INGENIX®

Billing Companion for
Ob/Gyn

2009

1st Edition

Contents

Introduction **1**
- Using the *Billing Companion* 1
- Structure of the *Billing Companion* 2

Chapter 1. The Fundamentals of Billing **5**
- Developing the Billing Process 5
- Coding 6
- Coverage Issues 7
- Medicare Participation 11
- Commercial Payer Participation 11
- Copayments, Coinsurance, and Deductibles 12
- Free or Discounted Services 13
- Setting Fees 14
- Insurance Verification 17
- Preauthorization and Precertification 18
- Secondary Payer Guidelines 19
- Antikickback Statutes and Self-Referrals 27
- Independent Diagnostic Testing Facility Issues 29
- Quality Initiatives 32
- Health Professional Shortage Area 35
- Physician Scarcity Area 36
- HIPAA and Billing 37
- Step-by-Step Claim Completion 38
- Items 1–13—Patient and Insured Information 40
- Items 14–33—Provider of Service or Supplier Information 44
- CMS Develops Contingency Plan for NPI 46

Chapter 2. The Principles of Billing Ob/Gyn Services 55
- Deductibles and Coinsurance 55
- Balance Billing 56
- Covered Services 57
- Coinsurance, Copayments, and Deductibles 59
- Balance Billing a Medicare Patient 60
- Billing Evaluation and Management Services 66
- Billing Diagnostic and/or Therapeutic Procedural Services—Surgery 82
- Multiple Procedures 89
- Ambulatory Surgery Center/Hospital Outpatient Surgery 90
- Inpatient Surgical Procedures 90
- Billing Radiological Services 90
- Laboratory Services 102
- Limited License Providers 103

Chapter 3. Remittance Advice: Friend and Foe **117**
- Using Remittance Advice As a Billing Tool 117
- Claims Returned As Unprocessable 118
- Multiple Forms of an RA 119
- Electronic Remittance Advice 119
- Data Elements of an RA 120
- Posting Payments or Adjustments from the RA 123
- RA Review of Critical Information 123
- Reason Codes on the RA 124
- Third-Party Payers and the RA 159
- Appeals and Letters of Medical Necessity 161

Chapter 4. Claim Submission— Paper and Electronic **175**
- Paper Claims 176
- Electronic Transactions 177
- Errors and Exclusions 181
- Compliance and Coverage Policy Denials 183
- Medicare 184
- National Correct Coding Initiative 189
- Medically Unlikely Edits 192
- Fraudulent Claims Concerns 192

Appendix 1. E/M Guidelines **195**

Appendix 2. Claim Adjustment Reason Codes **237**

Appendix 3. Claim Status Codes **243**

Appendix 4. Remittance Advice Remark Codes **255**

Appendix 5. CMS-1500 to 837p Crosswalk **277**

Appendix 6. Place of Service Codes **293**

Appendix 7. State Licensing Boards **299**

Appendix 8. CPT Modifiers **301**

Appendix 9. HCPCS Modifiers **317**

Appendix 10. Examples of Commercial Claims Errors **325**

Glossary **337**

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Inpatient Hospital Care—Subsequent (99231–99233)

Subsequent hospital care codes include the reviewing of medical record documentation, results of diagnostic tests and procedures, and changes in the patient's status. Two of the three key components must be performed and documented. The level of key component varies depending upon the level of service.

Ob/Gyn physicians who have not provided the initial admit services may find it necessary to report subsequent hospital services even though the patient encounter would be the first episode of care for them as a treating physician. In the absence of a request for a consult from another medical professional, this would be the only reportable service that would be appropriate for the initial visit.

The number of subsequent visits during a patient's length of stay is limited only by the documented medical necessity for the condition being treated. Multiple visits on the same day should be combined as one service as inpatient hospital care codes are reported only once per day.

Subsequent visits provided during the global follow-up period of a surgery would not be reported separately using the inpatient hospital care codes. However, medical record documentation of the patient encounter is still required. If services not related to the surgical procedure/condition are provided during a global follow-up period, subsequent hospital E/M services may be separately reported with an appropriate modifier. See E/M modifiers.

Emergency Department (99281–99285)

Unscheduled E/M services provided in a hospital-based facility are reported using the emergency department codes if the facility is open 24 hours a day and provides care to patients requiring immediate medical attention. All levels of service apply to new or established patients.

Ob/Gyn physicians seeing patients in the emergency department may want to consider reporting the appropriate level consultation services instead of emergency department E/M codes. In most cases, the service has been provided at the request of another medical practitioner and meets the criteria for reporting an E/M consultation level of care. See the consultation section.

When an established pregnant patient is seen in the emergency department due to a medical emergency such as hyperemesis, bleeding, or preterm labor, it may be appropriate to bill the encounter separately from the global obstetrical package, which includes all normal antepartum care. The appropriate level of care depends on the level of the three key components.

KEY POINT

An emergency department visit can be billed separately during the global surgery period when the encounter is due to an unrelated emergency, such as an auto accident. An ICD-9-CM code indicating the nature of the injury should be reported, and modifier 24 should be appended to the E/M code.

Office or Other Outpatient (99201–99215)

The most generally used E/M codes would come under the heading of "*office or other outpatient*" services. This grouping of E/M codes most generically represents services provided in an outpatient setting that is not otherwise identified by another specific grouping of E/M codes. These codes cover a range of five codes identifying a new patient and an additional five codes representing specific levels for an established patient.

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A patient being seen postoperatively after a laparoscopic tubal ligation has developed a Bartholin's gland abscess. An incision and drainage of the cyst is performed. See Figure 7.

- Supplies, such as surgical trays, splints, and casting materials when certain surgical services are performed in the physician's office

A gynecologist in the office inserts a pessary. HCPCS codes for pessary are usually recognized by most major payers. Services can be billed as shown in Figure 8.

Global Obstetrics Package

The global obstetrics package is very similar to the global surgery package in that it combines a set of services and procedures that are included in a single code. The global surgery package includes:

- Antepartum care, including the initial and subsequent histories, physical examination, recording of the weight, blood pressure, fetal heart tones, routine chemical analysis (dipstick), monthly visits up to 28 weeks of gestational age, biweekly to 36 weeks' gestational age and weekly thereafter until delivery.
- Delivery including hospital admission, history and physical examination, management of uncomplicated labor, vaginal delivery with or without episiotomy, or cesarean delivery.
- Postpartum care, including all hospital and office visits following delivery for uncomplicated care

Services that are not part of the normal obstetrical care may be billed separately. A diagnosis code indicating the medical necessity of the visit must be reported.

Obstetricians may bill separately for any services that fall out of the normal care defined above.

For example, a patient has spotting at 22 weeks' gestation and is seen by the obstetrician. The evaluation and management services for this procedure may be billed separately. It is important that the diagnosis indicate the antepartum bleeding, such as 640.93 in this instance. The encounter is reported as shown in Figure 9

See the evaluation and management section for more information on the appropriate billing of E/M codes.

Figure 7 (Unrelated procedure)

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
04	26	2008	04	26	2008	11		56420	79	1 2	180 00	1		NPI	123456789

Figure 8 (Supplies)

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
03	26	2008	03	26	2008	11		A4561		1 2	120 00	1		NPI	123456789

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advisable to attach the operative report with the claim in these instances to help prevent claim delay or a request for additional information.

Figure 12 (Twin deliveries using alternate coding method)

24. A. MM	DATE(S) OF SERVICE From DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR S (Explain Unusual Circumstances) CPT/HCPCS	MODIFI
07	15	2008	07	15	2008	21		59400	
07	15	2008	07	15	2008	21		59409	51

Figure 13 (Twin deliveries by different delivery methods)

24. A. MM	DATE(S) OF SERVICE From DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR S (Explain Unusual Circumstances) CPT/HCPCS	MODIFI
07	15	2008	07	15	2008	21		59510	
07	15	2008	07	15	2008	21		59409	51

When multiple births are performed by different methods—vaginally and by cesarean section—the appropriate c-section delivery code should be sequenced first on the claim, followed by the vaginal delivery only (59409) code with modifier 51 appended. The vaginal delivery only code is used since the peri- and postnatal care are included in the cesarean section code. Most payers reduce the second delivery by 50 percent (multiple surgery reduction) since many of the intraoperative steps are the same as used for the c-section delivery.

Multiple Procedures

Gynecological encounters may consist of multiple procedures during a single episode of care. To report multiple procedures, list the conditions the physician treated of importance, with the major problem listed first. As a rule of thumb, when medical and surgical problems are being managed, list the surgical problem first.

The place of service must be appropriately reported in box 24c of the CMS-1500 claim form to ensure the appropriate level of reimbursement in accordance with the contracted fee schedule:

- Physician's office—11
- Inpatient services—21
- Outpatient hospital services—22
- Ambulatory surgery center—24

Appropriate modifiers should be appended to billed charges when multiple procedures and/or other services are billed for the same episode of care:

- Multiple procedures—51 or 59
- E/M with procedure—24 or 25

BILLING AXIOM

Medicare payment guidelines rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Payments are based on the lower of the actual charge, or the fee schedule amount reduced by the appropriate percentage.

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