REIMBURSEMENT ADVISER

RhoGAM injections: payment levels vary among insurers

Q Physicians often send their patients to our hospital for RhoGAM shots. Why is this happening, and what is the best way to code for this service?

A First, many Ob/Gyns opt not to perform RhoGAM injections in their offices because of exceedingly poor reimbursement from third-party payers. Second, there was a shortage of the product in 1995 and early 1996. In many cases, RhoGAM was available only through local hospitals, so a shift in the site of service took place.

To bill for the injection, select 1 of the following codes: 90384 (Rho[D], IM full dose), 90385 (Rho[D], IM mini-dose), and 90386 (Rho[D], IV use). For example, if a full dose of RhoGAM is administered intramuscularly to a non-Medicare patient, report codes 90384 and 90782 (therapeutic or diagnostic injection [specify material injected]; subcutaneous or intramuscular). Some payers will require that you submit the HCPCS level 2 code J2790 (injection, Rho[D] immune globulin, human, one dose package) instead, so always check with the insurer before billing.

To facilitate fair payment, submit the National Drug Code number for the drug and the invoice.

While the coding is standard, reimbursement levels vary from payer to payer. Private payers set their rates for covered drugs based on either reasonable and customary charges, or drug wholesale prices. Many Medicaid and managed care companies, however, set their limits below the market value of the drug. If you believe the payment is unfair, appeal the claim and negotiate with the payer for fair market reimbursement.

To facilitate fair payment, submit both the National Drug Code (NDC) number for the drug, which is located on the package insert and identifies the drug name, manufacturer, and dosage, and the invoice that shows the acquisition cost. (NDC numbers are likely to become the sole method of billing for drugs as a result of HIPPA legislation, which includes a uniform code set, that will be implemented on October 1, 2002.)

Coding etiquette for 'shared' surgeries

Q What is the correct way to code for "shared" surgeries? For example, Dr. A performed an exploratory laparotomy with bilateral salpingo-oophorectomy (BSO), during which he found cancer. Dr. B, a gynecologic oncologist, then performed bilateral pelvic/para-aortic lymph node dissection, peritoneal biopsies, omentectomy, and diaphragmatic scraping.

The diagnosis was serous papillary carcinoma. Dr. B wants to bill 58960 (second-look laparotomy) and 49255 (omentectomy) and have Dr. A bill for the BSO. Would this be accurate?

A Coding for shared surgeries is dictated by the procedures rather than who performed them. Many times, each surgeon will try to bill for his or her individual procedures without taking into account that CPT already may have codes that describe the combination of surgeries performed. In fact, a standard rule for coding is that if it is considered unbundling for 1 physician to itemize procedures described in a single procedure code, it would be considered unbundling for 2 surgeons to do so as well.

That said, Dr. B's suggested coding choices would be incorrect. This is because the code for the second-look procedure includes an omentectomy and only a limited lymphadenectomy rather than a bilateral pelvic/para-aortic lymphadenectomy. In fact, none of the codes that apply to the treatment of ovarian cancer include a bilateral pelvic/para-aortic lymph node dissection procedure. Instead, they describe surgical combinations that comprise limited lymphadenectomy or biopsy.

To appropriately code for this particular combination of procedures, both physicians should report 59850-62 to indicate they were co-surgeons for the bilateral salpingo-oophorectomy for ovarian cancer and omentectomy. In other words, 2 physicians worked together to accom-

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plish distinct parts of a single reportable CPT code. Dr. B also should report code 38770-50-59. Code 38770 represents the pelvic/para-aortic lymph node dissection; the modifier -50 indicates that it was a bilateral procedure; and the modifier -59 states that the lymphadenectomy was distinct from the other procedures performed. If Dr. A assisted with the lymphadenectomy, he also should report code 38770 with the modifier -80 (assuming the surgery was not done on a Medicare patient because Medicare will not allow a physician who is billing as a primary surgeon to bill as an assistant during the same surgical session).

Coding for shared surgeries is dictated by the procedures rather than who performed them.

The second, less optimal coding option would be for Dr. A to report only the BSO using 58720 and Dr. B to code for the second-look procedure 58960-22 (unusual procedure). This method may delay payment for Dr. B due to the addition of the modifier -22 for the extra work required by the bilateral pelvic lymphadenectomy. Dr. A also may have difficulty obtaining reimbursement using this method; although he would be billing for a simple BSO, the procedure is linked to a code for cancer. Therefore, the payer may take a closer look at the procedure performed by both surgeons prior to payment.

Finally, the payment implications (using current Medicare relative value units [RVUs] for comparison) are different for these 2 options: The first will maximize reimbursement for Dr. B, while the second will do so for Dr. A.

This article was written by Melanie Witt, RN, CPC, MA, former program manager in the Department of Coding and Nomenclature at ACOG. She is now an independent coding and documentation consultant. Her comments reflect the most commonly accepted interpretations of CPT-4 and ICD-9-CM coding. When in doubt on a coding or billing matter, check with your individual payer.

If you have a reimbursement question that you would like answered in this column, please fax it to Rita Guarna, editor, at 201-391-2778, or e-mail it to obg@dowdenhealth.com.

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