REIMBURSEMENT ADVISER

Gravidas in the ER

Q It is our understanding that if a gravida is in the emergency room (ER) triage for less than 6 hours, we should bill an office visit/outpatient facility E/M code. Why not report an ER E/M visit unless the patient is admitted to observation status?

A Multiple problems arise when using the ER E/M codes (99281 to 99285), making the office visit/outpatient facility E/M codes a better alternative (99201 to 99215).

First, a payer may require that you prove it was an emergency, thereby slowing payment. Second, to report an ER code, you must document all 3 of the key components (history, exam, and medical decision-making), and you cannot use time as a default if any counseling or coordination of care took place. Third, the service must have been rendered in the ER; labor and delivery (L&D) does not qualify as an emergency department, even though that may be where all pregnant patients are sent. Fourth, the ER codes usually do not pay that well, especially since the physician may have only performed a problem-focused exam on the patient. This means that only a level 1 service can be billed because the lowest level of any of the 3 key components determines the level of service.

For these reasons, many physicians have decided simply to bill for the outpatient E/M service, and if the time with the patient was prolonged due to her condition, they bill for the additional time using the CPT "prolonged services" codes, provided that the time spent and medical necessity for the service have been documented in the patient's medical record.

Obstetric care under 2 different carriers

Q A payer wants our office to use the global obstetric code (59400) with the modifier -22 for a patient who switched insurance carriers mid-pregnancy so that another insurance company will be responsible for a portion of the bills. The company also wants us to attach a comment to the claim indicating how many times the patient was seen and the amount of reimbursement from the first insurance carrier. Is this proper?

A No, the insurance company's recommendations represent inappropriate coding practices. Conventionally, when a patient changes insurance companies mid-pregnancy, the global obstetric code becomes obsolete. Why? Billing for the antepartum visits must be divided between 2 different insurers. Instead, use the code 59425 (4 to 6 antepartum visits) or code 59427 (7+ antepartum visits) to bill each carrier separately and then bill the current payer for the delivery and postpartum care using the code 59410, if it is an uncomplicated vaginal delivery.

Further, the modifier -22 indicates that an unusual service was provided or the course of the pregnancy/delivery/postpartum was complicated. As this is not the case, the insurer's recommendations do not make sense.

My advice: Get the payer's requests in writing and inform the insurance plan's medical director about the recommendations, as well as the implications for incorrect coding.

Patient counseling for sonohysterography

Q Some of our physicians are billing for a level 2 or 3 counseling visit when they discuss the test results of sonohysterograms immediately after the procedure. Is this legitimate, or is patient counseling included in the sonohysterography codes?

A The sonohysterography codes, both for the injection of the saline (58340) and the radiologic supervision (76831), only include obtaining informed consent or telling the patient what to expect during the procedure, not patient counseling. Therefore, the physician also may bill for an E/M service, which encompasses a discussion of the results and appropriate follow-up. In addition, include the modifier -25 to indicate that the counseling was a significant, separate E/M service that took place on the same day as the procedure.

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E/M services: total-visit time versus counseling time

Q When a physician spends more than 50% of an in-office visit counseling and/or coordinating care, we select the appropriate E/M services code based on the amount of time spent counseling, not the total-visit time. How are the 2 different? And does the latter include only physician/patient interactions or can it include the time spent with nurses, medical assistants, etc.?

A Think of the criteria for selecting an E/M code based on time as consisting of 2 factors. First, the counseling time must represent more than 50% of the face-to-face time. Second, if the first condition is met, select the code based on the total face-to-face time documented in the patient's medical record. This total-visit time is reflected in the nomenclature of each E/M code as follows: "physicians typically spend XX minutes face-to-face with the patient and/or family."

When documenting the amount of time, record both the total time spent face-to-face with the patient and the amount of time spent counseling the patient. If you only did counseling, i.e., no exam, indicate this in the documentation and record only the face-to-face counseling time. For example, if the total-visit time was 25 minutes and the physician documented that 15 minutes was spent counseling (which meets the 50% requirement), the E/M code would be based on the 25 minutes (99214 for an established patient or 99202 for a new patient visit).

With regard to your second question, according to the CPT guidelines, the counseling time and total-visit time apply only to physician/patient interactions. Time spent with the patient by an RN, LPN, or medical assistant does not count toward this physician/patient time; therefore, it cannot be used to increase the total time of the visit. Note, however, that some payers will allow "counseling time" to be billed by a nonphysician practitioner, if this person provided the entire service. (Note: In these cases, payers usually require that the nonphysician practitioner be a nurse practitioner, certified nurse-midwife, physician's assistant, or certified nurse specialist.)

Failed hysteroscopic D&C procedure

Q One of our physicians attempted a hysteroscopic dilatation and curettage (D&C), but several attempts at cervical dilation were unsuccessful. The physician abandoned the procedure and proceeded with a traditional D&C. Should we use the code 58558 with the modifier -53, plus the code 58120?

A There are 2 problems with your suggested coding. First, the code 58120 (D&C) is included in the code 58558 (hysteroscopy, surgical; with sampling [biopsy] of endometrium and/or polypectomy, with or without D&C) and would likely be denied by the payer as a bundled service. Second, the modifier -53 is used only when a procedure is completely stopped due to the patient's condition, e.g., fall in blood pressure, and she is sent home or to the recovery room.

In this case, you abandoned the first procedure and began and completed a second procedure. If this were a Medicare patient, you would be allowed to bill only for the second procedure. Other payers may allow you to also bill for the "failed" procedure, especially if your documentation shows significant work. To do this, you might want to bill for the traditional D&C (58120) and add the modifier -22. As always, be sure to send documentation with the claim.

This article was written by Melanie Witt, RN, CPC, MA, former program manager in the Department of Coding and Nomenclature at ACOG. She is now an independent coding and documentation consultant. Her comments reflect the most commonly accepted interpretations of CPT-4 and ICD-9-CM coding. When in doubt on a coding or billing matter, check with your individual payer.