

# REIMBURSEMENT ADVISER

■ BY MELANIE WITT, RN, CPC, MA

## Hydrodistention, cystoscopy: Why and what code?

**Q** Can you enlighten me on therapeutic hydrodistention of the bladder: What is this for? What code would I use? A diagnostic cystoscopy was also performed.

**A** Cystoscopy with hydrodistention, usually done as an outpatient procedure under regional or general anesthesia, is used to diagnose and sometimes treat interstitial cystitis.

During cystoscopy, the inside of the bladder is examined. Then the bladder is filled to a high pressure with fluid (hydrodistended). This causes the bladder wall to stretch, allowing the physician to inspect for changes typical of interstitial cystitis. Hydrodistention may reduce pain and discomfort in some interstitial cystitis patients, and thus may be therapeutic as well as diagnostic.

For this procedure, code either 52260 (Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction [spinal] anesthesia) or 52265 (... with local anesthesia). Be sure to verify the anesthesia type before billing for this service.

## Low payment for cystectomy with oophorectomy

**Q** My physician removed a patient's ovaries and also performed a dilation and curettage. We coded these procedures as 58661 (Laparoscopy, surgical; with removal of adnexal structures [partial or total oophorectomy and/or salpingectomy]) and 58120-51 (Dilation and curettage, diagnostic and/or therapeutic [nonobstetrical]; multiple procedure), but received extremely low reimbursement.

The operative report stated extensive work was involved. An 8-cm ovarian cyst was excised, and some cystic fluid aspirated. Should

we appeal? Also, should we have added modifier -22 (unusual procedural services) to 58661?

**A** First, keep in mind that payers always reduce the allowable on the second procedure performed, since they are paying for only the intraservice work, not the procedure's entire global package.

Next: Code 58661 does not allow you to bill additionally for ovarian cyst removal or cystic fluid aspiration, because the physician also removed the ovary. However, there is 1 scenario in which additional reimbursement is possible.

An oophorectomy is by definition the removal of 1 ovary. For CPT codes in which oophorectomy is an integral part of the procedure (eg, total abdominal hysterectomy/bilateral salpingo-oophorectomy, open oophorectomy, open salpingo-oophorectomy) the language indicates whether they are used to report a partial or total *unilateral or bilateral* removal. Code 58661, however, only indicates "partial or total oophorectomy"—leading to the belief that it applies to only 1 side, not both.

If a physician removes the ovary on 1 side, but removes an ovarian cyst on the other, and if the payer agrees with this interpretation of the code, you might be able to bill both 58661 and 58662 (which covers both removal and aspiration of the ovarian cyst), placing the modifiers -RT (right side) and -LT (left side) as appropriate. Still, many payers—including Medicare—do not agree with this interpretation and will not reimburse in this manner.

Your question, however, indicates that both ovaries were removed. Thus, additional reimbursement is unlikely. ■

*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.*