REIMBURSEMENT ADVISER

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Can US scan be used to confirm a normal pelvic exam?

Q. We're seeing more and more patients who are obese. Because of their habitus, we are unable to evaluate the uterus and ovaries adequately at the time of the well-woman or diagnostic examination. In such cases, we've begun ordering transvaginal ultrasonography (US). Our billing staff reports that most of these claims are being denied for lack of medical necessity. Any suggestions?

A. This is a dilemma, to be sure—one where the payer has the deciding voice over what is and what isn't medically indicated. An option is to report a diagnosis of obesity linked to the US scan, along with **V72.31** for a preventive exam or another diagnosis code representing the presenting problem or complaint.

If the US scan is also inconclusive, you can report **793.91** (*image test inconclusive due to excess body fat*) with another code that represents the patient's documented body mass index.

Appeal the determination if the US scan is denied on the basis of medical necessity. Let the payer know that a thorough pelvic exam could not be completed because of the patient's body mass; point out that obesity is a risk factor for cancer.

Making those points should help you get paid, eventually—although The Centers for Medicare & Medicaid Services (CMS) and most payers have determined that US as a confirmatory adjunct to physical examination (in the absence of an abnormal finding) will not be reimbursed.

About obesity

The first question in this Reimbursement Adviser addresses a dilemma in the office-based care of obese women. For a comprehensive review of risks and remedies when an obese patient faces surgery, see page 34.

FAST TRACK

You'll find it difficult to be reimbursed for a sonogram performed as an adjunct to a physical examination

Slow payment for unlisted codes for lap hysterectomy

Q. My surgeon performed a total laparoscopic hysterectomy in which he removed the entire specimen through the laparoscope. Must I report an unlisted code for this procedure?

A. No. You have the option instead of reporting one of the codes for a laparoscopic vaginal hysterectomy (codes **58550–58554**) because the vaginal part is only for retrieving the specimen, which is otherwise released from its attachment through the laparoscope. This is the recommendation of ACOG and the American Association of Gynecologic Laparoscopists (AAGL).

(There is good news here: New codes for total laparoscopic hysterectomy will be available beginning January 1, 2008. Look for details on these and other changes in Reimbursement Adviser in the December 2007 issue of OBG MANAGEMENT.)

Of course, your other coding option is to report the unlisted code **58578** (*unlisted laparoscopic procedure, uterus*). If you choose that option, however, you will have to submit the operative report with the claim, along with a letter from the physician explaining why this procedure was more advantageous to the patient than LAVH. And although using an unlisted code will not mean denial of service, it will slow down payment.

No need for modifiers on self-performed US scans

Q. Our four-physician OB practice performs limited US scans on our pregnant patients. The only code we use is **76815**.

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The practice owns the US machine and all four of us perform the scans, print the photographs, and create reports from the machine ourselves. Should we be billing these scans with modifier **-26**?

A. No. Modifier **-26** is only reported when the global service is not provided—that is, when you do not own the US machine. The unmodified code **76815** represents the technical and professional components of the US procedure, so you are coding correctly by not adding a modifier.

Although you are acting as your own sonographer for your scans, this still represents the technical component of a scan, which is reimbursed when reporting the unmodified code for the service.

It's "false labor" if there's no bleeding—at any date

Q. My pregnant patient who delivered her previous pregnancy at 28 weeks because of premature labor is now complaining of contractions at 20.3 weeks. Would **640.03** (threatened abortion; antepartum condition or complication) be the appropriate code even though she is not bleeding?

A. Twenty weeks is very early to deliver, but you would have to report **644.13** (*other threatened labor*) because it is the default code for false labor regardless of gestational weeks, according to a staff member of the ICD-9-CM Coordination and Maintenance Committee. A hemorrhage code, such as **640.03**, should not be reported in the absence of documented bleeding. If contractions progress, however, move on to the next code that matches the situation.

FAST *TRACK*

Don't report a code for threatened abortion when faced with premature labor without bleeding—at any gestational age

Colporrhaphy? Do not code for posterior repair

Q. We have been told that we can report code **45560** (repair of rectocele [separate procedure]) for posterior repair of a rectocele. I've noted that the relative value units (RVUs) for this procedure are higher than for a posterior colporrhaphy. Please clarify: When is it appropriate to bill **45560**?

A. The simple answer is that you must bill the procedure that you've documented, and colporrhaphy is the procedure performed by 99% of ObGyns to repair a rectocele. Typically, this involves making a midline incision in the posterior vaginal wall, plicating rectovaginal tissue, suturing it together, cutting off excess tissue, and, sometimes, supporting weakened rectovaginal tissue with mesh.

The code **45560**, on the other hand, is listed in the digestive section of CPT and is, basically, a transanal approach procedure that has a vaginal component. It is much different than posterior colporrhaphy, and is typically performed when a patient with a rectocele has fecal incontinence.

Although **45560** does carry slightly more RVUs than **57250** (*posterior colporrhaphy, repair of rectocele with or without perineorrhaphy*), the physician work portion of the RVU total for both codes is now identical: 11.42.

Last, be aware: Payers consider it fraud for a surgeon to use the wrong code in this situation because it pays more, when, in fact, colporrhaphy has been performed and documented.

Patient asks for test; is that "medical necessity"?

Q. Occasionally, we see a patient with a family history of ovarian cancer who requests a test for cancer antigen 125. If the result is elevated and we decide to perform a US scan, what diagnosis code should we add for medical necessity? Our experience using a family history code with payers has not been good.

A. The correct primary diagnosis code for this situation is **795.82** (*elevated cancer antigen 125*), followed by **V16.41** (*family history of malignant neoplasm; genital organs; ovary*). ■