## Be consistent with the fifth digit across delivery codes!

**Q. Recently, we were denied a claim for hospital care related to a patient's premature labor. She was admitted to stop labor at 30 weeks but delivered 5 days after admission. The reason for denial? "Invalid ICD9 code." But the code we used, 644.03 (threatened premature labor), appears to be correct. We also reported 644.21 (early onset of delivery) with the delivery code. Should we appeal, given that care prior to delivery is well documented?**

**A.** I believe that your denial is based on incorrect use of the fifth digit on the reported diagnosis codes, not on refusal to reimburse separately for additional care before delivery. ICD9 guidelines related to fifth-digit coding for obstetric cases state:

"The fifth-digits, which are appropriate for each code number, are listed in brackets under each code. The fifth digits on each code should all be consistent with each other. That is, should a delivery occur all of the fifth digits should indicate the delivery."

In this case, although the patient was still in the antepartum period during initial care, she did deliver during that hospitalization. That means a fifth digit of "**3**" (*antepartum condition or complication*) is incompatible with a fifth digit of "**1**" (*delivered, with or without mention of antepartum condition*), which is probably what generated the denial message. You have 2 choices:

- Resubmit a corrected claim, indicating a fifth digit of "**1**" for both diagnostic codes
- Appeal the denial, indicating the diagnostic correction and supplying information regarding the additional care for this patient.

I recommend the second option if you have reason to believe that the payer might also deny the additional care without this information.

## Bundle codes for repair of a pelvic floor defect?

**Q. To treat a patient who has a pelvic floor defect, we performed an anterior repair, a posterior repair, and an enterocele repair, using mesh—plus cystoscopy. Does one code capture all these procedures?**

**A.** I assume that you used mesh to augment the anterior and posterior repairs. A single CPT code, **57265** (*combined anteroposterior colporrhaphy; with enterocele repair*) captures the first 3 procedures, and CPT allows the add-on mesh code **57267** (*insertion of mesh or other prosthesis for repair of pelvic floor defect, each site [anterior, posterior compartment], vaginal approach*) to be reported with **57265**.

Based on the definition of the add-on mesh code, it is appropriate for you to bill for a quantity of 2: 1 for the anterior compartment repair and 1 for the posterior compartment repair, which includes the rectocele and enterocele.

As for reporting the cystoscopy (with **52000** [*cystourethroscopy (separate procedure)*]), the reason that you provide for the procedure will determine whether you are reimbursed. There must be a medical indication for cystoscopy beyond your simply checking your work, which is considered a standard of surgical care by most payers. ■

**Melanie Witt, RN, CPC-OGS, MA**
Independent coding and documentation consultant; former program manager, Department of Coding and Nomenclature, American College of Obstetricians and Gynecologists

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- In-office lab test is not an occasion for a modifier
- Payer may balk at modified biophysical profile
- Hysteroscopy before but not during thermoablation

***FAST*** *TRACK*

**The fifth digits on diagnosis codes should be consistent across all codes for that delivery**