

■ BY MELANIE WITT, RN, CPC, MA

## Does morcellation change hysterectomy coding?

**Q** My physician performed a laparoscopic supracervical hysterectomy with morcellation. Would I bill 58550-52?

**A** This question has 2 parts: how to bill for a laparoscopic supracervical hysterectomy, and how to account for the morcellation.

Currently, no code exists for laparoscopic supracervical hysterectomy. Your proposed choice, 58550-52 (laparoscopy surgical; with vaginal hysterectomy for uterus 250 grams or less; reduced service), is sometimes used, but payers just as frequently accept unlisted code 58578 (unlisted laparoscopy procedure, uterus). The latter option, with documentation, sometimes results in prompter and fairer reimbursement over the -52 modifier option. The reason: The procedure is more completely described via the submitted documentation, and payers are less likely to reduce their allowable, even though the cervix was left in place.

When morcellation of the uterus is performed, however, the situation changes: This technique is performed to shred and extract a very large uterus, and CPT has a code (58553) for laparoscopic vaginal hysterectomy for a uterus weighing more than 250 g. Thus, your options would be to bill either 58553-52 or the unlisted code 58578.

## Vaginal bleeding after the postpartum period

**Q** I need a diagnosis code for vaginal bleeding 8 weeks postpartum. The physician says it is possibly retained products of conception. How would I code this?

**A** The standard postpartum period is 6 weeks. Beyond that time you can report this as a late effect of pregnancy (677)—how-

ever, since this code cannot be used as a primary diagnosis, you must look for another code to explain the symptom.

If there is a finding of retained products of conception, use 667.04 (retained placenta without hemorrhage) or 667.14 (retained portions of placenta or membranes, without hemorrhage) along with 677.

If the report shows no products but the physician believes the bleeding is related to pregnancy, your choices include:

- 665.34 for a laceration on the cervix,
- 665.74 for a hematoma of the vagina,
- 665.84 for some “other” specified obstetrical trauma, or
- 665.94 for an unspecified trauma.

If none of these fit or if the bleeding turns out to be unrelated to the pregnancy, bill 626.8 from the Gyn chapter for other dysfunctional bleeding.

## Screening after abnormal Pap: ‘Problem, not preventive’

**Q** One frustrating problem we frequently encounter is when the doctor wants a patient with a recent abnormal Pap to return every 6 months for repeat cytology.

Payers do not recognize Q0091 (screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) with the appropriate evaluation/management (E/M) code and with 795.0X (abnormal Pap smear) as the diagnosis. Because a Pap is not a routine procedure with our E/M visits, we typically bill out the Q0091 code.

CONTINUED

*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-9-CM coding. When in doubt on a coding or billing matter, check with your individual payer.*

**A follow-up abnormal Pap is a problem—  
not a preventive—E/M service. Collection is  
part of the exam and not coded separately.**

One insurance company told me I should use laboratory codes 88142-88150. Any advice?

**A** The American College of Obstetricians and Gynecologists (ACOG) takes the position that specimen collection at the time of the pelvic exam should not be billed separately—but Q0091, a Healthcare Common Procedure Coding System (HCPCS) code, was created by Medicare for use with Medicare patients.

It was developed in a time when Medicare did not cover annual preventive gynecologic examinations, but did pay laboratories for interpreting cervical smears collected at these preventive visits. Medicare wanted to give physicians some reimbursement for their time spent collecting the specimen. In 1998 Medicare began covering pelvic and breast exams, but continued to pay for specimen collection for screening Pap smears.

A follow-up abnormal Pap, however, is billed as a problem—not a preventive—E/M service. In this case, Medicare agrees with ACOG that the collection is part of the exam and not coded separately.

Many private payers have also adopted this view—even those that formerly reimbursed a small fee for collection with code 99000 (handling and/or conveyance of specimen for transfer from the physician's office to a laboratory).

Under no circumstance should a laboratory code be billed for collecting the specimen.

### **5-month follow-up after cancer resection**

**Q** Five months after surgery to remove endometrial cancer, a patient came in for a follow-up visit. Since the 90-day fol-

low-up period had passed, we billed for an office visit. The diagnostic codes used were V10.42 (personal history of endometrial cancer) and V76.2 (special screening for malignant neoplasms, cervix) for Pap screening. Because ICD-9 marks V10.42 as a secondary diagnosis, however, I fear this may be incorrect. Is it?

**A** Before answering this question, we need to better define the situation by making some assumptions. First, I will assume that the surgery involved removing the uterus as well as the cervix.

Second, I presume that the surgeon does not consider the patient cancer-free. ICD-9 states that a diagnosis of “personal history of cancer” is made only after all treatment is completed. At 5 months postsurgery, I am not sure this would be true—at least until 2 or 3 normal Pap interpretations assure the physician that the original cancer is gone.

And third, I assume the patient is not a Medicare beneficiary, which further changes the coding rules.

I would code the visit's primary diagnosis as endometrial cancer, with a secondary diagnosis of V67.01 (follow-up vaginal Pap smear). This code was created to report a vaginal Pap smear after a hysterectomy for malignancy.

Once you have obtained 2 or more negative Pap results, you can use V67.01 as the primary diagnosis and V10.42 as the secondary diagnosis for each Pap smear encounter. This will take care of the ICD-9 rule stating you cannot report a “personal history” V code as the primary diagnosis.

If the patient still has her cervix, use the code for endometrial cancer for the visit's diagnostic Pap. Once you have 2 or 3 normal Pap results, you can revert to V76.2 for the Pap interpretation. You would use this as the primary code and V10.42 for the secondary diagnosis. Note some payers will allow you to bill for a handling fee using 99000. ■