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Insurer won't pay for routine lab tests

Q When we bill for Pap tests (Q0091), vaginal cultures (87070), and stool guaiac (82270), insurance companies refuse to pay.

They tell me we can collect for obtaining the specimen, but I cannot find the correct CPT codes. How should I proceed?

A It depends on what payer you are billing and whether you have the correct Clinical Laboratories Improvement Act (CLIA) certificate to bill for laboratory procedures.

The code Q0091 was developed by Medicare to reimburse physicians for collecting a Pap smear at the time of an otherwise noncovered service. When they later added the code G0101 for the pelvic and breast exam portion of a preventive visit, they continued to reimburse for the collection as well.

Collection codes

This collection code is not recognized by all payers, however. In fact, the American College of Obstetricians and Gynecologists (ACOG) has indicated that collection is part of the exam and not a separately billable service. However, some payers will allow you to collect for handling the specimen by using the code 99000.

Lab codes

As for the lab tests you are billing, all providers are required to have the proper certificate before they can bill for laboratory tests. By billing the lab codes, you are telling the payer you are qualified to perform these tests and that you did, in fact, perform them. Once again, there is no collection code for either of these tests. Code 82270, which is a waived test, can be performed by the physician in the office, and the collection of the stool specimen is an integral part of the code. A waived test, by the way, still requires a certificate (visit www.cms.hhs.gov/clia/certypes.asp for definitions of the various certificate levels).

Culture codes

The culture code you are using, 87070, is considered a highly complex test for which the highest certificate level would be required. Again, there is no collection code for the vaginal specimen, but you might be able to bill 99000 for the handling. If the Pap smear and culture collection are performed at the same visit, you would only bill 99000 once.

A consult calls for more expertise, not less

Q A patient was sent to a midwife by the physician managing her pregnancy. She was sent to obtain information on midwifery so she could decide whether to transfer care.

Can this visit be billed as a consultation, since the physician asked the midwife to see the patient?

A No. A consultation happens when a physician or other health-care professional asks a physician for an opinion or advice about the patient's condition. Because a midwife has less training than a physician, a midwife is not allowed to bill for a consultation if asked to see a patient at an MD's request. Remember, the idea behind the consult is to send the patient to someone with more expertise, not less.

It was counseling, not consulting

Further, the reason for the patient's visit was not to seek the midwife's opinion or advice about the patient's condition.

CONTINUED

FAST TRACK

The vaginal culture code 87070 is a complex test that requires the highest CLIA certificate level

Rather, the midwife was asked to give the patient information, which is "counseling," not "consulting."

In this case, the payer may reimburse the midwife for an evaluation and management (E/M) service. Once the patient becomes an established patient for the pregnancy, the midwife will report the applicable maternity care code(s) for transfer of care for a portion of the pregnancy (eg, 59426 with 59410).

Limits to NSTs?

Q A patient was admitted to a hospital at 37 weeks' gestation for preterm labor. She stayed 15 days but did not deliver.

Can the attending physician charge outside the global fee for interpreting nonstress tests (NSTs) during this period? If so, how many readings a day can be billed?

A At 37 weeks, the patient does not have premature labor (644.0x), but "other threatened labor," which is ICD-9 code 644.13 if she does not go on to deliver during this hospitalization. The physician can bill for the admission and daily rounding, but billing for the NST will depend on whether one was performed.

To bill for 59025, the patient is required to mark the strip to indicate fetal movements throughout the 30 to 40 minutes of the test. It would only be necessary to do so if the physician suspected a fetal problem.

However, if external fetal monitors are being used to count contractions or monitor heart rate, the NST would be billed as part of the exam.

FAST TRACK

No protocols stipulate a limit for nonstress tests in a single day, but the payer may ask about necessity if more than 1 is performed

No limit on number of tests, if medically needed

If a true NST is performed and documented and the physician has interpreted the results, then the obstetrician can bill for it using 59025–59026. No protocols stipulate a limit for NSTs in a single day, but the payer will likely ask about medical necessity if more than 1 per day is performed—especially if the results are all reassuring and the patient is close to term.

New laparoscopic code on the way

Q What code should I use for laparoscopic supracervical hysterectomy? Code 58180 appears to be intended for the abdominal approach.

A CPT rules clearly forbid billing a laparoscopic procedure using a code for the abdominal approach. This leaves you with 2 options: Either use

- existing laparoscopically assisted vaginal hysterectomy codes (58550–58554) with modifier –52 added to denote a reduced service because the cervix was not removed, or
- unlisted laparoscopy code 58579.

ACOG is working on new codes for laparoscopic supracervical hysterectomy.

Minilaparotomy code depends on incision

Q A new doctor in our practice performed a minilaparotomy with ovarian cystectomy. Since none of our other physicians use this approach, I'm not sure how to code. Any pointers?

A It depends on what you mean by minilaparotomy. In some procedures the incision is small, but it is still an abdominal incision. In others, a "Hasson" or "open field" technique is used, with a small incision to direct the trocar into the correct position. In this case, CPT previously directed coders to add modifier –22 to the primary laparoscopic procedure. (These instructions appeared in CPT as a note before the laparoscopic procedures were distributed throughout the CPT book.)

However, if your physician always uses this technique for performing laparoscopy, the payer will ignore the –22 modifier. ■

Ms. Witt, former program manager in the Department of Coding and Nomenclature at the American College of Obstetricians and Gynecologists, is an independent coding and documentation consultant. Reimbursement Adviser reflects 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.