OBG MANAGEMENT

BY MELANIE WITT, RN, CPC, MA

Keeping up with CPT 2003

What do obstetric ultrasounds, large-uterus vaginal hysterectomies, and body-fat-composition tests have in common? They all got coding makeovers for 2003. Read on for details on these and more OBG-specific changes.

There's good news and bad news for OBG coders in 2003. The bad news is that the wealth of new Current Procedural Terminology (CPT) codes means practices must make some serious changes to their office procedures encounter form. The good news is that these long-awaited changes should make it easier for physicians to communicate to insurers the type and difficulty of many routine procedures.

In addition to the OBG-relevant changes highlighted in this article, a wide range of other code and editorial updates have been made. For instance, CPT has deleted the optional 5-digit modifier codes that could have been used instead of the 2 digit modifier. (For example, CPT defined that the modifier to signify a separate and significant E/M service could be reported as either modifier -25 or by using the code 09925. With CPT 2003, only the modifier would be reported.) This change was necessary because the uniform electronic claim set up as a result of Health Insurance Portability and Accountability Act regulations can only accommodate 2-character modifiers. Coders should therefore review CPT 2003 in full to ensure that all relevant changes are captured.

A note about formatting: Codes marked in red are new in CPT 2003, while blue codes have been revised since the last edition. When a code has 1 or more indented codes following it, the indented text replaces everything following the semicolon in the initial code.

KEY POINTS

- Obstetric ultrasound codes have been revamped to allow maternal-fetal specialists to report accurately the ultrasound procedures they perform.
- Several Ob/Gyn-relevant Category III codes—which represent emerging technology—have been added, though payers may not yet reimburse for these procedures.
- CPT changed the uterine-fibroid removal codes to account for the more-involved surgical work required for larger or multiple fibroids.
- Hysterectomy codes were revised to account for the additional work involved in removing a large uterus vaginally.

Updated Pap smear codes

Pap smear codes have been revised to more clearly represent current screening techniques. Codes 88144 and 88145—which described the ThinPrep (*Cytyc Corporation, Boxborough, Mass*) manual screening and computer-assisted rescreening—have been deleted, but 2 new codes have been added:

88174 Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation;

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Ms. Witt, former program manager in the department of coding and nomenclature at the American College of Obstetricians and Gynecologists, is an independent coding and documentation consultant.

screening by automated system, under physician supervision

88175 with screening by automated system and manual rescreening, under physician supervision

For manual screening, coders should refer to codes 88142 and 88143.

Counting leukocytes, testing semen

89055 leukocyte count, fecal

This new code, added to describe laboratory testing for fecal leukocytes, replaces the Health Care Financing Administrators Common Procedure Coding System (HCPCS) Level II G code G0026 (fecal leukocyte examination).

89300 Semen analysis; presence and/or motility of sperm including Huhner test (post coital);

89310 Motility and count, not including Huhner test.

While 89300 has not changed, 89310 was revised to specifically exclude Huhner testing. It will replace the HCPCS Level II G code G0027 (semen analysis presence and/or motility of sperm excluding Huhner test).

The biggest change: diagnostic ultrasound codes

Possibly the most significant change in CPT coding comes in the area of obstetric ultrasound. These codes have been revamped to allow maternal-fetal specialists to report accurately the ultrasound procedures they perform. A new guideline note that precedes this section gives a clear definition of what the codes in that section include. For instance, the guidelines state regarding 2 of the codes:

"Codes 76801 and 76802 include determination of the number of gestational sacs and fetuses, gestational sac/fetal measurements appropriate for gestation (<14 weeks 0 days), survey of visible fetal and placental anatomic structure, qualitative assessment of amniotic fluid volume/gestational sac shape and examination of the maternal uterus and adnexa."

Coders should spend time reviewing this section to ensure correct billing. Please also note that the codes 76802, 76810 and 76812 are designated by CPT as "add-on" codes. This means that they do not require a modifier to indicate a multiple procedure (i.e., modifier -51):

76801 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation

76802 each additional gestation (List separately in addition to code for primary procedure performed.)

(Use 76802 in conjunction with 76801.)

76805 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (≥ 14 weeks 0 days), transabdominal approach; single or first gestation

76810 each additional gestation (List separately in addition to code for primary procedure performed.)

(Use 76810 in conjunction with 76805.)

76811 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation

76812 each additional gestation (List separately in addition to code for primary procedure performed.)

(Use 76812 in conjunction with 76811.)

76815 Ultrasound, pregnant uterus, real

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time with image documentation, limited (e.g., fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses

(Use 76815 only once per exam, not per element.)

76816 Ultrasound, pregnant uterus, real time with image documentation, follow-up (e.g., reevaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, reevaluation of organ system[s] suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus

(Report 76816 with modifier -59 [distinct procedure] for each additional fetus examined in a multiple pregnancy.)

76817 Ultrasound, pregnant uterus, real time with image documentation, transvaginal

(If transvaginal examination is done in addition to transabdominal obstetrical ultrasound exam, use 76817 as well as the appropriate transabdominal exam code. For nonobstetrical transvaginal ultrasound, use code 76830 [ultrasound, transvaginal].)

Multiple births. There has also been a change in CPT instructions for coding multiple fetuses when performing a fetal biophysical profile (BPP). In the past, CPT instructed coders to use modifier -51 (multiple procedures) with each BPP code reported at that session after the first fetus (e.g., 76818, 76818-51 for twins). Now CPT indicates that a BPP done on additional fetuses should be reported separately by adding the modifier -59 (distinct procedure) to code 76818 (fetal biophysical profile; with non-stress testing) or 76819 (fetal biophysical profile without non-stress testing).

Transvaginal examination. CPT now explicitly states that if a transvaginal examination is done in addition to a transabdominal gynecologic ultrasound exam, coders should use code 76830 in addition to the appropriate transabdominal exam code (76856-76857).

Bone density studies

CPT now differentiates between a study done on the axial skeleton and one done on the peripheral skeleton, thanks to the revision of 1 code and the addition of a second:

76070 Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)

76071 appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

Vaginal hysterectomy

The codes listed below were revised or added to account for the additional work involved in removing a large uterus vaginally. Report these new codes when the operative report includes a description of how the uterus was removed—by bisection, morcellation, or myomectomy and coring—and confirms the weight of the uterus. As with an abdominal hysterectomy, fibroid removal prior to uterus removal is considered an integral part of the procedure, and therefore is not reported separately. Note that if the weight of the uterus is not known at the time the procedure is coded, the default would be to code for the uterus that weighs 250 g or less.

58550 Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less;

58552 with removal of tube(s) and/or ovary(s)

58553 Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;

58554 with removal of tube(s) and/or ovary(s)

58260 Vaginal hysterectomy for uterus 250 grams or less;
58262 with removal of tube(s) and ovary(s)
58263 with removal of tube(s), and/or ovary(s), with repair of enterocele
58267 with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270 with repair of enterocele

58290 Vaginal hysterectomy, for uterus greater than 250 grams;
58291 with removal of tube(s) and/or ovary(s)
58292 with removal of tube(s) and/or ovary(s), with repair of enterocele
58293 with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58294 with repair of enterocele

Myomectomy

CPT changed the uterine-fibroid removal codes to account for the more involved surgical work required for larger or multiple fibroids:

58140 Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 grams or less and/or removal of surface myoma(s); abdominal approach
58145 vaginal approach

58146 Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams, abdominal approach
(Do not report 58146 in addition to 58140-58145 or 58150-58240 [abdominal hysterectomy codes].)

58545 Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas
58546 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams

Coders should note that code 58551 (laparoscopy, surgical; with removal of leiomyomata [single or multiple]) has been deleted. In its place coders would report either 58545 or 58546. CPT has also clarified that the "abdominal approach" myomectomy codes should not be reported in addition to the abdominal hysterectomy codes (58150-58240).

Colposcopy procedures

CPT 2003 contains new and revised codes for colposcopy of the vulva, cervix, and vagina:

56820 Colposcopy of the vulva;
56821 with biopsy(s)

57420 Colposcopy of the entire vagina, with cervix if present;
57421 with biopsy(s)
(For cervicography, see Category III code 0003T.)

57452 Colposcopy of the cervix including upper/adjacent vagina;
57454 with biopsy(s) of the cervix and endocervical curettage
57455 with biopsy(s) of the cervix
57456 with endocervical curettage
57460 with loop electrode biopsy(s) of the cervix

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57461 with loop electrode conization of the cervix

Coders should note the following guidelines:

- If colposcopy is performed on both the vagina and vulva, both procedures may be reported, with modifier -51 added to the code of lesser relative value.
- A superficial cervical examination is considered part of a complete vaginal examination (codes 57420 and 57421), if performed.
- If the main purpose of the examination is to evaluate the cervix, not the vagina, only the cervical colposcopy codes (54452-57461) would be reported.
- Colposcopy of the cervix codes (54452-57461) include an examination of the entire cervix as well as the upper/adjacent portion of the vagina.
- Code 57460 has been revised and code 57461 added to clarify the 2 different cervical loop electrode excision procedures that might be done in conjunction with colposcopy. Code 57460 includes removal of the exocervix and a portion of the transformation zone, if necessary. Code 57461 represents a conization procedure that takes all of the exocervix, the transformation zone, and some or all of the endocervix.
- An endocervical curettage is included as part of a conization; therefore code 57456 would not be reported in addition to code 57461.

Bladder procedures, incontinence testing

Three new codes were developed to replace HCPCS code G0002 (office procedure, insertion of temporary indwelling catheter, Foley type [separate procedure]). These would be reported only when the catheter insertion is an independent procedure, not part of another procedure.

Codes 53670 and 53675 (both catheterization procedures listed under the heading "urethra") have been deleted. In their place are new codes that are more appropriate.

51701 Insertion of non-indwelling bladder catheter (e.g., straight catheterization for residual urine)

51702 Insertion of temporary indwelling bladder catheter; simple (e.g., Foley)

51703 complicated (e.g., altered anatomy, fractured catheter/balloon)

Urodynamics. Code 51798 (measurement of postvoiding residual urine and/or bladder capacity by ultrasound, nonimaging) replaces code 78730, which had been inaccurately placed in CPT's nuclear medicine section, as well as the HCPCS Level II G code G0050 (measurement of postvoiding residual urine and/or bladder capacity by ultrasound, nonimaging). The new code represents a more accurate description of this noninvasive procedure, which uses a handheld Doppler ultrasonic device. This code represents only the technical component of the procedure, and is not associated with physician work that involves interpretation because the device gives a numeric result.

Abdominal procedures

49419 Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (i.e., totally implantable)

This would be reported by gynecologic oncologists who want to provide intraperitoneal chemotherapy in women with ovarian or primary peritoneal cancer. The procedure requires an incision and the creation of a pocket for the reservoir.

For the removal of these devices, use code 49422.

Blood collection

36415 Collection of venous blood by venipuncture

36416 Collection of capillary blood specimen (e.g., finger, heel, ear stick)

Code 36415 was revised and code 36416 was added to better assign blood collection methods, and so that HCPCS Temporary G code G0001—routine venipuncture for collection of specimen(s)—could be deleted.

Excising skin lesions

Coders now choose which skin-lesion code to report based on the total amount of tissue removed at the site during the operative session, not just lesion size. These codes were revised so it's clear they describe a full-thickness removal of the lesion, including the margin, along with simple closure (if performed).

11420 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421 excised diameter 0.6 to 1.0 cm
11422 excised diameter 1.1 to 2.0 cm
11423 excised diameter 2.1 to 3.0 cm
11424 excised diameter 3.1 to 4.0 cm
11426 excised diameter over 4.0 cm

11620 Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11621 excised diameter 0.6 to 1.0 cm
11622 excised diameter 1.1 to 2.0 cm
11623 excised diameter 2.1 to 3.0 cm
11624 excised diameter 3.1 to 4.0 cm
11626 excised diameter over 4.0 cm

Coding for new technology

Category III codes represent emerging technology, and several that may be of use to Ob/Gyns have been added. Note that payers may not yet reimburse for these procedures. These procedure codes are listed in the CPT book just prior to Appendix A.

When a Category III code accurately describes the procedure or service performed, use that code rather than an unlisted code. CPT adds Category III codes to its database in January and July. To check on any Category III code updates, go to www.ama-assn.org/ama/pub/article/3885-4897.html:

0028T Dual energy x-ray absorptiometry (DEXA) body composition study, 1 or more sites.

This code represents the assessment of body fat composition—a procedure popular with athletes, but one unlikely to be covered by insurers in most cases. Its medical indications are generally children with growth disorders; adults with growth hormone deficiency; and patients with eating disorders, with rapid intervention or unintentional weight loss, or on long-term total parenteral nutrition.

0029T Treatment(s) for incontinence, pulsed magnetic neuromodulation, per day

This code would be used to report treatment with the NeoControl system (*Neotonus, Inc., Marietta, Ga*), in which the patient sits in a chair designed to induce contractions in the pelvic floor and urinary sphincter muscles via a pulsed magnetic field.

0030T Antiprothrombin (phospholipid cofactor) antibody, each Ig class

Code 0030T represents an antibody test to assess patients who may be at risk for, among other things, fetal loss.

0031T Speculoscopy;
0032T with directed sampling

These were added to report procedures, such as PapSure (*Watson Diagnostics, Corona, Calif*), in which light is used to examine the cervix for abnormal lesions and aid in specimen collection. ■

Ms. Witt reports no financial relationship with any companies whose products are mentioned in this article.