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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Attack the Age-Old "Can I Report Extensive Adhesiolysis?" Question

Follow these 4 tips to ensure you collect appropriate payment.

If your ob-gyn performs extensive lysis of adhesions, you can get paid separately for it but you better make sure the documentation is iron clad.

What they are: Pelvic adhesions are bands of fibrous scar tissue that can form in the abdomen and pelvis after surgery or due to infection. Because adhesions connect organs and tissue that are normally separated, they can lead to a variety of complications, including pelvic pain, infertility and bowel obstruction. Adhesions commonly form on the ovaries, pelvic sidewalls and fallopian tubes, but can also involve the bowel and omentum.

Capture Adhesiolysis With These CPT® Codes

Although ob-gyns generally deal with lysis of adhesions in only four sites, CPT® provides six codes for the associated procedures:

- 44005 Enterolysis (freeing of intestinal adhesion) (separate procedure)
- 44180 Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)
- 56441 Lysis of labial adhesions
- 58559 Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)
- 58660 Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)
- 58740 Lysis of adhesions (salpingolysis, ovariolysis).

Important: Generally, you won't use these codes if the ob-gyn does anything else, because they will be included in the other procedure.

You should separately report adhesiolysis when performed with another procedure(s) only when:

1. lysis of adhesions is extensive
2. the adhesions are in a different anatomic site from the main procedure(s).

Consider Mod 22 for Extensive, Nonincluded Lysis

If the lysis of adhesions is extensive and the Correct Coding Initiative (CCI) or other bundling software includes this extensive service in the primary procedure, you should add modifier 22 (Increased procedural services) to the primary procedure code. Otherwise, you should report extensive adhesiolysis separately.

You should use modifier 22 only rarely.

Caution:Every surgeon has cases that are harder than average and ones that are easier, and just because a case is more extensive or time-consuming than another is not sufficient reason to use modifier 22.

To report modifier 22, you should have supporting documentation that details the physician's extensive time and work effort. Modifier 22 will most certainly initiate a request for information from your carriers, so make sure the operative

report substantiates the claim.

The following tips will help you pin down when you should report lysis of adhesions separately.

Tip 1: Separate Codeable From Noncodeable

When determining whether you should code adhesiolysis in addition to the primary procedure, you first have to examine the ob-gyn's documentation. Carriers usually don't reimburse separately for removing soft, filmy adhesions by blunt dissection when the physician performs the lysis with other procedures. Documentation must describe the significant work associated with the removal (using sharp dissection and sometimes laser) of adhesions that are dense, very adherent and have a blood supply.

Example: The ob-gyn documents that while performing an ovarian cystectomy or the right ovary, he lysed adhesions that were dense, anatomy-distorting and took 40 minutes to remove them. In this case, if the adhesions were surrounding the ovary you may be able to separately report the lysis removal with 58740 because the adhesions were extensive and required significant time to lyse. If the adhesions involved the bowel or omentum instead you could not separately bill for enterolysis (44005) because CCI permanently bundles this code into 58925, and no modifier will bypass this edit. In that case you would want to add a modifier 22 to the primary procedure code.

Tip 2: Differentiate Bowel and Pelvic Adhesions

Establishing where the surgeon lysed the adhesions is the next major step to determine which code to select. If the ob-gyn performed adhesiolysis of the bowel, you would report 44005 or 44180, if appropriate, depending on the approach, says **Carol Pohlig, BSN, RN, CPC,** senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia. If the physician lysed pelvic adhesions, you should submit 58660 or 58740, if appropriate, depending on the adhesions- exact location, she adds.

Example: The surgeon notes that during a laparotomy, he encounters dense adhesions involving the bowel and omentum, which require two hours of adhesiolysis and enterolysis to adequately expose the uterus and pelvis so he could perform a hysterectomy. Based on this information, you might incorrectly report 44005 in addition to 58150 (Total abdominal hysterectomy [corpus and cervix], with or without removal of tube[s], with or without removal of ovary[s]).

But CCI bundles 44005 into 58150 with a "0" modifier indicator, meaning no modifier can override the edit, Pohlig says. Therefore, you should report the extra work involved with the extensive adhesiolysis by appending modifier 22 to 58150.

Tip 3: Learn When Adhesiolysis Changes Approach

Occasionally, an ob-gyn attempts a procedure laparoscopically, but because of extensive adhesions, he must change to an open approach to complete the surgery. In this case, Medicare rules and those of the many payers that follow Medicare bundle the laparoscopy into the open procedure, so you can't report it separately. The only option is to report the primary surgery appended with modifier 22.

Suppose the ob-gyn surgeon inserts the laparoscope intending to perform a colpopexy. Upon inserting the scope, he finds massive adhesions on the bowel's left side adhering not only the bowel to the pelvic sidewall but also the left tube and ovary. The right side is even worse. After attempting to remove the adhesions for an hour with little success, the physician decides to convert to a laparotomy to complete the procedure.

Because the surgeon took significant additional time attempting to perform the procedure laparoscopically, you should report 57280-22 (Colpopexy, abdominal approach). "Quantifying the additional time and specifying the increased effort in the documentation is crucial for reimbursement success," Pohlig says. Words to look for in the record might include

"very difficult," "unusually difficult," and so on.

In addition to reporting the time in the procedure note, include a cover letter that compares the additional time and effort to the average time and effort the procedure usually takes, Hollis says. The details that made the procedure difficult provide a better level of understanding to the insurance reviewer who may not be aware of the typical efforts involved in the procedure.

Tip 4: Estimate Dollar Amount When Using Mod 22

Experts say if you are not adding a dollar amount before submitting to your carriers, you are doing yourself a disservice.

When submitting a claim that includes modifier 22, you should include an estimate of what you expect to be paid for the extra work involved in the procedure. Otherwise, you are leaving the decision up to the carriers, and they will potentially base your reimbursement on their standard allowable. Including a dollar amount doesn't mean the payer will reimburse based on your charge, but as with all submissions, you don't want to leave the decision entirely up to the carrier.