Internal Medicine Coding Alert

Reader Questions: Post-Sigmoidoscopy Monitoring

Question: A Medicare patient with diagnosis 562.10 (diverticulosis of colon, without mention of hemorrhage) underwent a flexible sigmoidoscopy (45330). Patient had a reaction in office due to his improper prep. This resulted in: 789.0 (pain, abdominal), 787.01 (nausea and vomiting). Patient remained in the office for two hours after the procedure with monitoring by the physician and nurse (this was well-documented). Medicare would not allow 99215 (Level 5 office or other outpatient visit, established patient) and 99354-25 (prolonged physician service in the office or other outpatient setting requiring direct patient contact, first hour, plus separate procedure) for this extended visit. What do you suggest?

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Answer: First, says **Lee Ann Capello, CPC**, coding supervisor at St. Francis Hospital in Poughkeepsie, NY, the ICD-9 indicates that a fifth-digit subclassification is necessary when using the 789.0 code for abdominal pain. In this case, she would use 789.09 (with the fifth digit, 9, indicating other specified sites, multiple sites).

Its necessary to be more specific when using the 789 codes, she explains.

Billing for Prolonged Services

In addition, Capello would use the -21 modifier (prolonged evaluation and management services) on the 99215 code to indicate the extended amount of time involved in treating the patient.

She notes that the codes 99354-99357 can also be used (instead of the -21 modifier) to report an extended amount of time spent on patient care. However, the choice of code in this range is dictated specifically by the amount of time involved. (See story, Use Prolonged Services Codes Instead of -21 Modifier to Boost Reimbursement, Internal Medicine Coding Alert, October 1998.)

In this case, 99354 (prolonged physician service in the office or other outpatient setting requiring direct patient contact, first hour) would not cover the two hours spent on the patients care.

If the physician was in direct contact with the patient for a total of two hours time, then he or she could code 99354 and then code 99355 (each additional 30 minutes) twice.

Note: These codes can only be used for the time when the physician is in direct, face-to-face contact with the patient. If the nurse was alone monitoring the patient, that time cannot be included in the total time coded using 99354 and 99355.

In addition, the modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) should be attached to the E/M code only if the physician remains in the room constantly for two hours.

Another Opinion: Care Is Included in Global Period

However, an important consideration in cases such as these, is whether the care provided before and after the procedure is actually included in the global period, says **Catherine Brink**, president of Healthcare Resource Management in New Jersey.

As a surgical procedure, a flex sig has a global period under which normal pre- and post-op services are included in the

fee for the procedure.

This is really a gray area, Brink notes. The biller must be absolutely certain, before coding any additional services, that what was done by physician postoperatively is not part of the global surgical package.

If the procedure was scheduled, as it appears in this case, the 99215 definitely should not be billed because the E/M service is included in the global.

Note: If the procedure was not previously scheduled, and performed during the office visit in response to a physicians clinical findings, then the office-visit code with the modifier would be valid.

Its also debatable whether the -21 modifier or the prolonged services codes could be billed, she states. Im not sure I would advise it. Its really debatable whether or not they will get paid.

If the physician is absolutely sure that the care delivered is above and beyond what is normally included in the global, and that care is well documented in the patient record, then prolonged services could be billed, she explains. But, just because the patient didnt get right up off the table after the procedure does not mean you can bill [prolonged services], she adds. Billing for additional services that are included in the global, known as unbundling, is a red flag for auditors, particularly Medicare.