

Use of “complication” triggers Medicare denial

Q During a sling procedure for stress urinary incontinence, the surgeon accidentally knicked the bladder, which was then repaired, and a cystoscopy was also performed. These procedures were denied as included in the sling procedure. This was a Medicare patient.

A Unfortunately, your coding ran afoul of established National Correct Coding Initiative (NCCI) bundling and general guidelines.

I assume that you appropriately used the ICD-9-CM code 998.2 (*Accidental puncture or laceration during a procedure*) when billing for the suture of the bladder (51860, *Cystorrhaphy, suture of bladder wound, injury or rupture; simple or 51865,; complicated*).

Although neither of these codes is bundled with the sling procedure (57288, *Sling operation for stress incontinence [eg, fascia or synthetic]*), the general rules for NCCI state: “When a complication described by codes defining complications arises during an operative session, a separate service for treating the complication is not to be reported.” The use of the complication diagnosis would trigger the denial.

In addition, you apparently billed code 52000 (*Cystourethroscopy [separate procedure]*), and this code is bundled into code 57288 with a “0” indicator, which means that the edit cannot be bypassed using any modifier.

The good news

These rules would only apply to Medicare or to payers who use Medicare rules. Although you may find that 52000 may be a common bundle by many pay-

ers, you will not usually find commercial insurance denying the repair of the complication during surgery.

Few payers deny unlisted procedures

Q We plan to perform a laparoscopic right salpingo-oophorectomy and laparoscopic removal of the cervix. The patient had a previous laparoscopic supracervical hysterectomy and is now having abnormal bleeding and right lower quadrant pain. I know that the code for the RSO is 58661 (*Laparoscopy, surgical; with removal of adnexal structures [partial or total oophorectomy and/or salpingectomy]*), but how should we report the removal of the cervix?

A Although there is a CPT code for a trachelectomy (57530, *Trachelectomy [cervicectomy], amputation of cervix [separate procedure]*), this code cannot be reported because the procedure was performed laparoscopically. CPT rules dictate that correct coding would be an unlisted laparoscopic code.

2 options

This leaves you with 2 coding options. Because the cervix is part of the uterus, the code 58578 (*Unlisted laparoscopy procedure, uterus*) would be appropriate. If you choose this option, you would report 58661, 58578-51. Alternatively, you could add a modifier -22 (*Unusual procedural services*) to code 58661. Whichever option you choose, you will need to send documentation with the claim to explain the unlisted procedure or the additional work.

I prefer the first option because it will give you the opportunity to set your fee to account for the actual work performed.

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FAST TRACK

The code for trachelectomy cannot be reported if it is done laparoscopically

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Most payers will not deny unlisted procedures so long as they are not considered investigational or experimental, a concept that should not apply to this surgery.

Modifier needed to bill for anesthesia

Q An external cephalic version was performed on a breech baby as an outpatient procedure. I was told I could bill 01958 (*Anesthesia for external cephalic version procedure*) for the anesthesia, but have gotten an insurance denial because the “CPT and ICD logic do not match.” We used the diagnostic code 652.2. Are there some rules about anesthesia I should be aware of?

A There may be more than 1 problem here. First, the anesthesia codes are meant to be billed by the anesthesiologist, not the physician who is also performing the procedure. You have not indicated whether this was the case.

If you did perform the version procedure as well as providing the anesthesia to the patient, you would need to indicate this by adding a modifier -47 (*Anesthesia by surgeon*) to code 59412 (*External cephalic version, with or without tocolysis*). You would then report a 2nd code for the type of regional anesthesia you administered. For instance, if you used epidural anesthesia, you would report 59412-47, 62311 (*Injection, single [not via indwelling catheter], not including neurolytic substances, with or without contrast [for either localization or epidurography], of diagnostic or therapeutic substance[s] [including anesthetic, antispasmodic, opioid, steroid, other solution], epidural or subarachnoid; lumbar, sacral [caudal]*).

If you were only providing the anesthesia, then code 01958 is correct, but now the payer is indicating a mismatch between the CPT code and the diagnosis code.

You have indicated that you used code 652.2 (*Breech presentation without mention of version*). But as you are billing for anesthesia for a version, this code would no

longer be correct. In this case, the more correct code would be 652.13 (*Breech or other malpresentation successfully converted to cephalic presentation; antepartum condition or complication*) if the version was successful or 652.03 (*Unstable lie; antepartum condition or complication*) if it was not.

2 procedures in 10 days will trigger bundling

Q Our patient is scheduled for a cesarean delivery, but the surgeon wants to excise a large keloid scar prior to the cesarean. How should this be coded?

A I am not sure by your question of the sequence or timing of events.

If the physician is taking the patient to surgery to do only the keloid excision, you have several codes to select from, depending on the type of closure. The excision of the keloid scar would be reported using 11400–11406 (*Excision, benign lesion including margins, except skin tag [unless listed elsewhere], trunk, arms or legs*), where the code selected depends on the documented size of the scar removed.

If it is simple closure, no additional code is reported, but if the closure is either intermediate or complex, you will add a code from the repair section (12031–12037 or 13100–13102). But again the size in centimeters must be documented in order to use these codes.

Also remember that if the surgeon performs the cesarean within 10 days of the keloid excision, he/she will be in the global period for these codes and might have to use a modifier -79 (*Unrelated procedure or service by the same physician during the postoperative period*) on the global OB code you report. If the keloid is excised at the time of the cesarean, it will be included by most payers as part of establishing the operative site and incision closure. ■

FAST TRACK

Anesthesia codes are meant to be billed by anesthesiologists

GOT A CODING QUESTION?

Send it to obg@dowdenhealth.com. We'll answer as many questions as space permits.