

REIMBURSEMENT

ADVISER

Multisite injection might not be reimbursed as multiple procedures

Q. I have been injecting lidocaine in a grid pattern into the vulvar area of some of my patients to treat vestibulitis. Is there a specific CPT code for this procedure?

A. Although CPT includes codes for injection into nerves [eg, 64430, *Injection, anesthetic agent; pudendal nerve*], lesions [eg, 11900, *Injection, intralesional; up to and including seven lesions*], and trigger-point muscles [eg, 20552, *Injection(s); single or multiple trigger point(s), one or two muscle(s)*], it appears that the local anesthetic you are injecting is being placed subcutaneously. This means that code 90772 [*Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular*] is the correct code.

What may present a problem, however, is that you are administering lidocaine in several areas of the vulva. Many payers have a unit limitation for the number of injections you can bill at one time; if you use the same syringe and needle for injection at multiple sites, the payer may decide to reimburse for only a single injection.

Some practices have been successful in getting fair reimbursement by billing code 58999 [*Unlisted procedure, female genital system (nonobstetrical)*] for this treatment.

If you will be billing the injection procedure instead, note that the “J” code for lidocaine was deleted in 2006. To bill for lidocaine, report J3490 [*Unclassified drugs*]. Lidocaine would be included as a supply with code 58999 and therefore not separately billable.

Split preop visit from surgery? Maybe

Q. When a procedure (such as hysteroscopy) has no global days and the decision to perform the surgery was made at a previous visit (perhaps days or weeks before the procedure), can we bill a preoperative visit that is made the week of the surgery? This visit involves talking to the patient to answer any additional questions, taking a history and performing a physical exam, providing preadmission and preoperative instructions, and having her sign the informed consent form.

A. There isn't any black-and-white answer; the payer determines the coverage. Many payers consider the service that you are describing integral to performing any surgery and therefore included in the billing for the procedure—especially if the visit occurred within 48 hours before planned surgery.

Some payers will reimburse for this visit, however, and you owe it to them to indicate the nature of the visit. This means that you should not provide a diagnosis code for the visit that is the actual reason for doing the surgery; instead, code V72.83 [*other specified preop exam*] or V72.84 [*unspecified preop exam*]. This allows the payer to apply its policy on this matter. A payer that includes the preop exam will deny the claim; one that doesn't, will reimburse you. ■

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FAST TRACK

Use the same needle and syringe for multiple injections and you may be reimbursed for a single injection

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One surgery, two surgeons: How do both code to be reimbursed? Find the answer and read more “Reimbursement Adviser” on the Web at www.obgmanagement.com