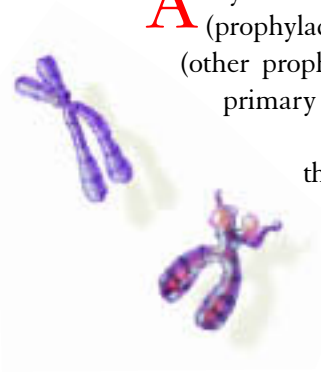
REIMBURSEMENT ADVISER

BY MELANIE WITT, RN, CPC, MA

How to make note of a BRCA mutation

Q I have a patient with a BRCA mutation that places her at high risk for breast and ovarian cancer. Which diagnosis code should I use?

A If you are removing the organ, use V50.42 (prophylactic ovary removal) or V50.49 (other prophylactic organ removal) as the primary diagnosis.



If you simply want to note the mutation as a reason for further evaluation and management (E/M), try V16.3 (family history of breast cancer) or V16.41 (family history of ovarian cancer). You may use these as the primary diagnosis if there is no other reason for the encounter, or as secondary diagnoses.

Current ICD-9 rules do not permit you to code V83.89 (other genetic carrier status) for this scenario. This code is used for patients who carry a disease that can be directly passed on to their offspring, rather than for those at high risk of disease due to genetic predisposition.

ICD-9 has addressed this issue with new codes that go into effect October 1. They will be V84.01 (genetic susceptibility to malignant neoplasm of breast) and V84.02 (genetic susceptibility to malignant neoplasm of ovary). (Look for further discussion of this and other ICD-9 changes in the November issue of OBG MANAGEMENT).

Abnormal quad screening: Which code is correct?

Q What diagnosis code would I use for an abnormal quad test?

A The quad test is an "enhanced prenatal screening test" for Down syndrome, trisomy 18, and neural tube defects that is performed between the 15th and 20th week of gestation. It measures 4 substances in the mother's blood that come from the developing fetus and placenta: alpha-fetoprotein, human chorionic gonadotropin (hCG), estriol, and inhibin-A (which is not included in the routine triple screen).

A positive result simply places the patient at higher risk for having a baby with one of the indicated conditions—it does not diagnose the child with anything. Unless the patient has a family history of Down syndrome or neural tube defects, the correct ICD-9 code is V28.8 (other antenatal screening). If there is a relevant family history, use V23.49 (pregnancy with other poor obstetric history) along with either V18.4 (family history of mental retardation) or V19.5 (family history of congenital anomalies).

For positive screening tests, use 655.13 (known or suspected chromosomal abnormality in fetus) or 796.5 (abnormal finding on antenatal screening), because you do not yet have a definitive diagnosis.

If a problem with the fetus is confirmed through additional testing, you will use the code for the diagnosed condition for the rest of the pregnancy.

Misoprostol for prodromal labor

Q I gave misoprostol to a woman in prodromal labor who was a high-risk pregnancy (due to previous miscarriage and preterm labor that was successfully suppressed

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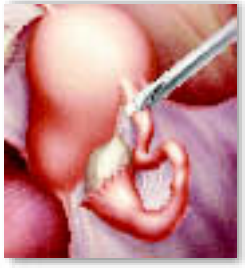
with bedrest and nifedipine). What would be the appropriate diagnosis for the misoprostol?

A The fact that this was a high-risk pregnancy has no bearing on the coding for the misoprostol administration. It is the prodromal labor—in which the early phase of labor is prolonged with contractions that do not increase in intensity—that is relevant.

The correct linking diagnosis is 662.0X (prolonged first stage of labor). If she was also preterm at this stage, you may indicate that as a secondary diagnosis.

Tubal ligation at cesarean: No assistant needed?

Q I always have trouble getting insurers to pay for code 58611 (ligation or transection of fallopian tube[s] when done at the time of cesarean delivery or intra-abdominal surgery). The explanation of benefits (EOBs) states that an assistant is not required. Do you have any suggestions?



A Actually, there are 2 issues here: payment of a tubal ligation at the time of cesarean, and using an assistant during the ligation. You will probably have to appeal each case—unless you can persuade the payer to make a policy change.

The American College of Obstetricians and Gynecologists (ACOG) may be able to help with this. Its Committee on Coding and Nomenclature published 2 Committee Opinions on these topics.[1,2]

In *Tubal Ligation with Cesarean Delivery*, ACOG states that tubal ligation is a distinct procedure with its own risks and liability; thus, it should be coded separately from the cesarean.[1] In the second opinion, *Statement on Surgical Assistants,* ACOG asserts that the surgeon's judgment should dictate whether a surgical assistant is used; this should not be overruled by any third-party payers.[2]

The American College of Surgeons also published data on the need for an assistant for all procedures with CPT surgical codes. It determined that an assistant is "almost always required" when procedure 58611 is performed.[3]

From a coding perspective, the assistant would bill the "delivery-only code" for the cesarean—59514-80 (cesarean delivery only, assistant surgeon) or 59620-80 (cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, assistant surgeon)—along with 58611-80 for the ligation.

Note that 58611 is a CPT add-on code; it does not take a "multiple surgery" modifier because it can only be reported with a cesarean delivery code.

REFERENCES

1. ACOG Committee on Coding and Nomenclature. T*ubal Ligation with Cesarean Delivery.* Committee Opinion #205. Washington, DC: ACOG; 1998.
2. ACOG Committee on Coding and Nomenclature. *Statement on Surgical Assistants*. Committee Opinion #240. Washington, DC: ACOG; 2000.
3. American College of Surgeons. P*hysicians as Assistants at Surgery: 2002 Study*. April 2002: page 132. Available at: http://www.facs.org/ahp/pubs/pubs.html. Accessed August 18, 2004.

14-day 5-FU application: Reimbursement unlikely

Q We are using a tampon coated with 5-fluorouracil (5-FU) cream (daily for 2 weeks) to treat a Medicare patient with high-grade vaginal lesion. Should we assign a low-level E/M code (it doesn't take long) or is there a better procedure code?

A You will likely have trouble securing reimbursement because 5-FU can be self-administered via a vaginal applicator.

If this had been a 1-time treatment, I would advise using 57061 (destruction of vaginal lesion[s]; simple)—the lesion is being destroyed via chemosurgery. This code has a relative value unit of 3.01 when performed in the office. It is unlikely, however, that the Medicare carrier will reimburse for this level of procedure for 14 consecutive days, even if you use modifier -76 (repeat procedure by the same physician).

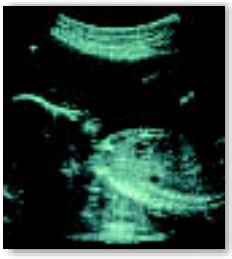
They might, however, allow you to bill a

low-level E/M service each day, assuming you can get past the coverage guidelines for medications that can be self-administered. Are you, as the physician, personally inserting the tampon each time? If this is the case, and no other E/M services are taking place at each encounter, I would recommend billing a level 2 E/M service (99212) each day.

You might want to communicate with the carrier regarding why you are inserting the tampon rather than having the patient do it. For instance, is she unable to comply with the treatment because of age-related problems such as dexterity or senility?

Obstetric ultrasound with no maternal evaluation

Q We received an error from an auditor regarding radiology readings for obstetric ultrasounds. We looked at the size and date of the fetus, and didn't document a maternal evaluation (the cervix, however, was documented).



For transabdominal, we use 76801 (Ultrasound, pregnant uterus, real time with image documentation, fetal & maternal evaluation, first trimester [<14 weeks, 0 days], transabdominal approach; single or first gestation) or 76805 (…after first trimester [≥ 14 weeks 0 days]). The auditor tells us that, when the maternal evaluation isn't documented, we should use 76816 (Ultrasound, pregnant uterus, real time with image documentation, follow-up [eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan], transabdominal approach, per fetus)

My impression was that 76816 is for follow-up ultrasound only. When we requested clarification, the auditor replied that this code was for either assessment or reassessment.

A In this case, the auditor is not interpreting the follow-up code correctly. The nomenclature clearly states that 76816 is for a reevaluation, not an initial assessment.

The auditor is correct, however, that you have not documented all the required elements for the codes you are billing.

Maternal evaluation is required under both CPT and American College of Radiology/American Institute of Ultrasound in Medicine (ACR/AIUM) rules. To bill 76801, ACR/AIUM requires location and number of gestational sacs, crown-rump length, presence or absence of fetal life, evaluation of uterus (including cervix), and adnexa. The guidelines for code 76805 use similar language.

Your coding options will depend on the fetal gestation: If the fetus is less than 14 weeks, consider billing a limited ultrasound (76815: Ultrasound, pregnant uterus, real time with image documentation, limited [eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume], one or more fetuses) instead of 76801 when maternal structures are not documented. You could also add a "reduced services" modifier (-52) to the code.

Modifier -52 is an even better choice when the fetus is past 14 weeks, since fetal scrutiny is greater than it is for the younger fetus.

Replacing eroded sling mesh

Q A patient underwent a sling operation last year, but the mesh didn't hold. She's scheduled to have the eroded mesh replaced, but I can't find a good diagnosis code.

A There actually is a very good diagnosis code: 996.76 (other complications of internal [biological] [synthetic] prosthetic device, implant, and graft; due to genitourinary device, implant, and graft). This is acceptable as the primary diagnosis. Use it in conjunction with CPT code 57287 (removal or revision of sling for stress incontinence [eg, fascia or synthetic]). ■