tci Newsletters

Ob-Gyn Coding Alert

Your practical adviser for ethically optimizing coding, payment, and efficiency in ob-gyn offices and clinics

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CPT 2012

These Deletions Will Impact How You Report Implanon Insertions in 2012

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 Z30.422 (*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 surface area*

- » 15272 — *... each additional 25 sq cm wound surface area, 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 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 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.

Example: A patient undergoes a skinning vulvectomy for extensive vulvar dysplasia (233.32, *Carcinoma in situ of vulva [VIN III]*). The ob-gyn places a skin graft to cover the area, which is 100 sq cm in size. The provider reports 56620, 15725-51 with a quantity of 1 and 15726 with a quantity of 3. Note that 15726 is an add-on code, which means you should not append a modifier, Witt says.

ICD-10: When your diagnosis coding system changes in 2013, then you will report D07 (*Carcinoma in situ of vulva*) rather than 233.32.

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*

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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. Observation Time Guidelines Could Help You Out

Have you ever wished that CPT® would put a time guide on all of its observation codes? Then you'll be in luck as of Jan. 1, when the new manual will offer specific typical times that relate to each of the initial observation care codes.

When CPT® 2011 debuted the subsequent observation care codes 99224-99226, many coders were left scratching their heads at the fact that those new codes featured typical times associated with them, even though the initial observation care codes 99218-99220 don't have typical times. The new edition of your CPT® manual, which takes effect on Jan. 1, will remedy that problem, with the addition of the following typical time guidelines:

- 99218 — *...Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit*
- 99219 — *...Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit*
- 99220 — *...Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit*

Although the specific reasons for the CPT® committee's inclusion of these codes won't be crystal clear until the AMA's November CPT® Symposium, it looks like the addition of typical times could open the door for coding based on time.

"There are only two ways that you can use time as a basis for selecting an E/M code," says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC,** president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. "If counseling/coordination of care takes up 50 percent or more of the visit, and if the code has a typical time associated with it. So by these codes now having a time reference, it sounds like we may have a way to reference time spent if counseling or coordination of care takes up at least 50 percent of a visit. In addition, this could open the door to collecting for prolonged service times if the time the doctor exceeds 30 minutes more than the allotted time for a medically indicated reason, and the visit notes are documented as such," Cobuzzi adds.

5. 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. ❑

Don't Forget Printed Additions of 90654, Mod 33

Remember how 90654 (*Influenza virus vaccine, split virus, preservative-free, for intradermal use*) went into effect Jan. 1, 2011? Now you can see it in your CPT manual.

Also, you'll see modifier 33 (*Preventive services*) printed in your CPT manual. It, too, went into effect Jan. 1, 2011. This modifier allows you to tell your payer that you performed a preventive service and that the patient's deductible and coinsurance do not apply under the new Patient Protection and Affordable Care Act (PPACA) rules.

Part B pay: Unfortunately, you're not likely to get any love from your MACs with this new modifier. According to a Q&A on WPS Medicare's Web site, Medicare does not recognize modifier 33 (www.wpsmedicare.com/part_b/resources/provider_types/awv-faq.shtml). The reason? Medicare can only pay for preventive services that are specifically legislated and all of these services have their own "G" codes to describe them. You can only place modifier 33 on a CPT code. ❑

ICD-10

Your Leukorrhea Code Will Become a General One in 2013

Don't overlook these Excludes1 notes.

If a patient has leukorrhea, she has whitish, yellowish, or greenish discharge from the vagina. The discharge can be normal or the sign of an infection.

Right now, you should report this condition with 623.5 (*Leukorrhea not specified as infective*). When you switch to ICD-10 in October 2013, you should report N98.8 (*Other specified noninflammatory disorders of vagina*) instead. These two codes have a one-to-one correlation, but you should examine how the descriptors differ.

Documentation: You should turn to code N89.8 when the provider documents leukorrhea. If your provider documents leukorrhea NOS, you'll still turn to N89.8 because this term appears as an explanatory term under N89.8.

Here's how you will arrive at these codes from the Alphabetic Index (specific to vaginal discharge):

Discharge (from)
- vaginal N89.8
Leukorrhea N89.8

Coder tips: Underneath the N89- category, you will find an Excludes1 note that forbids you from reporting these codes with abnormal results from cervical cytologic examination without histologic confirmation (R87.61-), carcinoma in situ of cervix uteri (D06-), HGSIL of vagina (R87.623), inflammation of vagina (N76-), senile (atrophic) vaginitis (N95.2), severe dysplasia of vagina (D07.2), trichomonal leukorrhea (A95.00), and vaginal intraepithelial neoplasia [VAIN], grade III (D07.2).

Under N89.8 itself, you'll see another Excludes1 note that forbids you from reporting this code with current obstetric trauma (O70-, O71.4, O71.7, O71.8) and old laceration involving muscles of pelvic floor (N81.8). ❑

OIG Report

Pay Attention to E/M Levels, G Modifiers, and More, OIG Warns

Check your compliance on the areas in the 2012 Work Plan before OIG does.

Every practice knows that with payer audits and recoupment requests coming in, now is the time to step up your compliance but where do you start? The HHS Office of Inspector General (OIG)'s *2012 Work Plan*, released on Oct. 5 can point you in the right direction.

The OIG has some big plans next year for reviewing Part B claims, and they span the whole spectrum of issues, according to the OIG. Get to know these hot buttons with this rundown.

Review Incident-to Billing Requirements

The OIG intends to determine whether payment for incident to services showed a higher error rate than non-incident to services. "Incident-to services represent a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record," the *Work Plan* notes. "They may also be vulnerable to overutilization and expose Medicare beneficiaries to care that does not meet professional standards of quality."

Best practice: Don't bill incident to — in the name and NPI number of the physician — unless you are sure you've met the requirements. To qualify for incident to, the physician must have seen the Medicare patient during a prior visit and established a clear plan of care. If the non-physician practitioner (NPP) is treating a new problem for the patient, or if the physician has not established a care plan for the patient, then you cannot report the visit incident to.

You Be the Coder

Repeat Pap Plus Urinary Tract Infection

Question:
A Medicare patient who is high risk due to sexual behavior came in for her annual wellness visit. The ob-gyn did a Pap, and the office reported G0438/V70.0 with Q0091/V76.2. He ordered a repeat Pap six months later, due to insufficient cells. The patient came back to have the repeat Pap, but she did complain at the visit that she had urinary frequency and pain. The ob-gyn evaluated her for a urinary tract infection (UTI). How should I code the repeat Pap? Should I report it with Q0091 again?
Maine Subscriber

Answer: See page 87. ❑

In addition, when meeting the requirements for a follow-up to an established plan of care, if the physician does not directly supervise the NPP, the incident-to rules do not apply. Direct supervision means a supervising physician must be immediately available in the office suite. The supervising physician, however, does not necessarily need to be the same physician who established the patient's care plan.

Pay Attention to Assignment Rules

When a physician accepts assignment with Medicare, he agrees to accept the Medicare-allowed amount from the carrier as the full charge for the service provided. In 2012, the OIG plans to review "to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare."

Best practice: Confirm with your billing department or contractor that you aren't inappropriately billing any excess patient balances to the beneficiary.

Review Your E/M Coding Practices

The OIG indicates in its *Work Plan* that it intends to review E/M claims to identify trends between 2000 and 2009, and to determine which providers "exhibited questionable billing for E/M services in 2009."

In addition, the OIG will review the number of E/M services that physicians provided during global surgery periods, and will review claims for which physicians appended a modifier so they could separately collect for E/M visits during the global period.

Rule of thumb: Don't bill separately for E/M-related services relating to the original surgery during the global period. The global surgical package includes routine postoperative care during the global period. You should only append modifier 24 (*Unrelated evaluation and management service by the same physician during a postoperative period*) to an appropriate E/M code when an E/M service occurs during a postoperative global period for reasons unrelated to the original surgical procedure.

Stay Up to Date on Hospital Observation Service Coding Rules

The OIG has determined that improper use of observation services "may subject beneficiaries to high cost sharing," and intends to review claims for outpatient observation visits to assess the appropriateness of the services.

Stay on top of CMS's often-changing observation coding rules. For instance, CMS recently clarified how to use subsequent observation care codes 99224-99226 in *MLN Matters* article MM7405, in which the agency noted that these codes should only be used by the "treating physician." CPT rules allow any physician seeing the patient in an observation setting (not a consultation) to then utilize the subsequent observation codes.

Differentiate 'G' Modifiers Correctly

The OIG intends to review Medicare payments for claims that included the "G" modifiers (GA, GZ, GX, GY) to indicate that a Medicare denial was expected. Often, these modifiers are used in tandem with an advance beneficiary notice (ABN). In the past, the OIG has found that Medicare inappropriately paid millions for services or supplies that should have been denied.

Key: Know the differences between the "G" modifiers with the chart below.

Learn more: To read the OIG's complete Work Plan, visit http://go.usa.gov/93X. ❑

Modifier	ABN Signed?	What does the modifier mean?
GA	Yes	**Definition:** *Waiver of liability statement issued as required by payer policy, individual case* **Meaning:** Medicare covers the service only under certain circumstances, and you expect Medicare to deny the service as not reasonable and necessary in this case. When you use this modifier, you expect your practice to hold the patient financially responsible for the service if Medicare denies the claim, because you have a signed ABN.
GX	Yes	**Definition:** *Notice of liability issued, voluntary under payer policy* **Meaning:** Medicare never covers the service (statutorily excluded), but you got the patient to sign an ABN anyway. You will get an automatic denial from Medicare, and then you can submit a claim to a secondary payer. The patient is fully responsible for the charges
GY	No	**Definition:** *Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit* **Meaning:** Medicare never covers the service (statutorily excluded), and the patient is always responsible for the service. You didn't have to get an ABN, and you're adding the modifier to get a denial from Medicare so secondary insurance might pay.
GZ	No	**Definition:** *Item or service expected to be denied as not reasonable and necessary* **Meaning:** The service is not medically necessary under Medicare rules based on the frequency or other coverage criteria such as payable diagnosis. The practice did not obtain an ABN, so the practice is responsible for the charges and can't bill the patient or secondary insurance.

Reader Questions

Take This Vaginal Cuff Dehiscence Challenge

Question:
My ob-gyn performed a Da Vinci assisted abdominal sacrocolpopexy, and I asked her if code 57425 was correct.. After looking at it, she replied, "This surgery also included a repair of vaginal cuff dehiscence." What should I report?

Virginia Subscriber

Answer:
You won't find a separate code to reflect vaginal cuff dehiscence. If the ob-gyn repaired it via the laparoscope, you could report an unlisted procedure code, but you have no close comparisons to submit with it. Another option is to add modifier 22 (*Increased procedural services*) to 57425 (*Laparoscopy, surgical, colpopexy [suspension of vaginal apex]*) and hope her documentation supports the additional work. ❑

Examine 57410 vs. 49000 for Exploratory Vaginal Surgery

Question:
My ob-gyn performed an exploratory vaginal surgery. The patient was status post normal spontaneous vaginal delivery with continuous vaginal bleeding after a vaginal repair of laceration. The vaginal packing was in place. Should I report 57410 or 49000?

New Mexico Subscriber

Answer:
This depends on the approach. You should report 57410 *(Female pelvic examination under anesthesia*) if the ob-gyn looked only at the vagina, and of course this procedure means it was a vaginal approach. Code 49000 (*Exploratory laparotomy, exploratory celiotomy with or without biopsy[s] [separate procedure]*) is an open abdominal procedure. ❑

You Won't Find CPT Guidelines For This 59850 Issue

Question:
I know to bill 59850 for the delivery of twins (both nonviable) 19-4/7 weeks, but should I bill this once or twice with modifier 51 for twin "B?"

California Subscriber

Answer:
You won't find any specific guidelines in CPT for this issue, because at that age, each fetus is very small. Your best bet may be to add modifier 22 (*Increased procedural services*) to 59850 (*Induced abortion, by one or more intra-amniotic injections [amniocentesis-injections], including hospital admission and visits, delivery of fetus and secundines*). The reason is that the ob-gyn is not really repeating 59850 twice, only a small part of it. ❑

Retained IUD Diagnosis Changes Based On This Factor

Question:
Can I use 996.32 for a retained intrauterine device (IUD)?

Nevada Subscriber

Answer:
Yes, you can use 996.32 (*Mechanical complication due to intrauterine contraceptive device*) so long as the patient is not pregnant.

ICD-10: This code will become T83.39xA (*Other mechanical complication of intrauterine contraceptive device, initial encounter*), T83.39xD (*... subsequent encounter*), or T83.39xS (*... sequela*).

If a pregnant patient has a retained IUD and this condition alters the management of the pregnancy because the ob-gyn suspects this has harmed the fetus, you should use 655.8x (*Other known or suspected fetal abnormality not elsewhere classified affecting management of mother ...*) instead.

ICD-10: The 655.8x range of codes will condense and become 035.8xx0 (*Maternal care for other [suspected] fetal abnormality and damage, not applicable or unspecified*). ❑

Avoid 99211 With 96372 at All Costs

Question:
If a patient pays for her medicine and goes to the clinic for the nurse to give the injection, we can bill 96372 (Therapeutic, prophylactic or diagnostic injection ...). But CPT says we should bill 99211 (Office or other outpatient visit ...) if this visit takes place without physician supervision. We used to bill an E/M code but stopped when we were told at a coding seminar a few years ago that we could not do this. What should we report?

South Carolina Subscriber

Answer:
You cannot ever bill 99211 with 96372. You have two options:

Option 1: You bill 96372 for the injection if a supervising provider is present in the office.

Option 2: You bill 99211 instead if no supervising provider is present in the office. You should interpret "supervising provider" to mean any qualified supervising care giver who can bill in their own right. This rule would only apply when a registered nurse (RN) is giving the injection, not the ob-gyn, nurse practitioner (NP), physician assistant (PA) or certified nurse midwife (CNM).

Heads up: You will also incur another problem if the RN gives the injection and you have no one who can supervise or is qualified to supervise if something goes wrong (called malpractice risk). And if this patient was a Medicare patient and you have no supervision, you should count this visit as a nonbillable event. ❑

You Be the Coder

Repeat Pap Plus Urinary Tract Infection

(Question on page 84)

Answer:
Yes. You should report Q0091 (*Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory*) for the repeat Pap smear. Don't forget to append modifier 76 (*Repeat procedure or service by same physician or other qualified health care professional*). Your diagnosis will be V76.2 (*Special screening for malignant neoplasms; cervix*) if the first smear was inadequate.

ICD-10: When your diagnosis coding system changes in 2013, V76.2 will become Z12.3 (*Encounter for screening for malignant neoplasm of cervix*).

As for the UTI, you should bill a separate E/M service (99211-99215, *Office or other outpatient visit for the evaluation and management of an established patient ...*) and append modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*). You should report the UTI with 599.0 (*Urinary tract infection, site not specified*).

ICD-10: Code 599.0 will become N39.0 (*Urinary tract infection, site not specified*). ❑

Count Oocytes for 89280-89281

Question:
Codes 89280 and 89281 don't have a Correct Coding Initiative (CCI) edit, but payers are denying these codes as "mutually exclusive." Can we bill both codes and why?

Rhode Island Subscriber

Answer:
You should report 89280 (*Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes*) or 89281 (*... greater than 10 oocytes*) based on the number of oocytes undergoing assisted fertilization under CPT guidelines, but not both. CCI would not have this edit because Medicare never covers infertility procedures. But you should not bill these codes together, because they are mutually exclusive under their CPT definitions.

For example, your ob-gyn fertilized eight oocytes, so you should report 89280. If your ob-gyn fertilized 11 oocytes, you would report 89281 instead. ❑

Simplify This Ectopic Pregnancy Scenario

Question:
The patient had a ruptured ectopic pregnancy. The ob-gyn did a laparoscopy. The ectopic pregnancy had blown through the isthmus tube and was at the junction of the cornua. He cauterized the surface of the uterus with a Kleppinger for hemostasis. She did not actually lose the tube. The op report reads diagnostic laparoscopy, cauterization of ectopic site. What CPT code(s) should I report? Should I code 49320 for lap and find another for the cauterization?

Virginia Subscriber

Answer:
You should report only 59150 (*Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy*). You should include the diagnostic laparoscopy as part of this procedure. Also, you would include any cauterization or suturing of the ruptured tube as well. ❑

— *The answers for* You Be the Coder *and* Reader Questions *provided by* ***Melanie Witt, RN, CPC, COBGC, MA,*** *an ob-gyn coding expert based in Guadalupita, N.M.*

Ob-Gyn CODING ALERT

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to *Ob-Gyn coding Alert* and reimbursement to the Editor indicated below.

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