

If IUD insertion fails and payer balks, try the manufacturer

Q How should I code a failed insertion of a Mirena IUD? The company advised us to use the modifier -53 for the supply and the procedure.

A In this situation, -53 (discontinued procedure) is not correct. The correct modifier for a failed procedure is -52 (reduced services), which should be added to the procedure code for the insertion (58300).

As for the supply, bill the payer for the IUD if an insertion attempt was made, because the attempt renders the supply unusable. In that case, it would be appropriate to add the modifier -52 to the supply code J7302. If the payer denies the claim for the supply, ask the manufacturer for a replacement or refund for the unusable IUD.

Discontinued service (modifier -53) can only be used when the procedure is discontinued due to a problem that threatened the well-being of the patient (such as increased or decreased blood pressure), and you must have carried out surgical prep and anesthesia induction.

Typically, IUD insertion fails because of cervical stenosis, and is coded 622.4 (stricture and stenosis of cervix)—unless another diagnosis explains the failed procedure.

Mesh is an internal graft for coding purposes

Q In a recent column, you indicated that the CPT code 57295 (revision [including removal] of prosthetic vaginal graft, vaginal approach) could be used to report revision or removal of an eroded vaginal mesh. What ICD-9 codes would be used for this procedure?

A Normally, erosion is reported as a complication of the procedure, even when it occurs after the global period for the procedure. Since the mesh is considered an internal graft, you will look under

the code category 996.6x (infection and inflammatory reaction due to internal prosthetic device, implant, and graft) or 996.7x (other complications of internal [biological] [synthetic] prosthetic device, implant, and graft). The code selection will depend on documentation of the problem with the mesh.

If there was evidence of infection or inflammation, the correct code would be 996.65, specific for a genitourinary device, implant, or graft.

If there was evidence of pain, fibrosis, stenosis, hemorrhage, or erosion, the diagnosis specific to a genitourinary device would be 996.76.

Luteal phase defect may warrant 2nd code

Q What is the diagnosis code for luteal phase defect?

A Use ICD-9-CM code 256.8 (other ovarian dysfunction) for this condition. The luteal phase refers to the span of time during the menstrual cycle between ovulation and onset of the next menses. Most women have a luteal phase of 10 to 14 days. If the luteal phase lasts less than 10 days or longer than 14 days, the patient may have a luteal phase defect.

You might also consider adding a second code to further clarify the reason for the visit. For instance, evaluation for this problem may be related to infertility or recurrent spontaneous abortions.

If the patient miscarries frequently, let the payer know that the visit was not related to infertility by adding the code V13.29 (personal history of other genital system and obstetric disorders) or 629.9 (habitual aborter without current pregnancy). ■

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.

FAST TRACK

The failed attempt to insert an IUD renders the device unusable

How to use new codes for 3D ultrasound

Q How should I bill a 3D ultrasound of the fetus?

A Keep in mind that most payers still consider 3-dimensional fetal ultrasound an expensive “new science” that is not being reimbursed. Be sure that you have a sound medical indication for 3D ultrasound, and be sure that the patient is made aware that this procedure may not be covered by her insurance company.

Two new codes represent 3D rendering of an ultrasound.

- Code 76376 is reported in addition to the basic service (detailed obstetric ultrasound 76811) when the image does not require image postprocessing on an independent workstation.
- Code 76377 is reported if image postprocessing is performed on an independent workstation.

According to CPT guidelines, these 2 codes also require “concurrent physician supervision of the image postprocessing 3D manipulation.” Previously, the only code available for 3D manipulation was 76375, a code that did not mention conversion from an ultrasound. Code 76375 has been deleted from CPT 2006.

Use new code for digital occult blood screening

Q Does the revised code 82270 for fecal occult blood replace the Medicare code G0107 (colorectal cancer screening; fecal-occult blood test, 1–3 simultaneous determinations)?

A No. Medicare will continue to require that a screening guaiac fecal occult blood test be billed using G0107.

The revised CPT code 82270, however, affects the way you can bill for the guaiac fecal occult blood test.

The CPT 2006 revised code now states that the patient is provided with 3 cards or a single triple card for consecutive collection. The changed nomenclature states that this code is to be used for screening.

Effective January 1, 2006, the code 82270 does not apply when the physician takes the sample in the office.

The new code, 82272 (blood, occult, by peroxidase activity [guaiac], qualitative, feces, single specimen [from digital rectal exam]) should be used for this circumstance.

Supracervical hysterectomy billing

Q How should I bill for a laparoscopic supracervical hysterectomy?

A If the ovaries are not removed, your code choices are 58550 (laparoscopy surgical with vaginal hysterectomy for uterus 250 grams or less) or 58553 (laparoscopy surgical with vaginal hysterectomy for uterus greater than 250 grams).

But you need to add a modifier -52 (reduced services) because the surgeon elected not to remove the cervix.

Keep in mind that a new “S” code (S2078, laparoscopic supracervical hysterectomy [subtotal hysterectomy] with or without removal of tube[s], with or without removal of ovary[s]) is added to the national code set by Blue Cross/Blue Shield.

If you are billing a carrier that uses the “S” codes for processing claims, you must use the S code instead of code 58550/58553-52.

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FAST TRACK

Be sure the patient is aware that her insurance may not cover fetal 3D ultrasound

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