A new year, a new CPT: Will these changes rattle your practice?

You need to revise your encounter form; Modifier-21 is gone; and there's mixed news about common urogyn surgeries. Our expert contributor offers a walk-through.

Take note, ObGyns: A number of changes in Current Procedural Terminology (CPT) 2009—those changes took effect January 1—are going to modify the way you bill and will have an impact on your reimbursement. Most of these changes are minor, although renumbering of infusion codes will require changes to the encounter form. And I have good and bad news for urogynecologists who perform **vaginal paravaginal repairs** and sling procedures for stress urinary incontinence. Read on for details!

Mesh for vaginal paravaginal defect repair—code error corrected

Code **57267** is an add-on code that describes the insertion of mesh, or other prosthesis, through a vaginal approach when native tissues have been determined to be weak and inadequate for repair—especially in patients who have undergone a previous attempt at repair. As an add-on code, it can be billed only in addition to other, specific procedures.

Before January 1, code **57267** could only be reported with an anterior or posterior colporrhaphy, or both, or with a rectocele repair without colporrhaphy.

When performing a vaginal approach **paravaginal** defect repair, however, the same weakened tissues also require use of the mesh, yet code **57285** (*paravaginal defect repair [including repair of cystocele, if performed]*) was not included as one of the allowed codes. This error is rectified in 2009.

You must still be aware that reporting the **57267** add-on code requires that you establish medical necessity for its use. Documentation of weakened, attenuated, or incompetent pubocervical tissue in the case of a paravaginal repair (International Classification of Diseases Clinical Modification [ICD-9-CM] code **618.81**) or rectovaginal tissue for rectocele/enterocele repair (**618.82**) continues to be important when reporting the add-on mesh code.

NOTE: Any mesh used with a colpopexy, sling procedure, or abdominal or laparoscopic paravaginal repair is not reported separately.

A reminder about anesthesia

Until January 1, codes **57400** (*dilation of vagina*), **57410** (*pelvic examination*), and **57415** (*removal of impacted vaginal foreign body*) read "under anesthesia." In a move to standardize terminology, these codes will be revised to add the wording "other than local." The revision clarifies that **1)** all surgical codes include administration of a local anesthetic and **2)** codes designated with "under anesthesia" refer to regional blocks and general anesthesia.

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Down with the work relative value of 2 urogynecology procedures for UI!

Although not a CPT change, it's worth noting that physicians who perform **1)** sling operations for correcting stress urinary incontinence or **2)** subsequent revisions because of problems with fascia or synthetic mesh need to be aware that the physician work relative value for these procedures **has been decreased** in 2009 by the Centers for Medicare and Medicaid Services (CMS). Why the drop? According to CMS, results of surveys by the American Urogynecologic Society and the American Urological Association indicate that the procedures are not as difficult to perform as once considered.

The two affected codes are:

57288 Sling operation for stress incontinence (e.g., fascia or synthetic)

57287 Removal or revision of sling for stress urinary incontinence (e.g., fascia or synthetic)

The change will result in a decline in payment for these procedures by Medicare and some non-Medicare payers, and will be felt harder with sling procedures than with revisions. Why? The work relative value units (RVUs) decreased for **57287,** but that decrease was offset by an increase in practice expense relative value—which resulted in total RVUs increasing for this code in 2009, from 18.31 to 18.53.

Code **57288,** on the other hand, has been tagged with a decrease in **both** the physician work and practice expense RVUs. Total RVUs for this code, therefore, have dropped from 21.59 to 19.62. In Medicare dollars, that equates to about $118 less for the same procedure when one applies the 2009 Medicare conversion factor of $36.07.

FAST TRACK

The physician work relative values for sling procedures and subsequent revisions (codes 57287 and 57288) have been lowered in 2009

New human papillomavirus vaccine, new code

A new code, **90650**, has been added to report the newer bivalent human papillomavirus (HPV) vaccine, which contains an adjuvant formulation and is intended to protect against infection by high-risk HPV types 16 and 18. The existing HPV vaccine code, **90649**, targets those high-risk types of HPV and two low-risk types (6 and 11).

Coverage recommendations for the new vaccine match those of the existing, quadrivalent vaccine, but not all payers are covering the HPV vaccine based on those recommendations. The new vaccine offers a less costly alternative for patients whose health-care insurance does not cover the vaccine or who are uninsured.

NOTE: The dosing schedules for these HPV vaccines also differ: **the new vaccine:** administered at 0,1, and 6 months and **the existing vaccine:** administered at 0, 2, and 6 months.

Wholesale reorganization of injection and infusion codes

Codes **90760–90779** (covering therapeutic, prophylactic, and diagnostic injections and infusions) are deleted in 2009 and renumbered, with the same descriptors, to **96360–96379**. This was done to organize all infusions and injections together. The biggest change for you and every other ObGyn? You must revise the practice's encounter form to reflect the requirement that intramuscular and subcutaneous injections are now coded **96372** instead of **90772**.

Modifier -21 and prolonged E/M services

Now deleted is **Modifier -21** (prolonged evaluation and management [E/M] service). This modifier represented acknowledgment that a continuous face-to-face E/M service could exceed the maximum time allowed by the highest level of E/M service for the type being billed.

In other words, before January 1, 2009, if a patient's condition was such that you documented an established or new patient visit (**99215** or **99205**) but in fact spent more time with her than the 45 or 60 minutes that typically accompanies these codes, you added modifier **-21** in the hope of receiving higher reimbursement. Now the modifier is deleted because there is already a mechanism in place to report such prolonged service.

Add-on codes **99354–99357** are used to report face-to-face outpatient and inpatient

prolonged E/M services. Guidelines for these codes mandate **cumulative time** rather than **continuous time,** and using the add-on codes is contingent on the additional time spent being **30 or more minutes above the typical time** allotted for the basic E/M service that you are billing.

Here's a case that exemplifies how coding works in these circumstances:

CASE

You evaluate a patient for severe uterine bleeding, and report a level-4 visit (99214), which has a typical time of 25 minutes. At the same visit, you determine that endometrial biopsy is required, and you perform it during the visit. But the patient faints during the procedure—and you spend an additional 35 minutes (cumulative time) with her before you send her home.

Because the typical time of 25 minutes was exceeded by at least 30 minutes, you should report **99354** (*prolonged physician service in the office or other outpatient setting requiring direct [face-to-face] patient contact beyond the usual service; first hour [list separately in addition to code for office or other outpatient Evaluation and Management service]*) in addition to **99214**.

Guidelines for correct use of these codes are also being revised to emphasize that only **outpatient** prolonged services codes are intended to be used to report **total duration of face-to-face time;** on the other hand, **inpatient** codes are intended to report the total duration of the time spent (whether continuous or noncontinuous) by the physician on the unit **actively involved in caring** for the patient.

UPDATE

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A further observation about PGS in women who have experienced recurrent pregnancy loss or IVF failure: Any impairment of embryos that is a consequence of the method of biopsy may further undermine the generally unsupportive results of PGS that have been documented in these patients.

Consensus on performing PGS

An assessment of European studies and practices reveals similar concerns voiced by the European Society for Human Reproduction and Embryology (ESHRE) PGD Consortium Steering Committee. The committee recently asserted a comparable opinion about "the insufficient data that demonstrate PGS is indeed a cost-effective alternative for standard IVF."[2] Gleicher and colleagues, in their review of the literature, conclude that **the indications for PGS are currently undefined** and, as such, screening should be considered experimental.

Gleicher's sentiments echo the recommendations of ASRM that, when PGS is considered,

- patients undergo counseling about its limitations, risk of error, and lack of evidence that it improves the live-birth rate
- available evidence does not support improvement in the live birth rate in women of advanced maternal age, who have failed previous implantation, who have experienced recurrent pregnancy loss, or who have experienced recurrent pregnancy loss specifically related to aneuploidy
- decisions about management should not be based on aneuploidy results of prior PGS cycles for a woman who has experienced recurrent implantation failure.

References

1. Staessen C, Platteau P, Van Assche E, et al. Comparison of blastocyst transfer with and without preimplantation genetic diagnosis for aneuploidy screening in couples with advanced maternal age: a prospective randomized controlled trial. Hum Reprod. 2004;19:2849–2858.

2. Sermon KD, Michiels A, Harton G, et al. ESHRE PGD Consortium data collection VI: cycles from January to December 2003 with pregnancy follow-up to October 2004. Hum Reprod. 2007;22:323–336.

FAST TRACK

A 2008 literature review concludes that:
1) the indications for preimplantation genetic screening are, at this time, undefined and
2) PGS should therefore be considered experimental