

REIMBURSEMENT ADVISER



Coding for postpartum care after at-home delivery

Q How should our practice bill for a woman who presents to the hospital for an evaluation after delivering at home? She is an established patient of one of our physicians.

A The answer depends on whether the home delivery was planned or the patient simply did not make it to the hospital in time. If planned and her physician or a collaborating nurse midwife did the delivery, use 59400 (routine obstetric care, including antepartum care, vaginal delivery [with or without episiotomy and/or forceps], and postpartum care) and do not bill separately for the postpartum evaluation in the hospital. If the patient delivered at home unintentionally, only bill for the postpartum care using 59430 for uncomplicated inpatient or outpatient visits until 6 weeks' postpartum, or report the global code with the modifier -52 (reduced services).



Making the most of Medicare's guidelines

Q I recently discovered that a nearby practice is using both the 1995 and 1997 Medicare guidelines for coding. However, it is my understanding that you have to choose one set or the other and use it exclusively. Our office uses the 1995 guidelines, and our audit form reflects that decision. Which strategy is correct?

A Both approaches are correct. According to Medicare, you are free to use either set of guidelines or take advantage of both. For example, you may change sets from one patient to the next. If you are audited by Medicare, the auditor will select the set that gives your practice the advantage and will not ask which set you utilized.

This rule was never officially included in the Medicare regulations. However, it was communicated to the former AMA president Percy Wooten, MD, by Nancy-Ann Min DeParle of the Health Care Financing Administration (HCFA). In April, 1998, she said: "I am directing carriers to continue to use both the 1995 and 1997 guidelines, whichever is more advantageous to

the physician, until the revisions [to the guidelines] have been completed and there has been an adequate period of time for testing and education."

Feel free to continue using only the 1995 guidelines. Actually the only difference between the 2 sets is the physical examination criteria.

Billing for ovarian cyst drainage with CT guidance

Q Which code should I report for a computed tomography (CT)-guided drainage of an ovarian cyst via a vaginal approach?

A You actually need to list 2 codes for this procedure. For the drainage of the cyst, report 58800 (vaginal approach). To bill for the CT guidance, report code 76003 (fluoroscopic guidance for needle placement, e.g., biopsy, aspiration, injection; localization device). This code is the best option because it most closely reflects the type of guidance used. (Fluoroscopic CT guidance is rapidly becoming the procedure of choice because it provides the physician with a continuous image of the needle's position, whereas conventional CT guidance takes 1 picture at a time.)

Reporting an omental sling procedure in a cancer patient

Q Which CPT code should I use for an omental sling procedure in a patient who was recently diagnosed with cervical cancer?

A I assume that, with the diagnosis of cervical cancer, the omental sling was performed to prevent radiation damage to the small bowel during treatment for the disease. Therefore, report code 44700 (exclusion of small intestine or native tissue, e.g., bladder or omentum, from pelvis by mesh or other prosthesis).

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.