Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 4 Tips Help OB-Gyn Practices Prepare for CPT 2012 Adjustments

Plus: Check out new pathology codes that reflect the tests your ob-gyn can order.

If you were concerned that 2012 might be a heavy year for ob-gyn code additions, then you can breathe easy -- but not too easy. You still need to check out these new skin substitute graft codes and potential gyn oncology services.

Getting to know these five CPT 2012 changes now means that you won't be scratching your head when that ob-gyn claim lands on your desk.

1. Prepare to Alter How You Report Implanon Insertions

CPT 2012 deletes 11975 (Insertion, implantable contraceptive capsules) and 11977 (Removal with reinsertion, implantable contraceptive capsules).

What this means for you: With the deletion of CPT codes 11975 and 11977, you will now have to look to the existing code 11981 (Insertion, non-biodegradable drug delivery implant) when your ob-gyn inserts Implanon for contraception, says **Melanie Witt, RN, COBGC, MA**, an independent coding consultant in Guadalupita, N.M.

The code 11976 (Removal, implantable contraceptive capsules) remains a valid CPT code; however, because some patients still have Norplant systems that an ob-gyn will need to be remove. "The old contraceptive implant codes were specifically developed for that system," Witt explains.

Example: If a patient comes in the removal of the Norplant and has an Implanon rod inserted at the same encounter, CPT instructions say to report 11976 and 11981. That means, your claim will look like this: 11976, 11981-51 (Multiple procedures). Your diagnosis code for this combination will be V25.13 (Encounter for removal and reinsertion of intrauterine contraceptive device).

ICD-10: When your diagnosis coding system changes in 2013, you should report Z30.433 (Encounter for removal and reinsertion of intrauterine contraceptive device) instead of V25.13.

2. Study These Skin Substitute Graft Additions

You'll have a few new skin substitute graft codes to learn in 2012, and the key here is to pay attention to the guidelines. These codes are for the topical application of a skin substitute graft to the wound surface and would not be reported if the graft was used internally. The new codes are:

- 15271 -- Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
- +15272 -- ... each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
- 15273: Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
- +15274: ...each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area or infants and children, or part thereof (List separately in addition to code for primary procedure)
- 15275 -- Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
- +15276 -- ... each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for

primary procedure)
- 15277 -- Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
- +15278 -- ... each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

Important: CPT guidelines state, "the supply of skin substitute graft(s) should be reported separately in conjunction with 15271-15278. For biologic implant for soft tissue reinforcement, use 15777 in conjunction with the code for primary procedure."

Code +15777 (Implantation of biologic implant [e.g., acellular dermal matrix] for soft tissue reinforcement [e.g., breast, trunk] [List separately in addition to code for primary procedure]) is also a new code in 2012. You'll find a bunch of parenthetical notes underneath this code, including:

- For bilateral breast procedure, report 15777 with modifier 50.
- For implantation of mesh or other prosthesis for open incisional or ventral hernia repair, use 49568 in conjuction with 49560-49566.
- For insertion of mesh or other prosthesis for closure of a necrotizing soft tissue infection wound, use 49568 in conjunction with 11004-11006.
- For topical application of skin substitute graft to a would surface, see 15271-15278
- For repair of anorectal fistula with plug [e.g., porcine small intestine submucosa [SIS]), use 46707.
- For insertion of mesh or other prosthesis for repair of pelvic floor defect, use 57267.
- The supply of biologic implant should be reported in conjunction with 15777.

3. Have Claims For a Gyn Oncologist? Implement 2 New Codes

If you code for a gynecology oncologist who see patients with ascites, then you should be aware of three new incision codes. They are:

- 49082 -- Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance
- 49083 -- ... with imaging guidance

Note: These codes replace deleted codes 49080 (Peritoneocentesis, abdominal paracentesis, or peritoneal lavage [diagnostic or therapeutic]; initial) and 49081 (... subsequent).

Example: The gyn oncologist has diagnosed the patient with Meigs' syndrome. The patient has a confirmed right malignant ovarian tumor (183.0) and has developed malignant ascites (789.51). Due to the patient's immediate discomfort from the ascites in her abdominal cavity, the ob-gyn performs an abdominal paracentesis. The physician uses ultrasound guidance to aid in the aspiration, documents his ultrasound observations, and reports code 49082.

ICD-10: When your diagnosis coding system changes in 2013, you'll report C56.1 (Malignant neoplasm of right ovary) instead of 183.0. Your malignant ascites code 789.51 will become R18.0 (Malignant ascites).

4. Check Out New Pathology Tests -- That You Won't Report

Your ob-gyn can order molecular pathology tests, but you should not report the codes to reflect them. However, your ob-gyn should know what tests are available, according to CPT.

If your ob-gyn sees a patient who has breast cancer and might develop other forms of cancer, then he might order a test to examine the BRCA1 and BRCA2 genes. For this reason, CPT 2012 introduces seven pathology codes to reflect these tests (81211-81217). The pathologist will report the code based on whether the ob-gyn orders both a BRCA1 and BRCA2 analysis, a BRCA1 test only, a BRCA2 test only, and whether the patient has a known familial variant.

If a pregnant patient is a cystic fibrosis gene carrier, this can impact the fetus. Therefore, the ob-gyn can order a cystic fibrosis gene analysis. The pathologist will report these tests with 81221-81224 and base their code selection on

common variants, known familial variants, duplication/deletion variants, full gene sequence, or intron 8 poly-T analysis.

Also, if the mother has Leiden Factor V, this can affect the pregnancy. Therefore, the ob-gyn can order this test to see if this gene is present, and the pathologist will report it with 81241.

If your ob-gyn is seeing an ob patient with a multiple gestation pregnancy, then the ob-gyn can order a comparative analysis using Short Tandem Repeat (STR) markers, for twin zygosity testing or maternal cell contamination of fetal cells. The pathologist will report 81265-81266 based on the number of specimens.

Another test an ob-gyn might order for a pregnant patient is the MTHFR gene analysis. This is a condition that can affect the pregnancy by leading to fetal loss. Pathologists will report this with 81291.