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More RVUs for 3 office hysteroscopy procedures

Q We perform diagnostic and operative hysteroscopy in our office. How do we recoup our loss compared with the hospital? Can we bill a separate physician and technical component?

A The Medicare Resource-Based Relative Value Scale (RBRVS) normally allows a practice expense increase for procedures that may be performed in the office and require expensive equipment, but are more typically performed in the hospital. The Medicare Relative Value Unit (RVU) is 9.42 for code 58558 (*Hysteroscopy, surgical; with sampling [biopsy] of endometrium and/or polypectomy, with or without D & C*). For hysteroscopy procedures, there is no difference in the RVU for site of service—with 3 exceptions:

- **Diagnostic hysteroscopy** carries .65 more (RVUs) for the office setting.
- **Endometrial ablation** has 63.25 RVUs for the office setting, but only 9.66 for the hospital setting.
- **Essure**, a new hysteroscopic sterilization technology, carries 57.91 RVUs in the office setting.

The vastly increased RVU for the latter 2 procedures in the office setting covers the more expensive equipment needed.

Hysteroscopic procedures do not have a professional and technical component in the typical sense. Although you may have additional practice costs such as a dedicated treatment room or special equipment, these may not be accurately reflected in the allowable for the hysteroscopic procedure you perform in the office setting. The current RVU system does not allow for separate payment of a "facility fee"; all practice costs associated with performing the procedure are added into the practice expense portion of the RVU for each procedure. Although all payers bundle the surgical tray into the reimbursement for the procedure, consider negotiating for a "facility fee" that adequately covers your additional expenses, by pointing out that money will be saved when the hysteroscopy is performed in the office.

FAST *TRACK*

RVUs are vastly higher for endometrial ablation and hysteroscopic sterilization in the office setting

HPV-positive test in a pregnant woman

Q How do you code a positive test for human papillomavirus high-risk DNA (795.05) in a pregnant patient?

A The most accurate code for this finding would be 647.63 (*Other viral diseases*). This code includes conditions classifiable to HPV. Your secondary diagnosis will be 795.05.

You must justify D&C with fibroid resection

Q I performed a resection of a submucous fibroid and also did uterine curettage. I will report code 58561 (*Hysteroscopy, surgical; with removal of leiomyomata*) for the primary procedure, but can I also bill for the curettage?

A Yes. Code 58120 (*Dilation and curettage, diagnostic and/or therapeutic [nonobstetrical]*) is not bundled with code 58561 under the National Correct Coding Initiative (NCCI). But to avoid denial you must establish medical justification for doing the curettage by indicating a diagnosis other than submucous fibroid (218.0).

GOT A CODING QUESTION?
Send it to **obg@dowdenhealth.com**
We'll answer as many questions as space permits.