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***FAST** TRACK*

A screening visit that includes a breast exam but no pelvic exam will be denied by the payer

Does breast exam only qualify as screening visit?

Q. I recently saw a 62-year-old Medicare patient for a breast examination only. Here is my documentation of the visit:

- **Patient is a virgin, takes no hormones, and refuses a pelvic exam and Pap smear. Blood pressure is in the normal range. Body mass index is 21. She reports no problems and has no questions.**
- **Examination of breasts reveals normal skin and nipples, no masses or tenderness, and no lymph-node swelling.**
- **Patient is given a slip for a routine mammogram and instructions on performing breast self-exam, and is instructed to return in 1 year, barring problems or concerns.**

My question is: Does this visit qualify for billing Medicare with code G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination) or should it be billed a low-level problem E/M service instead? We would use the diagnosis code V76.19 (other screening breast examination).

A. You face an interesting situation. This is a preventive service, but a diagnosis of **V76.19**, although accurate here, will cause code **G0101**, which requires that a pelvic exam have been performed, to be denied.

If you report this visit as a problem E/M service using only this diagnosis, on the other hand, you are more than likely to be denied by Medicare.

For Medicare to consider this a covered service billed as a problem E/M service, you would also have to list diagnostic codes that indicate a complaint, a history of a breast condition, or a strong family history of breast cancer. Medicare will pay for the screening mammogram, but the screening breast exam by itself may not be considered a covered service.

You have a few options:

- Contact the Medicare carrier and explain the situation. See if they propose a coding solution that they will accept. Get their answer in writing!
- Bill Medicare using a low-level E/M code (eg, **99212**, *problem focused exam with straightforward medical decision making*) linked to the diagnosis code **V76.19**. If you choose this option, have the patient sign a waiver that she is responsible for payment should Medicare deny the service. Add the modifier **–GA** (*waiver of liability statement on file*) to the problem E/M code. This will allow you to collect payment from the patient.
- Submit the unlisted code or preventive services **99429** because you performed an exam—although not one that meets the criteria of age-specific preventive codes. This code is never reimbursed by Medicare, but once you get a denial, you either can collect from the patient or are able to submit the charge to any secondary insurance she might have. A modifier **–GY** (*item or service statutorily excluded or does not meet the definition of any Medicare benefit*) would also need to be added to the preventive medicine code.

Fern testing: CLIA-waived but payer might not cover

Q. What is the correct code for fern testing? The codes recommended to us are 89060 or 87210, not Q0114, which isn't recognized by some of our payers. Can you give us advice?

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A. The fern test should never be coded **87210** because that code does not represent how the test is performed. (Fern testing is simply applying vaginal fluid to a slide, which is left to dry, and observing whether a ferning develops when the residue is viewed under a microscope.) The test is performed by the provider, not the laboratory; as such, **Q0114** is the correct code.

Code **87210**, in addition to requiring addition of saline or potassium chloride, is not a CLIA-waived test. You would not be able to bill for it unless you have an advanced lab certificate.

Code **89060** is assigned when looking for crystals in synovial fluid. It is also not a CLIA-waived or physician-performed microscopy test, so billing using this code would require an advanced lab certificate as well.

The advent of the national code set has meant that your payers are required to recognize all codes, although they can determine whether to cover a service or not. It may be that this test isn't covered by your payer, rather than the code not being recognized as correct.

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Coding for a fern test must indicate that you, not the lab, actually performed this CLIA-waived procedure

Two voiding studies: Bill together but specify parts

Q. **Can both the 51795 voiding pressure study and 51797 intra-abdominal voiding pressure study be billed together? When I checked the bundling software, it lists these codes as mutually exclusive, with 51795 having an indicator of "1" and 51797 a "9." If the codes can be billed together, should I use a modifier -59 (distinct service)?**

A. Voiding pressure studies (**51795**) measure urinary flow rate and pressure during bladder emptying; intra-abdominal voiding pressure studies (**51797**) measure how the patient must strain to void. These codes can be billed together because they measure different events. More important, they are not bundled.

The "**9**" indicator used by Medicare for bundled codes means that the edit was deleted. In this case, it was deleted on the same date it was added. For some reason, Medicare elects not to remove deleted code pairs from the master database. Although you will get paid for both of these codes, the code order is different depending on whether you are using your own equipment (because of differences in relative value units).

If you bill each test with a modifier **-26** (*professional component only*), you do not own the equipment and the place of service is a facility. In that case, list **51797-26** first and **51795-26-51** second. The modifier **-51** is used on the second code because this is a multiple procedure. If you are billing both professional and technical components (ie, you are using your equipment, in the office), billing order is reversed: List **51797** first and **51795-51** second. Do not use a modifier **-59** with this code combination.

Fetal genetic abnormality inferred from US; code for further study

Q. **What diagnosis code should we use for a bilateral choroid plexus cyst found on ultrasonography?**

A. Choroid plexus cysts (CPCs) are considered a "soft marker" for a gene abnormality called Edward's syndrome. Although these markers, taken alone, do the baby no harm, they may be associated with an increased risk of another abnormality, including cardiac defects. The presence of a soft marker is not diagnostic of this other abnormality; it is just a noted association.

At the time of the sonogram, therefore, you can only suspect a problem with the fetal genes; further testing is required. In that case, report **655.13** (*known or suspected chromosomal abnormality of the fetus affecting management of mother; antepartum condition or complication*) with a secondary diagnosis of

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793.99 (*other nonspecific abnormal findings on radiological and other examinations of body structure*).

Positive ANA—don't leap to "autoimmune disorder"

Q. One of our obstetric patients had a positive antinuclear antibody (ANA) test. We'll follow her with biophysical profiles and non-stress testing, and track amniotic fluid volume. Because we have not yet diagnosed systemic lupus erythematosus (SLE) or other specific condition, is it appropriate to use a diagnosis of unspecified autoimmune disorder (279.4) in addition to a pregnancy complication code?

A. Many illnesses and conditions are associated with a positive ANA, including rheumatoid arthritis, Sjögren syndrome, scleroderma, and SLE; infectious diseases such as mononucleosis; and autoimmune thyroid and liver disease. Some medications can cause a positive ANA, and many healthy people have a positive ANA.

Because you have not eliminated the other possibilities for the positive ANA, it is premature to assign the code for an autoimmune condition. Instead, report **648.93** as your primary code (*Other current conditions in the mother classifiable elsewhere, complicating pregnancy, childbirth, or the puerperium; antepartum condition or complication*), with the secondary diagnosis code **795.79** (*Other and unspecified nonspecific immunological findings*).

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It's premature to assign a code for an autoimmune condition just on the basis of a positive ANA test

Coding Zoladex depends on the patient's condition

Q. We have begun using Zoladex for our patients. How do we best code for administering this agent? We have been told to use chemotherapy codes, but this is not a chemotherapeutic agent.

A. Zoladex (goserelin acetate) is classified as a hormonal antineoplastic. It is used to treat endometriosis before surgery because it thins the lining of the uterus, and to treat breast cancer by inhibiting production of estrogen.

The drug is supplied as tiny pellets, which are injected under the skin of the abdomen using a small, "trocar-like" needle and syringe. The procedure constitutes an injection. If you are treating breast cancer with this drug, the correct code would be **96402** (*Chemotherapy administration, subcutaneous or intramuscular; hormonal antineoplastic*). The code for the pellets is **J9202** (*Goserelin acetate implant, per 3.6 mg*). If you administer more than 3.6 mg at a time, remember to adjust the quantity you bill for. If you are using this drug to treat endometriosis or fibroids, CPT directs you to report **90772** for the injection because it is then considered a non-antineoplastic hormone injection.

Call a contraceptive a contraceptive when coding

Q. How should we code for Implanon insertions?

A. Code this **S0180** (*Etonogestrel [contraceptive] implant system, including implants and supplies*). For the procedure, I recommend code **11975** (*insertion, implantable contraceptive capsules*).

Implanon's manufacturer thinks the correct code is **11981** (*Insertion, nonbiodegradable drug delivery implant*), but I disagree: This is a contraceptive that is implanted under the skin and, under CPT rules, you must use the code that most closely describes the procedure.

Note also that, although Implanon involves insertion of one rod (other systems require insertion of several), the code **11981** has greater relative value units than **11975**. This payment difference will not be lost on most payers because the diagnostic link for the procedure, whichever code is reported, is **V25.5** (*insertion of implantable subdermal contraceptive*). ■