2022 Adhesions Reimbursement Guide

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Finding the appropriate ICD-10-PCS Code[1]

STEP 1: Select the code below that best describes the procedure and associated body part.

Procedure Code	Description (Includes Body Part)	Procedure Code	Description (Includes Body Part)
0DN8	Release / Small Intestine	0DNN	Release / Sigmoid Colon
0DN9	Release / Duodenum	0DNV	Release / Mesentery
0DNA	Release / Jejunum	0DNW	Release / Peritoneum
0DNB	Release / Ileum	0FN	Release / Hepatobiliary System & Pancreas
0DNC	Release / Ileocecal Valve	0TN	Release / Urinary System
0DNE	Release / Large Intestine	0TQ6	Repair / Ureter, Right
0DNF	Release / Large Intestine, Right	0TQ7	Repair / Ureter, Left
0DNG	Release / Large Intestine, Left	0TS6	Reposition/Ureter, Right
0DNH	Release / Cecum	0TS7	Reposition/Ureter, Left
0DNJ	Release / Appendix	0T16	Bypass/Ureter, Right
0DNK	Release / Ascending Colon	0T17	Bypass/Ureter, Left
0DNL	Release / Transverse Colon	0T18	Bypass/Ureter, Bilateral
0DNM	Release / Descending Colon	0UN	Release / Female Reproductive System

STEP 2: Using your coding reference book or software, select the characters that best describe the associated body part (if not indicated above), approach, device and qualifier in the respective order.
Given the large number of individual procedure codes available for adhesiolysis procedures, please refer to your coding reference book or coding software to look up the associated Approach, Device and Qualifier that best align to the procedure code and body part you identified in Step 1 above.

STEP 3: Combine the code in Step 1 with the characters in Step 2 in the respective order. This is your ICD-10-PCS Code.
For example, the code for Release of Small Intestine, Open Approach (0DN80ZZ) would be created in the steps below:

Example: STEP 1: 0DN8 + STEP 2: Approach 0 + Device Z + Qualifier Z = STEP 3: 0DN80ZZ

Joint Coding Requirements

Note the following billing codes must be combined with one of the procedure codes below it and billed jointly to ensure proper reimbursement.*

*0UN00ZZ Release Right Ovary, Open Approach OR 0UN03ZZ Release Right Ovary, Percutaneous Approach
(must bill jointly with one of the following two procedures, and vice versa)
0UN50ZZ Release Right Fallopian Tube, Open Approach
0UN53ZZ Release Right Fallopian Tube, Percutaneous Approach

*0UN10ZZ Release Left Ovary, Open Approach OR 0UN13ZZ Release Left Ovary, Percutaneous Approach
(must bill jointly with one of the following two procedures, and vice versa)
0UN60ZZ Release Left Fallopian Tube, Open Approach
0UN63ZZ Release Left Fallopian Tube, Percutaneous Approach

*0UN20ZZ Release Bilateral Ovaries, Open Approach OR ØUN23ZZ Release Bilateral Ovaries, Percutaneous Approach
(must bill jointly with one of the following two procedures, and vice versa)
0UN70ZZ Release Bilateral Fallopian Tubes, Open Approach
0UN73ZZ Release Bilateral Fallopian Tubes, Percutaneous Approach

*0UN04ZZ Release Right Ovary, Percutaneous Endoscopic Approach
(must bill jointly with the following procedure, and vice versa)
0UN54ZZ Release Right Fallopian Tube, Percutaneous Endoscopic Approach

*0UN14ZZ Release Left Ovary, Percutaneous Endoscopic Approach (must bill jointly with the following procedure, and vice versa)
0UN64ZZ Release Left Fallopian Tube, Percutaneous Endoscopic Approach

*0UN24ZZ Release Bilateral Ovaries, Percutaneous Endoscopic Approach (must bill jointly with the following procedure, and vice versa)
0UN74ZZ Release Bilateral Fallopian Tubes, Percutaneous Endoscopic Approach

Surgeon CPT, APC, ASC & DRG Codes

Surgeon CPT Code[2]	Procedure		Nat Average Medicare Payment[3]
	Traditional Open Procedure		
44005	Enterolysis (freeing of intestinal adhesion) (separate procedure)		$ 1,126
47999	Unlisted procedure, biliary tract		Carrier priced
48999	Unlisted procedure, pancreas		Carrier priced
49999	Unlisted procedure, abdomen, peritoneum and omentum		Carrier priced
50715	Ureterolysis, with or without repositioning of ureter for retroperitoneal fibrosis		$ 1,227
50722	Ureterolysis for ovarian vein syndrome		$ 1,045
50725	Ureterolysis for retrocaval ureter, with reanastomosis of upper urinary tract or vena cava		$ 1,112
58740	Lysis of adhesions (salpingolysis, ovariolysis)		$ 929
	Laparoscopic Procedure		
44180	Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)		$ 949
47579	Unlisted laparoscopy procedure, biliary tract		Carrier priced
49329	Unlisted laparoscopic procedure, abdomen, peritoneum and omentum		Carrier priced
50949	Unlisted laparoscopic procedure, ureter		Carrier priced
58660	Laparoscopy, surgical, with lysis of adhesions (salpingolysis, ovariolysis) (separate procedures)		$ 703

OUTPATIENT FACILITY

APC	APC Description	Status	Nat Average Medicare Payment[4]
	Hospital Outpatient Department		
5071	Level 1 Excision/ Biopsy/ Incision and Drainage (CPT code: 48999)	T	$ 636
5301	Level 1 Upper GI Procedures (CPT code: 47999, 49999)	T	$ 826
5361	Level 1 Laparoscopy & Related Services (CPT codes: 44180, 58660, 47579, 49329, 50949)	J1	$ 5,168
N/A	Inpatient Only [CPT codes: 44005, 50715, 50722, 50725, 58740]	N	Inpatient Only

Ambulatory Surgery Center

ASC Group	CPT Codes	Nat Average Medicare Payment[5]
	Laparoscopic Procedure	
58660	Laparoscopy, surgical, with lysis of adhesions (salpingolysis, ovariolysis) (separate procedures)	$ 2,363

Surgeon CPT, APC, ASC & DRG Codes (continued)

INPATIENT FACILITY

DRG	Description*	Average Length of Stay (Days)[6]	National Average DRG Payment[6]
335	Peritoneal adhesiolysis with MCC	9.3	$ 25,807
336	Peritoneal adhesiolysis with CC	5.9	$ 15,110
337	Peritoneal adhesiolysis wit hout CC/MCC	3.7	$ 10,797
662	Minor bladder procedures with MCC	6.9	$ 19,369
663	Minor bladder procedures with CC	3.7	$ 10,548
664	Minor bladder procedures without CC/MCC	1.9	$ 7,806
715	Other male reproductive system O.R. procedure for malignancy with CC/MCC	5.0	$ 13,331
716	Other male reproductive system O.R. procedure for malignancy without CC/MCC	1.4	$ 8,413
717	Other male reproductive system O.R. procedure except malignancy with CC/MCC	3.7	$ 11,874
718	Other male reproductive system O.R. procedure except malignancy without CC/MCC	2.2	$ 8,141
736	Uterine & adnexa procedure for ovarian or adnexal malignancy with MCC	8.4	$ 28,096
737	Uterine & adnexa procedure for ovarian or adnexal malignancy with CC	4.2	$ 13,572
738	Uterine & adnexa procedure for ovarian or adnexal malignancy without CC/MCC	2.6	$ 9,733
739	Uterine & adnexa procedure for non-ovarian/adnexal malignancy with MCC	6.6	$ 25,217
740	Uterine & adnexa procedure for non-ovarian/adnexal malignancy with CC	2.8	$ 11,880
741	Uterine & adnexa procedure for non-ovarian/adnexal malignancy without CC/MCC	1.6	$ 8,440
742	Uterine & adnexa procedure for non-malignancy with CC/MCC	2.8	$ 11,330
743	Uterine & adnexa procedure for non-malignancy without CC/MCC	1.7	$ 7,470
749	Other female reproductive system O.R. procedures with CC/MCC	5.6	$ 17,896
750	Other female reproductive system O.R. procedures without CC/MCC	2.3	$ 9,653

NOTE: FY 2022 is effective October 1, 2021 for Inpatient Hospital DRGs

*CC stands for Complications and Comorbidities while MCC refers to Major Complications and Comorbidities. These are a measure of the severity of an illness indicating additional diagnoses present on a case that MAY increase the expected resource consumption beyond that of the same case without a CC or MCC under the current Medicare definition. Whether a complication or comorbidity is classified as a CC or MCC is defined by Medicare.

1. ICD-10 Procedural Coding System (ICD-10-PCS) is developed and maintained by the Centers for Medicare and Medicaid Services (CMS). 2. All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines and other material are copyright 2021 American Medical Association. 3. CY 2022 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B (CMS-1751-F, Vol 86, No. 221; November 19, 2021); Addendum B. All MPFS Fee Schedules calculated using CF of $34.6062 effective January 2022. 4. CY 2022 Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1753-F, Vol. 86, No. 218; November 16, 2021); Addendum B and Final ASC Addenda AA. 5. CY 2022 Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1753-F, Vol. 86, No. 218; November 16, 2021); Addendum B and Final ASC Addenda AA 6. Medicare Inpatient Prospective Payment System Final Rule [CMS-1752-F], Federal Register (Vol. 86, Issue 154), Friday, August 13, 2021; Final: National Average DRG Payment.

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