

■ MELANIE WITT, RN, CPC, MA

## Emergency repair of the vaginal cuff

**Q** We have a patient who, 3 weeks after a vaginal hysterectomy, presented to the emergency room with significant vaginal bleeding. She was taken to the operating room for a vaginal-approach exploration and suture of the vaginal cuff. How would I code for this?

**A** This situation seems to occur quite frequently, judging from the number of questions I get on the topic. There is no CPT code specific to the repair of the vaginal cuff. The closest codes seem to be:

- 57200 (colporrhaphy, suture of injury to vagina [nonobstetrical]),
- the complex repair codes 13131-13133 (repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet),
- 13160 (secondary closure of surgical wound or dehiscence, extensive or complicated), or
- the unlisted code 58999.

Of the 4 choices, I favor the complex repair codes, since they specifically mention repair of the genitalia—which would include both the external and internal structures. The downside is that, in order to use these codes, the size of the repair must be documented and more than just a layered closure must be used. Note that the codes for simple and intermediate repair (12001-12007 and 12041-12047) specify external genitalia, and therefore could not be used in this instance.

In order to select code 13160, the repair would have to be extensive or complicated—and, of course, the documentation would need to support that.

I am not sure how payers will look upon code 57200. You must use diagnosis code 998.31 (disruption of internal operation wound) to indicate the reason for the repair,

but some payers may not consider this a match with 57200.

Picking the unlisted code is the least desirable option, unless the physician did something other than repair the vaginal cuff.

No matter which code you choose, remember to add modifier -78 (return to operating room for a related procedure during the postoperative period).

## Chemical cauterization of the cervix

**Q** Our physician performed a chemical cauterization of the cervix for a patient with bleeding. I found a code for chemical cauterization of granulation tissue (17250) and one for cautery of cervix, electro or thermal (57510), but neither seems right. Do you have any suggestions?

**A** There is no specific code for chemical cautery of the cervix. This is because, normally, the procedure simply involves the application of a silver nitrate stick to the cervix, and does not require specialized equipment or expensive materials.

If you think you can make a case for significant physician work in applying the silver nitrate, you can bill this as an unlisted procedure (58999). Otherwise, I would simply consider this incidental to the exam and bill only an evaluation and management service. You can, however, bill for the supplies using 99070 (supplies and materials [except spectacles], provided by the physician over and above those usually

*Ms. Witt, former program manager in the Department of Coding and Nomenclature at the American College of Obstetricians and Gynecologists, is an independent coding and documentation consultant. Reimbursement Adviser reflects the most commonly accepted interpretations of CPT-4 and ICD-9CM coding. When in doubt on a coding or billing matter, check with your individual payer.*

included with the office visit or other services rendered).

## Postdelivery laceration repair, blood evacuation

**Q** Our physician did a laparotomy with evacuation of hemoperitoneum and a transvaginal repair of a cervicovaginal laceration. Both were performed on the same day as delivery. I was considering code 49020 for the hemoperitoneum, but am not sure about the laceration repair. Can you help?

**A** If your physician performed the delivery, the laceration repair will likely be included in the global service—unless it was a 3rd-degree or 4th-degree laceration. For such extensive wounds, look at codes 12001-12007, 12041-12047, and 13131-13133 to see which fits the situation described in the operative report.

If the laceration repair was done at the time of delivery, add modifier -51 (multiple procedure) to the repair code; if the patient was brought back to the operating room for the procedure, use modifier -78 (return to operating room for a related procedure during the postoperative period). Alternatively, you might consider adding modifier -22 (unusual services) to the delivery code for the documented significant additional work involved with the repair.

As for the return to the operating room for blood evacuation: You cannot use 49020, as that code is for draining a peritoneal abscess. Code 49002 (reopening of recent laparotomy) would also be incorrect, unless the delivery was by cesarean. For vaginal delivery, I would use either 49000 (exploratory laparotomy, exploratory celiotomy with or without biopsy[s] [separate procedure]) or 35840 (exploration for postoperative hemorrhage, thrombosis or infection; abdomen).

Note that I could find no CPT reference regarding the intended use of code 35840 as opposed to 49000. However, 35840 is located in CPT's cardiovascular-system section; this may influence a payer as to acceptable linking diag-

noses. The short descriptors for these 2 codes differ slightly: Code 35840 says "exploration of abdominal vessels" while 49000 reads "exploration of abdomen." Code 35840, by the way, has fewer relative value units than 49000.

## Billing for the ultrasound technician

**Q** Can we bill for our ultrasound technician using "incident to" rules? Our physician, though not present for the procedure, does the interpretation while the technician performs the scan.

**A** The "incident to" rules have no relevance when you are billing for ultrasound procedures. The scan, when performed in your office, is comprised of 2 parts:

- a professional component, which consists of the physician's interpretation of the results and his or her written report, and
- a technical component, consisting of the machine and supplies as well as the sonographer who performs the scan.

Therefore, when the ultrasound is performed in your office on your own equipment, you always bill the code under the physician's number, without a modifier.

## Modifiers needed for endometrial cryoablation?

**Q** Our doctor performed an endometrial cryoablation with ultrasonic guidance (code 0009T). The hospital tech performed the ultrasound, while our doctor supervised. Do we still charge for the global component of 0009T?

**A** Actually, for the Category III code 0009T, I am not sure anyone thought about creating a professional and technical component, since ultrasonic guidance is integral to the procedure.

So long as the physician supervised the procedure, I would bill the code with no modifiers attached. The hospital can bill separately for the use of the machine and the hospital tech. ■