OBG MANAGEMENT

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4 CPT gems for 2005

Codes for all vaginal vault suspensions ... Cryoablation promoted from Category III ... Codes recognize hysteroscopic sterilization ... More fetal Doppler choices

Coding is catching up with practice

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The near-universal acceptance of the resource-based relative value scale (RBRVS) means that accurate and complete *coding* is essential for accurate and complete *payment.* Lack of appropriate codes for all of the gynecologic surgery procedures we perform has been an impediment to appropriate reimbursement.

This year in particular, the American College of Obstetricians and Gynecologists (ACOG) made important strides in helping us code for the procedures we perform.

- **New codes for hysteroscopic sterilization and endometrial cryoablation** signify recognition by the American Medical Association and Current Procedural Terminology (CPT) that these technologies represent major advances in women's health. They allow us to supply services in the office setting with appropriate reimbursement to cover our costs.
- **Pelvic floor reconstruction procedures** have become more sophisticated, and it has been difficult to accurately describe our surgical approaches with existing codes. These codes have been revised, allowing us to distinguish between intraperitoneal and extraperitoneal suspension of the vaginal vault. In addition, a new code describes the use of graft material (any type) to augment anterior, posterior, or apical repairs.
- **New Fetal Doppler codes**, describing studies of the umbilical and middle cerebral arteries, allow us to code for the assessment of fetal anemia and fetal growth restriction.

1 *All* vaginal vault suspensions can be coded

The American College of Obstetricians and Gynecologists (ACOG) requested new codes to address the various techniques of vaginal vault suspension. Until this year, only 1 vaginal colpopexy code was available: sacrospinous ligament fixation. For any other type of suspension, we had to bill for the procedure using either the unlisted code 58999 or the code that was closest, 57282 (sacrospinous ligament fixation for prolapse of vagina).

As of January 1, the 2 code revisions, 57282 and 57283, will address any suspension technique (**TABLE**). Which you choose will depend on whether the suspension occurs outside the peritoneal cavity (by attaching it to the iliococcygeus muscle or sacrospinous ligament), or inside (using the uterosacral ligament or performing a high midline levator myorrhaphy).

Note that the code for the intraperitoneal approach cannot be billed with code 58263 (vaginal hysterectomy with bilateral salpingo-oophorectomy and enterocele repair).

Mesh augmentation

A new code was created for mesh augmentation, when the patient's tissue is weak or inadequate for cystocele, rectocele, or enterocele repair. Code 57267 is an "add-on" code, meaning it is never used without an

TABLE

Quick reference: CPT updates 2005

THE TOP 4 UPDATES

Vaginal vault suspension

▲	**57282**	Colpopexy vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)
•	**57283**	intra-peritoneal approach (uterosacral, levator myorrhaphy)
+•	**57267**	Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)

Endometrial cryoablation

•	**58356**	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage when performed

Hysteroscopic sterilization (Essure)

•	**58565**	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants

Fetal Doppler

•	**76820**	Doppler velocimetry, fetal; umbilical artery
•	**76821**	middle cerebral artery

OTHER NOTABLE CHANGES

•	**11004**	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum
•	**11006**	external genitalia, perineum and abdominal wall, with or without fascial closure
+•	**11008**	Removal of prosthetic material or mesh, abdominal wall for necrotizing soft tissue infection (List separately in addition to code for primary procedure)
⊙	**58823**	Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)
•	**58956**	Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy
•	**84163**	Pregnancy-associated plasma protein-A (PAPP-A)
▲	**89346**	Storage [per year]; oocytes

Symbols
This article uses the standard CPT symbols:
- • Codes new to CPT 2005
- ▲ Codes revised in CPT 2005
- + Add-on code—does not take a modifier
- ⊙ Procedures that include conscious sedation

Indentation
For codes followed by an indented code: Indented text replaces everything after the semicolon in the initial code.

additional "base" code. It is billed with 45560 (rectocele repair), 57240 (anterior colporrhaphy), 57250 (posterior colporrhaphy), 57260 (combined anterior and posterior repair), or 57265 (combined anterior and posterior repair with enterocele repair).

Note that the code's description indicates "each site." Thus, if mesh is required in both the anterior and posterior compartments, code 57267 is listed twice.

FAST TRACK

For extraperitoneal vaginal vault suspensions, choose 57282; for intraperitoneal, use 57283

2 Cryoablation promoted from "developing technology"

Now rescued from Category III (temporary code 0009T), endometrial cryoablation has its own code, 58356, in the surgery section.

You should not bill separately for endometrial biopsy (58100), dilation and curettage (58120), saline-infusion sonogram/hysterosalpingogram (58340), abdominal ultrasound (76700), or pelvic ultrasound (76856); all are included in

58356. Note that the nomenclature states that ultrasound guidance is also included.

3 Less hassle for less-invasive sterilization

Hysteroscopic sterilization (*Essure; Conceptus, San Carlos, Calif*)—which requires no abdominal incisions and can be performed in an office setting—now has its own code, 58565. Previously, the Healthcare Common Procedure Coding System (HCPCS) code S2555 and the code for an unlisted hysteroscopy (58579) were used to fill this coding gap. Physician practices will be happy to note that this code was given 57.77 relative value units (RVUs) when performed in a nonfacility setting—enough to cover the cost of the implants.

Do not report this with diagnostic hysteroscopy (58555) and/or dilation of cervix (57800). Since the code is valued as a bilateral procedure, add a modifier -52 (reduced services) if the device is placed unilaterally.

FAST TRACK

Happily, the code for hysteroscopic sterilization (Essure) has 57.77 relative value units when performed in a nonfacility setting—enough to cover the cost of the implants

4 More options for fetal Doppler

The addition of 2 codes for fetal Doppler of the umbilical and middle cerebral arteries (76820 and 76821) is most welcome for maternal-fetal medicine specialists evaluating fetal anemia and fetal growth restriction. Until now, these 2 scans were reported using the Doppler echocardiography codes 76827 (Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete) or 76828 (Doppler echocardiography, ... ; follow-up or repeat study).

Still no uterine artery Doppler code

For this, ACOG recommends continuing to use codes 76827 or 76828—but a closer code might be 93976 (Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study).

Note the slight change in nomenclature for 76827. The phrase "cardiovascular system" was removed for CPT 2005.

ULTRASOUND

New requirement: Images must be recorded

Most noteworthy of the new ultrasound guidelines is the *requirement* that an image be recorded. Permanently recorded images with measurements are required for all diagnostic ultrasound examinations (when such measurements are clinically indicated).

Ultrasound guidance procedures also require permanently recorded images of the site to be localized, and a documented description of the localization process, either separately or within the procedure report for which the guidance is utilized. A final, written report should be placed in the patient's medical record.

For anatomic regions that have "complete" and "limited" ultrasound codes:

- Note the elements that comprise a "complete" exam, and include in the report a description of each or the reason an element could not be visualized.
- Use the "limited" code—once per patient exam session—if reporting less than the required elements for a complete exam (eg, limited number of organs or limited portion of region evaluated).
- Do not report a "limited" exam for the same exam session as a "complete" exam of that same region.

Doppler evaluation of vascular structures (other than color flow used only for anatomic structure identification) *is separately reportable*.

Use of ultrasound without thorough evaluation of organ(s) or anatomic region, image documentation, and final written report *is not separately reportable*.

Nonobstetric ultrasound

When to code complete ultrasound. The code for complete nonobstetric ultrasound (76856, Ultrasound, pelvic [nonobstetric], B-scan and/or real time with image documentation; complete) encompasses the

comprehensive evaluation of the female pelvic anatomy, including:

- measurement of uterus and adnexal structures
- measurement of the endometrium
- measurement of the bladder (when applicable)
- description of any pelvic pathology

When to code limited ultrasound. The code for limited nonobstetric ultrasound (76857, Ultrasound, pelvic [nonobstetric], B-scan and/or real time with image documentation; limited or follow-up [eg, for follicles]) represents:

- focused examination limited to the assessment of 1 or more elements listed in code 76856, and/or
- reevaluation of 1 or more pelvic abnormalities previously seen on ultrasound.

Use this code when imaging the urinary bladder alone (not kidneys). If you measure bladder or postvoid residual volume at the same time as the bladder ultrasound, code 51798 (postvoid residual urine and/or bladder capacity by ultrasound, non-imaging) is *not* added.

ALSO NOTABLE

Total omentectomy

Previously, no code existed to describe removal of the uterus and omentum for malignancy without lymph-node dissection. But when omental metastasis is present, pelvic and paraaortic lymph node dissection for staging is not usually necessary, since the disease has already spread into the abdominal cavity. New code 58956 addresses this problem. To report this code, the documentation must clearly indicate a total omentectomy (removal of both the lesser and greater omentum, also referred to as a supracolic omentectomy).

Debridement of genitalia

Three codes address debridement of the external genitalia and perineum skin for necrotizing soft tissue infection.

Screening for chromosome abnormalities

A new laboratory services code, 84163, describes the pregnancy-associated plasma protein-A (PAPP-A) screening test, used to identify women at highest risk of carrying a fetus with Down Syndrome, trisomy 18, or other chromosomal abnormality.

Oocyte storage

A revision to make "oocyte" plural in code 89346 (storage [per year]; oocytes) clarifies that each oocyte stored is not coded separately.

New appendices

Appendix F lists codes exempt from modifier -63 (Procedure performed on infants less than 4 kg).

Appendix G lists procedures that include conscious sedation. A new symbol, ⊙, was created to denote this for the individual codes included in this section. The only Ob/Gyn-specific code that carries this symbol is 58823 (drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous [eg, ovarian, pericolic]).

Appendix H is an alphabetic index of Category II code performance measures (the index lists them by clinical condition or topic), and includes a brief description of the performance measure and its source.

Appendix I lists genetic testing code modifiers. Report these with the molecular lab procedures related to genetic testing. The modifiers are categorized by mutation: The first digit indicates the disease category, the second denotes the gene type. For instance, 0A signifies testing for the BRCA1 gene. ■

Bonus tables on the Web!

- Breast procedures code revisions
- New Category II revisions

www.obgmanagement.com

FAST TRACK

Ultrasound guidelines *require* that images be permanently recorded