# Part B Insider (Multispecialty) Coding Alert

## Part B Coding Coach: Tighten up Your Adhesiolysis Coding Knowledge With These 5 Tips

**Key: Your ob-gyn's documentation must emphasize the unusual difficulty.**

If you've ever coded an ob-gyn chart, you're likely to have encountered a claim for lysis of adhesions, which can be a puzzling scenario when it comes to coding. You can ethically report lysis of adhesions with your obgyn's primary surgery, either with a specific code or with modifier 22, in these situations:

1. The lysis of adhesions is extensive. Words to look for in the record might include "very difficult," "unusually difficult," and so on.

2. The adhesions are in a different anatomic site from the main procedure(s).

Remember: 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.

**Scenario 1: Highlight 'Significant Time to Lyse'**

The ob-gyn documents that while performing abdominal surgery, he lysed pelvic adhesions that were dense, anatomy-distorting, and took a very long time. Can you report lysis of adhesions?

Solution 1: Your answer will depend on the type of adhesions and whether payers bundle the code you want to bill. For instance, payers bundle 44005 (Enterolysis [freeing of intestinal adhesion] [separate procedure]) into almost all surgical procedures that involve abdominal surgery. On the other hand, payers only bundle 58740 (Lysis of adhesions [salpingolysis, ovariolysis]) into certain procedures.

In other words, if the patient had pelvic adhesions and you could report 58740, then you should do so -- so long as the physician documentation is adequate. You should not add modifier 22 (Increased procedural service) to 58740, because the only time you can make a case for billing lysis separately is when the adhesions represented a significant amount of work, not just done to access the surgical site, says **Melanie Witt, RN, COBGC, MA,** an independent coding consultant in Guadalupita, N.M.

Documentation: Remember, when determining whether you should code adhesiolysis in addition to the primary procedure, you first have to examine the obgyn'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. And of course, the ob-gyn should also document the amount of time it added to the operative session, Witt adds.

**Scenario 2: When CCI Bundles, Turn to Modifier 22**

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. Can you report lysis of adhesions?

Solution: Yes, with modifier 22. 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, says **Carol Pohlig, BSN, RN, CPC**, senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia. Therefore, you should report the extra work involved with the extensive adhesiolysis by appending modifier 22 to 58150.

**Scenario 3: Absence of Documentation? Consider Bundled**

The ob-gyn performs a repeat c-section that includes lysis of adhesions. He notes omental adhesions in lower uterine segment and cauterizes additional areas of adhesions, which exposes an adequate amount of space to do procedure. Can you report the lysis of adhesions?

Solution 3: This depends. The ob-gyn notes the adhesions exist in and around the uterus, which means you might be able to report 58740 (Lysis of adhesions [salpingolysis, ovariolysis]). Many payers, however, bundle 58740 into another procedure. You have the option of adding modifier 22 to the cesarean delivery code to show the extra work involved with the adhesiolysis,  but the documentation has to adequately describe the extensive nature of this procedure.

**Scenario 4: Check Out Your Lap Lysis Code Options**

Your ob-gyn documented the following laparoscopic op note: "Omental adhesions made visualization of the pelvis difficult. These were covering the fundus of the uterus and anterior parietal peritoneal surface. Also, theycompletely obliterated the cul-de-sac. I found chronic and acute pelvic inflammatory disease as well as pelvic abscesses. Due to the large amount of adhesions, I spent a lot of time visualizing and freeing the fundus of the uterus, left adnexa, left tube and ovary, right adnexa structures, right tube and ovary, posterior cul-de-sac, and the sigmoid bowel. I lysed loops of bowel, and I removed the appendix. I exposed additional adhesions of the sigmoid bowel to the right cul-de-sac and lower pelvis as well as a large abscess, right of the sigmoid bowel. I placed a Jackson-Pratt drain to drain the pelvis." Can you report the lysis of adhesions?

Solution: You have only two codes for laparoscopic lysis of adhesions: 44180 (Laparoscopy, surgical, enterolysis [freeing of intestinal adhesion] [separate procedure]) and 58660 (Laparoscopy, surgical;with lysis of adhesions [salpingolysis, ovariolysis][separate procedure]). Notice both are CPT® "separate procedures," which means the payer is probably going to bundle either one into any other surgical procedure performed through the scope, like an appendectomy. Payers also bundle 44180 into 58660, so you cannot report both. If you are going to bill only for the lysis, you will have to choose which code represents more surgical work. Given the above brief description, you choice would likely be 58660.

**Scenario 5: Tackle This Converted Approach Example**

Suppose the ob-gyn surgeon inserts the laparoscope intending to perform a uterosacral vaginal vault suspension. 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.

Solution 4: 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. In this case, you should report 57283- 22 (Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy).

This reason why is because the surgeon took significant additional time attempting to perform the procedure laparoscopically. "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. 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.