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Updated CPT codes: Few (and overdue), but mighty

New codes for biopsy with colposcopy, removal of infected or eroded mesh, and consultations

Changes in procedural terminology (CPT) codes for 2006 include only 2 new codes and 1 revised code that directly affect ObGyn practices. Besides needing to know about the addition of a code for the revision of a vaginal graft and a new "add-on" code for reporting an endometrial biopsy with colposcopy, ObGyn practices will need to amend any encounter forms containing codes for confirmatory consultations or follow-up inpatient consultations, because all of these code sets will be deleted effective January 1, 2006.

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Dr. Levy represents ACOG on the AMA-RBRVS Update Committee, and is ex-officio, ACOG Coding and Nomenclature committee.

ACOG's coding committee is eager to support you, and welcomes your suggestions!

Email your coding ideas to:
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Common sense codes were long in coming

At last, ACOG has succeeded in capturing the additional work of performing endometrial biopsy at the time of colposcopy with biopsies and/or endocervical curettage. The Centers for Medicare and Medicaid services had been bundling the work of endometrial sampling into the broader code for colposcopy with biopsies. The bundled code meant we did not get paid for these biopsies. Although that policy was clearly inappropriate, the fix was long in coming. Beginning January 1, 2006, we can use a new add-on code (+58110) when endometrial biopsy is performed with colposcopy (usually for patients with atypical glandular cells on Pap smear). It will be important to train ourselves and our staff to use the new code rather than attempt to use a modifier on the code for typical endometrial biopsy (58100).

New complications and misadventures sometimes ride in on the coattails of new technology, and must be corrected surgically. Along with the use of mesh to enhance pelvic reconstructive surgery has come the problem of mesh erosion. Removal of infected or eroding mesh is a nasty experience that, until now, had only an unspecified code, necessitating letters back and forth to payers and difficulty obtaining reimbursement. A new code properly describes the work performed in these difficult dissections: 57295.

No more "second opinion" codes. Several redundant and difficult codes have been discarded. One of the last remnants of managed care, the confirmatory consultation ("second opinion"), has been removed from CPT.

In addition, follow-up consultations in the hospital were determined to be indistinguishable from subsequent hospital visits and therefore this category of codes was also eliminated.

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CONTINUED

REVISION OF VAGINAL GRAFT
NEW CODE: 57295

Ms. A had a cystocele repair 6 months ago. Her pubocervical fascia was so weak that a surgical mesh was placed to keep the bladder in position. She now complains of vaginal pain and discharge. Examination reveals the mesh has eroded into the vagina, and surgical repair is required. How would you code this situation?

In 2005, the only way to code this situation was to use the unlisted code 58999 because the existing code for revision of a graft (57287) is reserved for revision of a urethral sling for stress urinary incontinence.

The good news is that starting January 1, a new code (57295) can be used for revision (including removal) of prosthetic vaginal graft, vaginal approach. This code will apply when the original surgery that resulted in the complication with the graft was reported with any of the following codes: the add-on code 57267 (insertion of mesh or other prosthesis for repair of pelvic floor defect, each site), one of the colporrhaphy codes (54250–56265), the rectocele repair code 45560, or the abdominal approach colpopexy code 57280.

ENDOMETRIAL BIOPSY
NEW CODE: 58110

Last month, Mrs. B's Pap test found "AGC - atypical glandular cells" (ICD-9-CM code 795.00). Because of this finding, the physician will perform colposcopy and obtain endocervical and endometrial biopsies. How would you code this situation?

Unfortunately, until the end of 2005, the ObGyn can be paid only for the endocervical curettage because the endometrial biopsy code (58100) was bundled with the colposcopy codes, in the National Correct Coding Initiative rules.

An "add-on" code for endometrial biopsy can be reported when the procedure is performed at the time of colposcopy. The new code, +58110, endometrial sampling performed in conjunction with colposcopy (list separately in addition to the code for the primary procedure), is valued under the resource-based relative value scale for the intraservice work only.

Notes added under the colposcopy codes 57420, 57421, and 57452–57461 indicate that if endometrial biopsy is also performed, the new code 58110 should be added to the colposcopy code. Because 58110 is an "add-on" code, no modifier is required when billed with 1 of the colposcopy codes.

Vagina and cervical biopsies also unbundled. Because of the addition of the new 58110 code, CPT also revised code 57421 to clarify that it is only for biopsy of the vagina and cervix (if performed), and not an endometrial biopsy.

2ND OPINION CODE KAPUT
RELATIVE VALUE UNITS RAISED

Confirmatory consultation codes (99271–99275) will disappear on January 1—a welcome change for most practices because confirmatory consultation codes could not be used when counseling or coordinating care dominated the visit.

In the future, if the patient is seen for a confirmatory consultation, the physician should bill an inpatient or outpatient evaluation and management (E/M) code rather than a consultation. The rationale is that confirmatory consultations are requested by the patient, rather than by a qualified health care provider. If the second opinion is requested by a third party, for example to confirm that recommended surgery was medically indicated, adding modifier 32 (mandated services) is appropriate.

The follow-up inpatient consultation codes (99261–99263) will also be eliminated in 2006. The CPT guidelines for 2006 instruct the physician to report the subsequent hospital care codes (99231–99233) if the patient requires a follow-up visit after the initial inpatient consultation. This change is a positive one for ObGyns, however, because the relative value units for the hospital care codes are slightly higher than were the follow-up consultation codes. ■

FAST TRACK

If the visit is a confirmatory consultation, bill an inpatient or outpatient evaluation and management (E/M) code rather than a consultation