Here is some medical coding guidance on diagnosis code for history of MI; better pay for C-sections; billing facility versus nonfacility fees; and much more.

**Q** Can you please tell me which ICD-9 code is correct for a patient that has a history of myocardial infarction?

**A** ICD-9 412 is described as "old myocardial infarction." The inclusion notes state "healed myocardial infarction" and "past myocardial infarction diagnosed on ECG or other special investigation, but currently not presenting symptoms." The codes in the V section that describe personal history of diseases specifically exclude old myocardial infarction (see V12.5).

**Q** I have never understood why insurance companies reimburse the same global fee for vaginal deliveries and C-sections. Intra-abdominal surgery, including C-sections, requires special training in surgical techniques and carries with it more risks and time spent with the patient. Why then, is it not compensated as such? Is there any way to get increased compensation?

**A** According to fee schedule surveys done by Physicians Practice, payers usually do pay more for C-sections (about $2,295) than vaginal deliveries (about $1,926). That is not a huge difference, but it's something.

To get that additional money, first make sure you are using the right codes:

- 59510 for antepartum, C-section and postpartum care
- 59618 for antepartum, C-section and postpartum care following attempted vaginal delivery after previous C-section
- 59400 for antepartum, vaginal delivery, and postpartum care

For truly unusual circumstances, you also can add the -22 modifier -- unusual procedural services -- indicating that you provided a greater than usual service, and back it up with strong ICD-9 coding and proof of medical necessity.

If you are being paid exactly the same for surgical and non surgical births and are coding correctly, review your payer contracts. If you are paid a percentage of Medicare payments for all services, then you should contact the payer. In the 2005 Medicare fee schedule, C-sections have total RVUs of 49.62 versus vaginal deliveries at 43.78. Sometimes, obstetrical care is paid under a different formula. Check your contract carefully.

**Q** A patient visits to discuss multiple problems and data. At the end of the appointment, the patient wants to discuss a couple more problems that may or may not require a redirected examination. Can I bill a second CPT with modifier?

**A** You are unlikely to get paid for two office visits on the same date of service -- especially since what you describe really is just one office visit that turned out to be more complex than expected. You could take either of these approaches:

1. Address the additional issues there and then but be sure to account for the added complexity of the visit when you select an E&M code. You might be able to code a 99214 versus a 99212, for example. Code according to what you did, not what was scheduled. Of course, any procedures done in addition to the office visit could be coded separately with a modifier.
2. Ask the patient to schedule another appointment to discuss the additional issues. This is a tough balance to strike. You don't want to inconvenience a patient who is sitting right in front of you, and you certainly shouldn't postpone care that has immediate implications. However, you also don't want to put yourself way behind schedule, frustrating patients in the waiting room.
Q I'm an independent physician with my own practice. If I perform a service on an inpatient in the hospital, do I bill the nonfacility or the facility fee that is in the Medicare fee schedule?
A The place of service (POS) code you submit on your claim form determines which fee schedule is utilized for reimbursement, not necessarily what you charge. Most physicians have a single fee schedule that is not related to where the service is provided. You simply submit the codes along with your established fee. The POS code tells Medicare what to pay. However, if you want to track the accuracy of those payments, services rendered in the hospital should reflect the facility payment. Nonfacility payments are made for office-based services.

Q What is the correct code for wide, local excision of a melanoma on the arm? Is it coded as a malignant skin lesion by size or as a removal of arm mass?
A The proper code depends on the depth of the lesion or mass. The codes in CPT for lesion removal define excision as full-thickness (through the dermis) removal of a lesion including margins, plus simple closure when performed. The proper excision code is determined by measuring the lesion diameter plus the most narrow margins required for complete excision. The codes for excision of soft tissue masses indicate involvement in subcutaneous tissue or the subfascial or intramuscular areas.

Q We have a purchased service agreement to bill MRIs/CTs done outside our office. We bill globally for commercial payers. What would be the place of service (POS)? Right now we are billing time of service (TOS) -- diagnostic X-ray and POS office -- even though the service is not performed in our office.
A It is somewhat difficult to assign an actual POS code since you do not specify the exact location where the service is being provided. If these services are being provided by a mobile unit, use POS code 15. The POS code for an outpatient clinic is code 49 while outpatient hospital is code 22. The POS codes are maintained by CMS and are available on the Medicare Web site. It is always best to check with your individual payer to determine what code(s) are recognized for reimbursement.

Q How do I code for a Pap smear conducted the same day as an annual exam?
A Usually, the collection of a Pap smear is included in a well-woman exam or other evaluation and management service so you can't really code or bill for it. Your compensation is included in your compensation for the well-woman or office visit code. But that is just true of collecting the specimen. One can code for interpretation of the Pap smear, if it's covered by the payer, but most practices send such samples to labs that do the interpretation and bill for it themselves. Medicare does reimburse separately for the collection of a screening Pap smear reported with HCPCS Q0091. It cannot be reported for the collection of a diagnostic Pap smear.

Q I am in a multispecialty group practice and sometimes ask my colleagues in other specialties for a consult. Can the consulting physician bill for the visit? Even if we share a group ID number?
A The consulting physician should be able to bill and collect. If the requirements for a consultation code are met, the physician may report a consultation code even though the requesting physician is in the same group practice. In general, the problem must be outside the area of expertise of the requesting physician. Most payers, including Medicare, will verify that the physicians are of different specialties or subspecialties as a means to evaluate that particular criteria.

The deciding factor may not be whether you are in the same group. What matters is whether you've followed all the rules for billing a consult.
You can report a consultation code, if:

- the service involves rendering a specific opinion or advice at the request of another physician or other appropriate source;
- the request and the need for a consultation is documented in the patient's medical record; and
- the consultant provides a written report of his or her findings to the referring physician.

If these criteria are not met, then the receiving physician reports a new or established patient visit instead.
Q We sometimes see children with behavioral problems. They don't have a defined psychological diagnosis but are just acting out and the mother wants some advice. How should we code for these visits? We don't want to use a psychiatric diagnosis code; none seems right.

A Typically, payers expect you to use V codes to report reasons for healthcare encounters other than identified illness, injury, or condition. There may be some codes in the V section that would be appropriate for these patients. You might also look in the 780-799 section of ICD. This section lists signs and symptoms that can be used when a definitive diagnosis has not been determined.

Q When a patient comes for a "get acquainted" visit with no serious complaints, we are coding as an annual exam. Are there separate procedure charges for the breast exam, prostate exam, etc.? Or are these global in the E&M code? If so, should modifier -25 be used anywhere?

A There is no CPT code for a "get acquainted" visit, so you'll need to perform a true well-male or well-female check in order to bill for these. If you are, the likelihood is that all of the services (e.g., DRE) are indeed included in the E&M. Diagnostic tests and immunizations are reported separately. Most payers do not require the -25 modifier on the E/M service when billed in conjunction with diagnostic tests.

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