REIMBURSEMENT ADVISER

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

Pinpoint pelvic pain to avoid denial for US scan

Q **We often are denied for ultrasonography (US) scans performed for pelvic pain (625.9). This is one of the symptoms that may indicate a problem with the uterus or ovaries, so why isn't the payer allowing this diagnosis?**

A For many payers, a diagnosis of 625.9 represents an unspecific symptom that can turn out to be something—or nothing at all. In the absence of additional diagnosis codes that more strongly indicate the need for US, many believe that medical necessity is not established.

If the patient can pinpoint which quadrant the pain is in, a better option is to report 789.0X (*abdominal pain*; the fifth [X] digit reports the site, such as left lower-quadrant or right upper-quadrant, etc.). Using this code more specifically identifies the complaint and location; I have found that fewer payers deny a US scan when this code is reported.

Problem with -52 modifier for US follicle evaluation

Q **Our infertility practice often performs transvaginal US scans to check for follicles. We have been billing 76830 (ultrasound, transvaginal) with a -52 modifier (reduced service) instead of 76857 (ultrasound, pelvic [nonobstetric], real time with image documentation; limited or follow-up [e.g., for follicles]) and, so far, have had no problems getting paid. We also perform 76817 (ultrasound, pregnant uterus, real time with image documentation, transvaginal) with a modifier -52 for cervical checks or 76830 for endometrial thickness checks.**

Can you comment on our coding strategies for these services?

A You say you are being reimbursed with "no problems"—but have you checked to see if you are being reimbursed at a reduced level? Not all payer systems do anything with a modifier -52, by way of reducing the allowed amount; if you are not being asked for additional information about the amount of work you did perform, I suspect you are being paid for the full service. This constitutes an overpayment to you for a service you did not document, according to CPT requirements.

Among payers that recognize -52, almost all put the claim into manual review before payment. If you are being paid a reduced amount, have you compared it with the reimbursement you might be getting by reporting 76857 instead? Note that neither code 76857 (which specifies checking for follicles) nor code 76815 (which specifies a limited exam such as you would perform for a quick cervical check on a pregnant patient) specifies the approach—in other words, the word "pelvic" does not imply strictly a transabdominal approach. These codes can therefore be used to report either an abdominal or transvaginal scan. In my opinion, either code more accurately describes the procedures that you are performing.

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FAST TRACK

Having the patient identify the quadrant of pain allows you to code 789.0X (abdominal pain), where the fifth digit specifies the quadrant

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Dx/procedure mismatch when checking for fibroids

Q **For an obstetric patient with fibroids, we just performed a Doppler ultrasound scan to check the vascularity of the fibroid. Can we use code 93975 (duplex scan**

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of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study) with an obstetric US code?

A Yes. You may report a duplex-Doppler scan with an obstetric US procedure because there are no bundles within the National Correct Coding Initiative that preclude your doing so. But your diagnosis code will be taken from the obstetric complications chapter (e.g., **654.13**, *tumors of body of uterus*), which may create a mismatch in the diagnosis/procedure check in the payer's computer. This doesn't mean you won't be paid for the nonobstetric sonogram being linked to an obstetric complication, but you might have to submit additional information with the claim.

Also, understand that the duplex procedures are only reported when you are trying to characterize the pattern and direction of blood flow in arteries or veins. This year, CPT clarified that, although evaluation of vascular structures using both color and spectral Doppler is reportable separately, color Doppler alone, when performed for identification of anatomic structures in conjunction with a real-time US exam, cannot be reported separately.

Last, the code you are billing, **93975**, represents a complete study. Examination of a single fibroid within the uterus constitutes a limited study, billed using **93976**. ■

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meet the formal criteria for Parkinson's disease) as well as an increased risk, which did not attain statistical significance, of Parkinson's disease itself.

Taken in totality, the evidence suggests that when HT is initiated in young menopausal women, protection against dementia and other neurologic disease may result. These findings parallel the evidence on the risk of CAD during HT use presented at the beginning of this article. ■

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