Metformin for infertility

Q If a patient is on metformin for insulin resistance, what is the diagnostic code for insulin resistance if the patient is not pregnant? She will be undergoing in vitro fertilization.

A Metformin is generally used as an oral agent to help control type 2 diabetes, but your question suggests another use for the drug. Recent evidence indicates that metformin may facilitate ovulation in some women with polycystic ovary syndrome (PCOS) when taken in combination with clomiphene. Since the PCOS usually causes the insulin resistance that may, in turn, cause the infertility, I would suggest PCOS (ICD-9-CM 256.4) as the most accurate diagnosis. Still, infertility remains the primary diagnosis, which means you'll need to list code 628.0 (female infertility associated with anovulation) first on the claim.

Codes for new Pap follow-up test

Q What is the CPT code for the new PapSure exam (*Watson Diagnostics, Inc, Corona, Calif*)?

A PapSure, according to the company's brochure, is a new visual cervical screening exam that is performed right after the Pap smear sample is collected. The physician first washes the cervix with a mild solution, then examines it visually using a small disposable blue light and a special magnifying lens. The blue light causes abnormal tissue to appear bright white, helping clinicians better detect possibly harmful abnormalities.

To my knowledge, no payers are covering this exam yet. A few of the practices I talked to are collecting directly from the patient, using the unlisted code 58999. This is because, until recently, there was no CPT code for the procedure. But in July 2002, CPT added two Category III codes to cover billing for this procedure: 0031T (speculoscopy) and 0032T (speculoscopy; with directed sampling).

Category III codes, to be used in place of the unlisted codes, are assigned to new technologies that either are not currently a standard of care or need more data to prove their efficacy. It is unlikely that payers will reimburse for this test at present, but 1 or 2 might consider it if you can negotiate the service.

Coding for more than 10 antepartum visits

Q One of our providers (a midwife) had 13 antepartum visits with a patient, only to have the patient require a cesarean. I know 59426 covers 7 or more visits, but with 13, should we submit the related notes with a paper claim?

A The code 59426 is used for any number of antepartum visits equaling 7 or more, so the midwife's care will indeed fall under this code definition. However, you might be interested to know that the code was valued under the Medicare resource-based relative value scale system on the assumption that the average number of visits would be 10 (1 initial and 9 subsequent antepartum visits). If the midwife documented significant additional work due to developing complications at the end of the pregnancy, adding modifier -22 (unusual services) may be appropriate. ■

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.