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***FAST** TRACK*

Generally, you will not get paid for a hospital visit the day of delivery

Code for perineoplasty depends on setting

Q Can a perineoplasty be performed in the office as a minor procedure or does this require an operating room? Is there some way to bill for a simple repair in the office?

A CPT code 56810 *(perineoplasty, repair of perineum, nonobstetric [separate procedure])* was valued under the Resource-Based Relative Value Scale as an inpatient procedure, and there are no practice expense relative value units added if the procedure is done in the office. That does not mean that a private payer will not pay for it in an office setting, but you would not be paid for the added expense of performing it in the office setting. Also keep in mind that the perineoplasty code, which has a 10-day global period, was valued based on hospital admission and subsequent hospital care as well, so if the payer denies it in the office setting it will be because you are not providing these services.

If a repair only is documented, your other possibility is to use codes 12001–12004 (*simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities [including hands and feet]*; *2.5 cm or less up to 12.5 cm*). These codes do have a practice expense differential when the procedure is carried out in the office. Like the perineoplasty code, this code series has a 10-day global period.

Getting paid for pregnancy complications

Q A patient was admitted on December 22, at 35 weeks, for a diagnosis of oligohydramnios. The maternal-fetal medicine (MFM) specialist tried unsuccessfully to do an amniocentesis and then decided to induce labor on December 23. The patient delivered on December 24. Our payer is denying all 3 hospital visits as global.

Would it be appropriate to add a -57 modifier (*decision to do surgery*) to the admission, and if so, what modifier should be added to subsequent hospital visits?

A Generally, you will not get paid for a hospital visit on the day of the delivery, and you need to realize that the admission prior to delivery is also included as part of the global.

But some payers will acknowledge that the patient is being treated for a complication of the pregnancy and not for admission for delivery and will allow both the admission and any subsequent visits except on the day of delivery.

The problem with any modifier prior to delivery with global obstetric care is that "delivery" is the inevitable outcome of the care, so the modifier -57, in my opinion, is not appropriate in this setting for the physician who is providing the global care. If the MFM specialist has not been providing maternity care and then determines that an emergency delivery must be performed, modifier -57 might be warranted. There are no other applicable modifiers for the care prior to delivery.

I suggest that you appeal the denial. Explain that the admission was not planned, and the reason for admission and care on the second day was for a complication of pregnancy, not labor management.

GOT A CODING QUESTION?
Send it to us at **obg@dowdenhealth.com**
We'll answer as many questions as space permits.

CONTINUED

TABLE

You have to do the math: Coding prolonged physician services

TOTAL TIME W/ PATIENT	BASIC SERVICE	BILLABLE PROLONGED SERVICE	PROLONGED SERVICES WITH CODES REPORTED
Day 1 120 minutes	**99222** (50 minutes)	120 min – 50 min = 70 minutes	**99356** for first 60 minutes, but no extra codes for last 10 minutes
Day 2 480 minutes	**99232** (25 minutes)	480 min – 25 min = 455 minutes	**99356** for first 60 minutes; 455 min – 60 minutes = 395 minutes **99357** X 13 for remaining time (13 times for each 30-minute increment)

Payment for services during miscarriage

Q At 19 weeks' gestation, our patient presented to the emergency room leaking amniotic fluid. The umbilical cord was protruding through the vagina and the fetus was in breech presentation. She was not in active labor. Ultrasound showed no amniotic fluid around the fetus and no fetal heart rate. We induced labor, which lasted 16 hours. How can we bill?

A If this labor was induced with misoprostol or another cervical dilator, the correct code is 59855 (*induced abortion, by one or more vaginal suppositories [eg, prostaglandin] with or without cervical dilation [eg, laminaria], including hospital admission and visits, delivery of fetus and secundines*). It is not appropriate to bill for delivery unless the fetus is older than 20 weeks 0 days gestation or is born alive, which was not the case here.

Induction with IV oxytocin would be classified as medical management of an abortion. Under CPT rules and ACOG guidelines, you would bill only for the evaluation and management (E/M) services. However, this means you would be billing for the hospital admission, subsequent care, and, prior to delivery, prolonged physician services. In this case you would report the hospital prolonged care codes that account for the actual time you spent with the patient managing her labor, as long as that time exceeds by 30 minutes the typical time of the E/M code you reported (**TABLE**).

For instance, if she is admitted at 10 PM on day 1 and delivers on day 2 at 2 PM, with your having documented that you spent a total of 2 hours at the patient's bedside on day 1 and 8 hours at the patient's bedside on day 2, you could bill as follows:

Day 1: Hospital admission (*eg, 99222, requiring comprehensive history and exam and moderate medical decision-making with a typical time of 50 minutes*)

Prolonged services on day 1: 120 minutes total – 50 minutes = 70 minutes of prolonged service. Bill code 99356 (*first 60 minutes*), but no additional code for the last 10 minutes of prolonged service.

Day 2: Subsequent hospital care (*eg, 99232 requiring an expanded problem, focused history or exam with moderate complexity of medical decision-making with a typical time of 25 minutes).*

Prolonged services for 8 hours on day 2: 480 minutes total – 25 minutes = 455 minutes of prolonged service; bill code 99356 *(first 60 minutes),* and 99357 with a quantity of 13 for the remaining 395 minutes.

New 3D ultrasound codes are not for routine use

Q Is there a code for a 3D gyn ultrasound, for example, to detect endometriosis? Or can you only bill the 76856 code (*ultrasound, pelvic [nonobstetric], B-scan and/or real time with image documentation; complete*)?

A As it happens, CPT added new codes this year to allow billing for 3D ultrasound: 76376 and 76377 (*right*). The 3D code is billed in addition to the basic service, which in your example is 76856. However, keep in mind that many payers still consider 3D investigational and will not pay without strong medical necessity. You should not be routinely billing for this technology.

***FAST** TRACK*

New CPT codes for 3D ultrasound

- 76376 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation
- 76377 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation