

■ MELANIE WITT, RN, CPC, MA

## Coding for sacrospinous ligament fixation

**Q** How would you code a sacrospinous ligament vaginal suspension, repair of enterocele, and cystocele? This is a Medicare patient with a preoperative diagnosis of total vaginal prolapse, status post-vaginal hysterectomy with anterior and posterior repair, third-degree enterocele, and second-degree rectocele recurrent.

**A** When coding any surgery for Medicare submission, it's always a good idea to check the Correct Coding Initiative (CCI) to see which code combinations are bundled. In this case, the codes you can choose from include 57282 (for sacrospinous ligament fixation), 57240 (for cystocele repair), and 57268 (for vaginal-approach enterocele repair).

Unfortunately, CCI indicates code 57268 is not payable with code 57282. To make matters worse, you can't bypass the edit, since this code combination is never paid. According to CCI, this is because the vaginal-approach enterocele repair is a CPT "separate procedure" and Medicare has decided that it and the sacrospinous ligament fixation are always integral to each other.

If this had been a case where a posterior repair had been done along with the anterior colporrhaphy and enterocele repair, you could have assigned code 57265 (combined anteroposterior colporrhaphy; with enterocele repair) as your second procedure, since it isn't bundled with the sacrospinous ligament fixation procedure. You may be tempted, then, to bill code 57265 with a modifier -52 (reduced services) to get the claim paid, but I would advise against it, as this coding isn't the most accurate description of what was done.

Instead, because there was a symptomatic enterocele that needed to be repaired, I would

add a modifier -22 (unusual procedure) to code 57282 and send in supporting documentation regarding the need for the enterocele repair. Centers for Medicare & Medicaid Services staff recommended this solution a few years ago for any procedure that's always bundled into a larger procedure, when the documentation supports performing it.

## Adhesions and ovarian excrescence

**Q** For laparoscopy with lysis of adhesions, peritoneal washings, peritoneal biopsies, and left ovarian excrescence removal for biopsy, should I use code 58662?

**A** Code 58662 (laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method) would cover the removal of the left ovarian excrescences, but does not capture the lysis of adhesions. Many payers bundle this procedure because they believe it is incidental. However, if the adhesions were extensive and the extra time the physician spent in removing them is well documented, you can either bill the lysis separately using code 58660-59-51 (to indicate it was a distinct, multiple procedure) or you can add modifier -22 (unusual procedure) to code 58662 to indicate extensive additional work. Note that you would only use this latter option for payers you know always bundle lysis of adhesions when billed separately (Medicare, for example).

The payer is unlikely to reimburse separately for peritoneal washings and biopsy. ■

*Ms. Witt, former program manager in the Department of Coding and Nomenclature at the American College of Obstetricians and Gynecologists, is an independent coding and documentation consultant. Reimbursement Adviser reflects the most commonly accepted interpretations of CPT-4 and ICD-9CM coding. When in doubt on a coding or billing matter, check with your individual payer.*