

OB-GYN CODING ALERT

Your practical adviser for ethically optimizing coding, payment, and efficiency in ob-gyn offices and clinics

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CCI 16.1:

Seize the Opportunity to Report 0193T — But Don't Get Tripped Up by These Edits

▶ **Overlooking these new Interstim and hemorrhoid destruction bundles could mean denial headaches.**

Don't let CCI version 16.1's lack of ob-gyn mutually exclusive edits lull you into a false sense of security. Here's what you need to know to prevent a denial from landing on your desk.

Payers like Noridian Part B will cover the female stress urinary incontinence treatment code 0193T, but before you submit a 0193T claim, you'll have to check with the Correct Coding Initiative (CCI) version 16.1's edits. For instance, as of April 1, the work represented by 0193T will include that of cystourethroscopy codes 52000-52001 and 52281.

1. Look For 0193T in Both the Column 1, Column 2 Position

In 2009, CPT added 0193T (*Transurethral, radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence*) to your possible stress urinary incontinence (SUI) treatment coding options. This code includes the Renessa transurethral collagen radiofrequency denaturation procedure. Ob-gyns typically perform this nonsurgical, minimally invasive alternative for women who have failed other nonsurgical treatments or who aren't good candidates for surgery.

What happens: The ob-gyn uses controlled heat at low temperatures and targets tissue in the woman's lower urinary tract. The heat changes the structure of the patient's natural tissue collagen. This helps the firmness of tissue and improves her continence. Although the ob-gyn may use heat on multiple sites and document multiple cycles, you should report 0193T once to represent all the treatment cycles performed during an encounter.

As of April 1, 0193T will include the work represented by 52000-52001 (*Cystourethroscopy ...*) and 52281 (*Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female*).

Reaction: "These edits don't surprise me at all because 0193T says 'transurethral' which implies the use of the scope," says **Jan Rasmussen, CPC, AGS-GI, ACS-OB**, president of Professional Coding Solutions in Eau Claire, Wis. For instance, you should always include "inserting the scope (52000) into the major procedure." As for 52281, "that is a little less obvious," but CCI "probably bundled that because these services may be part of the approach," Rasmussen adds.

You should also include 53660-53666 (*Dilation of female urethra ...*) and 90901 (*Biofeedback training by any modality*). CCI describes these edits as "misuse of column

(Continued on next page)

2 code with column 1 code” (0193T). *Remember:* Column 1/column 2 edits describe “bundled” procedures. The column 1 code generally represents the comprehensive service, and the column 2 code is the component that is part of the more extensive column 1 procedure, says **Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO**, consultant with MJH Consulting in Denver.

All of these edits carry a modifier indicator of “1,” meaning you can use a modifier (such as 59, *Distinct procedural service*) to separate them — but make sure your documentation supports the modifier.

Additionally, as of April 1, you should do the opposite and bundle 0193T **into** the following services:

- 51845 — *Abdomino-vaginal vesical neck suspension, with or without endoscopic control (e.g., Stamey, Raz, modified Pereyra)*
- 51990 — *Laparoscopy, surgical; urethral suspension for stress incontinence*
- 51992 — *... sling operation for stress incontinence (e.g., fascia or synthetic)*
- 57160 — *Fitting and insertion of pessary or other intravaginal support device*
- 57288 — *Sling operation for stress incontinence (e.g., fascia or synthetic).*

CCI describes these bundles as “misuse of column 2 code” (which is 0193T) “with column 1 code.” Again, all of these edits carry a modifier indicator of “1,” meaning

you can use a modifier to separate it — but make sure your documentation supports the modifier, or you’ll face a denial.

2. Take Note of New Fluoroscopy Bundle With Interstim Procedure

If your ob-gyn tests electrodes for the Interstim procedure, you’re probably used to reporting 64561 (*Percutaneous implantation of neurostimulator electrodes; sacral nerve [transforaminal placement]*).

What you may not be used to is including fluoroscopy codes (76000-76001, *Fluoroscopy ...*; 77002-77003, *Fluoroscopic guidance ...*). CCI 16.1 tacks these codes as column 2 codes with a modifier “1” indicator, which means you’ll have to append — and justify — a modifier onto the fluoroscopy code to separately report both procedures.

Reaction: Notice how 64561 contains the term “percutaneous.” The physician “has to have some way to visualize the placement,” Rasmussen points out.

3. Count 46930 as Part of More Extensive Hemorrhoid Procedure

Do you report 46930 (*Destruction of internal hemorrhoid[s] by thermal energy [e.g., infrared coagulation, cautery, radiofrequency]*) with any regularity? If so, then you should be wary of reporting this code with

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We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to ob-gyn coding, and reimbursement to the Editors indicated below. Suzanne Leder at suzannel@inhealthcare.com.

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46255-46258 (*Hemorrhoidectomy ...*), which are “more extensive procedures,” according to CCI.

You cannot separate these bundles with a modifier under any circumstance — except for the case of 46258 (*Hemorrhoidectomy, internal and external, single column/group; with fistulectomy, including fissurectomy, when performed*) with 46930. In this one case, you can use a modifier if necessary, but you have to have documentation to back this up.

You shouldn't report 46930 with 46500 (*Injection of sclerosing solution, hemorrhoids*) — a code combination you shouldn't be reporting anyway. Because this edit carries a modifier indicator of “0,” you cannot separate this bundle with a modifier under any circumstance. □

Diagnosis challenge:

End Endometrial Thickening Confusion by Crossing Out Hyperplasia

► ***Think you're getting a more specific code in ICD-10? Think again.***

If you're scratching your head when your physician documents “endometrial thickening,” you're not alone. Tackle this common scenario, avoid this major pitfall, and you'll be applying the correct diagnosis every time.

Scenario: Your ob-gyn suspects hyperplasia. He detects and documents “endometrial thickening” during an ultrasound examination. What diagnosis should you report?

Steer Clear of Making This Hyperplasia Mistake

Just because your ob-gyn documents endometrial thickening does not mean the patient has endometrial hyperplasia (621.30, *Endometrial hyperplasia, unspecified*; or 621.31, *Simple endometrial hyperplasia without atypia*). Many coders make this mistake.

ICD-10: When you report hyperplasia in 2013, you'll use the straight forward equivalents N8500 (*Endometrial hyperplasia, unspecified*) and N8501 (*Simple endometrial hyperplasia without atypia*).

“You should not code this as hyperplasia because physicians don't [necessarily] consider the thickening of the uterus ‘abnormal;’ in fact, it's just a monthly ‘ramp up’ for all women,” says **Tara Onder, CPC**, ob-gyn specialty coder for the Vancouver Clinic in Wash.

Important: If the patient requires more diagnostic tests because she presents with conditions that would increase the risk of hyperplasia, then you should report the ICD-9 codes that describe these conditions. For instance, you would report morbid obesity as 278.01.

To indicate that a patient was currently taking Tamoxifen (an estrogen antagonist), you would report V07.51 (*Prophylactic use of selective estrogen receptor modulators [SERMS]*). Of course, the patient would not be taking Tamoxifen unless she was estrogen-receptor positive, so you would also report V86.0 (*Estrogen receptor positive status [ER+]*) and V86.1 (*Estrogen receptor negative status [ER-]*), according to ICD-9 rules.

Also, if you knew the patient was susceptible to endometrial cancer due to her BRCA gene status, you would also report V84.04 (*Genetic susceptibility to malignant neoplasm of endometrium*) for the complete picture.

ICD-10: Your ICD-10 equivalents include E6601 (*Morbid [severe] obesity due to excess calories*), Z79.810 (*Long term [current] use of selective estrogen receptor modulators [SERMs]*), Z17.0 (*Estrogen receptor positive status [ER+]*), and Z15.04 (*Genetic susceptibility to malignant neoplasm of endometrium*).

Bottom line: You cannot say report hyperplasia until the ob-gyn does a biopsy.

Follow This ‘Nonspecific’ Route Instead

Because you have no code to describe this condition, you should report 793.5 (*Nonspecific abnormal findings by ultrasound of genitourinary organs*).

Rationale: Endometrial thickening is a finding — not a diagnosis. Therefore, you should locate the diagnosis code in the signs and symptoms section of ICD-9. If you look under “thickened endometrium,” this will lead you to 793.5, Onder says.

Remember, the title for the 793 states, “Nonspecific (abnormal) findings on radiological and other examination of body structure.” The fourth digit of “5” indicates the problem is in the genitourinary organs (for which the uterus would qualify). When endometrial thickening is abnormal, that usually means a hormonal imbalance. This commonly occurs during menopause when physician prescribes progesterone therapy.

Think of it this way: An ob-gyn can only see the thickened endometrium on an ultrasound, so this is the logical place to put it. Codes like 793.5 are “beneficial when you end up ordering multiple studies on a patient to come up with a definitive diagnosis,” says **Elizabeth Hollingshead, CPC, CMC**, corporate billing/coding manager of a practice in Marysville, Ohio.

(Continued on next page)

ICD-10: You'll still see "thickened endometrium" referencing this type of nonspecific (abnormal) finding code. In fact, 793.5's ICD-10 equivalent is R93.8 (*Abnormal findings on diagnostic imaging of other specified body structures*). □

Streamline E-Scribe Coding From 3 Codes to 1

► **2010 brings a new code and a new number to meet if you want your bonus.**

Physicians who adopt e-prescription systems are eligible to earn a bonus of 2 percent of their total Medicare allowed charges. But the rules on how you should report your e-prescribing changed for 2010, so take heed.

Narrow 2010 Option to G8553

2010: CMS issued a new numerator G code with the following descriptor:

- G8553 — *At least one prescription created during the encounter was generated and transmitted electronically using*

a qualified ERX system. Effective Jan. 1, you'll report an e-prescribing code only when a visit results in an electronic prescription being placed. You'll need to report this code at least 25 times (unique visits) during the reporting period for Medicare to consider you a successful e-prescriber.

Remember: "You have an incentive to report this, but the actual code has a zero charge," says **Gina Jarrell, CPC, CPP**, senior coder for Jefferson Center for Women's Medical Specialties in Philadelphia.

You also need to be sure that this measure's denominator codes make up 10 percent of the eligible professional's Medicare Part B charges. The denominator codes you'll probably use most often for your ob-gyn practice are office and outpatient E/M codes 99201-99215.

2009: In contrast, you previously reported on 50 percent of applicable cases and had more coding options:

- G8443 — *All prescriptions created during the encounter were generated using a qualified E-prescribing system*
- G8445 — *No prescriptions were generated during the encounter; provider does have access to a qualified E-prescribing system*
- G8446 — *Provider does have access to a qualified e-prescribing system and some or all of the prescriptions generated during the encounter were printed or phoned in as required by state or federal law or regulations, patient request or pharmacy system being unable to receive electronic transmission; or because they were for narcotics or other controlled substances for narcotics or other controlled substances.*

Example: Mary Jane, who has a very large uterine fibroid, sees her gynecologist regarding treatment options. The patient is experiencing heavy periods and is currently anemic, and although surgery will be an option soon, the physician suggests that she begin taking Lupron prior to the surgery date to decrease the bleeding and improve the anemia, as well as temporarily shrinking the fibroid to make surgery easier. Her physician performs a level four established patient office visit and e-prescribes Lupron.

You report the denominator code 99214 (*Office or other outpatient visit for the evaluation and management of an established patient ...*) and appropriate ICD-9 code, such as 218.0 (*Submucous leiomyoma of uterus*). But the e-cribe code differs. In 2009, you would have reported G8443, but in 2010, you'll report G8553.

Tip: If 2010 will be your first time participating, contact your local pharmacies to ensure they are ready to receive your e-prescriptions. "This can be the difference between success and failure," says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC**, president of CRN Healthcare Solutions in New Jersey.

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Reader feedback:

Check Descriptor for Unilateral, Bilateral Before Appending Modifier 52

► ***Have your own success story to share? Email the editor.***

Over-applying modifier 52 may mean you're cutting out ethical reimbursement your physician deserves, and in these tough economic times, that's the last thing you want to do.

A subscriber wrote to the editor regarding "3 Details Narrow Down Your Tubal Ligation Coding Options" featured in the *Ob-gyn Coding Alert* 2010 Volume 13, No. 1. The article states, "when the ob-gyn ligates only one tube or places the device on only one tube, CPT indicates that you should add modifier 52 (*Reduced services*) to the code."

This advice would be correct for codes that specify "bilateral" but not for codes specifying "unilateral or bilateral," points out **Donna Cuifolo, CCS-P**, coding/compliance coordinator at Jamestown Area Medical Associates in N.Y. "Coders need to understand this difference because adding modifier 52 when it is not necessary will inappropriately reduce the payment to the physician," Cuifolo emphasizes.

For example, take a look at codes 58600 (*Ligation or transection of fallopian tube[s], abdominal or vaginal approach, unilateral or bilateral*) and 58605 (*Ligation or transection of fallopian tube[s], abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization [separate procedure]*). Because these code descriptors state "unilateral or bilateral," you would not add modifier 52 if the ob-gyn only ligates one tube. The "unilateral" takes care of that.

Along the same lines, you might also argue that code 58615 (*Occlusion of fallopian tube[s] by device [e.g., band, clip, Falope ring] vaginal or suprapubic approach*) might represent a unilateral or bilateral procedure since the description includes "tube(s)" rather than "tubes."

Beware of Payer Intricacies

Watch out: The 2010 Medicare Physician Fee Schedule clearly indicates that you should consider every tubal procedure inherently bilateral — and many payers agree. Additionally, CPT considers laparoscopic and hysteroscopic approaches for tubal occlusion or fulguration to be bilateral. In other words, codes 58670-58671 (*Laparoscopy, surgical; with fulguration of oviducts [with or without transection] ...*) read "oviducts." Similarly, 58565's definition states, "Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants." This means if the ob-gyn performs only one implantation or fulgurates only one fallopian tube using a scope, then you should add modifier 52 to show a reduced service.

Editor's Note: Thanks to Ms. Cuifolo for shedding light on this important distinction. Do you have a clarification or success story to share? Email the editor at suzannel@inhealthcare.com. □

You Be the Coder

Apply Modifier 78 For Delivery and Same-Day Surgery

Question: *The patient delivered on the same day as the following surgery:*

PREOPERATIVE DIAGNOSIS: Postpartum hemorrhage.

POSTOPERATIVE DIAGNOSES: Postpartum hemorrhage with a large amount of clots in the uterus, as well as cervical laceration.

OPERATIONS:

1. Exam under anesthesia.
2. Dilation and curettage (D&C) under ultrasound guidance.
3. Repair of cervical laceration.
4. Reapproximation of original vaginal laceration.
5. Repair of small new vaginal laceration due to speculum placement.

In the full op report, the ob-gyn stated he examined the original laceration and found it to be intact. How should I report this?

Georgia Subscriber

Answer: Turn to page 31. □

READER QUESTIONS

Modifier 57 Isn't for Consults Only

Question: *In our ob-gyn office, we used to apply modifier 57 to inpatient consult codes. Now that Medicare doesn't accept consult codes, how should we use this modifier?*

Kentucky Subscriber

Answer: The short answer is that you should append modifier 57 (*Decision for surgery*) to the non-consult inpatient E/M code that the documentation supports.

Suppose the ob-gyn performed a 2009 level-three inpatient consult in which the ob-gyn determined the patient required an exploratory laparotomy later that same day due to severe abdominal distention and pain as well as some uterine bleeding. Adding the modifier to the E/M code will help show payers why you're reporting an E/M in addition to the major surgery performed later that day, 49000 (*Exploratory laparotomy, exploratory celiotomy with or without biopsy[s] [separate procedure]*).

For 2010, the exact E/M code you choose will depend on the circumstances specific to the visit, such as whether the visit is the first or second ob-gyn visit during the admission. But as an example, suppose you're coding the ob-gyn's first visit to an inpatient. Your documentation may support 99221 (*Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity ...*), which has requirements similar to 99253 (*Inpatient consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of low complexity*).

You should append modifier 57 to the E/M code. If, instead, the ob-gyn is the principal physician — the one overseeing the patient's care and the one who is admitting the patient — be sure to append modifier AI (*Principal physician of record*), as well. This would be the case if the ob-gyn admitted the patient for observation for the abdominal pain and bleeding but later made the decision to take her to surgery that same day.

You Can Append Mod 25 to Preventive Code

Question: *The patient came in for a well woman exam. During this visit, the ob-gyn removed her*

intrauterine device (IUD). The insurance company denied the preventive code, because they say the IUD removal includes the preventive visit. Should I appeal with modifier 25? I thought this modifier only applies to E/M codes. Can you apply this modifier to a preventive code?

Texas Subscriber

Answer: Yes. The IUD removal is a procedure, and you can apply modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) to any E/M (problem or preventive) code. Your ob-gyn should receive reimbursement for both services.

You should report the removal of an IUD (through the cervix, which is the only accepted way of doing this service) with 58301 (*Removal of intrauterine device [IUD]*).

You'll report the well woman exam (WWE) using preventive visit codes (99381-99397) with modifier 25 appended.

Keep in mind: You may encounter payers who will deny the visit or WWE when the ob-gyn performs a procedure on the same date — even with this modifier. Sometimes you only get paid for one. You must know your payer rules.

Same Day 58661, 58862 Reporting? Check Payer Habits

Question: *My ob-gyn's documentation shows he laparoscopically removed the patient's fallopian tubes but saved the ovaries. Then he documented an ablation of the ovarian wall for endometriosis. What modifier should I use when billing for these two procedures?*

Iowa Subscriber

Answer: If he removed the tubes (instead of removing a cyst on the tubes), then you should code 58661 (*Laparoscopy, surgical; with removal of adnexal structures [partial or total oophorectomy and/or salpingectomy]*). For ablation of endometriosis, you should submit 58662 (*... with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method*).

The Correct Coding Initiative (CCI) does not bundle these codes. So you would apply modifier 51 (*Multiple procedures*) to 58661.

Some coders report, however, that McKesson edits are bundling these two procedures for some payers. McKesson is a clinical editing system that is not in a public domain, and therefore you are not given specific information about

what edits your payer is applying each time you bill. Most of the time, you learn what they are by following the denial patterns. When your payer bundles 58661 and 58662 and you know the surgery is in two different places, you would tack on modifier 59 (*Distinct procedural service*) to the code the payer is bundling.

Here's How to Report History of Chlamydia

Question: *What diagnosis code should I report for a history of Chlamydia?*

California Subscriber

Answer: You should report V13.29 (*Personal history of other diseases; other genital system and obstetric disorders; other genital system and obstetric disorders*) or V13.02 (*Personal history, urinary [tract] infection*), as Chlamydia can cause urinary tract infections.

Be on the lookout: As neither of these codes is very informative, the ICD-9 staff will put this issue on the agenda for discussion at the next Coordination and Maintenance Committee meeting to perhaps develop a V code just for this. Keep watching *The Ob-gyn Coding Alert* for the latest information.

ICD-10: When ICD-9 becomes ICD-10 in 2013, you'll report Z87.49 (*Personal history of other diseases of the genitourinary system*) instead of V13.29 and Z87.41 (*Personal history, urinary [tract] infection[s]*) instead of V13.02.

Counseling During Preventive Visit? Do This

Question: *A new patient came in for her annual well woman exam and during this visit the ob-gyn gave her preconception counseling. He states, "I spent an additional 15 minutes counseling over and above the usual time spend or an annual exam." The preventive codes, however, are based on age, not time. Am I correct in assuming we cannot bill an additional E/M visit code based on this statement?*

South Dakota Subscriber

Answer: You are correct. You should include the 15 minutes of preconception counseling in the new patient preventive service code (99385, *Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender- appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering*

of appropriate immunization[s], laboratory/diagnostic procedures, new patient; 18-39 years or 99386, ... 40-64 years).

If the ob-gyn documented the patient sought counseling for a problem she had with her last pregnancy, however, you can carve out a problem E/M service (99201-99215, *Office or other outpatient visit ...*) and append modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*). But to do this

(Continued on next page)

You Be the Coder

Apply Modifier 78 For Delivery and Same-Day Surgery

Answer: You should report 57720-78 (*Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach; Unplanned return to the operating/procedure room by the same physician following an initial procedure for a related procedure during the postoperative period*) and 59160-51-78 (*Curettage, postpartum; Multiple procedures*). You can also bill for the ultrasound guidance (76998, *Ultrasonic guidance, intraoperative*) without a modifier.

Heads up: You have indicated in the operative summary that the surgeon reapproximated the original vaginal laceration and repaired a small additional vaginal laceration. You may want to look again at the medical need for the reapproximation of the original laceration. You state that in the full operative report, this ob-gyn stated he examined the original and found it to be intact. That means you don't have medical need for this reapproximation. Also, the speculum placement caused a small additional laceration during this procedure, and as you don't say the ob-gyn documented the size of wound, you should assume an incidental repair and not code for it without much more information.

For the cervical laceration, you should report 665.31 (*Laceration of cervix; delivered with or without mention of antepartum*). For the postpartum hemorrhage, you'll report 666.12 (*Postpartum hemorrhage; other immediate postpartum hemorrhage; delivered, with mention of postpartum complication*).

ICD-10: In 2013, these codes become O71.3 (*Obstetric laceration of cervix*) and O72.1 (*Other immediate postpartum hemorrhage*). □

he could not use his statement regarding time to pick the level of service. Instead, he would document something like “The patient also presented for a discussion of preconception problems regarding . . . I spent a total of 15 minutes counseling this patient regarding these issues/problems.”

2 Surgeons for TAH and Appendectomy? Look Here

Question: *My ob-gyn assisted on a total abdominal hysterectomy bilateral salpingo-oophorectomy (TAH/BSO) for another surgeon. Then, he performed an appendectomy as the primary surgeon on the same with patient (with other surgeon as the assist). How should I bill this so that each surgeon is paid appropriately?*

New York Subscriber

Answer: Assuming you have a medical indication for removing the appendix (other than a ruptured appendix), your ob-gyn bills 44950-52 (*Appendectomy; Reduced services*) and 58150-80 (*Total abdominal hysterectomy [corpus and cervix], with or without removal of tube[s], with or without removal of ovary[s]; Assistant surgeon*). You would need modifier 52 because the ob-gyn did not open or close the abdominal procedure.

The other doctor will bill 58150, 44950-80. □ The other doctor does not report modifier 52 with 49950, because he did open and close.

Watch out: You should not report +44955 (*Appendectomy; when done for indicated purpose at time of other major procedure [not as separate procedure] [List separately in addition to code for primary procedure]*), because it is an add-on code only for the surgeon who does both the primary surgery and the appendectomy. Refer to *CPT Assistant*, September 1996.

— The answers for Reader Questions provided by **Melanie Witt, RN, CPC, COBGC, MA**, an ob-gyn coding expert based in Guadalupita, N.M. □

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