REIMBURSEMENT ADVISER

■ BY MELANIE WITT, RN, CPC, MA

Postcoital exam denied: Now what?

Q We performed a postcoital examination on a patient. We have always used 89300 (semen analysis; presence and/or motility of sperm including Huhner test [post coital]), but now an insurance company has denied the claim. Any suggestions?

A First you need to determine the rationale for the denial. One of the most common reasons for denial of a service is an improper diagnosis code. Inquire if the payer objected to something specific about the code you used. For instance, some insurance companies will accept a diagnosis of infertility testing (V26.29, other investigation or testing; or V26.21, fertility testing) as the reason for the postcoital test, while others require an infertility diagnosis—either female or male.

Another issue may be that the patient does not have coverage for infertility services, including testing.

If neither of these is the problem, and the payer won't simply tell you how to bill for the exam, you might try the Health Care Financing Administration Common Procedure Coding System (HCPCS) code for this service, Q0115 (post-coital direct, qualitative examinations of vaginal or cervical mucous).

Document the reason for a nonstress test

Q I billed a nonstress test (NST) that was rejected. The note in the chart says the test was nonreactive. What should I do? Should we not have billed the NST at all, or can I just submit a diagnosis of no fetal movement?

A A nonreactive fetal NST is the finding of the exam—not the reason it was conducted. To justify performing the NST, you need to consider why it was ordered in the first place. Since this exam is done to measure fetal well-being, there are several possibilities. To name just a few:

- complaints of decreased fetal movement (655.73)
- fetal size that is small or large for dates (656.53 or 656.63)
- previous intrauterine fetal demise (V23.49)
- abnormal fetal heart rate (659.73)
- maternal abdominal trauma (659.83, along with a diagnosis indicating the injury)

Whatever the reason for the test, make sure it is documented; if it is not and the records are audited, returning money to the payer would be your best-case scenario. The worst-case scenario? Accusations of fraud for billing a service not documented (meaning, to the payer, that it never happened).

When is an infant no longer a newborn?

Q We performed a circumcision in the office. Code 54150 is listed as "Circumcision with a clamp on a newborn," while 54152 is simply "Circumcision with a clamp." What is the definition of newborn?

A "Newborn" refers to a liveborn infant during the first 25 days, 23 hours, and 59 minutes of life (from the 1972 American College of Obstetricians and Gynecologists book *Obstetric-Gynecologic Terminology*, edited by Edward C. Hughes, MD). CPT uses this same definition. ■

Ms. Witt, former program manager in the Department of Coding and Nomenclature at the American College of Obstetricians and Gynecologists, is an independent coding and documentation consultant. Reimbursement Adviser reflects 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.