Reporting Intra-Abdominal Tumor Excision or Destruction (49186-49190, 58958)

CPT® Assistant.

February 2025; Volume 35: Issue 2

For the Current Procedural Terminology (CPT®) 2025 code set, codes 49203-49205 and 58957 and their related parenthetical notes were deleted, and codes 49186-49190 were created

to report the open excision or destruction of intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal) primary or secondary tumors or cysts. Code 58958 was revised by removing the semicolon because it is no longer a child code with the deletion of code 58957. In addition, guidelines and parenthetical notes were added and revised to accommodate the addition of the new codes and to provide guidance regarding their intended reporting. Refer to the CPT 2025 code set for more detailed information regarding these codes. This article provides an overview of these changes and the intent and use of these codes.

Digestive System

Excision, Destruction

49186 Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 5 cm or less

49187 5.1 to 10 cm

49188 10.1 to 20 cm

49189 20.1 to 30 cm

49190 greater than 30 cm

(Do not report 49186, 49187, 49188, 49189, 49190 in conjunction with 49000, 49010, 49215, 58943, 58950, 58951, 58952, 58953, 58954, 58956, 58958, 58960)

(For excision of perinephric cyst, use 50290)

(49203, 49204, 49205 have been deleted. For open excision or destruction of intra-abdominal [ie, peritoneal, mesenteric, retroperitoneal] primary or secondary tumor[s] or cyst[s], see 49186, 49187, 49188, 49189, 49190)

(For excision or destruction of endometriomas, open method, use 58999)

Codes 49203-49205, which were reported based on the excision or destruction of the largest tumor, were deleted to accommodate the establishment of codes 49186-49190.

Subsection guidelines were added to clarify how to report codes 49186-49190 based on the sum of the maximum length of each tumor or cyst excised or destroyed (eg, ultrasound desiccation), which should not include the tissue (eg, mesentery) in which the tumor(s) and cyst(s) were embedded. According to the guidelines, the tumor(s) and cyst(s) should be measured in situ before the excision or destruction. If only a portion of a tumor or cyst is excised or destroyed, only the excised or destroyed portion is measured, and the measurements should not include the margins. If both an organ and tumor(s) are removed as part of the resection, any tumor(s) removed as part of the organ removal is not separately reported. In contrast, if a separate resection that requires distinctly separate efforts to remove the tumor is performed, then the tumor resection may be separately reported using the new codes.

Cross-reference parenthetical notes were added and revised throughout the CPT 2025 code set to accommodate the addition of these new codes, to direct

users to the appropriate codes for other procedures, and to clarify when other codes may or may not be reported. In addition, parenthetical notes were added to direct users to the appropriate codes in place of the deleted codes.

Coding Tip

An open resection of recurrent ovarian, endometrial, tubal, or primary peritoneal gynecological malignancies without lymphadenectomy may be reported with codes 49186-49190. All other open resections of initial or recurrent ovarian, endometrial, tubal, or primary peritoneal gynecological malignancies should be reported with code 58943, 58950-58954, 58956, 58958, or 58960. For an open excision or destruction of endometriomas, report code 58999.

Female Genital System

Excision

58958 Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed, with pelvic lymphadenectomy and limited para-aortic lymphadenectomy

(Do not report 58958 in conjunction with 38770, 38780, 44005, 49000, 49186, 49187, 49188, 49189, 49190, 49215, 49255, 58900-58960)

Code 58957 was deleted to accommodate the addition of codes 49186-49190 for the open excision or destruction of a retroperitoneal tumor(s). Because code 58958 is no longer a child code of deleted code 58957, the semicolon was removed from its descriptor. Parenthetical notes were also added and revised within the Excision subsection of the Ovary subsection.

A cross-reference parenthetical note in the Female Genital System section was revised by deleting codes 49203-49205 and 58957 and directing users to

code 58999, Unlisted procedure, female genital system (nonobstetrical), for the open method excision or destruction of endometriomas.

The following clinical examples and procedural descriptions reflect typical clinical scenarios for which new codes 49186-49190 would be appropriately reported.

Clinical Example (49186)

A 45-year-old female presents with a 4-cm mesenteric mass involving the small bowel mesentery near the base. She undergoes a resection of the mass.

Description of Procedure (49186)

Make a skin incision using sharp dissection. Achieve hemostasis using electrocautery and small ligatures, as necessary. Identify and carefully divide the linea alba. Grasp, elevate, and carefully incise the peritoneum to avoid injury to the bowel. Enter the peritoneal cavity under direct vision. Clear adhesions using sharp dissection in order to expose all of the abdominal viscera. Perform a visual and manual complete exploration of the abdominal cavity and its contents. Place the nasogastric tube and confirm its position. Inspect the stomach and palpate for pathology. View the duodenum and palpate. Inspect the gallbladder and palpate for the presence of stones. Palpate the liver and the porta hepatis bimanually. Inspect the pancreas through the hepatogastric ligament and palpate for possible masses. Palpate the tail of the pancreas for possible lymphadenopathy. Inspect the small bowel and palpate from the ligament of Treitz to the ileocecal valve. Inspect the small bowel mesentery and palpate for the presence of lymphadenopathy.

A large mass is identified in the mesentery of the distal small bowel. Inspect and palpate the cecum and appendix, ascending, transverse, and descending colon. Inspect and palpate the cul-de-sac and pelvic contents. Carefully insert a self-retaining retractor, while avoiding injury or entrapment of abdominal contents. Confirm the location and extent of the primary lesion. Pack away the abdominal contents, with the exclusion of the right colon, using laparotomy pads, and place additional retractors for optimal exposure. Mobilize the right colon and distal small bowel lateral to medial by incising the line of Toldt. Identify the small bowel mesentery containing the mass and the corresponding loop of small bowel. Resect the 4-cm mass along with the corresponding mesentery, avoiding division of the blood supply to the corresponding small bowel loop and right colon. During this dissection, identify the right ureter and

place a vessel loop for continual identification and protection of the ureter. Irrigate the abdominal cavity copiously with antibiotic solution. Obtain hemostasis. Inspect the abdomen for injury and the presence of any instruments or lap pads (ie, conduct a count). Remove and count all the retractor components to ensure all components are accounted for. Return the abdominal organs to normal anatomical position. Drape the omentum over the abdominal contents. Place drain(s) as required. Close the fascia with running suture. Conduct a second count of the instrument, needle, sponge, and lap pad. Irrigate and approximate the subcutaneous tissues and close the skin.

Clinical Example (49187)

A 62-year-old male has progressive colorectal carcinoma with limited peritoneal disease. Multiple implants, which measure 8 cm in total size, are removed from the peritoneal cavity.

Description of Procedure (49187)

Make a skin incision using sharp dissection. Achieve hemostasis using electrocautery and small ligatures, as necessary. Identify and carefully divide the linea alba. Grasp, elevate, and carefully incise the peritoneum to avoid injury to the bowel. Enter the peritoneal cavity under direct vision. Clear adhesions using sharp dissection in order to expose all of the abdominal viscera.

Perform a visual and manual complete exploration of the abdominal cavity and its contents. Place the nasogastric tube and confirm its position. Inspect the stomach and palpate for pathology. View and palpate the duodenum. Inspect the gallbladder and palpate for the presence of stones. Palpate the liver and the porta hepatis bimanually. Inspect the pancreas through the hepatogastric ligament and palpate for possible masses. Palpate the tail of the pancreas for possible lymphadenopathy. Inspect the small bowel and palpate from the ligament of Treitz to the ileocecal valve. Inspect the small bowel mesentery and palpate for the presence of lymphadenopathy. Inspect and palpate the cecum and appendix, ascending, transverse, and descending colon. Inspect and palpate the cul-de-sac and pelvic contents. Examine the greater vessels of the abdomen and the urinary tract. Inspect all other intra-abdominal organs systematically. Following peritoneal and retroperitoneal exploration, perform excision and destruction of all macroscopic tumor deposits on parietal, omental, and peritoneal surfaces. Perform resection of the small lesions and multiple surface nodules of the omentum, visceral, and peritoneal surfaces.

Desiccate some lesions on the small intestine serosal surface with ultrasonic desiccation. The in situ measured total dimension of all excised tumors is documented as 8 cm. Copiously irrigate the abdominal cavity with antibiotic solution. Obtain hemostasis. Inspect the abdomen for injury and the presence of any instruments or lap pads (ie, conduct a count). Remove and count the retractor components to ensure all components are accounted for. Return the abdominal organs to normal anatomical position. Drape the omentum over the abdominal contents. As required, place drain(s). Close the fascia with running suture. Conduct a second count of the instrument, needle, sponge, and lap pad. Irrigate and approximate the subcutaneous tissues and close the skin.

Clinical Example (49188)

A 70-year-old female, who was diagnosed with peritoneal mesothelioma with a 6-cm right lower quadrant mass and multiple intraperitoneal and retroperitoneal implants, undergoes a resection of the mass and excision and destruction of the implants.

Description of Procedure (49188)

Make a skin incision using sharp dissection. Achieve hemostasis using electrocautery and small ligatures, as necessary. Identify and carefully divide the linea alba. Grasp, elevate, and carefully incise the peritoneum to avoid injury to the bowel. Enter the peritoneal cavity under direct vision. Clear adhesions using sharp dissection in order to expose all of the abdominal viscera. Perform a visual and manual complete exploration of the abdominal cavity and its contents. Place the nasogastric tube and confirm its position. Inspect the stomach and palpate for pathology. View and palpate the duodenum. Inspect the gallbladder and palpate for the presence of stones. Palpate the liver and the porta hepatis bimanually. Inspect the pancreas through the hepatogastric ligament and palpate for possible masses. Palpate the tail of the pancreas for possible lymphadenopathy. Inspect the small bowel and palpate from the ligament of Treitz to the ileocecal valve. Inspect the small bowel mesentery and palpate for the presence of lymphadenopathy. Inspect and palpate the cecum and appendix, ascending, transverse, and descending colon. Inspect and palpate the cul-de-sac and pelvic contents. Examine the greater vessels of the abdomen and the urinary tract. Inspect all other intra-abdominal organs systematically. Following peritoneal and retroperitoneal exploration, perform resection of the large lower abdominal mass and multiple surface nodules of the omentum, visceral, and peritoneal surfaces. Perform resection of the small lesions and multiple surface nodules of the omentum, visceral, and peritoneal surfaces. The in situ measured total dimension of all excised tumors is

documented as 19 cm. Irrigate the abdominal cavity copiously with an antibiotic solution. Obtain hemostasis. Inspect the abdomen for injury and the presence of any instruments or lap pads (ie, conduct a count). Remove the retractor components and ensure that all components are accounted for. Return the abdominal organs to normal anatomical position. Drape the omentum over the abdominal contents. Make a lateral incision and pull a closed suction drain through the abdominal wall and place in the resection bed. Suture the drain to the skin with monofilament suture. Place additional drains as required. Close the fascia with running suture. Conduct a second count of the instrument, needle, sponge, and lap pad. Irrigate and approximate the subcutaneous tissues and close the skin.

Clinical Example (49189)

A 55-year-old male, who has a 28-cm retroperitoneal sarcoma and no evidence of distant metastases, undergoes a resection of the sarcoma.

Description of Procedure (49189)

Make a skin incision using sharp dissection. Achieve hemostasis using electrocautery and small ligatures, as necessary. Identify and carefully divide the linea alba. Grasp, elevate, and carefully incise the peritoneum to avoid injury to the bowel. Enter the peritoneal cavity under direct vision. Clear adhesions using sharp dissection in order to expose all of the abdominal viscera.

Perform a visual and manual complete exploration of the abdominal cavity and its contents. Place the nasogastric tube and confirm its position. Inspect the stomach and palpate for pathology. View and palpate the duodenum. Inspect the gallbladder and palpate for the presence of stones. Palpate the liver and the porta hepatis bimanually. Inspect the pancreas through the hepatogastric ligament and palpate for possible masses. Palpate the tail of the pancreas for possible lymphadenopathy. Inspect the small bowel and palpate from the ligament of Treitz to the ileocecal valve. Inspect the small bowel mesentery and palpate for the presence of lymphadenopathy. Inspect and palpate the cecum and appendix, ascending, transverse, and descending colon. Inspect and palpate the cul-de-sac and pelvic contents. Examine the greater vessels of the abdomen and the urinary tract. Inspect all other intra-abdominal organs systematically. Following peritoneal and retroperitoneal exploration, mobilize the ascending colon by dividing the peritoneal reflection and take down the hepatic flexure of the colon. Elevate the second portion of the duodenum and the head of the pancreas from the retroperitoneum to expose the vena cava

and aorta.

Mobilize the base of the small bowel mesentery to the third portion of the duodenum to further expose the vena cava and aorta. Identify the kidneys, vasculature, and ureters. Control the proximal aorta, iliac arteries, subrenal vena cava, and iliac veins superiorly and inferiorly to the retroperitoneal tumor. Resect the 28-cm tumor from the retroperitoneum with sequential ligation of inflow and outflow vasculature of the tumor. Irrigate the abdominal cavity copiously with an antibiotic solution. Obtain hemostasis. Inspect the abdomen for injury and the presence of any instruments or lap pads (ie, conduct a count). Remove the retractor components and ensure all the components are accounted for. Return the abdominal organs to the normal anatomical position. Drape the omentum over the abdominal contents. Make a lateral incision and pull a closed suction drain through the abdominal wall and place in the resection bed. Suture the drain to the skin with monofilament suture. Place additional drains as required. Close the fascia with running suture. Conduct a second count of the instrument, needle, sponge, and lap pad. Irrigate and approximate the subcutaneous tissues and close the skin.

Clinical Example (49190)

A 58-year-old female, who has a previous colon resection for appendiceal adenocarcinoma, develops extensive peritoneal carcinomatosis. She undergoes a tumor excision and destruction.

Description of Procedure (49190)

Make a skin incision using sharp dissection. Achieve hemostasis using electrocautery and small ligatures, as necessary. Identify and carefully divide the linea alba. Grasp, elevate, and carefully incise the peritoneum to avoid injury to the bowel. Enter the peritoneal cavity under direct vision. Clear adhesions using sharp dissection in order to expose all of the abdominal viscera.

Perform a visual and manual complete exploration of the abdominal cavity and its contents. Place the nasogastric tube and confirm its position. Inspect the stomach and palpate for pathology. View and palpate the duodenum. Inspect the gallbladder and palpate for the presence of stones. Palpate the liver and the porta hepatis bimanually. Inspect the pancreas through the hepatogastric ligament and palpate for possible masses. Palpate the tail of the pancreas for

possible lymphadenopathy. Inspect and palpate the small bowel from the ligament of Treitz to the ileocecal valve. Inspect and palpate the small bowel mesentery for the presence of lymphadenopathy. Inspect and palpate the cecum and appendix, ascending, transverse, and descending colon. Inspect and palpate the cul-de-sac and pelvic contents. Examine the greater vessels of the abdomen and the urinary tract. Inspect all other intra-abdominal organs systematically. Following peritoneal and retroperitoneal exploration, perform cytoreduction of all macroscopic tumor deposits on parietal, omental, and peritoneal surfaces. Perform resection of multiple surface nodules of the omentum, visceral, and mesenteric surfaces. Mobilize the liver fully and resect the peritoneum from both diaphragms. Perform resection of the small lesions and multiple surface nodules of the omentum, visceral, and peritoneal surfaces. The in situ measured total dimension of all excised tumors is documented as 35 cm. Irrigate the abdominal cavity copiously with an antibiotic solution. Obtain hemostasis. Inspect the abdomen for injury and the presence of any instruments or lap pads (ie, conduct a count). Remove and ensure all retractor components are accounted for. Return the abdominal organs to normal anatomical position. Drape the omentum over the abdominal contents. Make a lateral incision and pull a closed suction drain through the abdominal wall and place in the resection bed. Suture the drain to the skin with monofilament suture. Place additional drains as required. Close the fascia with running suture. Conduct a second count of the instrument, needle, sponge, and lap pad. Irrigate and approximate the subcutaneous tissues and close the skin.

