2009 Procedures Adult Criteria

Laparoscopy, Diagnostic (Pelvic) (Custom) - UDOH[1*MDR, 2]

Created based on InterQual Subset: Laparoscopy, Diagnostic (Pelvic)

Version: InterQual® 2009

CLIENT:	Name	D.O.B.	ID#	GROUP#
CPT/ICD9:	Code	Facility	Service Date	
PROVIDER:	Name		ID#	Phone#
	Signature		Date	

ICD-9-CM: 54.21

INDICATIONS (choose one and see below)

- ☐ 100 Adnexal/pelvic mass by PE/KUB
- ☐ 200 Acute abdominal/pelvic pain, unknown etiology ♦
- ☐ 300 Chronic abdominal/pelvic pain, unknown etiology
- ☐ 400 Suspected ectopic pregnancy ♦
- ☐ 500 PID
- ☐ 600 Suspected ovarian cyst rupture ♦
- ☐ Indication Not Listed (Provide clinical justification below)

- ☐ 100 Adnexal/pelvic mass by PE/KUB **[One]**[3, 4]
  - ☐ 110 US nondiagnostic for etiology of mass
  - ☐ 120 CT nondiagnostic for etiology of mass
  - ☐ 130 MRI nondiagnostic for etiology of mass

- ☐ 200 Acute abdominal/pelvic pain, unknown etiology **[All]** ♦[5]
  - ☐ 210 Premenopausal woman[6*RIN]
  - ☐ 220 Lower abdominal tenderness
  - ☐ 230 Pelvic examination nondiagnostic for etiology of pain[7]
  - ☐ 240 CBC normal
  - ☐ 250 Pregnancy excluded **[One]**[8*RIN, 9]
    - ☐ 251 HCG negative[10]
    - ☐ 252 Sterilization by Hx[11]
    - ☐ 253 Patient not sexually active by Hx[12]
  - ☐ 260 U/A or urine culture normal
  - ☐ 270 Cervical cultures **[Both]**
    - ☐ 271 Gonorrhea test negative

- ☐ 272 No chlamydia by DNA/antibody testing
- ☐ 280 US nondiagnostic for etiology of pain[13]

☐ 300 Chronic abdominal/pelvic pain, unknown etiology **[All]**[14, 15, 16]
- ☐ 310 Premenopausal woman[6*RIN]
- ☐ 320 Hx & PE nondiagnostic for etiology of pain
- ☐ 330 CBC normal
- ☐ 340 U/A or urine culture normal
- ☐ 350 US nondiagnostic for etiology of pain
- ☐ 360 Continued pain **after** Rx **[One]**
  - ☐ 361 NSAID ≥ 4 wks
  - ☐ 362 Depot medroxyprogesterone/OCP ≥ 8 wks
  - ☐ 363 GnRH agonist ≥ 8 wks[17]
  - ☐ 364 Abx Rx x1 course

☐ 400 Suspected ectopic pregnancy **[All]** ♦
- ☐ 410 Findings **[One]**
  - ☐ 411 Abdominal/pelvic pain
  - ☐ 412 Abnormal vaginal bleeding
  - ☐ 413 Adnexal mass/tenderness by PE
  - ☐ 414 Abnormal increase/lack of increase in quantitative HCG levels[18]
- ☐ 420 HCG positive
- ☐ 430 Diagnostic testing **[One]**
  - ☐ 431 US nondiagnostic for ectopic pregnancy[19*RIN, 20]
  - ☐ 432 Blood by culdocentesis[21, 22]

☐ 500 PID **[One]**[23]
- ☐ 510 Suspected acute PID **[All]**[24*RIN]
  - ☐ 511 Lower abdominal pain
  - ☐ 512 Cervical motion tenderness
  - ☐ 513 Adnexal tenderness
  - ☐ 514 HCG negative[10]
  - ☐ 515 Findings **[One]**
    - ☐ -1 Temperature > 100.4 F(38.0 C)
    - ☐ -2 WBC ≥ 12,000/cu.mm($12x10^9$/L)
    - ☐ -3 ESR ≥ 15 mm/hr
    - ☐ -4 Purulent material by culdocentesis[21]
    - ☐ -5 Gonorrhea test positive
    - ☐ -6 Chlamydia by DNA/antibody testing

- ☐ -7 > 5 WBCs per oil immersion field by Gram stain of endocervical smear
- ☐ 516 Continued Sx/findings **after** IV Abx ≥ 24 hrs **[Two]** (25*MDR)
  - ☐ -1 Continued/worsening abdominal pain
  - ☐ -2 Continued/worsening abdominal tenderness
  - ☐ -3 Temperature increasing
  - ☐ -4 WBC increasing
- ☐ 517 US nondiagnostic for Sx/findings (26)

☐ 520 Second episode of suspected/documented PID

☐ 530 Suspected ruptured tubo-ovarian abscess ♦ (27)

☐ 600 Suspected ovarian cyst rupture **[All]** ♦ (28, 29)

- ☐ 610 Abdominal tenderness/rebound
- ☐ 620 Pregnancy excluded **[One]** (8*RIN, 9)
  - ☐ 621 HCG negative (10)
  - ☐ 622 Sterilization by Hx (11)
  - ☐ 623 Patient not sexually active by Hx (12)
- ☐ 630 Suspected bleeding **[One]** (30)
  - ☐ 631 Tachycardia/hypotension
  - ☐ 632 Increasing intraperitoneal fluid by repeat US
  - ☐ 633 Hct decrease ≥ 6% w/in 4 hrs

Notes

(1)-MDR:
The role of second look surgery in the treatment of ovarian cancer remains controversial and is usually relegated to specific cancer protocols. Requests for second look surgery require secondary medical review.

(2)
Diagnostic laparoscopy often converts to an operative laparoscopy if pathology is found.

(3)
US is the study of choice to evaluate a pelvic mass discovered on PE or by KUB. If the US is not diagnostic, CT or MRI of the pelvis may be performed to identify the characteristics of the mass or to rule out ovarian or uterine pathology such as fibroids, abscesses, or cancer.

(4)
If the etiology of the mass is obvious, the appropriate procedure is an operative laparoscopy or a laparotomy.

(5)
Acute lower abdominal or pelvic pain can be of ovarian origin (e.g., ovarian torsion, a hemorrhagic ovarian cyst) or represent an inflamed or ruptured appendix. A definitive diagnosis can be made by laparoscopy early in the patient's evaluation and is especially useful in young women of child bearing age who have a broad range of differential diagnoses.

(6)-RIN:
For abdominal pain in postmenopausal women, see the "Laparoscopy, Diagnostic (Abdomen)" criteria subset in the General Surgery category. These patients need a complete examination of their abdomen and pelvis to exclude abdominal pathology (e.g., malignancy, diverticular abscess).

(7)

Pelvic examination is performed to exclude diagnoses such as PID, ovarian cyst, or ectopic pregnancy (Kamin et al., Emerg Med Clin North Am 2003; 21(1): 61-72).

(8)-RIN:
A positive HCG with abdominal pain would raise the question of an ectopic pregnancy. If the HCG is positive, see indication 400 within this criteria subset.

(9)
Pregnancy and related complications (e.g., ectopic pregnancy, incomplete abortion, inevitable abortion) must be excluded before performing this procedure.

(10)
Pregnancy testing can be by measurement of either a serum or urine HCG and may be documented in either the PCP's, gynecologist's, or surgeon's records.

(11)
The healthcare provider should document a history of sterilization (i.e., tubal ligation) without a subsequent pregnancy. This criteria does not include sterilization of a partner, nor does it cover alternate birth control methods (e.g., OCP use, IUD insertion).

(12)
Patients have varying definitions of sexual activity (e.g., number of partners, timing of most recent episode, frequency of sexual activity). Unless the provider can confirm on exam that the patient has never had sexual intercourse, whether a patient is sexually active or not is a matter of clinical judgment.

(13)
US is the diagnostic test of choice in differentiating potential causes of acute lower abdominal or pelvic pain in female patients. The major considerations include ovarian abnormalities (e.g., ovarian torsion, ruptured hemorrhagic ovarian cyst) or an inflamed or ruptured appendix.

(14)
These criteria address chronic pain of unknown etiology, not abdominal or pelvic pain of acute onset. Chronic pelvic pain refers to pain that lasts 6 months or longer (Williams et al., Obstet Gynecol 2004; 103(4): 686-691; Obstet Gynecol 2004; 103(3): 589-605). Some of the gynecologic causes of chronic pelvic pain include endometriosis, chronic PID, and fibroids. Other diagnoses that need to be excluded may be related to the digestive system (e.g., irritable bowel), the urinary tract (e.g., interstitial cystitis urethritis), or pain in the muscles and nerves around the pelvis (e.g., fibromyalgia).

(15)
Laparoscopy has controversial utility in the evaluation of chronic pelvic pain. Pathologic findings are frequently detected secondary to improved laparoscopic technology but their significance and association with the pain is debated (Scialli et al., eds., Chronic Pelvic Pain, 2000, p23). Conscious laparoscopic mapping, defined as identifying lesions that correlate with some or all of the patient's pain while undergoing laparoscopy under local anesthesia, may eliminate unnecessary surgery or identify lesions amenable to medical therapy (ACOG Practice Bulletin. Obstet Gynecol 2004; 103(3): 589-605). Many cases of pelvic pain not caused by infection or pregnancy are due to endometriosis. Endometriosis is suspected by pain generally beginning midcycle and increasing through menstruation. PE is usually normal except for tenderness; rarely, large areas of endometriosis may be palpable (Vercellini et al., Obstet Gynecol Clin North Am 2003; 30(1): 163-180).

(16)
If endometriosis is found on diagnostic laparoscopy, conversion to an operative laparoscopy for ablation or excision of the abnormal areas and lysis of any adhesions occurs.

(17)
The GnRH agonists include leuprolide acetate, nafarelin, and goserelin. These compounds mimic the action of GnRH and, thereby, suppress the hormones produced by the ovary that stimulate endometrial growth.

(18)
In normal early pregnancy, HCG levels double every 48 hours.

(19)-RIN:
If the US is diagnostic for an ectopic pregnancy, the appropriate procedure is not laparoscopy for diagnosis but an operative laparoscopy for salpingectomy or salpingostomy.

(20)
A transvaginal US can diagnose an ectopic pregnancy at a much earlier stage than a transabdominal study. A gestational sac is the earliest US finding and can be visualized between 4 and 5 weeks gestational age on endovaginal scanning. Visualization of an intrauterine pregnancy virtually excludes the diagnosis of ectopic pregnancy (Harrison and Crystal, Emerg Med Clin North Am 2003; 21(3): 711-735).

(21)-DEF:
Culdocentesis is the transvaginal passage of a needle into the posterior cul-de-sac.

(22)
Culdocentesis is now rarely performed due to the availability of US. It is reasonable to perform culdocentesis if diagnostic information is needed and US is not available or doing an US would result in an undesirable delay.

(23)-DEF:
Although often synonymous with salpingitis, PID is actually a more general term referring to infections of the upper female genital tract, including endometritis, salpingitis, pelvic peritonitis, and tubo-ovarian abscess.

(24)-RIN:
These criteria address diagnostic laparoscopy performed to confirm a diagnosis of PID or to follow-up PID to exclude complications. For acute pelvic pain of unknown etiology, diagnostic laparoscopy is performed to exclude appendicitis or ovarian torsion as a cause of the pain. For these cases, see indication 200 within this criteria subset. For cases of known PID, refer to the appropriate procedure for definitive treatment (e.g., salpingectomy, salpingostomy).

(25)-MDR:
Oral, rather than IV, medications can be given in less severe cases. However, worsening on an oral regimen would call for a trial of IV therapy rather than immediate diagnostic laparoscopy (Workowski and Berman, MMWR Recomm Rep 2006; 55(RR-11): 1-94). A request for laparoscopy due to worsening symptoms on oral therapy requires secondary medical review.

(26)
Pelvic US should be performed prior to proceeding to laparoscopy for suspected PID and may detect an inflammatory mass, obviating the need for diagnostic surgery.

(27)
Sudden severe pain, increasing temperature, or worsening signs of peritoneal irritation (direct or referred rebound) in a patient with suspected PID are suggestive of a ruptured tubo-ovarian abscess. This may require intraoperative conversion of the laparoscopy to a more extensive procedure.

(28)
Diagnostic laparoscopy is done to confirm the diagnosis of a ruptured cyst and will convert to an operative laparoscopy for treatment of continued bleeding from the cyst.

(29)
The stability of the patient determines whether it is appropriate or necessary to do an US prior to surgery. Unstable patients should receive aggressive resuscitation and proceed directly to surgery.

(30)
Ruptured ovarian cysts, most commonly corpus luteum cysts, do not rebleed after they stop bleeding and most do not result in heavy bleeding requiring surgery. For suspected continued bleeding or rebleeding, diagnostic laparoscopy is appropriate as the initial procedure, with intraoperative conversion to a more extensive procedure if necessary.