BY MELANIE WITT, RN, CPC, MA

The extra effort of transvaginal injection

Q We treated an ectopic pregnancy with an injection of potassium chloride transvaginally. How is this coded?

A First, was ultrasound guidance of the needle used—and documented? If so, you can report 76942 (ultrasonic guidance for needle placement [eg, biopsy, aspiration, injection, localization device], imaging, supervision, and interpretation).

CPT does not have a code for the injection itself, and I do not advise the unlisted injection procedure code—that implies an injection in the skin or another easily accessibly location. I recommend 59899 (unlisted procedure, maternity care and delivery). You will need to submit documentation with this claim.

Multiple procedures follow pelvic pain in ER

Q I performed laparoscopic evaluation of a patient with pelvic pain who came to the emergency room (ER). The woman was found to have both a hemorrhagic ovarian cyst, which was cauterized, and appendicitis, for which an appendectomy was performed. What are the rules for billing these procedures together?

A Were you called for a consultation in the ER? If so, bill an outpatient consultation code with modifier -57 (decision to do surgery), as this was the visit at which surgical intervention was deemed necessary. (I assume the procedure was performed either the day of or the day after the decision.)

If no consultation was requested, use an outpatient code for the service, again with modifier -57. If the ER physician is billing for an ER service, you should not do so.

As for the surgery itself: For the cyst cautery, use 58662 (laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method); for the appendectomy, use 44970 (laparoscopy, surgical, appendectomy) with modifier -51 (multiple procedure). You can bill these together, as a different diagnosis supports each procedure and the appendectomy was not incidental.

If you assisted on the appendectomy, still bill codes 58662 and 44970, but add modifier -80 (assistant surgeon) to the latter code.

"Saddle block": Be prepared to appeal

Q How do you code a "saddle block" (spinal anesthesia confined to the perineum, buttocks, and inner aspect of the thighs)?

A If you, as the delivering obstetrician, performed the saddle block, add modifier -47 (anesthesia by surgeon) to the delivery code, then add 62311-51 (injection, single [not via indwelling catheter], not including neurolytic substances, with or without contrast [for either localization or epidurography], of diagnostic or therapeutic substance[s] [including anesthetic, antispasmodic, opioid, steroid, other solution], epidural or subarachnoid; lumbar, sacral [caudal]; multiple procedure).

If the procedure was performed by an anesthesiologist during vaginal delivery, the code is 01960 (anesthesia for vaginal delivery only).

This is in line with CPT guidelines, but some payers won't reimburse delivering physicians for the block—so be prepared to appeal, especially if no anesthesiologist was available. ■

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.