Inserting tandem and ovoids

Q Our patient had tandems and ovoids (T&O) inserted by the same physician on April 30 and then again on May 7. Our claim-manager software indicated that we could not bill for both procedures because of the global period. Should we use the modifier -76 (repeat procedure by the same physician) to bill for the second T&O?

A You actually have 2 options in this case. The modifier -58 would be the modifier of choice if the second T&O insertion was planned at the time of the first insertion, i.e., a staged procedure. On the other hand, if the physician decided on a second insertion at some point after the first insertion, the modifier -76 would be the better code.

Dividing postpartum care between the FP and Ob

Q Many patients in our practice see their family physician (FP) for prenatal care. Our obstetrician then performs the delivery and inpatient postpartum care, and the FP handles the outpatient postpartum care in the clinic. The dilemma arises when a cesarean delivery is performed and the FP's office bills 59430, a postpartum care-only code that includes both inpatient and outpatient care. How should the Ob bill for his services?

A Unfortunately, the cesarean delivery-only codes (59514 and 59620 for failed VBAC) do not include any postpartum care, and the cesarean delivery plus postpartum care codes (59515 and 59622) include both inpatient and outpatient postpartum care, per the ACOG Coding Manual. However, in the case you described, you need to communicate to the payer that the postpartum care was divided between the obstetrician and the FP. Otherwise, some payers might deny the service billed by the FP or inquire why the Ob billed for a service not provided.

One way to avoid this dilemma: Bill for the cesarean delivery plus the postpartum care using the code 59515 or 59622 and add the modifier -52; be sure to carefully document which part of the service (i.e., outpatient) was not provided. Then contact the FP's office and suggest that when they use code 59430, they should add the modifier -52 and explain to the payer which part of the postpartum care (i.e., inpatient) was not performed. That way, both health-care providers should be reimbursed fairly.

Removing sutures due to latent side effects

Q After having a total vaginal hysterectomy with anterioposterior (A&P) repair performed by another physician a year ago, a new patient presented to my practice with persistent spotting. I noted that a nonabsorbable suture was used in the vaginal cuff, and therefore resected the tail of the suture. I removed the protruding stitch that seemed to be causing the problem. Which codes should I use for the diagnosis and the procedure?

A Because the complication was the result of previous surgery, consider using 909.3 (late effect of complications of surgical and medical care) and 998.83 (other specified complications of procedures not elsewhere classified) to describe the suture that was causing the irritation. Or, if you think the

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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-9CM coding. When in doubt on a coding or billing matter, check with your individual payer.

problem with the suture was more closely related to disruption of the wound, use 998.3 as the second code instead of 998.83.

As for the suture removal, bill an E/M service because CPT only allows physicians to report suture removal as a surgical procedure when a regional block or general anesthesia is administered (15851, removal of sutures under anesthesia [other than local]), with another surgeon. (Note, however, that some payers only allow the use of this code with general anesthesia). If you replaced the suture after removing the original, bill 57200 (suture of vagina) in addition to the E/M service, and use the modifier -25 to indicate that the E/M service was significant and separate from the procedure.

Counseling patients on contraceptive options

Q How do I bill for patient counseling on contraception when no exam was performed? An insurance carrier has denied the code 99211 with V25.49.

A The diagnostic code V25.49 implies the patient already has been placed on a contraceptive other than birth control pills (an IUD or implantable device). If you are counseling a patient prior to initiating contraceptives, use a code from the V25.0 category (general counseling and advice).

Further, the code 99211 describes a minimal E/M service. If the physician or a nonphysician practitioner saw the patient and took a history before determining her options, this level of service would be incorrect. In fact, contraceptive counseling is actually a "preventive" service. Therefore, the preventive medicine counseling codes (99401 to 99404) are more appropriate. Bear in mind that to use these codes, you must know the length of time you spent counseling the patient. For instance, the documentation for code 99401 (preventive medicine counseling and/or risk factor reduction intervention[s] provided to an individual [separate procedure]; approximately 15 minutes) should include the content of the counseling session and the time spent. However, some payers do not cover contraceptive management, making the patient responsible for the bill. When in doubt, check with your individual payer.

Reporting prolonged patient care for postop complications

Q A patient who underwent a total abdominal hysterectomy and bilateral salpingo-oophorectomy (TAH/BSO) had multiple severe postoperative complications (hypotension, acute renal failure with anuria, hypokalemia, and a broken humerus due to a fall sustained while trying to get out of bed). As a result, the physician spent 2 to 4 hours per day with the woman, but she was not transferred to the intensive care or critical care units (ICU/CCU). How can we get reimbursed for the extra time spent with the patient?

A First, it is important to know if the surgeon who operated and the physician who provided postoperative care for the complications are one and the same. If so, and if the problems were related to the TAH/BSO, the payer (e.g., Medicare) may include the postoperative care in the global fee, even if the physician spent more time with the patient each day than is typical. If the documentation clearly shows care of these problems were not related to the TAH/BSO, bill the inpatient hospital E/M services code and add the modifier -24.

You also can use the prolonged-services codes (99356 to 99357) for face-to-face contact—as well as the subsequent hospital care service—if the time was carefully documented.

Also consider the Critical Care services codes (99291 to 99292), as there is no requirement that the patient be admitted to the ICU or CCU to report them. However, the patient would have to meet the CPT definition of critically ill or injured. ■