REIMBURSEMENT ADVISER

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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

FAST TRACK

Denial of a claim for a lab test may reflect lack of a required CLIA certificate, rather than being a global matter

Delayed delivery of twin #2 not a "multiple pregnancy"

Q. My patient delivered the first of her twins vaginally but is still carrying the second fetus. When we report our services, how should we code for both the first and (eventual) second delivery? I know that I will be billing 59409 (vaginal delivery only [with or without episiotomy and/or forceps]) for the first delivery and 59400 (Routine obstetric care including antepartum care, vaginal delivery [with or without episiotomy, and/or forceps] and postpartum care) for the second—assuming that a cesarean section is not required. But can I use the diagnosis code 761.5 (multiple pregnancy) with these codes, as well?

A. Here is one of those situations that ICD9 was not constructed to handle! You may not report 761.5 on the mother's record because this is still one pregnancy for both events. Code 761.5 can only be reported on the baby's record once he or she is receiving direct care. Therefore, report the twin diagnosis code 651.01 for both deliveries. However, consider waiting and billing the deliveries together, on the same claim, with the different delivery dates specified (as so: "4/21: 59409, 651.01"; then "5/xx: 59400, 651.01"), and include an explanation with the claim to ensure payment for both deliveries.

In-office lab test is not an occasion for a modifier

Q. We billed an office visit and a wet mount (87210 [smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)]). The lab service was determined to be global by the insurance company and was denied. What is the appropriate code for the wet mount?

A. The A modifier is usually unnecessary for a laboratory test with an office visit. The closest modifier that would apply is -25 (*significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure*).

I suspect that your problem may not be a global issue, but one of coverage for a lab test performed by your practice under CLIA (Clinical Laboratory Improvement Amendments). [Editor's note: Details about coding for office lab tests (eg, wet mounts and KOH preps) in relation to CLIA certificate requirements were discussed in Reimbursement Adviser in the August 2006 issue of OBG MANAGEMENT. Read this installment at obgmanagement.com by linking to "Past Issues" on the top navigation bar of the home page.]

To sort out this situation, you first need to contact the payer to find out whether it considers a lab test global to an office visit, which should never be the case. Perhaps your billing staff misinterpreted the denial message. Or maybe this payer does, in fact, require a modifier for any service billed at the same time as an office visit.

On the other hand, it could also be that you do not have the required CLIA certificate to bill for the wet mount using code 87210.

Payer may balk at modified biophysical profile

Q. We are performing a limited ultrasonography to evaluate amniotic fluid volume and a fetal non-stress test at

the same time on our pregnant patient. How can we best code this evaluation to ensure proper reimbursement?

A. No single code describes this modified (so to speak) biophysical profile. Instead, you have 2 coding options, either of which may cause a headache with the payer:

- Code for the complete biophysical profile (**76818**) but add a modifier **-52** for a reduced service. The problem? Not all payers permit use of this modifier with an imaging code.
- Itemize your services by reporting **59025** for the fetal non-stress test and **76815** (*limited pelvic ultrasound*) for evaluation of amniotic fluid volume. The problem here? Code **59025** is bundled into code **76815**; although you are allowed to use the modifier **-59** (*distinct procedural service*) to bypass the edit, you can only do so if you can meet the criteria for doing so (eg, care involves a different incision or excision, a different patient encounter, or a different injury or site). Some payers may not accept that you've met those requirements, although I would disagree with that decision: Each test is performed independently and measures different things. So, to bill this combination of tests, add modifier **-59** to the bundled code: **76815, 59025-59.**

Hysteroscopy before but not during thermoablation

Q. **Please clarify: How do we correctly report a thermoablation procedure when hysteroscopy is performed *before* the procedure but not for guidance *during* the procedure? Are 58353 (endometrial ablation, thermal, without hysteroscopic guidance) and 58555-51 (Hysteroscopy, diagnostic [separate procedure]; multiple procedure) appropriate codes?**

A. The problem is that code **58555** is bundled into **58353** under National Correct Coding Initiative (NCCI) rules. Because of this, the modifier **-51** (*multiple procedures*) cannot be used. Although this bundled code allows the use of a modifier **-59** (*distinct procedure*), meeting the criteria for using it is almost impossible.

Modifier **-59** is defined as follows in CPT: "…used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician."

In the situation that you describe, the hysteroscope was inserted in the same area as the ablation, not at a different site; no separate excision or incision was made when inserting the hysteroscope; this was not a different surgical session; and, last, although hysteroscopy might, technically, be a distinct procedure from the ablation, it was directly related to the performance of the ablation in that it represented initial "exploration."

I believe, therefore, that correct coding in this case is to report the all-inclusive **58563** (*Hysteroscopy, surgical; with endometrial ablation [eg, endometrial resection, electrosurgical ablation, thermoablation]*). Support for this opinion is found in ACOG's *Ob/GYN Coding Manual: Components of Correct Procedural Coding 2007*. A comment included with code **58353** states: "If hysteroscopy is also performed, report code **58563** instead." ■

***FAST** TRACK*

Not all payers permit use of a reduced service modifier (-52) with an imaging code