CPT changes for ObGyns are minor in 2010; the big news is Medicare's toss of consult codes

CMS won't pay for most consultations any longer, but is raising the relative value of all new and established patient services

Current Procedural Terminology (CPT) 2010, which took effect January 1, doesn't bring many changes for ObGyn practice, but there's been a major backpedaling in Medicare coverage of consultations that you must be aware of. In conjunction with this move by the Centers for Medicare & Medicaid Services (CMS), CPT has added a definition of "transfer of care" and established two possible reasons for providing a consultation. I'll have more to report about these important developments later in this article.

Among the changes to billing codes for the work performed in ObGyn: rebundling of commonly performed urodynamics procedures and new codes for revision of a vaginal graft. There is also a new (and unpublished) code for administering the H1N1 influenza vaccine.

Last, CPT has revised the explanation of non–face-to-face prolonged services. Read on!

IN THIS ARTICLE

New codes bundle urodynamic studies—a product of joint CMS and CPT input

The biggest changes in coding for ObGyn procedures are urodynamics study codes. The American Medical Association (AMA) has **1)** created three new codes that represent test bundles and, in the process, **2)** deleted the stand-alone urodynamics codes **51772** (*urethral pressure profile studies [UPP] [urethral closure pressure profile], any technique*) and **51795** (*voiding pressure studies; bladder voiding pressure, any technique*).

These changes were made because the most commonly reported codes for a female patient were billed together 90% of the time (**51726**, **51772**, **51795**, and **51797**); the AMA reasoned that the most frequent combinations were considered overvalued when billed separately—that is, there was no repeat of pre-test and post-test work when these combinations were performed and there was no duplication in the cost of supplies and staff time.

The new bundles were therefore considered to better reflect current medical practice, and the Relative Value Update Committee (RUC) recommended, and CMS accepted, the relative value units (RVU) for the combination codes to reflect the true physician work value and practice expense

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of the combined procedures.

New and revised codes are:

51726 Complex cystometrogram (i.e., calibrated electronic equipment)

51727 …with urethral pressure profile studies (i.e., urethral closure pressure profile), any technique

51728 …with voiding pressure studies (i.e., bladder voiding pressure), any technique

51729 …with voiding pressure studies (i.e., bladder voiding pressure) and urethral pressure profile studies (i.e., urethral closure pressure profile), any technique.

According to the clinical vignette submitted to the AMA for code **51727**, this procedure will include a sustained Valsalva maneuver as part of the urethral closure pressure profile. CPT did, however, retain the add-on code **+51797** (*voiding pressure studies, intra-abdominal [i.e., rectal, gastric, intraperitoneal]*) and has clarified that **51797** may be billed in addition to **51728** and **51729** if a rectal catheter is placed to determine if the patient is straining during the voiding event.

In other words, the add-on code may be reported only when the primary procedure includes a voiding pressure study.

RVU for these new procedures have also been revised (see the **TABLE**, page 52). Notable is the seeming discrepancy in RVU between code **51726** (cystometrogram alone) and the bundled tests. This is the case because the practice expense for **51726** has not reached its final level (the practice expense RVU are being increased or decreased in increments over several years); for 2010 only, therefore, this code will have a higher total RVU value than the new codes (**51727**, **51728**, **51729**), despite having a lower physician work relative value.

The discrepancy will be corrected in 2011, when **51726** will have lower RVU than the other urodynamics combination test codes.

CONTINUED ON PAGE 52

TABLE Changes in 2010 to RVU for urodynamic studies

	2009		2010	
CPT code	Work RVU	Total RVU	Work RVU	Total RVU
51726	1.71	9.02	1.71	8.71
51727	Not applicable (NA)	NA	2.11	8.07
51728	NA	NA	2.11	8.06
51729	NA	NA	2.11	8.14

Laparoscopic revision of a vaginal graft

In 2006, the AMA added the code for a vaginal approach to revising a graft (**57295**, *revision [including removal] of prosthetic vaginal graft; vaginal approach*). Then, in 2007, it added a code for an abdominal approach (**57296**, *revision [including removal] of prosthetic vaginal graft; open abdominal approach*).

Now, you have a code for a laparoscopic approach, completing the code set for this procedure. As with **57295** and **57296**, report the new code when the graft is either revised or removed entirely.

57426 Revision (including removal) of prosthetic vaginal graft, laparoscopic approach

FAST TRACK

Use new CPT code 90470 for intramuscular or intranasal administration of the H1N1 flu vaccine, not established code 90471

Other, miscellaneous changes take effect

OBSTETRIC PANEL

Although code **80055** comprises a battery of tests that are performed routinely on obstetric patients, a new code, **86780**, was created to report syphilis screening **using a treponemal antibody method**, in which IgM and IgG antibodies are measured. This test is not the same syphilis test that is now part of the **80055** panel. CPT has therefore cautioned that, when you use code **86780** instead of the standard syphilis test code **86592**, you should not report the obstetrics panel but, instead, separately report each test performed.

REPRODUCTIVE MEDICINE

New code **89398** (*unlisted reproductive medicine laboratory procedure*) has been added, but CPT still directs billers to use the unlisted miscellaneous pathology test code **89240** to report cryopreservation of reproductive ovarian tissues.

BILLING FOR THE H1N1 INFLUENZA VACCINE

Because of the urgency of collecting data on the H1N1 influenza epidemic, CPT has revised code **90663** to include the H1N1 formulation of the flu vaccine product. In addition, CPT has created a new code, **90470**, for administering the H1N1 flu vaccine, which became valid in September (but which isn't included in the hard-copy version of CPT 2010). The new code is to be used for intramuscular injection or intranasal administration, and includes any time spent counseling.

In addition:

- Do not report established code **90471** (*immunization administration [includes percutaneous, intradermal, subcutaneous, or intramuscular injections]; one vaccine [single or combination vaccine/toxoid]*) when you administer the H1N1 flu vaccine

- Report the vaccine product code only when your practice has purchased the vaccine, or when the payer requires the code with a **0** charge to match the administration code.
- Medicare coding for administering the H1N1 flu vaccine is different than what I've just described. Do not use CPT codes for Medicare patients; instead, code H1N1 flu immunization as:

G9141 Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)

G9142 Influenza A (H1N1) vaccine, any route of administration

Medicare will not reimburse for the vaccine product because it is being given to its providers without cost. Some carriers may require that the new vaccine product code be listed with a **0** charge.

Prolonged inpatient E/M services

CPT has revised guidelines for prolonged services that do not involve direct face-to-face contact with a patient. Keep in mind, however, that, although these changes are welcome, many payers don't reimburse separately for work that isn't performed face to face.

These codes are no longer considered add-on codes; they can be reported on a different date than the related E/M service.

CONTINUED ON PAGE 54

According to CPT, codes **99358** and **99359** are reported when the prolonged time:

- is greater than would be expected for normal pre-service and post-service work associated with the E/M service
- exceeds 30 minutes
- is related to an E/M service that has already occurred, or to one that will occur and represents ongoing patient management (for example, your review of extensive patient records that weren't available at the time of the visit)
- is in addition to any telephone services codes (**99441–99443**)—but not with more specific codes, such as medical team conferences, online medical evaluation, or care plan oversight services, which have no upper limit to the time required to accomplish the service.

Consultation codes and clarifications

Two changes of note, from a CPT perspective, have been made in the area of consultations. CPT has:

- added a definition for a transfer of care
- defined two circumstances under which a consultation can be coded. **These revisions come at the same time Medicare has made the decision to no longer pay for consultations other than tele-health consults** (see following section).

For 2010, CPT defines transfer of care as

> *...the process whereby a physician who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician who agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services.*

The guidelines also explain that **1)** a transferring physician is no longer responsible for caring for the problem for which the patient was referred and **2)** the consultation codes should not be reported by the physician who accepts care.

Two alternative conditions must now apply for a consultation to be considered provided:

- A physician requested an opinion or advice for a specific condition or problem, or
- The consulting physician saw the patient first to determine whether to accept ongoing management of her entire care or of a specific condition or problem (i.e., transfer of care).

The second condition is new; it remains to be seen if payers will accept it as a valid reason to bill for consultation.

As with all billable services, you should ensure that the criteria required by the payer you are billing have been met. CPT also directs that the written request for consultation can be documented by either the requesting or the receiving physician—something that was unacceptable under Medicare guidelines.

Last, CPT has added instructions to clarify the type of consultation code to bill under certain circumstances:

- When the patient is admitted after an outpatient consultation but the physician does not see the patient on the unit on the date of admission, **bill only for outpatient consultation**
- When the patient is seen for an office visit, emergency room visit, or outpatient consult on the date of admission and the physician then sees the patient on the unit that day, **bill only the inpatient consultation or initial hospital care code, whichever applies**. All services that day are used to determine the final level of service.

FAST TRACK

Medicare will no longer recognize or reimburse for codes for outpatient or inpatient consultations

Medicare tilts the playing field on consultations

Although CPT has retained all consultation codes, and although the hope is that commercial payers will continue to reimburse for such services in the near future, the big news is that **Medicare has announced that it will no longer recognize (or reimburse for) codes for outpatient or inpatient consultations**. (Note: This story is still unfolding, however. The changes announced by Medicare that I discuss below are still before Congress as this article goes to press. Although Medicare has, in fact, released the transmittal letter to all carriers instructing them about the changes, Senator Arlen Specter [D-Pa] has introduced an amendment to the Patient Protection and Affordable Care Act [H.R. 3590] to postpone the policy change for 1 year. If Congress has not passed this bill before the end of 2009, the changes go through as planned. Stay tuned for developments!)

Assuming the changes go through, here is what is expected of you in the circumstances of providing consultations and billing Medicare (Medicaid payers aren't required to follow this policy change but may opt to do so):

Outpatients. Document, and report, the appropriate level of visit for a new or established Medicare patient using outpatient codes **99201–99215**.

Inpatients. If you are a non-admitting physician asked to see a patient for the first time, report the appropriate level of initial hospital care (codes **99221–99223**). Note the following three points:

- Initial hospital care includes only three levels of service—not the five levels from which you choose for consultation codes
- The lowest level of history and exam for these initial visit codes is a **detailed history and examination**—no matter the level of medical decision-making. If the level of history or exam is documented lower than "detailed"—say, as "expanded problem-focused"—you are required to report the unlisted E/M code **99499**.
- The admitting physician adds the new Healthcare Common Procedure Coding System (HCPCS) modifier **–AI** (that is, "'A' upper-case 'i'") to the initial visit code, so that Medicare can distinguish the admitting physician from others providing care for the patient.
- All subsequent visits with the inpatient continue to be billed with the subsequent care inpatient codes (**99231–99233**).

Fallout from this change? Medicare is studying the implications of its new policy on secondary payments—that is, when Medicare is the primary payer and there is a supplemental carrier, or when Medicare is the secondary payer. Note: Medicare strongly advises all providers to check with their primary payers, because **1)** Medicare will not accept a consultation code when a primary insurer has paid on that code and **2)** it's doubtful that a commercial payer will accept a consultation code when Medicare has paid for a new or established patient service.

To add to the turmoil…

The CMS has announced that, as a result of the changes in Medicare policy on consultations, it is increasing the relative values for all new and established patient services and initial hospital care. CMS is doing this, however, by reducing the relative values of some consultation codes.

In addition, all surgical procedure codes that carry a 10- or 90-day global period will see an increase in work RVU because of the increase in E/M services that are a part of all global care. Keep in mind that payers who use the Resource-Based Relative Value Scale (RBRVS) to reimburse services will probably adopt the new values when contracts are up for renewal, although many will be unable to do so in the short term.

It also remains to be seen if any commercial payers adopt Medicare policy or continue to pay for consultations. This area might be a contract issue with payers.

FAST TRACK

As a result of changes in Medicare policy on consultations, CMS is increasing RVU for all new and established patient services and initial hospital care—but also reducing the RVU of some consultation codes