

Low anterior resection with Sigmoidoscopy **ICD**-10-CM/PCS Coding Clinic, **Second Quarter ICD-10 2017** Pages: 15-16 Effective with discharges: May 17, 2017

Robotic-assisted low anterior resection of colon **ICD**-10-CM/PCS Coding Clinic, **First Quarter ICD-10 2022** Pages: 49-50 Effective with discharges: March 18, 2022

- Coding Tip: Excision vs. Resection ICD-10 PCS – HIA code 12/10/18
- ICD-10-CM Official Guidelines for Coding and Reporting
- ACADIS Anatomy of a Surgical Note: A CSI Analysis of Operative Notes Gone Bad 2017

Note: While the above education will assist the coder with accuracy each encounter may have specific variations of documentation for both diagnosis coding and/or procedure coding. Please note all encounters should be reviewed for possible query for clarification of **documentation in the health record for accurate code assignment.**