

Tracking down the correct Medicare LMPR

Q I'm trying to find out if Medicare will reimburse for intralesional injections into genital warts (CPT code 11900: Injection, skin intralesional, 1-7 lesions) with interferon alpha-n3.

When I looked this up under the heading "office injectable," the Medicare carrier policy stated that a diagnosis of genital warts (078.10, Viral warts, unspecified; or 078.19, Viral warts, other specified) was allowed only when billed with intralesional administration of bleomycin.

Is this correct?

A This brings up an interesting question: How easy is it to zero in on the correct Medicare local medical policy review (LMPR)?

I've found I usually have to search their policy database (www.cms.hhs.gov/mcd/search.asp) trying several different terms to get the results I need. I usually start with a term that is broad but specific, and then move to terms that are very specific.

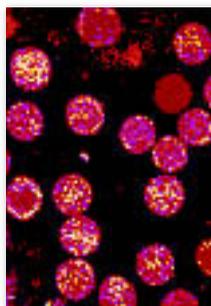
Searching for code 11900 would produce too many hits; simply using the phrase "office injectable" is also not specific enough, since it implies intramuscular injections or supplied drugs. In this case, I started with "intralesional injection" and came up with 2 LMPRs. When I entered "interferon alfa-n3" I got 1 hit for Regence Blue Cross/Blue Shield, which indicates the injection is covered.

Following are the policies of 2 Medicare carriers (my notes appear in brackets). Based on these results, it looks like the injection should be covered:

- **AdminaStar Federal policy.** Intralesional injection of interferon alfa-n3 [coded using J9215] has been associated with complete or partial resolution of lesions associated with infection by HPV. It is currently indicated for the local treatment of Condylomata acuminata [coded as 078.11]. Coverage will be provided for those applications in which clinical utility has been demonstrated.

- **Cahaba policy.** Recombinant interferon alfa-2b, interferon alfa-n1 (1ns), and interferon alfa-n3 are indicated by intralesional injection for treatment of refractory or recurrent external condyloma acuminatum (genital warts).

Note that it's possible your carrier hasn't yet addressed this issue. My advice is to bill for it and see what happens. Just be sure you use code 078.11 (condyloma acuminatum) rather than 078.10 or 078.19—which are less specific—in case the carrier requires an ICD-9 diagnostic link.



Human papillomavirus causes genital warts

When searching the Medicare policy database, start with broad-but-specific terms, then get more specific.

Placing an ON-Q: Incidental to surgery?

Q Can I bill for placing an ON-Q device during surgery?

A The ON-Q Elite (*I-Flow Corporation, Lake Forest, Calif*) is a system that automatically delivers local anesthesia into a surgical incision. It consists of a small electronic, reusable pump that has a single-use, disposable bag and tubing set to hold the anesthetic, plus a tiny tube to deliver it.

The only work required for this system is placing the tube into the incision site

before closing. The company recommends using code 58999 (Unlisted procedure, female genital system [non-obstetrical], for placement of needles and catheters) for non-Ob procedures and 59899 (Unlisted procedure, maternity care and delivery) for obstetric surgery.

Reimbursement will depend on the payer's policy regarding placing catheters during surgery: Many hold the opinion that this is incidental to the procedure. However, I'm told that on appeal Aetna, Avmed, and Cigna HMO have reimbursed for placing the catheter, but United and Blue Cross/Blue Shield have not.

You can also bill for the system itself if you—not the hospital—supplied it to the patient.

E/M visit before Ob care: What's OK?

Q The American College of Obstetricians and Gynecologists instructs us to bill an evaluation and management (E/M) visit with the ICD-9 code for suppression of menses (626.8) if the Ob record is not initiated. I simply need to document the patient's signs and symptoms; if I determine she's pregnant, I can start the Ob record at her next visit.

My question is, what other services can I provide at this E/M visit? Can I order prenatal labs? Gyn probe? Prenatal vitamins? I don't want to cross the line.

A According to ICD-9-CM rules, you must code what you know at the end of the visit. If a urine pregnancy test performed during the visit is positive before the patient leaves, the diagnosis code is V22.0 (Supervision of normal first pregnancy) or V22.1 (Supervision of other normal pregnancy)—not suppressed menses. However, 626.8 can also be linked to both the pregnancy test procedure and the E/M service.

As to what else is allowed: You can perform any service that is not normally part of the Ob global package (meaning it can be billed separately).

Prescribing vitamins and ordering labs is permissible, since these are minor activities that do not impact the level of E/M service you bill.

The Gyn probe is questionable, since it is not done unless the patient is pregnant. However, since this is generally a separately billable service, the payer may allow it.

Just be sure you're not counseling for the pregnancy or taking pregnancy measurements, and then coding a higher level of E/M service. Any payer will likely construe this as initiation of global care.

Both ER and Ob deliver: Who gets paid?

Q An Ob patient presented to the emergency room (ER) in labor. The ER doctor immediately delivered the baby.

Labor and delivery staff had by then arrived. They took neonate and mom to the Ob suite, where I delivered the placenta and inspected and attended to the vagina.

The ER coded that their physician performed the "delivery," using 59409 (Vaginal delivery only [with or without episiotomy and/or forceps]). They felt they would be out of compliance if they did not bill as such. I disagree. They took a large part of the Ob fee, and we were denied the payment for our complete obstetric care.

What should they have coded?

A The ER physician can certainly bill for delivering the baby, but this is not always done. Sometimes an agreement exists between the hospital and the attending physicians/Ob unit stating that any delivery performed by ER physicians will be billed by the attending obstetrician; compensation is then handled internally.

In this case, the ER physician may bill for delivery, but should have included modifier -52 to indicate a reduced service. Code 59409 includes the delivery of the placenta (and episiotomy, if required), which the ER physician did not perform.

For your part, you have 2 coding options: You can bill for the global care, but add modifier -52 to 59400 (Routine

You may include any service that is not part of the Ob global package in the E/M visit.

obstetric care including antepartum care, vaginal delivery [with or without episiotomy, and/or forceps]). You'll need to submit documentation indicating what part of the global care you did not perform. Here I would emphasize that the ER physician did not do labor management, delivery of the placenta, episiotomy, or any follow-up care—and that as such, the total amount for the delivery should not be deducted from your global fee.

Conversely, you can itemize the services you performed. This could consist of the following codes:

- 59426: seven or more antepartum visits (your fee will be the total for all visits)
- 9922X: hospital admission
- 59300: episiotomy repair (this code has 0 global days)
- 59414-51: delivery of placenta (again, 0 global days)
- 9923X: subsequent hospital care
- 99238: hospital discharge (if applicable)
- 59430: postpartum care (outpatient)

Ovarian detorsion: Limited coding options

QI performed surgical treatment for torsion of the ovary using the following procedures: diagnostic laparoscopy, exploratory laparotomy, detorsion of left tube and ovary, bivalve of left ovary, and left oophoropexy.

Two coding scenarios have been suggested: The first is 58925 (Ovarian cystectomy, unilateral or bilateral) 58825 (Transposition, ovary[s]), and 49320 (Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen[s] by brushing or washing). I hesitate to use these, though, since an ovarian cystectomy was not performed and the tube and ovary were detorsed, not transposed elsewhere.

The second option is 49000 (Exploratory laparotomy, exploratory celiotomy with or without biopsy[s]) with modifier -22 (unusual procedural services), plus 49320. Are these appropriate?

AThe diagnostic laparoscopy, presumably performed to evaluate the problem, can be coded as 49320—but be aware that you may not receive reimbursement if you planned to do the surgery laparoscopically, then converted to an open procedure.

The exploratory laparotomy is not separately billable, since you'll be billing for open surgical procedures. When this happens, the exploratory becomes integral to the surgical technique.

Next is detorsion of the left ovary: CPT does not have a code for this.

You then bivalved the ovary, which is analogous to performing a wedge resection, code 58920 (Wedge resection or bisection of ovary, unilateral or bilateral).

Finally, for the oophoropexy, you are correct that code 58825 is not applicable. If you had moved the ovary out of harm's way due to radiation treatment, the procedure is referred to as transposition of the ovary and 58825 is reported. In this case, however, I'm guessing you sutured the ovary in place so it can no longer twist. Like the detorsion, CPT has no code for this.

Your coding options are limited, but I would suggest 58920-22—which covers the bivalving, detorsion, and oophoropexy—plus 49320-59 for the diagnostic laparoscopy. (The “distinct procedure” modifier indicates that the laparoscopy was not integral to the rest of the procedure.)

As far as diagnosis, the code linked to 58920 is 620.5 (Torsion of ovary, ovarian pedicle, or fallopian tube), or 752.0 (Congenital anomalies of ovaries) if you know the problem is congenital. Consider a different diagnosis for the laparoscopy, such as lower quadrant abdominal pain (789.03 or 789.04) or ovarian pain (625.9). Finally, add V64.41 to indicate the conversion from laparoscopy to an open procedure. ■

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.

Code 58920-22 covers bivalving and detorsion of the ovary, plus oophoropexy.