

3 elements are required for an emergency code

Q If I saw my patient in the Emergency Department (ED), can I bill one of the 99281–99285 codes for ED visits? Or are these codes only for providers who work for that hospital's ED?

A No, these codes do not apply exclusively to services provided by the hospital's ED employees.

You may use ED codes if you are the *only* one who provided services in that setting. But remember, the codes for ED services require that all 3 key components—history, examination, and medical decision-making—be documented. The “typical times” that are part of most E/M service definitions have not been established for these codes, so selecting the level based on counseling and/or coordination of care is not an option.

Lower relative values

Also keep in mind that the relative values assigned to lower level ED codes 99281 (*ED visit; problem-focused history and exam with straightforward medical decision-making*) and 99282 (*ED visit; expanded problem-focused history and exam with low complexity of medical decision-making*) are lower than their equivalent outpatient codes (99201, 99202, 99212, or 99213).

If the ED physician saw the patient first and is billing for that service, you need to bill the outpatient evaluation and management codes (99201–99215) or an outpatient consultation (9941–99245) if you documented a consultation in the record and if the patient is not being seen in the ED for a condition you are actively treating in your office setting.

This assumes you did not admit the

patient to either observation status or as an inpatient. In that case, CPT rules would let you bill only the admission, but the code level selected would be based on all services you provided to that patient, on that day.

Coding a new patient's 2 visits in 1 day

Q One of our doctors saw a new patient in labor and delivery, and then she was seen in our office for a more extensive exam and ultrasound on the same day, but by a different doctor. Normally I would bill both with a -59 modifier (*Distinct procedural service*) assigned to an evaluation-and-management (E/M) code, but I was recently told that the -59 modifier should not be assigned to an E/M code. How should I bill for these 2 separate encounters?

A You are correct. While the modifier -59 may be assigned when a distinct and separate service was provided on the same date of service, such as when there is a separate patient encounter, the services referred to in the CPT guidelines are medicine and procedural services, not E/M services. An article in the American Medical Association's *CPT Assistant* (January 1999) clarified that the modifier -59 may not be appended to E/M services.

If the patient is seen for the same reason and the physicians are considered the same under the payer's rules, bill only 1 E/M service for that day, but take into account all of the care the patient received

**Melanie Witt, RN,
CPC-OGS, MA**

Independent coding and documentation consultant; former program manager, Department of Coding and Nomenclature, American College of Obstetricians and Gynecologists

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You may use ED codes if you are the only one who provided the services

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We'll answer as many questions as space permits.

during both encounters to select the right E/M service level. The ultrasound, of course, will be billed as well.

If the payer allows more than 1 encounter on the same day, the second encounter in the office must be reported as an established patient service, since a new patient service applies to the first encounter that day.

There are no appropriate modifiers that can be added to the second E/M service.

For observation codes, it's when, not where

Q When a patient presents to the hospital for preterm labor and is seen within 23 hours, which observation codes are appropriate: 99217–99220 (*Initial observation care with discharge on second day*) or 99234–99236 (*Observation or inpatient care services including admission and discharge on the same day*)?

There is no designated area in our hospital for 99217–99220, if I understand the coding book correctly.

A The code choice depends on *when* the services took place.

No designated place in the hospital is required in order to bill the observation codes, but the physician should state in the record that the patient is being kept for observation.

If the patient is “admitted and discharged” from observation care on the same calendar date, you bill the codes 99234–99236. If she is admitted on day 1 and discharged on day 2, then go with the 99217–99220 codes. Some payers have a time requirement for you to be able to bill for observation care, but many do not. If you cannot bill for observation care, then the default is the outpatient E/M codes, 99201–99215.

Remember these requirements for observation care:

- The minimum documentation is a detailed *history* and *detailed exam* with any level of medical decision-making (straightforward, low, moder-

ate, or high complexity). If you fail to document both at the minimum level, you cannot use an observation code.

- The physician must physically see the patient on the date of admission and discharge in order to bill for observation care.

The setting determines code for nonstress test

Q Can I bill a nonstress test (NST) 59025 with TC (*Technical component*) as a modifier?

A A physician never uses the -TC modifier, even if he or she personally performed the NST. If this procedure is performed in the hospital, the -TC modifier is reported by the hospital for the use of the equipment.

The physician reports the service with modifier -26 (*Professional component*).

If the procedure is performed in the office setting and the physician owns the equipment, code 59025 is billed without modifiers, as it represents both technical and professional components.

Payers discourage multiple sonograms

Q Can we bill for a 3-dimensional (3D) sonogram (76375), a transvaginal sonogram (76830), and a hysterosonogram at the same encounter or session? Our physicians do both the injection procedure (58340) and the ultrasound component (76831) and the 3D as well because they say they get a better picture.

A Your question involves 3 issues that I will address separately.

Transvaginal ultrasound

This procedure is included as part of 76831 (Saline infusion sonohysterography [SIS], including color flow Doppler, when performed). Transvaginal ultrasound should not be billed in addition unless it was performed to document a problem not related

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to the hysterosonogram. The ACOG coding manual agrees; it indicates that a transvaginal ultrasound should not be reported separately because it is included in the global service when performed. Since the Correct Coding Initiative (CCI) also bundles this code combination, you could bill it only if it was done during a separate session. A modifier -59 (Distinct procedural service) would be added to 76831 because this procedure is bundled into the code for the transvaginal ultrasound.

3D ultrasound

Your second coding problem is performing a 3D ultrasound at the time of the hysterosonogram. Here, there are 2 issues: insurance coverage and billing.

Many payers do not reimburse for 3D ultrasound because they consider it experimental—and none reimburse 3D ultrasound when done routinely. Medical necessity must be established for 3D rendering. Be sure to inform your patients that this procedure may not be covered by their insurance company, so that they can make an informed choice.

Billing

The CPT code you indicated, 76375, has been replaced by 2 new codes:

- Code 76376 (*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation*) and
- Code 76377 (*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation*).

CPT indicates that in order to bill either of these 2 new codes, a basic scan must be reported in addition. These 2 codes also require “concurrent physician supervision of the image postprocessing 3D manipulation.”

CPT does not stipulate which codes

can serve as the basic scan, but as 76831 is an ultrasound procedure, the payer may allow it to be used in this fashion.

Don't fail to dispute inappropriate bundling

Q A patient's insurance company bundles an ultrasound procedure with a consultation, and quotes Medicare rules as the basis. For instance, we bill 99242 (*Office consultation; expanded problem focused history and exam with straightforward medical decision-making*) with 76811 (*Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation*) and the services are being provided by a maternal-fetal specialist.

I have appealed many times, but they refuse to pay for both. Do you have any suggestions?

A My first suggestion is that you inform ACOG's Department of Practice Management about this problem. For more information, see http://www.acog.org/departments/dept_notice.cfm?recno=19&bulletin=1932. ACOG has been helpful to many practices in the past on just such payment issues.

The payer is not correct in this case. Medicare rules stipulate that a consultation can be billed with a diagnostic procedure on the same day and both will be paid. You should ask for the exact reference to the Medicare rule they are using.

In addition, I suggest that you add a modifier -25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) to the consultation code you are billing. This tactic will clearly identify the E/M service as significant and separate from the diagnostic test. ■

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.

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You can bill a consultation with a diagnostic procedure on the same day and both will be paid