

■ MELANIE WITT, RN, CPC, MA

## Medicare coding guidelines for cancer screening

**Q** Which CPT codes are recommended for low-risk and high-risk Medicare pelvic/breast exams for women aged 65 and older? Are the rules the same for non-Medicare third-party payers?

**A** For any screening pelvic/breast exam, Medicare requires that the alphanumeric Healthcare Common Procedure Coding System code (rather than a CPT preventive medicine code) you submit be linked to a specific ICD-9 code.

For the screening, you would report G0101 (cervical or vaginal cancer screening, pelvic and clinical breast examination), regardless of whether the patient is at low or high risk for cervical or vaginal cancer. Medicare only differentiates between the risk categories via the ICD-9 diagnostic code you use.

If the patient is at low risk, use ICD-9 code V76.2 (special screening for malignant neoplasms, cervix) or V76.49 (special screening for malignant neoplasms, other sites). Effective October 1, 2003, the code V76.47 (special screening for malignant neoplasms, vagina) may also be used. Note that V76.49 (and V76.47) is used only when the patient has had her uterus removed for reasons other than malignancy. If the patient is at high risk, the diagnosis changes to V15.89 (other specified personal history presenting hazards to health), along with a second code indicating which of Medicare's 5 high-risk criteria applies. For a woman past childbearing age (which is all patients 65 or older), these criteria are:

- early onset of sexual activity (under 16 years of age) or multiple sexual partners (5 or more in a lifetime)—use V69.2, high-risk sexual behavior;
- history of a sexually transmitted disease

(including HIV infection)—use V13.8, personal history of other diseases; V08, asymptomatic HIV; or 042, HIV infection;

- fewer than 3 negative Pap smears within the previous 7 years—use the diagnosis known at the time of the last Pap smear (if normal, use the code V13.2 for personal history of genitourinary disorder to indicate a previous abnormal Pap result); and
- diethylstilbestrol-exposed daughters of women who took the drug during pregnancy—use 760.76 (DES exposure).

Non-Medicare insurers have different rules: Unlike Medicare, they tend to pay for a comprehensive well-woman exam each year, billed using 1 of the CPT preventive medicine codes (99381 to 99397). The diagnostic coding is also different—specifically V72.3, gynecologic exam with Pap smear.

## Enterocoele repair via LAVH and McCall's culdoplasty

**Q** Our physician performed a laparoscopically assisted vaginal hysterectomy (LAVH) and McCall's culdoplasty. What is the McCall's, exactly, and can we bill for it?

**A** McCall's culdoplasty is a vaginal approach repair of an enterocele (CPT 57268) and is coded only if an enterocele was present and the sac removed.

In general, an enterocele is a peritoneal sac or space between the vagina and rectum that begins to prolapse after multiple pregnancies or after a long period of time due to gravity. When the enterocele causes pain and bulging, the sur-

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geon will remove the sac during vaginal surgery. If documentation confirms the presence of the symptomatic enterocele, the payer will likely reimburse for it. Note, however, that you'll have to add modifier -59 (distinct procedure) to 57268, since this is a CPT "separate procedure" that the payer normally bundles.

If the surgeon sews up the cul-de-sac at the time of the LAVH to prevent a future problem, it's considered "tying up" and preventive and, therefore, not separately billable.

### **At-home labor following discharge**

**Q** We recently had an obstetric patient who was admitted for observation due to upper-quadrant abdominal pain. During her stay, a general surgeon performed a cholecystectomy. She was discharged 6 days after admission, but immediately went into preterm labor, delivering at home at 27 weeks' gestation. She and the baby were readmitted on the day after her discharge. How do I charge this?

**A** Did you provide all of the obstetric care except for the delivery? If so, you can bill the global obstetric service, should the payer allow, but should also add modifier -52 to indicate reduced services.

Alternatively, you may want to bill only for those services that were actually performed, by splitting the care into its component parts. This would mean billing for:

- the antepartum care using 59425 (4 to 6 visits) or 59426 (7 or more visits);
- the hospital admission after delivery (codes 99221-99223);
- the delivery of the placenta (code 59414) or an episiotomy (code 59300), if performed after the delivery; and
- the postpartum care (code 59430).

Note that the American College of Obstetricians and Gynecologists Coding Manual states that code 59430 includes both inpatient and outpatient postpartum care, but that the services captured with this code do not

start until after delivery of the placenta. This means you can bill the hospital admission, but not the subsequent care or discharge home.

### **TVT and colposcopy-directed vaginal biopsy**

**Q** Our physician performed colposcopy-directed vaginal biopsies and a transvaginal tape (TVT) procedure with cystoscopy. The diagnosis was a Pap result consistent with vaginal intraepithelial neoplasia I (VIN I). How should these procedures be coded?

**A** First, I hope there was another diagnosis besides VIN I—this condition justifies the directed biopsies but not the TVT procedure, which would be done for stress urinary incontinence (ICD-9-CM code 625.6).

For the TVT, the code you use will depend on the surgical approach. Use code 57288 for a vaginal approach or code 51992 for a laparoscopic approach. This sling procedure would be listed first on the claim, since it is the most extensive procedure.

Coding for the directed biopsies depends on whether your payer accepts the new CPT code for colposcopy with vaginal biopsy(s) (57421). If so, the claim should be submitted as 57288 or 51992 + 57421-51.

If your payer is still using the 2002 CPT codes, the only way to capture the colposcopy with vaginal biopsy would be to bill 2 codes: 57452 for the colposcopy plus either 57100 for a simple biopsy or 57105 for a biopsy that required suturing. Note that codes 57100 and 57452 are CPT "separate procedures" that are sometimes bundled together by the payer. For this reason, you'll want to add modifier -59 (distinct procedure) to these codes. The result for these additional procedures: 57100-59-51 + 57452-59-51 or 57105-51 + 57452-59-51.

Some payers require modifier -51 (multiple procedure) be added when listing a second or third procedure, so their computer can handle the claim from a fee-reduction standpoint. ■