Optum

Clinical Documentation Integrity for ICD-10-CM and Procedure Coding

Documentation guidelines supporting ICD-10-CM and CPT® code assignments

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Contents

Section 1: Introduction

Medical record documentation, whether paper or electronic, is one of the cornerstones of the health system today. The primary function of the medical record is to provide a record of patient care with emphasis placed on what services were provided to the patient and why. A complete and well-organized medical record will allow any member of the care team to quickly access vital information about the patient's health. Only accurate, consistent, and complete documentation can translate into the data and information necessary to ensure clinical quality, substantiate medical necessity, and determine the most appropriate reimbursement. No matter the setting, the health record documentation, as designated by the physician provider, remains the foundation upon which many decisions are based. As a result, efforts to improve the quality of that documentation have been on-going for many years.

Origins of Clinical Documentation Improvement (CDI) Efforts

Providers' focus on clinical documentation has its beginnings in the administration of President Ronald W. Reagan in the early 1980s. Ironically, President Reagan's initial opposition to government intervention in private industry gave way to the heavily regulated payment systems that characterize Medicare today. Following the creation of the Medicare program in the 1960s, Medicare costs increased rapidly. By the late 1970s, it was a "runaway" program that had thwarted all voluntary efforts by hospitals to slow costs.

However, as voluntary restraints proved to be ineffective at controlling the costs of the Medicare program, President Reagan and Congress pragmatically turned to prospective payment. The resulting diagnosis related group (DRG) system pays hospitals based on a patient's medical condition and other factors, including procedures provided. Clinical documentation is a fundamental element in securing appropriate provider payment under the DRG payment system. Under DRGs, poor documentation results in lower payments.

Since its inception, Medicare's DRG payment system has saved the government hundreds of billions of dollars. Due to its success, the Centers for Medicare and Medicaid Services (CMS) has expanded its use of prospective payment systems (PPS) and introduced other payment methodologies to control Medicare program costs. In each instance, provider reimbursement hinges on documentation. CMS's intent to move to "value-based payments" is the latest example. Demonstrating value means showing how a patient's medical condition has improved or has been addressed by specific care, as found in the Quality Payment Program. Communicating a patient's improved condition relies upon clinical documentation.

The Clinician's View of CDI

There has been much deliberation between administrative staff and clinicians over clinical documentation. Too often, clinical detail is lacking in clinical documentation, which makes it difficult to code claims and answer auditor's questions. There are two issues that contribute to a misalignment of physician and facility interests:

- Physicians have traditionally been paid based on procedures performed, with the patient diagnosis considered secondary. The procedure was either performed, or not performed. It is a simple matter in the mind of the physician and does not require detailed documentation. Today, however, diagnosis documentation has become more important in order to confirm medical necessity for procedures and to accurately identify the patient's medical condition. Additionally, the lack of detail of the service or procedure performed often leads to a less complex procedure or service being reported on the claim and, therefore, reimbursement is at a lower rate.
- Clinical detail required for billing is not usually an independent clinician's first concern. Extra work or effort from clinicians to help billing does not reward physicians.

Several factors, however, are now working to enhance clinician motivation toward improving documentation, including audits of professional claims by payers, such as Medicare's recovery audit contractors (RAC), and concerted efforts by billing personnel and auditors to gain clinician cooperation with documentation through CDI programs. Both internal and payer auditors find that lack of documentation is the most common reason for claim denials. But in a broader way, clinicians are now more aware of documentation issues as a result of the implementation of the ICD-10 coding systems and CMS's intention to shift payments in a way that requires more clinical detail for demonstrating value-based care.

Section 2: Clinical Documentation Improvement Processes—Best Practices

As mentioned earlier, the clinical documentation improvement process should be a collaborative one in order to be successful. The health care setting and whether the clinical conditions treated involve only a few, such as in a specialty clinic, or encompass the entire spectrum of diseases and disorders, such as in a full-service acute care hospital, will determine the scope and breadth of the program. However, there are many attributes that are commonly seen in successful programs of any size. Many physicians have found that participating in a CDI program at their local hospital also improves documentation in the office setting as well.

There are three main components to a successful clinical documentation improvement program: assessment, implementation, and sustainability.

Assessment

The first step in any CDI program must be an assessment. The assessment will identify those areas that are compliant as well as areas where improvement is needed.

There are several steps involved in performing the CDI assessment:

- Develop a CDI team
- Develop a review process
- Identify areas of risk
- Identify the root cause

Staffing

Before an assessment can take place, a clinical documentation improvement team must be established. This team should include members from all groups involved (e.g., clinicians, coders, information technology, etc.). Each team member can provide insight into what is needed for his or her particular responsibilities.

Staff members who will work on the CDI program can come from a variety of different backgrounds. Typically they include health information management (HIM) coding professionals, compliance officers, physicians, nursing staff, and other professionals with either a coding or clinical background. Some programs involve a variety of the above-mentioned individuals and job titles are not as important as specific attributes and skills, such as: clinical knowledge of the individual code sets and the reporting guidelines associated with that code set; understanding health care compliance as it relates to documentation, coding, and billing; and strong written and verbal communication skills. The importance of strong verbal skills cannot be overemphasized; these staff members will be communicating with physicians on a daily basis and must convey professionalism and significant clinical and coding knowledge. Many successful programs have one or more physician "champions," who act both as advisors to the other staff members in the program and are liaisons with the medical staff providing the documentation.

Physician Advisor or Liaison

Many CDI professionals believe that a major component of a successful program is a strong physician advisor. This major role is to act as a liaison between the CDI staff members, HIM coding, and the medical staff and to facilitate accurate coding and representation of acuity and severity. As a result, the corresponding reimbursement should also be enhanced, regardless of the setting.

Just as importantly, the physician advisor is responsible for communicating with and educating the medical staff in both the general concepts of severity and acuity as they relate to documentation and coding, and in encouraging and recommending specific documentation enhancements. To accomplish these goals, the physician advisor should have knowledge related to physician performance profiling, physician E/M payment and pay for performance, and appropriate documentation for hospital reimbursement and profiling (if working in that setting). Publicly available data tools are available that can be incorporated in the CDI strategy, including the Surgical Care Improvement Project (SCIP) outcomes, risk of mortality (ROM), and severity-of-illness (SOI) data instruments. Helping other physicians become more aware of outcomes data and the documentation and coding effect on them is a very successful way of reaching those most responsible for providing the documentation upon which these data instruments are based.

Physician advisors can also emphasize the continuity of care approach to other physicians on the medical staff. This approach reinforces the fact that what is documented accurately represents not only the patient conditions, but what was done for the patient. Other physicians participating in the care of the patient need to ensure that what they review in the medical record is accurate and complete to provide additional input and/or services. Continuity of care is an essential goal of any CDI program and should be the number one reason that conflicting information in the medical record is addressed quickly and thoroughly via the CDI process.

Asthma

Code Axes

Note: All asthma codes (with the exception of subcategory J45.99) have fifth or sixth characters that represent the following three classification axes: uncomplicated, with (acute) exacerbation, with status asthmaticus: defined as an acute exacerbation of asthma that does not respond to standard treatments of bronchodilators and steroids.

Mild intermittent asthma	**J45.2-**
Mild persistent asthma	**J45.3-**
Moderate persistent asthma	**J45.4-**
Severe persistent asthma	**J45.5-** HCC
Other asthma (exercise induced bronchospasm, cough variant asthma, other)	**J45.99-**

Description of Condition

Clinical Tip
Respiratory insufficiency is integral to asthma. Hypoxemia is reported separately as it is not inherent.

Key Terms
Key terms found in the documentation may include:

- Allergic asthma
- Allergic bronchitis
- Allergic rhinitis with asthma
- Atopic asthma
- Extrinsic allergic asthma
- Hay fever with asthma
- Idiosyncratic asthma
- Intrinsic nonallergic asthma
- Nonallergic asthma
- Reactive airway disease

Coding Tip

If there is an obstructive component to the patient's asthma, ensure that it is documented appropriately. These cases are coded and classified differently and require two codes: one from category J44 for chronic obstructive pulmonary disease and one from category J45 for asthma.

Asthma Severity Levels

Mild intermittent asthma (J45.2-)
Mild intermittent asthma is the least severe of all types, involves a frequency of symptoms no more than two days a week, and nighttime symptoms no more than two times a month. This type of asthma typically does not interfere at all with daily activities.

Mild persistent asthma (J45.3-)
Patients with mild persistent asthma may have symptoms more than twice weekly, but not daily, and the condition can typically be controlled with one controller medication. A rescue inhaler may be used on a regular basis, but not daily. This type of asthma may interfere with daily activities in a minor way.

Moderate persistent asthma (J45.4-)
A classification of moderate persistent asthma requires that the patient have asthma symptoms daily that are controlled with two medications. A rescue inhaler may be used daily, and the patient may wake with asthma symptoms more than once a week, but not daily. The effect on daily activities is moderate.

Severe persistent asthma (J45.5-)
This is the most severe asthma classification and these patients have asthma symptoms daily. In some cases symptoms are experienced throughout the day, regardless of the use of two or more medications. The patient wakes from asthma symptoms nightly and must use a rescue inhaler multiple times a day. The effect on daily activities is extreme.

Exercise induced bronchospasm (J45.99Ø)

This condition is defined as a reversible transient bronchoconstriction that affects patients both with and without a history of asthma. The symptoms of shortness of breath, wheezing, cough, or chest tightness occur during strenuous exercise and may peak at five to ten minutes after exercising. Spirometry is commonly used to rule out underlying asthma.

Cough variant asthma (J45.991)

The major symptom of cough variant asthma is a dry nonproductive cough that persists for six to eight weeks. Other typical asthma symptoms, such as wheezing or shortness of breath, are absent. The condition may be triggered by cold air or environmental allergens and is treated with a rescue inhaler.

Clinical Findings

Physical Examination

History and review of systems may indicate:

- Coughing
- Wheezing
- Chest tightness
- Shortness of breath

Medication List

- Bronchodilators
  - long-acting beta agonists (LABAs)
    - formoterol (Brovana, Perforomist, Symbicort)
    - salmeterol (Serevent)
  - short-acting beta agonists
    - albuterol (Proair HFA, Proventil HFA, Ventolin HFA, Xopenex HFA)
    - ipratropium (Atrovent HFA)
    - levalbuterol (Xopenex HFA)
  - theophylline (Elixophyllin, Theo-24)
- Inhaled corticosteroids
  - beclomethasone (Beconase AQ, QNasl, QVAR Redihaler)
  - budesonide (Entocort EC, Symbicort, Uceris)
  - ciclesonide (Alvesco, Omnaris, Zetonna)
  - flunisolide
  - fluticasone (Flonase, Flovent HFA, Trelegy Ellipta)
  - mometasone (Asmanex HFA, Asmanex Twisthaler, Dulera, Nasonex 24Hr, Ryaltris, Sinuva)

Diagnostic Procedures and Services

- Imaging
  - pulmonary function tests (PFT)
  - chest x-ray
  - electrocardiogram
  - allergy testing
- Leukotriene modifiers
  - montelukast (Singulair)
  - zafirlukast (Accolate)
  - zileuton (Zyflo)
- Combination inhalers: corticosteroids and LABAs
  - fluticasone and salmeterol (Advair Diskus, Advair HFA, AirDuo Respiclick, Wixela Inhub)
  - budesonide and formoterol (Airsupra, Breyna, Breztri Aerosphere, Symbicort)
  - mometasone and formoterol (Dulera)
- Oral or intravenous corticosteroids

Clinician Documentation Checklist

Clinician documentation should indicate the following:

- Identify any triggers
- Exposure to environmental tobacco smoke
- Exposure to tobacco smoke in the perinatal period
- History of tobacco use
- Occupational exposure to environmental tobacco smoke
- Tobacco dependence
- Tobacco use
- Include additional conditions
  - allergic (predominantly) asthma
  - allergic bronchitis
  - allergic rhinitis with asthma
  - atopic asthma
  - extrinsic allergic asthma
  - fever with asthma
  - idiosyncratic asthma
  - intrinsic nonallergic asthma
  - nonallergic asthma
- Type
  - mild intermittent
  - mild persistent
  - moderate persistent
  - severe persistent
  - other
    - exercise-induced bronchospasm
    - cough variant asthma
  - unspecified
    - asthmatic bronchitis
    - childhood asthma
    - late onset asthma
  - document if any of the above type is:
    - uncomplicated
    - with (acute) exacerbation
    - with status asthmaticus

Influenza

Code Axes

Influenza due to identified novel influenza A virus with pneumonia **JØ9.X1**

Influenza due to identified novel influenza A virus with other respiratory manifestations **JØ9.X2**

Influenza due to identified novel influenza A virus with gastrointestinal manifestations **JØ9.X3**

Influenza due to identified novel influenza A virus with other manifestations **JØ9.X9**

Influenza due to other identified influenza virus with unspecified type of pneumonia **J1Ø.ØØ**

Influenza due to other identified influenza virus with the same other identified influenza virus pneumonia **J1Ø.Ø1**

Influenza due to other identified influenza virus with other specified pneumonia **J1Ø.Ø8**

Influenza due to other identified influenza virus with other respiratory manifestations **J1Ø.1**

Influenza due to other identified influenza virus with gastrointestinal manifestations **J1Ø.2**

Influenza due to other identified influenza virus with other manifestations **J1Ø.8-**
Subcategories represent conditions with encephalopathy, myocarditis, otitis media, and other manifestations.

Influenza due to unidentified influenza virus with pneumonia **J11.Ø-**
Subcategories identify whether the pneumonia is unspecified or specified.

Influenza due to unidentified influenza virus with other respiratory manifestations **J11.1**

Influenza due to unidentified influenza virus with gastrointestinal manifestations **J11.2**

Influenza due to unidentified influenza virus with other manifestations **J11.8-**
Subcategories represent conditions with encephalopathy, myocarditis, otitis media, and other manifestations.

Coding Tip

Codes in these categories representing specific forms of influenza should only be assigned if the specific disease process (e.g., novel influenza A virus) is documented as confirmed. The specific codes in these categories should not be assigned if the corresponding documentation contains terminology such as "possible," "suspected," or "probable." In those instances, assign the appropriate code(s) for the presenting symptoms.

Description of Condition

Influenza (all types) with pneumonia (J09.X1, J10.0[Ø,1,8], J11.0[Ø,8])

Clinical Tip
Influenza due to novel virus A is most commonly isolated from birds, whether domestic poultry or wild birds, which act as asymptomatic carriers of influenza A virus. The category also includes influenza designated as that due to swine or other animals. The course of the disease largely depends on the manifestations, which can range from pneumonia or other respiratory conditions, to encephalopathy or myocarditis.

Key Terms
Key terms found in the documentation for novel influenza A virus may include:

- Avian flu
- Avian influenza
- Bird flu
- Bird influenza
- H5N1
- Influenza A/H5N1
- Influenza of other animal origin, not bird or swine
- Swine influenza

Documentation Tip

Ensure that the medical record indicates the causal agent or virus, if possible. If the condition is due to influenza A virus, treatment typically involves oseltamivir or zanamivir.

Electrocardiogram

Code Axes

Electrocardiogram **93000–93010**

Description of Procedure

An electrocardiogram is the recording of the electrical activity of the heart on a moving strip of paper that detects and records the electrical potential of the heart during contraction. These may be performed as part of a routine physical examination or due to cardiac symptoms or to monitor cardiac conditions.

Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report (93000)

Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report (93005)

Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only (93010)

Key Terms
Key terms found in the documentation may include:

- ECG
- EKG

Clinician Note
Careful documentation is necessary to identify the medical necessity of the procedure, otherwise it is considered routine screening and noncovered by most third-party payers. The following list identifies those conditions which frequently support the medical necessity:

- Acid-base disorders
- Arteriovascular disease including coronary, central, and peripheral disease
- Cardiac hypertrophy
- Cardiac rhythm disturbances
- Chest pain or angina pectoris
- Conduction abnormalities
- Drug cardiotoxicity
- Electrolyte imbalance
- Endocrine abnormalities
- Heart failure
- Hypertension
- Myocardial ischemia or infarction
- Neurological disorders affecting the heart
- Palpitations
- Paroxysmal weakness
- Pericarditis
- Pulmonary disorders
- Sudden lightheadedness
- Structural cardiac conditions
- Syncope
- Temperature disorders

Documentation Tip

When reporting the interpretation and report of an EKG, the physician's findings should be clearly documented in the medical record, even when within normal limits. Some payers may require that measurement of all intervals and axis, rhythm and heart rate, as well as an interpretation be recorded and signed by the provider. A notation of "within normal limits" or WNL may not be sufficient.

A preoperative EKG may be reasonable and necessary under the following conditions:

- In the presence of pre-existing heart disease such as angina, congestive heart failure, coronary artery disease, dysrhythmias, or prior myocardial infarction
- In the presence of known comorbid conditions that may affect the heart, such as chronic pulmonary disease, diabetes, peripheral vascular disease, or renal impairment
- When the pending surgical procedure requires a general or regional anesthetic

Section 4: Terminology Translator

To use the table below, find the term used in the medical record documentation in column one. Column two indicates the term(s) used in the ICD-10-CM system for that condition.

Medical Record Terminology	Coding System Terminology
Abscess of lung	Gangrene and necrosis of lung
Achalasia and cardiospasm	Achalasia of cardia
Acute coronary occlusion without MI	Acute coronary thrombosis not resulting in MI
Acute infective polyneuritis	Guillain-Barré syndrome
Acute pyelonephritis w/ or w/o lesion of medullary necrosis	Acute tubulo-interstitial nephritis
Acute respiratory failure following trauma and surgery	Postprocedural respiratory failure
Adenocarcinoma of intrahepatic bile duct	Intrahepatic bile duct carcinoma
After-cataract	Other secondary cataract
Allergic alveolitis and pneumonitis	Hypersensitivity pneumonitis (due to: cause)
Allergic rhinitis cause unspecified	Vasomotor rhinitis
Angina decubitus	Other forms of angina pectoris
Asbestosis	Pneumoconiosis due to asbestos and other mineral fibers
Asiderotic anemia	Anemia secondary to blood loss
Atrial flutter	Persistent/Atypical/Typical atrial flutter
Atrophic gastritis	Chronic superficial gastritis
Attacks without alteration of consciousness	Localization-related epilepsy
Autoimmune/Non-autoimmune hemolytic anemias	Drug-induced autoimmune hemolytic anemia
Avian Influenza virus (pneumonia, other resp infection)	Identified novel influenza A virus (with manifestation: pneumonia, other respiratory)
Backwash ileitis	Ulcerative colitis
Bacterial colitis	Bacterial intestinal infection, unspecified
Basilar migraine	Juvenile myoclonic epilepsy
Bed sore	Pressure ulcer
Benign childhood epilepsy with centrotemporal EEG spikes	Localization-related epilepsy
Biliary cirrhosis	Primary biliary cirrhosis Secondary biliary cirrhosis
Blood in stool	Melena
Bloodstream infection [although necessary to differentiate from bacteremia]	Septicemia due to (organism)
Bowen's disease	Carcinoma in situ site unspecified
Brachial neuritis or radiculitis	Radiculopathy
Brittle diabetes	Type I diabetes mellitus
C. difficile colitis	Enterocolitis due to Clostridium difficile
Cancrum oris	Necrotizing ulcerative stomatitis
Cataracta brunescens	Age-related cataract
Cataracta complicate	Complicated cataract
Cerebrospinal fluid rhinorrhea	Cerebral spinal fluid leak
Cervical degenerative disc disease with radiculopathy	Cervical disc disorder
Cervical DJD with myelopathy	Cervical disc disorder
Cervical DJD with radiculopathy	Cervical disc disorder
Cervical myelopathy	Cervical disc disorder

Appendix 1: Physician Query Samples

The major purpose of queries is to obtain clarification when documentation in the health record impacts an externally reportable data element and is illegible, incomplete, unclear, inconsistent, or imprecise. As noted earlier in this manual, queries should not lead the provider to a specific diagnosis or response; introduce new information not documented elsewhere; reference directly or indirectly any financial, severity of illness, or risk of mortality impact of the query response; or appear to question a provider's clinical judgment.

The query examples that follow here are intended to provide those actively working with physicians in clinical documentation improvement activities, to encourage accurate and appropriate documentation.

Anemia Clarification

Dr. Davis:

This patient was admitted with a duodenal bleed per your admission note. At that time, her hemoglobin was 7.4gm/dl and her hematocrit was 22.6 percent. The H&P states "anemia." After admission, the patient was treated with two units packed red blood cells (PRBC).

Can your diagnosis of anemia be further specified to any of the following?:

Acute blood loss anemia: _____

Chronic blood loss anemia: _____

Other type of anemia: _____

Unable to determine: _____

Please document any clarification in the progress notes or on the discharge summary.

Signature _____

Date _____

Thank you,

John Jay

QPP Measures Category

1 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
24 Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Years and Older
47 Advance Care Plan
134 Preventive Care and Screening: Screening for Depression and Follow-up Plan
141 Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care
145 Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy
181 Elder Maltreatment Screen and Follow-Up Plan
236 Controlling High Blood Pressure
320 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
418 Osteoporosis Management in Women Who Had a Fracture
422 Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury

Code	Description	CMS-HCC Model Category	QPP Individual Measures–Claims
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)		320
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);		422
58512	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)		422
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)		422
58260	Vaginal hysterectomy, for uterus 250 g or less;		422
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)		422
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele		422
58267	Vaginal hysterectomy, for uterus 250 g or less; with colp-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control		422
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele		422
58275	Vaginal hysterectomy, with total or partial vaginectomy;		422
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele		422
58290	Vaginal hysterectomy, for uterus greater than 250 g;		422
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s), and/or ovary(s)		422
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s),		422
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele		422
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;		422
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)		422
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g		422
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)		422
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;		422
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)		422
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;		422
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)		422
58570	Laparoscopy, surgical; with total hysterectomy, for uterus 250 g or less;		422
58571	Laparoscopy, surgical; with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)		422
58572	Laparoscopy, surgical; with total hysterectomy, for uterus greater than 250 g;		422