Conference Name: Coding Gynecology Surgery: Strategies for Reimbursement Success

Scheduled Conference Date: Friday, August 12th, 2005

Scheduled Conference Time: 1:00 p.m.–2:30 p.m. (Eastern), 12:00 p.m.–1:30 p.m. (Central), 11:00 a.m.–12:30 p.m. (Mountain), 10:00 a.m.–11:30 a.m. (Pacific)

Scheduled Conference Duration: 90 Minutes

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Sincerely,

Frank Morello
Director of Multimedia
HCPro, Inc.
Coding Gynecology Surgery: Strategies for Reimbursement Success

A 90-minute interactive audioconference

Friday, August 12, 2005

1:00 p.m.–2:30 p.m. (Eastern)
12:00 p.m.–1:30 p.m. (Central)
11:00 a.m.–12:30 p.m. (Mountain)
10:00 a.m.–11:30 a.m. (Pacific)
In our materials we strive to provide our audience with useful, timely information. The live audioconference will follow the enclosed agenda. Occasionally our speakers will refer to the materials enclosed. We have noticed that other non-HCPro audioconference materials follow the speaker’s presentation bullet-by-bullet, page-by-page. Because our presentations are less rigid and rely more on speaker interaction, we do not include each speaker’s entire presentation. The materials contain helpful forms, crosswalks, policies, charts, and graphs. We hope that you find this information useful in the future.

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Dear colleague,

Thank you for participating in our “Coding Gynecology Surgery: Strategies for Reimbursement Success” audioconference with Lolita M. Jones, RHIA, CCS, Maggie M. Mac, CMM, CPC, CMSCS, CCP, ICCE, and Brian Murphy (moderator). We are excited about the opportunity to interact with you directly and encourage you to take advantage of the opportunity to ask our experts your questions during the audioconference. If you would like to submit a question before the audioconference, please send it to jhutchins@hcpro.com and provide the program date in the subject line. We cannot guarantee your question will be answered during the program, but we will do our best to take a good cross-section of questions.

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Along with these audioconference materials, we have enclosed a fax evaluation. We value your opinion. After the audioconference, please take a minute to complete the evaluation to let us know what you think.

Thanks again for working with us.

Best regards,

Leokadia Marchwinski
Audioconference Producer
Fax: 781/639-2982
E-mail: lmarchwinski@hcpro.com
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   - Lysis of adhesions
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II. Repair of Pelvic Support Defects
    - Diagrams
    - Coding guidelines
    - Case studies

III. Hysteroscopies and Laparoscopies
    - Diagrams
    - Coding guidelines
    - Case studies

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Coding Gynecology Surgery: Strategies for Reimbursement Success
Speaker profiles

**Lolita M. Jones, RHIA, CCS**

*Lolita M. Jones, RHIA, CCS,* is the principal of Lolita M. Jones Consulting Services and the vice president of Educational Programs, Medical Marketing Resources, Inc.

She has over 15 years of experience in publishing, training, and auditing for the hospital outpatient and freestanding ambulatory surgery center markets.

**Maggie M. Mac, CMM, CPC, CMSCS, CCP, ICCE**

*Maggie M. Mac, CMM, CPC, CMSCS, CCP, ICCE,* has served the healthcare industry for over 20 years. She currently serves as a consulting manager with Pershing Yoakley & Associates in Clearwater, FL. Her background and experience as a practice administrator and practice management consultant for individual and group practices has provided her with a comprehensive understanding of medical practice operations and personnel issues.

Her firm provides assistance to physician practices across the country in the areas of compliance, office management, collections, practice productivity analysis, coding and billing, human resources, conflict management, and team building.

Mac is a certified medical manager through the Professional Association of Health Care Office Managers and a certified professional coder through the American Academy of Professional Coders and the Professional Association of Healthcare Coding Specialists. She is also a Certified Compliance Professional (CCP) with the Healthcare Fraud & Abuse Compliance Institute.

She is active in many associations and supports networking with other medical office managers/administrators and physicians for the unique opportunity it provides in solving medical practice problems. Mac is a national speaker delivering information to audiences about topics dealing with medical practice compliance, personnel management and team-building, human resource issues, internet resources, coding and reimbursement, chart audits, and federal regulations.

She also conducts specialized seminars, practice chart reviews, and professional consults nationally. She is a frequent contributor to and serves on the editorial advisory board of many health management and coding publications nationally.

She has earned numerous awards, recognition, and respect for her professional achievements and contributions to the healthcare community across the country.

**Brian Murphy (moderator)**

*Brian Murphy* is managing editor of *Briefings on APCs* and *APC Answer Letter*, two monthly publications dedicated to managing under OPPS.
Exhibit A

Presentation by Lolita M. Jones, RHIA, CCS, and Maggie M. Mac, CMM, CPC, CMSCS, CCR, ICCE
Gynecology Surgery:
Current Trends for Coding and Reimbursement Success

Presented by
Maggie Mac, CMM, CPC, CMSCS, CCP
Pershing Yoakley & Associates
August 12, 2005

Chromotubation
GYN Surgery Coding: Common Problem Areas

- Chromotubation (also called Hydrotubation)
  - Introduction of saline solution into the uterine tube; solution containing dye may be used to determine patency of the tube.
Methylene blue dye is injected into the uterus and then fills the fallopian tubes and spills freely from the tubes.

**Chromotubation**

- 58350 Chromotubation of oviduct, including materials
  
  – Used to determine whether fallopian tubes are anatomically normal and open
  
  – Used to check patency following surgical procedure
Chromotubation

• Coding Guidelines:
  – Global Days = 10
  – Facility RVU’s = 2.05 ~ $77.69
  – Non-Facility = 2.62 ~ $99.29
  – Infertility diagnosis usually not covered
  – Subject to the NCCI Edits
    • Modifier required to break these edits when appropriate

Chromotubation

• Coding Guidelines:
  – If performed prior to a procedure for diagnostic purpose, may be billable
  – When performed in the course of another surgery to check surgical work, it is not separately billable
  – Per the Medicare Carriers Manual Section 1568 (MCM 15068):
    • All services integral to accomplishing a procedure are considered bundled into that procedure and, therefore, are considered a component part of the comprehensive code.
Lysis of Adhesions

GYN Surgery Coding:
Common Problem Areas

• Lysis of Adhesions
  – abnormal attachments between abdominal organs. Because internal organs normally move independently of each other, adhesions affect the functioning of organs and result in chronic abdominal or pelvic pain.
Lysis of Adhesions

Infection, surgery or trauma can cause adhesions to form within the body

Adhesions
Lysis of Adhesions

- 58740 ~ Lysis of adhesions (salpingolysis, ovariolysis)

- 58660 ~ Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)

Lysis of Adhesions

- Coding Guidelines:
  - Global Days = 90
  - 58740 Facility RVU’s = 22.78 ~ $863.31
  - 58660 Facility RVU’s = 17.90 ~ $678.36
  - Infertility diagnosis usually not covered
  - Subject to the NCCI Edits
    - Modifier required to break these edits when appropriate
Lysis of Adhesions

• Coding Guidelines:
  – When performed in the course of another surgery in order to complete the procedure, it is not separately billable (with exception)
  – Per the Medicare Carriers Manual Section 1568 (MCM 15068):
    • All services integral to accomplishing a procedure are considered bundled into that procedure and, therefore, are considered a component part of the comprehensive code.

Lysis of Adhesions

• Coding Guidelines:
  – Per the National Correct Coding Initiative:
    • Lysis of adhesions (CPT code 58660) is not to be reported separately when done in conjunction with other surgical laparoscopic procedures.
GENERAL CORRECT CODING POLICIES
NATIONAL CORRECT CODING POLICY MANUAL

• These "generic" activities are assumed to be included as acceptable medical/surgical practice and, while they could be performed separately, they should not be considered as such when a code descriptor is defined. Accordingly, all services integral to accomplishing a procedure will be considered included in that procedure.

GENERAL CORRECT CODING POLICIES
NATIONAL CORRECT CODING POLICY MANUAL

• 1. The service represents the standard of care in accomplishing the overall procedure.
• 2. The service is necessary to successfully accomplish the planned procedure; failure to perform the service may compromise the success of the procedure.
• 3. The service does not represent a separately identifiable procedure unrelated to a more comprehensive planned procedure.
Endometrial Ablation

New CPT Category I Code for 2005

- Endometrial Cryoablation
  - outpatient surgical procedure which was designed to destroy the lining of the uterus (endometrium) by freezing the tissue.
  - This procedure has proven to be an excellent alternative to hysterectomy when the woman suffers from excessive uterine bleeding.
Endometrial Cryoablation

- Cryoprobe is placed at the fundus angled toward first cornu. Probe placement is visualized on ultrasound.
- Freeze is initiated and cryo zone monitored on ultrasound. Probe is then warmed and removed to internal os. Probe is repositioned toward contralateral side reaching second cornu and procedure is repeated.
- The completed procedure covered entire endometrium (6 min freeze = approximately 5 cm x 3 cm).

Endometrial Ablation
Endometrial Ablation

- 58356 ~ Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed

Endometrial Ablation

- Coding Guidelines:
  - Global Days = 10
  - Facility RVU’s = 9.83 ~ $372.53
  - Non Facility RVU’s = 14.02 ~ $531.32
  - Subject to the NCCI Edits
    - Modifier required to break these edits when appropriate
Modifiers

Modifier Problem Areas

• Modifier 22 ~ **Unusual Procedural Services:**
  – When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.
GENERAL CORRECT CODING POLICIES
NATIONAL CORRECT CODING POLICY MANUAL

• In general, multiple methods of accomplishing a procedure are not performed at the same session (see general policy on mutually exclusive services); therefore, only one method of accomplishing a given procedure can be reported. In the event that an initial approach is unsuccessful, and an alternative approach is undertaken, the approach which successfully accomplishes the procedure becomes the medically necessary service and is reported; if appropriate, modifier -22 may be appended to the procedure code for the successful approach.

Modifier 22

• **Significant** additional work
  – Document additional work and additional time. Time alone, is not a determining factor. State reason for additional work (scarring/adhesions, etc).
• Complications
  – Difficulty controlling profuse bleeding with unusual blood loss
  – Unexpected findings; infection
• Special techniques
  – Use of special equipment requiring significant work
• Morbid obesity causing increased work
Modifier 22

- Do not append to unlisted procedures
- Do not append routinely
- Attach documentation and highlight information needed to support claim
- Attach narrative letter if necessary
- Increase fee at least 30% (expect 20%)
- **DOCUMENTATION** is key to reimbursement

Modifier Problem Areas

- **Modifier 59 ~Distinct Procedural Service:**
  - Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances.
EXHIBIT A

Modifier 59

- Different session or patient encounter
- Different procedure or service
- Different site or organ system
- Separate incision/excision
- Separate lesion
- Separate injury
- Most often used to bypass the NCCI Edits

OIG Workplan 2005 ~ Use of Modifiers With National Correct Coding Initiative Edits

- We will determine whether claims were paid appropriately when modifiers were used to bypass National Correct Coding Initiative edits. The initiative, one of CMS’s tools for detecting and correcting improper billing, is designed to provide Medicare Part B carriers with code pair edits for use in reviewing claims. A provider may include a modifier to allow payment for both services within the code pair under certain circumstances. In 2001, Medicare paid $565 million to providers who included the modifier with code pairs within the National Correct Coding Initiative. We will determine whether modifiers were used appropriately.
  - (OEI; 03-02-00771; expected issue date: FY 2005; work in progress)
Modifier Problem Areas

• Modifier 62 ~ Two Surgeons:
  – When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding the modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons.

Modifier 62

• Co-surgeons from different specialties performing separate parts of one billable code:
  – Example: 58152 ~ Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpop-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)
Modifier 62

– Each surgeon reports:
  • 58152 – 62
  • Co-surgeon referenced on CMS 1500
  • May require documentation of operative note for claim payment
  • Each surgeon should receive 62.5% payment (Paid at 125%)
II. Repair of Pelvic Support Defects

A. Diagrams
New CPT Category I Code

- +57267  Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment) vaginal approach (list separately in addition to code for primary procedure – (Add-on code)

What is the pelvic floor?

- The pelvic floor is a group of muscles that stretch across the opening of your pelvis.
- These muscles and their surrounding tissue support your pelvic organs - your bladder, uterus, and rectum - keeping them in place.
- When these muscles are weakened or damaged, that support is lessened and those organs can slip out of place, or prolapse, and cease to function properly resulting in symptoms like incontinence.
What causes pelvic floor defects?

- The leading cause of pelvic floor defects is normal vaginal childbirth. During delivery, the tissues in the pelvis can be torn, broken or detached.
- Muscle and nerve damage is also possible.
- Other causes include chronic straining due to coughing, constipation, or lifting.
- And age and gravity certainly play a role as well.
- An estimated 25% of American women will suffer some type of pelvic support problem during their lifetime.
Anterior Repair with Mesh

Posterior Repair with Mesh
New CPT Category I Code

• 57283 Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)

What is a Colpopexy?

• Colpopexy: The use of surgical-quality stitches to bring a displaced vagina back into position against the abdominal wall.

• Also called: Vaginapexy, vaginopexy, vaginofixation
Repair with Mesh

- The procedure utilizes an abdominal or vaginal approach to expose the vaginal vault and the anterior surface of the first and second sacral vertebrae.

- A Mersilene mesh is fastened to the anterior and posterior vaginal walls then anchored to the sacrum without tension.
Placement of Mesh
B. Coding Guidelines and Case Studies

Repair of Female Hernia and Pelvic Support Defects

Sources: *CPT Changes 2001: An Insider’s View*, AMA.; June 2002 *CPT Assistant* newsletter, AMA.

Pelvic support is provided primarily by the skeletal structure. Secondary pelvic support is provided mainly by the superior structure of the bilateral levator muscles (pubococcygeus, iliococcygeus, and ischiococcygeus muscles). This muscular sling supports the three canals (urinary, vaginal, and rectal) of the pelvic floor. The ligaments and pseudo-fascia of the pelvic anatomy accomplish the tertiary support, which is most subject to injury.

**Cystocele** is a herniation of the bladder indicated by descent, bulging and protrusion of the bladder floor of the anterior vaginal wall toward and at times, beyond the vaginal introitus and may be accompanied by symptoms of stress incontinence.

**Rectocele** is a rectovaginal herniation of the fibrous connective tissue (rectovaginal fascia) that appears as a protrusion of the rectal wall into the vaginal canal, with pouching of the rectal wall.

**Enterocele** is a herniation of the peritoneum of the cul-de-sac that appears as an encroachment of the sac containing small bowel, into the rectovaginal septum behind the cervix, or in absence of the uterus (posthysterectomy vaginal vault prolapse)

**57240 Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele**

Description of Procedure:

Using a vaginal approach, the weakened, thin, or redundant vaginal wall tissue may be excised and the resulting defect closed, possibly with a layered closure. The optimal position of the urethra is restored through reinforcement of the pubourethral fascia support and suspension of the urethra into a retro-public position, with further support of the bladder.
Case Study: Code 57240

OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Cystocele
POSTOPERATIVE DIAGNOSIS: Cystocele
OPERATION: Anterior colporrhaphy

PROCEDURE: The 60-year-old patient was placed under general anesthesia in the lithotomy position, prepped with Betadine and draped in the usual manner. Foley catheter was placed and connected to a drainage bag. The anterior midline of the vagina was infiltrated with 0.25% Marcaine. We made a midline vaginal incision with the cautery. We developed a plane between the vagina and the bladder using the Metzenbaum scissors and blunt dissection. We used 0 chromic catgut horizontal mattress sutures laterally on either side to give the bladder good support. When we tied these, we had excellent support. We trimmed excess vagina. We irrigated with 0.5% Marcaine. We looked for bleeding. None was found. We closed the vaginal mucosa with figure-of-eight 0 chromic catgut sutures. The patient went to the recovery room in good condition. She tolerated the procedure well. Blood loss was minimal and all counts correct.
57250 Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy

Description of Procedure:

The approach is a posterior midline incision of the vaginal mucosa and may include the perineum. The diverging fibers of the rectovaginal fascia are repaired and brought to midline. The levator ani muscles are reinforced over the anterior rectal wall in order to strengthen the posterior paravaginal tissue until the defect is repaired. Repair of the vagina and the fibrous tissue separating the vagina and the rectum will also be performed with excision of excess posterior vaginal wall. A perineorrhaphy may also be performed which includes midline approximation of the levator ani and perennial muscles and the puborectalis fibers.

57267 Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)

Description of Procedure:

Occasionally, with many reconstructive procedures performed for the anterior and posterior compartments of the vagina (eg, procedures described by codes 57240, 57250, 57260, 57265, 45560), the native tissues are determined to be weak and inadequate for repair, especially in patients who have had previous attempts at repair. Consequently the decision is made to insert an intervening prosthetic material (eg, autograft, allograft, xenograft, synthetic), which involves attachment of the graft to the surrounding tissues in addition to the routine vaginal repair(s). The physician work involved in performing the insertion of prosthetic material, including placed extra separate sutures, preparing the prosthesis for insertion (sizing), and ensuring proper placement for repair of pelvic floor defect(s), is distinct from the physician work involved in performing the primary pelvic floor defect repair(s) which primarily involves re-approximation of pelvic fascial tissues only. Therefore, code 57267 should be reported in addition to the primary vaginal repair procedure (codes 45560, 57240-57265). (Source: CPT Changes: An Insider’s View 2005, AMA, Chicago, IL, 2004).
57288 Sling operation for stress incontinence (e.g., fascia or synthetic)

Description of Procedure:

Placement of fascia or other material at the urethrovesical junction to encircle and suspend the urethra for treatment of stress incontinence. The ends of the sling are pulled toward the symphysis pubis and fastened to the rectus abdominus sheath. This procedure is a combined anterior vaginal and abdominal approach.

Code 57288 is unique from other anti-incontinence procedures [e.g., Marshall-Marchetti-Krantz, Burch procedure (51840, 51841), and Pereyra type procedure (57289)] because it utilizes graft material to achieve the desired urethral suspension. For example, code 51841 describes a complex Marshall-Marchetti-Krantz, Burch procedure which utilizes only sutures. Source: *CPT Changes 2001: An Insider’s View*, AMA.

Coding Tips:

* It would not be appropriate to report code 52000 (Cystourethroscopy) in addition to code 57288 (Sling operation for stress incontinence) when a cystoscopy is performed to confirm that the Sling procedure was successful. (Source: *CPT Assistant* newsletter, October 2000, page 24).

* Tension-free vaginal tape procedure. Assign code 57288 for this procedure. Source: April 2002 *CPT Assistant* newsletter, AMA.
Case Study: Codes 57250, 57267, 57288

Operative Report

OPERATION: In situ vagina sling with transvaginal bone anchors and rectocele repair with Vicryl mesh.

ANESTHESIA: General endotracheal anesthesia.

POSITION: Dorsal lithotomy position.

PREOPERATIVE DIAGNOSIS: Stress urinary incontinence, symptomatic rectocele.

POSTOPERATIVE DIAGNOSIS: Stress urinary incontinence, symptomatic rectocele.

OPERATIVE INDICATIONS: The patient is a 77-year-old woman who has undergone previous procedures for stress urinary incontinence who presents now with stress urinary incontinence and a symptomatic rectocele. The patient on urodynamic testing was noted to have a peak line pressure of approximately 67 cm of water. The patient now enters for in situ sling with transvaginal bone anchors and rectocele repair.

OPERATIVE PROCEDURE: The patient was identified in the holding area, brought to the operating room and placed on the operating table in the supine position. She was then intubated and given general anesthetic and maintained under intravenous antibiotics. She was then repositioned in the dorsal lithotomy position and cleaned and prepped in a sterile fashion. Then, an A type incision was made in the anterior vaginal wall using a 15 blade scalpel. The apex of the A was then carefully dissected out to be used as an in situ vaginal sling. Then, microinvasive transvaginal bone anchors were placed on either side of the midline without difficulty. The Prolene sutures attached to the bone anchors were then brought through the vaginal wall sling on either side using a free Mayo needle. The Foley catheter was removed and the in situ vaginal wall sling was then tied to the bone anchors. The Foley catheter was then replaced without difficulty. The vaginal wall was then reapproximated using 2-0 Vicryl running sutures.
Case Study: Codes 57250, 57267, 57288 cont’d

At this point in the procedure, the operation was directed towards the posterior aspect of the vaginal canal where there was noted to be a rectocele present. A midline vaginal wall incision was then made into the posterior aspect using a 15 blade scalpel. The rectocele was then carefully dissected from the vaginal wall tissue using Metze scissors. The Denovilliers fascia was then reapproximated to the perineal body using 2-0 PDS suture. A strip of Vicryl mesh was then tacked down over Denovilliers fascia using a 2-0 Vicryl suture. Then, the perirectal tissue was reapproximated over the Vicryl mesh using figure-of-eight interrupted 2-0 Vicryl sutures as well as figure-of-eight interrupted 2-0 PDS sutures. The vaginal wall was then trimmed and closed using running 2-0 Vicryl sutures. There was also a 4-0 Vicryl suture used to reapproximate the perineal body. The patient tolerated this procedure well. A vaginal pack with Premarin cream was then placed in the vaginal canal. The patient was taken out of the dorsal lithotomy position and extubated in the operating room. She was brought to the recovery room awake, alert and in stable condition.

ESTIMATED BLOOD LOSS: Approximately 100 cc.

DRAINS: 16 French Foley catheter abdomen a vaginal pack with Premarin cream.
57260  Combined anteroposterior colporrhaphy

Description of Procedure:

The technique is that which is described above for CPT codes 57240 and 57250. When both procedures are performed at the same operative session, only code 57260 should be reported. If a vaginal hysterectomy with removal of tubes and ovaries (CPT code 58262) is performed at the same session as an anteroposterior colporrhaphy, it would be appropriate to report both procedures performed at this surgical session.

57284  Paravaginal defect repair (including repair of cystocele, stress urinary incontinence, and/or incomplete vaginal prolapse)

Description of Procedure:

CPT code 57284 is reported for performance of a surgical correction of a paravaginal defect (causing stress urinary incontinence), and subsequent cystourethrocele repairs that are the sequelae of a lateral detachment of the pubovesical fascia from the arcus tendineus (tendinous arch of pelvic fascia). Most commonly performed through an abdominal incision, entry is made into the space of Retzius and extending the dissection along the entire paravesical and paravaginal space. This allows surgical exposure from the posterior inferior surface of the pubic ramus following along the obturator internus muscle to the ischial spine. Sutures are placed through the anterior fascial lateral edge of the vaginal wall, through the fascia condensation over the obturator internus muscle from the inferior aspect of pubic bone along the arcus tendineus to the ischial spine.

For correction of stress urinary incontinence in with cystocele correction, some surgeons, based on their experience and/or judgment, will elect to use other anchoring points such as the periosteum of the pubic bone of Coopers ligament for sutures placed at the level of the urethrov vesical junction, as opposed to the fascia covering the obturator internus muscle. However, this does not constitute a separate, distinct surgical procedure.

If an abdominal-vaginal vesical neck suspension (e.g., Stamy, Raz, modified Pereyra) with or without inclusion of an anterior colporrhaphy is performed with the performance of this paravaginal defect repair, it would be appropriate to code these procedures given the separate, distinct and additional work. Therefore, codes 51845, 57289, or 57240 may be reported in addition to code 57284 when indicated.
When either a vaginal or abdominal paravaginal defect repair is performed to correct stress urinary incontinence or cystocele formation, and in addition a separate procedure for correction of vaginal vault inversion such as a sacrospinous ligament fixation (code 57282) or an abdominal colpopexy (code 57280) is performed, then code 57282 or 57280 may be reported in addition to code 57284.
57287  Removal or revision of sling for stress incontinence (e.g., fascia or synthetic)

Description of Procedure:

A small percentage of transabdominal and transvaginal sling procedures described in code 57288 need to be reversed or taken down due to complication of anti-incontinence surgery (e.g., graft infections, erosions and persistent urinary retention caused by bladder outlet obstruction).

CPT code 57287 describes the removal or revision of a previous sling procedure described in code 57288. It involves mobilizing and removing the infected, nonfunctioning or obstructive synthetic or fascia type graft material that was previously inserted during the original corrective procedure described in code 57288.
Case Study: Code 57287

OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS(ES):
Urinary retention after pubovaginal sling.

POSTOPERATIVE DIAGNOSIS(ES):
Urinary retention after pubovaginal sling.

OPERATION PERFORMED:
Release of pubovaginal sling.

ANESTHESIA:
General.

ESTIMATED BLOOD LOSS:
Less than 25 cc.

PROCEDURE: Following induction of satisfactory general anesthesia the patient was placed in the dorsal lithotomy position and prepped and draped in the usual manner for vaginal surgery. Allis clamps were applied to the anterior vagina, just beneath the urethra and a 2 cm vertical incision was made in the vagina. The overlying vaginal mucosa was sharply and bluntly dissected from the underlying bladder. The TVT sling could then be palpated beneath the urethra and it was isolated with a hemostat and incised in the midline. There was immediate release of the tension on the mid-urethra but the arms of the sling were left in place to maintain continence. Small bleeders were then cauterized and the vaginal incision was closed in a vertical fashion using a running locking 2-0 chromic suture. There was good hemostasis at surgery’s end. The incision was also checked with a diluted Pitressin solution for hemostasis. The patient was then sent to the recovery room.
Hysteroscopy & Laparoscopy
GENERAL CORRECT CODING POLICIES
NATIONAL CORRECT CODING POLICY MANUAL

• When an endoscopic procedure is performed as an integral part of an open procedure, only the open procedure is reported.

• If the endoscopy is confirmatory or is performed to assess the surgical field ("scout endoscopy"), the endoscopy does not represent a diagnostic or surgical endoscopy. The endoscopy represents exploration of the surgical field, and should not be separately reported under the diagnostic or surgical endoscopy codes.

GENERAL CORRECT CODING POLICIES
NATIONAL CORRECT CODING POLICY MANUAL

• When an endoscopic procedure is attempted unsuccessfully and converted to an open procedure, only the open procedure is reported.
GENERAL CORRECT CODING POLICIES
NATIONAL CORRECT CODING POLICY MANUAL

• If the endoscopy is performed for **diagnostic** purposes and a subsequent therapeutic service can be performed at the same session, the procedure is coded at the highest level of specificity.

GENERAL CORRECT CODING POLICIES
NATIONAL CORRECT CODING POLICY MANUAL

• If the *CPT Manual* narrative includes endoscopy, then the **diagnostic** endoscopy is not separately coded.

• If the narrative does not include endoscopy and a separate endoscopy is necessary as a **diagnostic** procedure, this can be reported separately.
  – Modifier -58 may be used to indicate that the diagnostic endoscopy and the subsequent therapeutic service are staged or planned procedures.
  – The medical record must describe the intent and findings of the **diagnostic** endoscopy in these cases.
Hysteroscopy

- The procedure is completed using a hysteroscope, an instrument guided through the cervix into the uterine cavity allowing visualization of the uterine interior.
  - Examine the uterine lining (endometrium)
  - Biopsy
  - Remove growths
  - Perform other procedures
Hysteroscopy ~ Corpus Uteri

- **58555** Hysteroscopy, diagnostic (separate procedure)
  - Surgical hysteroscopy always includes diagnostic hysteroscopy.

- **58558** Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D&C
- **58559** with lysis of intrauterine adhesions (any method)
- **58560** with division or resection of intrauterine septum (any method)
- **58561** with removal of leiomyomata
- **58562** with removal of impacted foreign body
- **58563** with endometrial ablation (any method)

- **58579** Unlisted hysteroscopy procedure, uterus

Laparoscopy

- A lighted viewing instrument (laparoscope) is inserted into the lower abdomen through a small incision (usually just below the navel). The abdomen is inflated with gas injected through a needle. This pushes the abdominal wall away from the organs allowing visualization.
Laparoscopy

- Diagnostic
- Operative
  - Remove abnormal growths
  - Fulguration
  - Incision and drainage
  - Biopsy
  - Tubal ligation
  - Repair organs
  - Remove diseased tissue and/or organs
  - Treat ectopic pregnancy
  - Appendectomy

Laparoscope
Laparoscope

Pelvic laparoscopy is a less-invasive procedure than open surgery and recovery is quicker.

Laparoscopy ~ Abdomen, Peritoneum & Omentum

- **49320** Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
  - Surgical laparoscopy always includes diagnostic laparoscopy.

- **49321** Laparoscopy, surgical; with biopsy (single or multiple)
- **49322** with aspiration of cavity or cyst (e.g. ovarian cyst) (single or multiple)
- **49323** with drainage of lymphocele to peritoneal cavity
- **49329** Unlisted laparoscopy procedure, abdomen, peritoneum and omentum
Laparoscopy ~ Corpus Uteri

- **58545** Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas.
- **58546** 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams.
- **58550** Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less;
- **58552** with removal of tube(s) and/or ovary(s).
- **58553** Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;
- **58554** with removal of tube(s) and/or ovary(s).
- **58578** Unlisted laparoscopy procedure, uterus.

Laparoscopy ~ Oviduct/Ovary

- **58660** Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)
- **58661** with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
- **58662** with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method
- **58670** with fulguration of oviducts (with or without transection)
- **58671** with occlusion of oviducts by device (e.g. band, clip, or ring)
- **58672** with fimbrioplasty (**Unilateral procedure**)
- **58673** with salpingostomy (salpingoneostomy) (**Unilateral procedure**)
- **58679** Unlisted laparoscopy procedure, oviduct, ovary.
Laparoscopy ~ Bladder

- **51990** Laparoscopy, surgical; urethral suspension for stress incontinence
- **51992** sling operation for stress incontinence (e.g. fascia or synthetic)

Multiple Endoscopy Guidelines

- Per Medicare Carrier’s Manual
  - Section 4826.C.12
  
  *When multiple endoscopies are billed, the special rules for multiple endoscopic procedures apply. Pay the full value of the highest valued endoscopy, plus the difference between the next highest and the base endoscopy.*
III. Hysteroscopies and Laparoscopies

C. Case Studies
Case Study: Code 58660 (laparoscopic salpingolysis/ovariolysis)

OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS:
1. Chronic Pelvic Pain
2. Dysmenorrhea
3. Dyspareunia

POSTOPERATIVE DIAGNOSIS:
1. Chronic Pelvic Pain
2. Dymenorrhea
3. Dyspareunia
4. Pelvic adhesions

OPERATION. Diagnostic laparoscopy

DESCRIPTION OF PROCEDURE: After adequate counseling, the patient was taken to the operating room and placed in the supine position where she underwent general endotracheal anesthesia without difficulty. The legs were placed in the low lithotomy position, abdomen and vagina steriley prepped and draped in the usual fashion. Speculum was placed within the vagina. Cervix grasped with a single tooth tenaculum and Hulka tenaculum placed intrauterine without difficulty. Speculum was removed as was the single tooth tenaculum. At that time, a small infraumbilical incision was made. Veress needle was inserted intra-abdominally verified by free flowing H20. Approximately two liters of CO2 were insufflated in the abdomen, the Veress needle was removed and a 5 mm trocar placed intra-abdominally. Anterior abdominal wall was free of adhesions and therefore, a suprapubic incision was made on the patient’s left side and a 5 mm trocar placed. Inspection of the pelvis at that time revealed normal anterior and posterior cul-de-sac. The ovary and the fallopian tube was adhered to the posterior broad ligament bilaterally. A third 5 mm tocar site was then placed on the patient’s right side suprapubically. Manipulating probe, graspers and cautery scissors were then used to lyse adhesions from the ovary to the posterior broad ligament bilaterally as well as from the ovary to the fallopian tube bilaterally. When this was completed, the ovary and fallopian tube were hanging in their normal position bilaterally. No other areas of endometriosis were noted on the posterior broad ligament. Appendix was visualized and was normal. Liver edge was normal. At that time, the suprapubic incision trocars were removed, umbilical trocar was removed and the abdomen was deflated. The suprapubic incisions and umbilical incisions were closed with 4-0 plain sutures. Band-Aid was applied. The patient was extubated in the OR and taken to the recovery room in stable condition. Estimated bloodloss was minimal. Fluid replacement was 900 cc lactate of Ringer’s. Sponge and needle counts correct.
Case Study: Codes 58558 (hysteroscopic polypectomy with D & C), 57522 (LEEP)

OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: High-grade squamous intraepithelial lesion (cervical intraepithelial neoplasia II); endocervical polyp.

POSTOPERATIVE DIAGNOSIS: High-grade squamous intraepithelial lesion (cervical intraepithelial neoplasia II); endocervical polyp.

PROCEDURES:
1. Hysteroscopic polypectomy.
2. D & C
3. Loop electrical excision.

ANESTHESIA: Laryngeal mask airway.

COMPLICATIONS: None.

DRAINS: None.

OPERATIVE FINDINGS: Endocervical polyp with base near internal os, otherwise normal-appearing endometrial cavity.

INDICATIONS: This is a 37-year-old female from Nepal, gravida O, who presents high-grade SIL and CIN II at 7 o’clock and a recurrent endocervical polyp. The polyp stalk was located near the internal os causing dilation of the cervical canal and recent worsening and cramping. She has difficulty with extensive office procedures, and therefore we discussed a polypectomy and LEEP procedure completed with anesthesia in an outpatient setting. The risks, benefits, and alternatives were discussed with the patient, and she agreed to proceed.

DESCRIPTION IN DETAIL: The patient was taken to the operating room and placed supine on the table.

After adequate induction of general anesthesia and placement of laryngeal mask airway, the patient was prepped and draped in the usual sterile fashion. Her bladder was drained, and she was placed in the dorsal lithotomy position. A bimanual examination revealed an anteflexed midline uterus. A weighted speculum was placed in the posterior vagina, and the cervix was grasped in an anterior location with a single-tooth tenaculum. I was
Case Study: Codes 58558, 57522 cont’d

careful not to grasp the cervix at a point where the LEEP would be completed. The polyp
was evident. The cervix was sequentially dilated with Hegar dilators, and the
hysteroscope was placed. The polyp was identified and was removed at its base with
polyp forceps. Next, the hysteroscope was continued up through the endocervical canal.
The canal was noted to be normal at this time, free of polyps or other structures. The
endometrial cavity was noted to be normal. Both cornua were noted to be normal. There
was some sloughing endometrium seen posteriorly in the uterine body. A curettage was
followed in a standard fashion. Next, all other instrumentation was removed, and
LEEP safe instruments were placed. A suction smoke evacuator was placed, and
using appropriate electrical surgical generator settings the area of concern was
removed after it had been outlined with Lugol solution. This was removed in two
portions, portion A, the superior portion, was tagged at 12 o’clock with nylon suture. The
portion B, the inferior portion, was tagged at 3 o’clock with nylon suture. A roller ball
was then used for hemostasis, and a small amount of Monsel was placed at the base of the
LEEP bed. Once hemostasis was achieved, all instrumentation was removed. The patient
was returned to the supine position, awakened, and taken to the recovery room in stable
condition. All sponge, needle, and instrument counts were correct. The patient tolerated
the procedure well.
Case Study:  Codes 58670 (laparoscopic oviduct fulguration)  
58671-59 (laparoscopic oviduct occlusion)

OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Undesired fertility and pelvic pain, dysmenorrhea, skin tag probably a fibroepithelial polyp.

POSTOPERATIVE DIAGNOSIS: Undesired fertility and pelvic pain, dysmenorrhea, skin tag probably a fibroepithelial polyp.

OPERATION: Laparoscopic tubal ligation with Falope ring on the right and Kleppinger fulguration on the left and removal of skin tag in the vulvar area.

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: Minimal.

COMPLICATIONS: None.

PROCEDURE: Consent was obtained. The patient was taken to the OR with an IV running. She was placed in the dorsal supine position and underwent induction of general endotracheal anesthesia. She was placed in the Allen stirrups in the dorsal lithotomy position, prepped and draped in the usual sterile fashion and in-and-out catheterization was performed. Weighted speculum was placed in the patient’s vagina and single tooth tenaculum was used to grasp the anterior lip of the cervix and an Acorn cannula was inserted through the endocervical canal and attached to the single tooth to manipulate the uterus. Next, attention was turned to the patient’s abdominal area where 0.25% Marcaine was injected in the umbilical fold and suprapubic area about two fingerbreadths above the pubic symphysis midline. A stab incision was made with the #11 blade scalpel and Veress needle was inserted with a normal saline drop test. CO2 hose was attached and opening pressure was 7 mm of mercury. Pneumoperitoneum was created with CO2 gas and insufflated. Next, the 5 mm trocar and sleeve were inserted in the umbilical stab incision. Camera was used to confirm placement. The patient was placed in Trendelenburg and our second trocar, 11 mm, was inserted. We used the Falope ring applicator to push the bowel out of the way. The right tube was followed out to its fimbriated end. We grasped an avascular segment and the Falope ring applicator was fired. We looked at the second tube and thought we could find an avascular segment. When we tried to fire the Falope ring, there was a little bit of bleeding noted, and the tube appeared to be slightly dilated. With this, we went ahead and asked for the Kleppinger’s and inserted this through our incision and grasped the tube of concern and cauterized it about three times until good burning was noted. Following this, the instruments were removed from the abdominal cavity.
Case Study: Codes 58578 (unlisted laparoscopic procedure, uterus)  
58662 (laparoscopic fulguration of lesions)  
44200 (laparoscopic enterolysis) [CCI BUNDLED]

OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Uterine retroversion; pelvic pain; family history of endometriosis.

POSTOPERATIVE DIAGNOSIS: Uterine retroversion; pelvic pain; family history of endometriosis; moderate endometriosis noted on the posterior cul-de-sac, in the left uretersacral ligament, some in the right uterosacral ligament and a little bit on the right broad ligament and on the posterior uterine wall.

OPERATION PERFORMED:
1. Operative laparoscopy with:
   A. Fulguration of pelvic endometriosis.
   B. Lysis of sigmoid colon/anterior pelvic wall adhesions.
   C. Uterine suspension (Inlet Medical).

PROCEDURE: The patient is brought to the operating room where she was placed under satisfactory general anesthesia in standard fashion by Dr. W. In the dorsal lithotomy position, the perineum was prepped, scrubbed and draped. Foley catheter was inserted into the urinary bladder and a Hulka manipulator was placed in the uterine cervix after a paracervical block was administered with 1% Xylocaine.

I then proceeded to anterior abdominal wall, where a small stab wound was made in the inferior aspect of the umbilicus and a sharp trocar was introduced into the peritoneal cavity. Panoramic visualization of the pelvic organs was then performed. Visualization revealed a large web of adhesions over her previous appendectomy site; however, the pelvic organs showed no evidence of adhesions, especially the right side was nice and free and easily mobile.

The anterior cul-de-sac was clear. The posterior cul-de-sac was clear. On elevation of the retroverted uterus, we found the endometriosis, moderate in nature, on the posterior wall of the uterus and on the uterosacral sigmoid reflection at the cul-de-sac and in the left uterosacral ligament and the right uterosacral ligament.
Case Study: Codes 58578 (unlisted laparoscopic procedure, uterus)  
58662 (laparoscopic fulguration of lesions)  
44200 (laparoscopic enterolysis) cont’d

The ovaries otherwise were normal on both sides. At this point in time, secondary trocars were placed. Retroverted uterus was then antverted and the cul-de-sac was approached. **Bipolar cautery was used to grasp and cauterize the areas of endometriosis and coagulate them.** Sharp trocars were then used to lyse the adhesions from the colon and free the colonic wall up from the pelvic peritoneal sidewall.

At this point in time, after this was all done and adequate hemostasis was obtained, **we then proceeded with the uterine suspension.**

Using the Inlet Medical device, a small incision was made laterally over top of the **round ligament** on both sides, dissected down to fascia. **Using the laparoscopic needle suspender supplied with the kit and also the suture, the suture was then threaded down through the fascia into the round ligament** down through the parenchyma of the round ligament to exit approximately 1 to 2 cm lateral to the insertion of the round ligament on the uterus. This was then grasped and then brought back into the Inlet device, which was brought down through the round ligament, again pulled back up to accordion the round ligament anteriorly. This was done on both sides very nicely, very easily. **Good uterine suspension was noted.**

Ringer’s Lactate was used in copious quantities to flush the peritoneal cavity and then the peritoneum was then injected with 0.5% Marcaine with Demerol for postoperative analgesia. She did very well and went to the recovery room in stable condition. The incisions were closed and no problems were noted.

“I authorize my name to be mechanically affixed to this report signifying that I dictated this report and reviewed the dictation.”
Case Study:

**Codes 58559** (hysteroscopic lysis of intrauterine adhesions)

- 58660 (laparoscopic salpingolysis/ovariolysis)
- 58120 (dilation and curettage)
- 58350 (chromotubation of oviduct)
- 58555 (hysteroscopy) [CCI BUNDLED]

**OPERATIVE REPORT**

PREOPERATIVE DIAGNOSIS: Pelvic adhesions, rule out pelvic endometriosis, rule out uterine synechia, pelvic pain.

POSTOPERATIVE DIAGNOSIS: Pelvic pain, pelvic adhesions, and uterine synechia.

OPERATION: Laparoscopy, lysis of adhesions, hysterectomy, injection of dye, lysis of synechia, and dilation and curettage.

MEDICATION: General anesthesia.

PROCEDURE: With the patient under general anesthesia and in the lithotomy position the abdomen and peritoneum were adequately prepped and draped. An infraumbilical semi-elliptical incision was made and carried to the subcutaneous tissue. A Veress needle was inserted into the peritoneal cavity and the insufflation of carbon dioxide gas was carried out, up to 3 liters under low pressure. The needle was removed. The incision was widened and a larger trocar was put in place. The scope was put in the sleeve of the trocar and then under vision a small suprapubic incision was made through skin and subcutaneous tissue. A small probe was inserted through a small trocar.

Visualization of the pelvic organs revealed the following. The fundus was retroverted. The right ovary was plastered to the posterior surface of the fundus. The right tube was adherent to the lateral pelvic wall. The fimbria on the right side was normal. There was a small hydatid cyst of Morgagni on the left side. The tube was adherent to the lateral pelvic wall. The ovary was normal in size and shape. Using a 5 mm trocar where an irrigator aspirator was introduced lysis of the adhesions was done between the right ovary and posterior surface of the fundus, and between the tube and the lateral pelvic wall on the right side. This was done by hydrodissection and by blunt dissection. On the left side the adhesions between the left pelvic wall were lysed with blunt dissection. The fimbria on the left side was normal.
Codes 58559 (hysteroscopic lysis of intrauterine adhesions)  
58660 (laparoscopic salpingolysis/ovariolysis)  
58120 (dilation and curettage)  
58350 (chromotubation of oviduct)  
58555 (hysteroscopy) cont’d

After all the adhesions were lysed an injection of dye revealed prompt patency from both tubes. The uterus itself was normal in shape. There were no endometrial implants and no fibroids.

At this stage the posterior lip of the cervix was grasped with a single tooth tenaculum. The cavity sounded 8 cm. Dilation was done. Hysteroscopy was done under Hyskon injection. The tubal ostia were visualized on both sides and were normal. There were multiple uterine synechia joining the anterior and posterior wall of the uterine cavity. These were lysed with blunt dissection. Hysteroscope was then concluded. The instruments were then removed. Then curettage was done with the retention of a moderate amount of tissue that were sent to the lab for analysis. The cavity was smooth without any major irregularities.

Another look with the laparoscope revealed intrapelvic organs as described previously. The scope was removed. The abdomen was deflated. Suturing from the umbilical incision was carried out with a single 3-0 Dexon suture, the suprapubic incision with a single 3-0 Dexon suture. The procedure was concluded. The estimated blood loss was minimal. The operative time was one hour. The patient tolerated the procedure well and left the operating room to the recovery room in good condition.
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attended

“Coding Gynecology Surgery: Strategies for Reimbursement Success”

a 90-minute audioconference

on

August 12, 2005

Suzanne Perney
HCPro, Inc., 2005
# Winter/Spring Education Program Schedule 2005

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<td>12-13th</td>
<td>Legal Challenges for Hospital and Medical Staff Leaders: How to stay out of trouble, stay out of court, and improve physician relationships</td>
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<td>Medical Executive Committee Institute: The essential training program for all medical staff leaders</td>
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<td>Physicians and Patient Safety: Practical tools to help leaders change physician culture and behavior</td>
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<td>13-14th</td>
<td>Surgical Team Summit: Bringing together chiefs of surgery, chiefs of anesthesia, and surgical services leadership to tackle the toughest OR challenges</td>
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<th><strong>J u n e</strong></th>
<th>Mandalay Bay Resort &amp; Casino, Las Vegas, NV</th>
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<tbody>
<tr>
<td>2-3rd</td>
<td>The 8th Annual Credentialing Resource Center Symposium</td>
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<td>A Practical Approach to JCAHO Survey Preparation</td>
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</tbody>
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SELECT SEMINARS OFFERING CATEGORY 1 CME, NURSING CONTACT HOURS AND NAMSS CEUS

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November
Loews Philadelphia Hotel, Philadelphia, PA
3-4th
A Practical Approach to JCAHO Survey Preparation
Credentialing and Privileging: What physician leaders and credentialing professionals must know today!
Physicians and Patient Safety: Practical tools to help leaders change physician culture and behavior

The Ritz-Carlton Palm Beach, Palm Beach, Fl
16th
VPMA/CMO Retreat
17-18th
Effective JCAHO Survey Preparation for the Medical Staff
Medical Executive Committee Institute: The essential training program for all medical staff leaders