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FAST TRACK

Payment for endometrial ablation depends on place of service

Is discount unfair for outpatient ablation?

Q Our ObGyn providers perform endometrial ablations in the outpatient department of our local hospital. Medicare and some other major carriers state we are to be reimbursed at the facility fee reimbursement rate. We disagree with this reduction in payment and would like some guidance on how to dispute this discount.

A The payment level is determined by the place of service, not the category of health care professional performing the surgery.

In the office setting the practice expense portion of the relative value assigned to a procedure is higher than when the procedure is performed in an outpatient setting, which does not incur the expense of supplies, treatment room, anesthesia, and equipment. The physician is still reimbursed the same for the physician work and malpractice elements of the procedure's relative value, but the total RVU is less because the practice expense portion is less. **A physician would be paid at the lower RVU level** for a facility setting, for performing a procedure in a hospital outpatient department, under Medicare rules, since the outpatient facility has incurred the expenses of staffing the procedure as well as the expensive disposable equipment.

The only exception to this rule is when a procedure performed in this setting does not appear on the ambulatory surgical center (ASC) list of procedures. In that case, the higher nonfacility fee allowance would be reimbursed. Unfortunately, both codes for an endometrial ablation—58353 (endometrial ablation, thermal, without hysteroscopic guidance) and 58563 (hysteroscopy surgical; with endometrial ablation)—appear on the ASC list.

Can nurse-midwife bill for prolonged physician services?

Q How can a certified nurse-midwife (CNM) recoup time spent with a laboring patient when a physician performs the delivery? A seminar speaker once indicated CNMs could bill prolonged physician services. For instance, what if the CNM admits the patient for delivery on day 1 and spends 1 hour with her and then on day 2 spends 6 hours with her before the decision is made to proceed to cesarean delivery?

A You can only use the add-on prolonged services codes 99356 (prolonged physician service in the inpatient setting, requiring direct [face-to-face] patient contact beyond the usual service; first hour) and 99357 (each additional 30 minutes) if you are also billing for inpatient care and the record clearly documents the need for the prolonged care. Face-to-face time must be documented to use these codes, not unit/floor time. This is one way that the CNM or family practice physician can bill for labor management when they do not do the delivery.

To report these codes, the typical time included in the base inpatient service you are billing for must be exceeded by 30 minutes. For instance, code 99222 (initial hospital care, requiring a comprehensive history; a comprehensive exam and medical decision making of moderate complexity) has a typical time of 50 minutes. Since in your example the CNM spent only 1 hour face-to-face with the patient on the admission day, the criterion for reporting prolonged services has not been met and code 99356 cannot be billed in addition to 99222.

On the second day, however, prolonged services can be billed. Let's use the example

of 6 hours and assume the subsequent hospital care code billed on that day was 99233 (subsequent hospital care, requiring high complexity of medical decision making and a detailed history or exam). The typical time for this code is 35 minutes.

To determine billable prolonged service time, subtract typical time from the total face-to-face time (in this case 360 minutes), then subtract 30 because the first 30 minutes of prolonged time is not reported (360 – 35 – 30 = 295). Thus on day 2 you could bill 99233, plus 99356 × 1 for the first hour of prolonged service, and 99357 × 8 for the 8 remaining half-hour increments of prolonged time.

Two caveats, however. First, CPT nomenclature for the prolonged services codes indicate "physician service," which means that some payers may not reimburse for prolonged services unless provided by a physician.

Second, if the CNM is unable to bill for the global service, but instead must itemize the services provided by billing separately for antepartum care (eg, 59426, antepartum care only; 7 or more visits) and postpartum care (59430, postpartum care only [separate procedure]), some payers may include the time spent with the laboring patient as part of the antepartum services. Check with the individual payer to see if they have a written policy regarding this situation.

Pregnancy state affects CMV test code

Q What diagnosis code should be used for cytomegalovirus testing in a patient with fetal demise?

A The answer depends on whether the patient was pregnant at the time of the testing. If the patient was pregnant, use code V28.8, other specified antenatal screening; if she was not pregnant, use code V73.89, special screening examination for other specified viral diseases. ■

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.