Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 4 Tips Improve Your 51701

Combat E/M and catheterization denials with documentation, diagnoses and modifier

When billing for office visits that result in urine catheterizations, you may face denials for the E/M, the catheterization and/or the catheterization kit. But you can recoup payment when you follow these four steps:

1. Document Separate E/M

You should bill for an office visit (99201-99215, Office or other outpatient visit for a new or established patient...) in addition to urine catheterization (51701, Insertion of non-indwelling bladder catheter [e.g., straight catheterization for residual urine]) if documentation supports a separately identifiable E/M service. Usually, the physician will perform a history, examination and medical decision-making prior to catheterization.

Problem: **CPT 51701** is no longer a starred procedure and is now a zero-day global procedure. So, payers may include a minor pre-, intra- and post-E/M service with the catheterization.

Solution: Show that the E/M service led the physician to decide that the patient needed surgery.

Here's how: Write a separate office and procedure note. If you have to appeal for office visit payment, separate documentation will substantiate that your physician couldn't perform the procedure without the office visit.

Illustration: A 9-month-old girl presents with fever and a bagged urine specimen that suggests infection. Your physician decides to perform a urine catheterization to obtain a sterile urine sample for urinalysis and culture.

The office note should describe the E/M service. Include the child's history of present illness, review of systems and the physical examination findings, says **Michael A. Ferragamo Jr., MD, FACS**, clinical assistant professor of urology for the **Health Science Center** at the **State University of New York** in Stony Brook. Add your physician's assessment, such as "fever of unknown origin" (780.6, Fever). Then, note the plan, such as "Need to do a urine catheterization to obtain sterile urine sample for urinalysis and culture."

Next, you should write a separate paragraph or use a different sheet for your procedure note. After recording the pre- and post-diagnoses and the findings, record the final assessment and plan, Ferragamo says. "For instance, in your final assessment, you may determine: Child has a urinary tract infection (599.0)," he says. Your plan would then describe the antibiotic and treatment regime.

Listing your physician's assessment and plan twice shows the payer that you didn't have a final diagnosis at the E/M service's conclusion. Therefore, the office visit led to the decision to perform the catheterization.

2. Report Separate Service, Procedure Diagnosis

Using different ICD-9 codes with the office visit and the catheterization will also support billing both the service and the procedure. "Insurers like having separate diagnoses for 99201-99215 and 51701," Ferragamo says.

Example: A pediatrician saw a child at 10:30 p.m. for acute urinary retention due to perineal pain after a straddle injury. The insurer paid only for the established patient office visit and denied the catheterization.

In this case, Ferragamo recommends reviewing the claim's ICD-9 codes. You should use 959.14 (Injury, other and unspecified; trunk; other injury of external genitals) for the perineum injury and 788.20 (Retention of urine, unspecified) for the urinary retention, he says. Link 959.14 to 99201-99215 and 788.20 to 51701.

3. Use Modifier -25 or -57

You should also use a modifier to further describe the E/M service for the insurer. You should consider two possibilities: modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) and modifier -57 (Decision for surgery).

When billing for an E/M and catheterization, many coding experts recommend appending modifier -25 to 99201-99215. Modifier -25 informs the payer that the office visit is a significant, separately identifiable service from the catheterization's minor E/M service, says **Sandra Holman**, medical reimbursement specialist at **Growing Up Pediatrics** in Cornelius, N.C.

But not all insurers will pay for 99201-99215-25 with 51701. Payers deny the E/M as included in the catheterization, Holman says. Alternatively, insurers may include the catheterization in the office visit.

Another way: If you're faced with denials, some coding experts recommend using modifier -57 instead of modifier -25 on the E/M code. Modifier -57 indicates that the office visit led to the decision for surgery.

Modifier -57 appropriately describes many E/M-catheterization encounters. You would rarely perform a urine catheterization without performing a history, evaluation and medical decision-making, Ferragamo says. Since these components lead to the decision for catheterization, modifier -57 may be appropriate.

Many insurers, however, don't associate modifier -57 with minor surgeries, such as catheterization. "A lot of payers expect modifier -57 only on major surgeries," Ferragamo says.

Tip: Check your major payers' surgery modifier policies. "Call the company and ask if the insurer wants modifier -25 or modifier -57 on an E/M with catheterization," Ferragamo says.

4. Don't Sweat Supply Cost

Frequent 51701 or 99201-99215 denials may have led you to look for additional billable codes. But, there's one thing you shouldn't bill for - the catheterization supply.

A pediatrician shares this experience: An infant presents for rule-out of sepsis. Part of the workup requires catheterization for sterile collection of urine. He billed Medicaid for the catheterization kit (A4353, Intermittent urinary catheter, with insertion supplies), but the carrier denied payment.

Why: Many payers include the kit's cost in the procedure. "In-office catheterization often reimburses at $75-100," Ferragamo says. The high fee is due to the practice expense relative value units including the equipment cost. In the hospital, catheterization only pays about $30 because the physician is using hospital equipment, he says.