OBG MANAGEMENT

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Easier reimbursement: How the new ICD-9 helps

Securing payment for HPV testing is now much simpler, thanks to much-needed coordination of diagnostic codes with the revised Bethesda System.

Mrs. Smith undergoes a screening Pap smear at her annual exam. It has been several years since her last Pap test. The report indicates atypical glandular cells, favor neoplastic. You ask her to return for further testing. The coding dilemma: Should you report this as cancer in situ (233.1) or atypical cells of undetermined significance "favor dysplasia" (795.02)?

New codes were added to report findings of HGSIL and LGSIL.

Thanks to the newly revised Pap smear section of the International Classification of Diseases–9th Revision–Clinical Modification (ICD-9-CM), frustrating scenarios like the one above are now a thing of the past.

The updated Pap codes are the most welcome changes to ICD-9 for 2005, but they're not the only revisions that will ease coding difficulties in the coming year. A clip-and-save chart (page 59) details the changes most relevant to Ob/Gyn practice.

Reporting Pap smear results

The ambiguous nature of Pap smear coding in recent years stemmed from some unfortunate timing: In October 2001, the codes for abnormal Pap smear (795.0X) were revised to correspond to Bethesda system findings, reported by more than 90% of US laboratories. Just before this revision was implemented, however, the Bethesda Committee revised its terminology, so the new codes no longer matched.

The codes now reflect the hierarchy of conditions as described by Bethesda. Thus, reference to "favor benign" and "favor dysplasia" were removed.

Category 795 was changed to "Other and nonspecific abnormal cytological, histological, immunological and DNA test findings." Next, the heading for code 795.0 was changed to allow coding for both an abnormal Pap smear and cervical human papillomavirus (HPV).

New codes were added to report findings of a high-grade squamous intraepithelial lesion (HGSIL) and low-grade squamous intraepithelial lesion (LGSIL), and to differentiate between these results from a Pap smear specimen and histologic confirmation of dysplasia from a tissue biopsy.

A few notes:

- Glandular cell changes are now coded to 795.00. This includes a "favor neoplastic" finding, which solves the dilemma posed by the case example.
- Unsatisfactory or inadequate smear, previously coded with 795.09, is now 795.08.
- Code 795.09 is now used when a DNA test indicates a low risk for HPV (HPV

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Quick reference: ICD-9-CM updates

CODE	CODE IS …	2005 LANGUAGE	NOTES
Revised Pap smear codes			
622.10	New	Dysplasia of cervix, unspecified	Used when the pathology result refers to anaplasia of the cervix, cervical atypism, or cervical dysplasia without further clarification.
622.11	New	Mild dysplasia of cervix	Includes a designation of CIN 1.
622.12	New	Moderate dysplasia of cervix	Includes a designation of CIN 2.
Category 795	Revised	Other and nonspecific abnormal cytological, histological, immunological and DNA test findings	
795.0	Revised	Abnormal Papanicolaou smear of cervix and cervical HPV	Allows coding for both an abnormal Pap smear and cervical human papillomavirus (HPV).
795.00	Revised	Abnormal glandular Papanicolaou smear of cervix	Used to report atypical glandular cells of any type: endocervical, endometrial, or not otherwise specified.
795.01	Revised	Papanicolaou smear of cervix with atypical squamous cells of undetermined significance (ASC-US)	
795.02	Revised	Papanicolaou smear of cervix with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)	
795.03	New	Papanicolaou smear of cervix with low-grade squamous intraepithelial lesion (LGSIL)	
795.04	New	Papanicolaou smear of cervix with high-grade squamous intraepithelial lesion (HGSIL)	May include a report of cytologic evidence of carcinoma, if noted.
795.05	New	Cervical high risk human papillomavirus (HPV) DNA test positive	Requires an additional code for the associated HPV (079.4)
795.08	New	Unsatisfactory smear	Also used for reports indicating an inadequate sample.
795.09	Revised	Other abnormal Papanicolaou smear of cervix and cervical HPV	Use for low risk HPV result (HPV type 6 or 11). Requires an additional code for the associated HPV (079.4).
Revised genital prolapse codes			
618.00	New	Unspecified prolapse of vaginal walls	
618.01	New	Cystocele, midline (or not otherwise specified)	
618.02	New	Cystocele, lateral	Used to support performing a paravaginal defect repair.
618.03	New	Urethrocele	
618.04	New	Rectocele or proctocele	
618.05	New	Perineocele	
618.09	New	Other prolapse of vaginal walls without mention of uterine prolapse	Includes cystourethrocele.
618.81	New	Incompetence or weakening of pubocervical tissue	
618.82	New	Incompetence or weakening of rectovaginal tissue	
618.83	New	Pelvic muscle wasting	Used for disuse atrophy of the pelvic muscles and anal sphincter.
618.89	New	Other specified genital prolapse	
788.38	New	Overflow incontinence	Can be used as a secondary diagnosis with any prolapse code (618.00-618.9).

CIN = cervical intraepithelial neoplasia

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Quick reference: ICD-9-CM updates

CODE	CODE IS …	2005 LANGUAGE	NOTES
Other noteworthy diagnostic codes changes			
621.30	New	Endometrial hyperplasia, unspecified	Use when the pathology report does not clarify or qualify the hyperplasia.
621.31	New	Simple endometrial hyperplasia without atypia	
621.32	New	Complex endometrial hyperplasia without atypia	
621.33	New	Endometrial hyperplasia with atypia	Use for simple or complex hyperplasia with atypia
629.20	New	Female genital mutilation status, unspecified	
629.21	New	Female genital mutilation Type I status	Involves total or partial amputation of the clitoris.
629.22	New	Female genital mutilation Type II status	Involves excision of both the clitoris and the labia minora.
629.23	New	Female genital mutilation Type III status	Called infibulation, involves removal of the clitoris, amputation of some of the labia minora, and incisions into the labia majora to create a hood of skin that covers the urethra and most of the vagina.
648.6X	Clarified	Other cardiovascular diseases	Excludes peripartum cardiomyopathy; use 674.5X.
Revised V codes			
V01.71	New	Contact or exposure to varicella	
V01.79	New	Contact or exposure to other viral diseases	
V07.4	Revised	Hormone replacement therapy (postmenopausal)	Should be reported with V82.81 (osteoporosis screening), if applicable. Do not use V58.69 (long-term [current] use of other high-risk medications) for patients on hormone replacement therapy.
V45.77	Clarified	Acquired absence of genital organs	Excludes female genital mutilation, as described in new codes 629.20–629.23.
V58.66	New	Long-term (current) use of aspirin	
V58.67	New	Long-term (current) use of insulin	
V69.4	New	Lack of adequate sleep	Excludes insomnia
V72.31	New	Routine gynecological examination	Includes Pap smear, if performed. Do not use with V76.2 (special screening for malignant neoplasms, cervix).
V72.32	New	Encounter for Papanicolaou cervical smear to confirm findings of recent normal smear following initial abnormal smear	
V72.40	New	Pregnancy examination or test, pregnancy unconfirmed	Use when result is not known at end of visit. If test is positive, the diagnosis is V22.0 or V22.1 on the lab test code.
V72.41	New	Pregnancy examination or test, negative result	
V84.01	New	Genetic susceptibility to malignant neoplasm of breast	Can be used to indicate the reason for prophylactic organ removal. A genetic test confirming an abnormal gene should be documented.
V84.02	New	Genetic susceptibility to malignant neoplasm of ovary	Can be used to indicate the reason for prophylactic organ removal. A genetic test confirming an abnormal gene should be documented.
V84.09	New	Genetic susceptibility to other malignant neoplasm	Can be used to indicate the reason for prophylactic organ removal. A genetic test confirming an abnormal gene should be documented.
V84.8	New	Genetic susceptibility to other disease	Can be used to indicate the reason for prophylactic organ removal. A genetic test confirming an abnormal gene should be documented.

types 6 and 11)
- When reporting 795.05 or 795.09, use an additional code for the associated HPV (079.4).

Why these revisions were crucial. Without a code for "atypical squamous cells–cannot rule out high-grade squamous intraepithelial lesions" (ASC-H) versus "atypical squamous cells–undetermined significance" (ASC-US), it was difficult to establish the medical need for HPV tests. The American Society for Colposcopy and Cervical Pathology recommends HPV testing for ASC-US, but not for ASC-H, which should proceed to follow-up colposcopy.

The revision also clarifies that category 795 diagnostic codes are not used for cervical intraepithelial neoplasia (CIN) or dysplasia pathology results.

CIN or dysplasia

For tissue biopsy pathology results indicating CIN 3 or severe dysplasia of the cervix, use code 233.1. For CIN 1 or 2 or mild to moderate dysplasia, use one of the expanded dysplasia codes from the 622.1 series.

Remember: The dysplasia codes are reported as a result of histologic confirmation; codes 795.00 to 795.09 involve a cytologic examination only.

Genital prolapse: More detail on the cause

Previously, code 618.0 covered a range of conditions, from cystocele to vaginal prolapse. However, since CPT is more specific about the various prolapse-repair procedures, ACOG requested an expansion of this code to provide additional detail.

Note, also, that a new code for overflow incontinence, 788.38, was added.

Female genital mutilation

A new subcategory—629.2, female genital mutilation (FGM) status—includes codes representing the range of FGM procedures, from partial clitoris amputation to the procedure known as infibulation.

Use these codes for a primary diagnosis in a nonpregnant patient seeking treatment to correct the mutilation, or as a secondary diagnosis when the the patient is currently pregnant, or to medically justify cesarean delivery or a complicated vaginal delivery.

Endometrial hyperplasia

Code 621.3, previously used to report endometrial cystic hyperplasia, has been expanded to 4 new codes.

Peripartum cardiomyopathy

Code 648.6X (other cardiovascular diseases) now specifically excludes peripartum cardiomyopathy, which is coded 674.5X.

Diabetes mellitus

Diabetes is no longer termed insulin-dependent and non–insulin-dependent, but rather type I or type II (differentiated by the functioning of pancreatic beta cells, not by insulin use). Thus, the fifth-digit subclassification used with the diabetes codes in category 250 was revised as follows:
- 0 – type II or unspecified type, not stated as uncontrolled
- 1 – type I (juvenile type), not stated as uncontrolled
- 2 – type II or unspecified type, uncontrolled
- 3 – type I (juvenile type), uncontrolled

Report fifth-digits 0 and 2 even if the patient requires insulin—in which case, you may also report the new code V58.67 (long-term current use of insulin). This can be used as a secondary diagnosis, or as a primary diagnosis when the patient is seen for possible long-term effects rather than diabetic control. (Long-term current use of aspirin was also given a code, V58.66.)

The code for vaginal prolapse was expanded to provide additional detail.

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V code changes

Gynecologic exam

Per ACOG's request, V72.3 has been expanded into 2 codes:

V72.31 covers routine gynecologic examination—including a Pap smear, if performed. Thus, do not report V76.2 (special screening for malignant neoplasms, cervix) with V72.31 for the exam. Note, however, that if the patient's cervix is absent and a vaginal Pap smear is collected at the time of the visit, code V76.47 (routine vaginal Pap smear) is also needed.

V72.32 describes a repeat Pap smear in the following scenario: A patient has an abnormal Pap test and is brought back 3 months later for a follow-up Pap. (The diagnosis for that visit is the abnormal result.) The results come back normal and she is asked to return in a few months. You will use V72.32 for this last encounter.

ACOG clarifies V72.32 may be used more than once at the physician's discretion, since the usual protocol is to perform more frequent Pap smears until obtaining 3 consecutive negative results. Caveat: Check with your Medicare carrier before using this code for the repeat Pap smears.

V72.31 covers routine gynecologic examination—including a Pap smear, if performed.

Pregnancy tests

With the expansion of V72.4, ICD-9 now has an option for a pregnancy test done prior to a procedure that may harm a fetus, or simply because you suspect pregnancy:

Use V72.40 when you perform a pregnancy test, but have not determined whether the patient is pregnant by the end of the visit (ie, a blood rather than urine test). Note that if the pregnancy test is positive, also report code V22.X, per ICD-9 guidelines. This pregnancy diagnosis can be linked to the CPT pregnancy test code.

Use V72.41 if you confirm she is not pregnant during this visit. (Again, if the test is positive, use code V22.X.)

Hormone replacement therapy

The term "postmenopausal" was moved to a parenthetical note for code V07.4, to denote that this code should be reported anytime a woman is placed on estrogen replacement therapy. ICD-9 also has clarified that it is not appropriate to use V58.69 (long-term [current] use of other high-risk medications) for patients on hormone replacement therapy—instead, select code V07.4.

Screening for osteoporosis

ICD-9 has clarified that code V07.4 should be reported with the code for osteoporosis screening (V82.81), if applicable.

Genetic susceptibility to disease

A new category addresses prophylactic organ removal. Until now, ICD-9 had codes to indicate that an encounter was for organ removal, but not to describe the reason for the removal.

Further, these codes were needed because the "carrier status" codes can be used only when the patient is a disease carrier, able to pass it to offspring—not when she herself is at risk.

Note that before you can use these codes, the patient's record should show an abnormal gene confirmed by genetic test.

Acquired absence of organ

ICD-9 has clarified that code V45.77 (acquired absence of genital organs), excludes the new FGM status codes (629.20 to 629.23).

Exposure to communicable diseases

The American Academy of Pediatrics requested the addition of exposure codes to viral and other communicable diseases. Most important to Ob/Gyns is exposure to chickenpox (varicella), if the mother was not previously exposed. This new code, V01.71, may be enough to support the medical necessity for laboratory work to test for immunity to chickenpox.

Report code V01.79 for exposure to other viral diseases.

Lack of adequate sleep

New code V69.4 is reported for sleep deprivation, but excludes insomnia. ■