Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Excisions, Perineoplasties, Anoscopies, and E/M Top Ob-Gyns' CCI Target List

Pay attention to the modifier indicator for each edit or face a denial.

You may want to hold off if you are planning on reporting two E/M codes for the same patient on the same calendar date of service. The latest version 20.2 of the Correct Coding Initiative (CCI) edits that came into effect on July 1, 2014, includes new edit bundles that do not allow you to report these services together. You also need to apply caution when planning on reporting skin lesion destruction codes with excision codes.

Check Out These Ob-Gyn Specific Edits

Lymph node: Code 38505 (Biopsy or excision of lymph node(s); by needle, superficial [e.g., cervical, inguinal, axillary]) is bundled into 56632 (Vulvectomy, radical, partial; with bilateral inguinofemoral lymphadenectomy) and 56637 (Vulvectomy, radical, complete; with bilateral inguinofemoral lymphadenectomy), because you should consider 56632 and 56637 the more extensive procedures. Although you could bypass the edit with a modifier, you may only do so if the biopsy was not an inguinal node.

Perineoplasty: Code 56810 (Perineoplasty, repair of perineum, nonobstetrical [separate procedure]) is bundled into 57010 (Colpotomy; with drainage of pelvic abscess), 57282 (Colpopexy, vaginal; extra-peritoneal approach [sacrospinous, iliococcygeus]), and 57283 (Colpopexy, vaginal; intra-peritoneal approach [uterosacral, levator myorrhaphy]) due to it being a "separate procedure." These edits have a modifier indicator of "0," meaning you cannot use a modifier to bypass the bundle.

Colpotomy: 57000 (Colpotomy; with exploration) is bundled into 57135 (Excision of vaginal cyst or tumor), because it is considered a misuse of this code combination. As this edit has a modifier indicator of "1," you can use a modifier (such as 59, Distinct procedural service) to bypass the edit if you can meet the criteria for doing so.

Anoscopy: Code C9735 (Anoscopy; with directed submucosal injection[s], any substance) is bundled into 58240 (Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube[s], with or without removal of ovary[s], with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof). The cited reason is that C9735 is considered a "separate procedure" which would normally be included when this pelvic exenteration procedure is performed.

Note: The "C" HCPCS codes are unique temporary pricing codes established by CMS for the Prospective Payment System and are only valid for Medicare on claims for hospital outpatient department services and procedures.

Reporting 2 E/M Services on Same Date? Not So Fast

Although you will usually report only one E/M code for a patient visit on one calendar date of service, you may encounter instances when you will have to report more than one E/M code for the same patient on the same calendar date of service.

As stated in section 30.6.5 of chapter 12 of the Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual, "Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services

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are for unrelated problems."

So, if your ob-gyn or two of your physicians evaluate the patient twice (typically at different times) on the same calendar date service for unrelated problems, you may report two E/M codes for the two distinct encounters. The version 20.2 of the CCI edits bundles office/outpatient new patient E/M codes (99201-99205) with established patient codes (99211-99215). Also, lower level established patient codes are bundled into a higher level established patient code.

For example, a level two established patient code (99212) is bundled into a level two new patient code (99202) and other new patient office/outpatient E/M codes. Another example of this bundling between established patient codes is a level three established patient code (99213) being bundled into a level four or level five established patient code (99214 or 99215).

Modifier indicator: Even though you face edits when trying to report two office visit E/M codes for a patient on the same calendar date of service, you can report both the codes for the patient separately. You are permitted to do this because the modifier indicator for the above mentioned code bundles is '1,' which means you can unbundle the codes by using a modifier. The modifier that you will have to use with the column 2 code is 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service).

Example: An established 70-year-old female patient returns to your ob-gyn after suffering a skin laceration while trying to climb into a vehicle. The patient had earlier visited your physician for a scheduled E/M visit to check for a bladder infection. Since the evaluation of the skin laceration is in no way related to her earlier bladder infection visit and represents a significant, separately identifiable E/M service, you may report it with a separate E/M code.

If the first visit was reported with 99213 and the second visit warranted you to report 99212, you will have to report 99212 with the modifier 25 appended.

Be Cautious About Reporting G0463 With a Procedure Code

CCI 20.2 bundles G0463 (Hospital outpatient clinic visit for assessment and management of a patient) into every procedure code.

What this means: This code replaced CPT® codes 99201-99205 (new patient visit) and 99211-99215 (established patient visit), for facility billing of outpatient clinic visits. This new bundle will not affect physician payment, but will impact a facility that is trying to bill an outpatient clinic visit as well as the service it is bundled into.

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