

How do we code for new HPV vaccine?

Q When we start giving the new HPV vaccine, how do we bill for it?

A On June 8, 2006, the Food and Drug Administration (FDA) officially licensed the HPV vaccine for use in girls and women ages 9 to 26.

• **90649 is the vaccine product code** (*human papilloma virus [HPV] vaccine, types 6, 11, 16, 18 [quadrivalent], 3-dose schedule, for intramuscular use*). A 3-dose schedule means you will be billing for the procedure 3 times during a 6-month period.

• **90471 can also be reported for the administration of the vaccine.** (*Immunization administration [includes percutaneous, intradermal, subcutaneous, or intramuscular injections]; one vaccine [single or combination vaccine/toxoid]*)

Adding modifiers. CPT guidelines state that a modifier -51 (*multiple procedure*) would not be added to either of these codes, and of course if you provide a significant and separate evaluation and management (E/M) service at the time the vaccine is given, you may also bill an E/M code with a modifier -25 added to let the payer know that the E/M service was separate.

Note that almost no payers will pay separately for the E/M code 99211 plus an injection procedure because it represents a minimal, not a significant E/M service.

Insurance coverage unlikely, for now

Until such time as the CDC comes out with a recommendation for the vaccine, coverage is going to be a problem. Insurance plans can be expected to cover the cost of the vaccine only if the CDC Advisory Committee on Immunization Practices recommends HPV vaccination as standard.

Tell patients! Until then, you may want to

advise your patients who are candidates for the vaccine that this vaccine may be an out-of-pocket expense for them. Merck, the company that produces the quadrivalent vaccine, has stated that the price will be \$120 per injection. The company has indicated that they have created a new program to provide free vaccines including HPV vaccine, for uninsured adults unable to pay.

Use OB or GYN code if fetal pole is absent?

Q When a patient has a sonogram to check for fetal heart tones and only a gestational sac (g-sac) with no fetal pole is found, is the sonogram coded as a limited OB or a GYN ultrasound, because the patient is not pregnant? Also, for a diagnosis of g-sac with no fetal pole, is it correct to code a blighted ovum (usually these patients are less than 10 weeks pregnant)?

A Technically, when a gestational sac is present, the patient is still pregnant, so the GYN codes are inappropriate. And yes, you should assign the diagnostic code for blighted ovum (ICD-9-CM code 631).

If the purpose of the ultrasound is only to check for fetal heart tones, then the correct code is 76815 (*ultrasound, pregnant uterus, real time with image documentation limited [eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume], one or more fetuses*).

While this scan could be performed transvaginally, the amount of work in checking only for fetal heart tones is significantly less than that involved in the OB transvaginal procedure.

Therefore, I recommend that you use the limited ultrasound code even if a vaginal probe was used.

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FAST TRACK

Insurance coverage can be expected only if the CDC will recommend HPV vaccination as standard

CONTINUED

ICD code depends on why labor was induced

Q What diagnosis should be reported for an induced delivery at 30 weeks for preeclampsia?

A The answer depends on whether you induced labor for delivery or went immediately to a cesarean delivery.

In either case, report the ICD-9-CM code that supports the type of preeclampsia (eg, 642.51, *severe preeclampsia; delivered with or without mention of antepartum condition*). But if labor was induced, add code 644.21 (*early onset of delivery; delivered with or without mention of antepartum condition*). This code represents premature labor with delivery before 37 completed weeks of gestation.

If the delivery was accomplished by performing a cesarean, in addition to an outcome code such as V27.0 (*single liveborn*), you might add a code if the patient had a previous cesarean delivery (654.21).

If this was her first cesarean delivery, only the preeclampsia and outcome diagnosis codes would be assigned.

Correct coding when the patient goes to ER

Q My patient who was 7 months pregnant presented to the ER with abdominal pain. She was sent to labor and delivery, where I treated and discharged her. Should I use the observation codes for this or just an outpatient visit code?

A You need to determine whether you admitted the patient to observation status (which is not the same thing as admission to the hospital) or saw the patient, treated her, and then sent her home.

Timing is everything. Although the codes for observation care do not stipulate a time period, the record must clearly show that she was observed before a determination could be made to send her home or admit her to the hospital. This would include being seen first by you and then having

nursing staff observe for problems prior to your deciding to send her home.

The observation codes require, at a minimum, documentation of a detailed history and exam (with any level of medical decision making). If your patient was admitted and discharged on the same service date, the codes you would select from are 99234–99236 (*observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date*).

If, on the other hand, you saw the patient, treated her, and then immediately released her to go home or you left orders to send her home after a test had been performed such as a nonstress test, you should consider this to be an outpatient service and you would report one of the established patient problem codes (99212–99215).

Which code for Gartner's duct cyst procedure?

Q What CPT code should I use for marsupialization of Gartner's duct cyst?

A If the cyst was excised, code 57135 (*excision of vaginal cyst or tumor*), is appropriate.

But if it was a marsupialization procedure in which the cyst was drained first and then the walls of the cyst were sewn in place to form a pouch, then the procedure should be coded using the unlisted code, 58999 (*unlisted procedure, female genital system [nonobstetrical]*).

The Gartner's duct is usually located in the lateral wall of the vagina, so the code to report marsupialization of a Bartholin gland cyst, 56440, would not apply.

Be sure to let the payer know that the procedure is very similar to the 2 codes 56440 (Bartholin's) and 57135 (excision). Code 56440 has 4.89 RVUs, while 57135 has 5.25 RVUs. ■

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.

FAST TRACK

Admitting the patient to observation status is not the same as admission to the hospital