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Ultrasound included with D&C?

Q I performed 2 dilation and curettage (D&C) procedures with ultrasonic guidance. One was for retained placental fragments; the other, for manual removal of a placenta after elective termination due to severe fetal abnormalities. I am unable to find a code for the ultrasonic guidance to use in addition to the procedure codes—are these services considered inclusive in the surgical procedures? Would I just use 76999 (unlisted ultrasound procedure)?

A While ultrasound guidance is not specifically bundled into the delivery/abortion codes, you cannot count on it being reimbursed separately when done at the time of a D&C. The payer may decide that it is not medically indicated, or that it is routinely performed by the physician in all cases and is thus part of his or her procedure technique. The most appropriate code in this case would be 76986 (ultrasound guidance, intraoperative), rather than the unlisted procedure 76999.

"You cannot count on separate reimbursement for ultrasonic guidance done with D&C."

Estradiol assessment: What's the difference?

Q When we draw estradiol on our fertility patients, we use CPT code 82670 (assay of estradiol). The insurance company changed this to 80415 (chorionic gonadotropin stimulation panel; estradiol response panel), saying it "better represents the services performed." Is that correct?

A Code 80415 includes a baseline level of estradiol, preferably pooled with 3 samples at 15- to 20-minute intervals. After the baseline is taken, 5,000 U of human chorionic gonadotropin (hCG) are administered intramuscularly. Then, 3 days later, a pooled sampling of estradiol is repeated for response to the evocative agent. This is done to detect ovarian production of estradiol in response to hCG.

If you are not giving hCG to test the response, then the insurer is incorrect and you are right to assign 82670.

Unconfirmed pregnancy: Tips on a new code

Q When do I use the new diagnosis code V72.40 (Pregnancy examination or test, pregnancy unconfirmed)?

A Use V72.40 only when you have not confirmed that the patient is pregnant at the end of the visit. For example: if a blood specimen was drawn and a serum hCG ordered to confirm pregnancy. Since you would not have results before the patient left, V72.40 is appropriate.

If, on the other hand, a urine color test is performed with a positive result, your diagnosis would be V22.0 or V22.1 (supervision of a normal pregnancy). This is per official ICD-9 guidelines stating that you must code what you know at the end of the visit—unless no problem is found, in which case you can code for symptoms or complaints.

Note, however, that when V codes are used, many payers try to bundle the visit at which pregnancy is diagnosed into the global care. If this happens, try using 626.8 (missed period) for the primary diagnosis on the evaluation and management code, and V22.0 or V22.1 for the urine lab test that confirmed pregnancy. ■

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.