

ObGyn Medicare and CPT coding changes that could affect your income in 2015

➔ Although Medicare reimbursement looks bleak for the coming year, awareness of some coding changes could help your bottom line

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Medicare changes kick off a melancholy 2015

Surgical global periods: A move to eliminate them is underway

I begin this article not with a new or revised code, but with an active proposal, which, if implemented, could adversely affect your surgical income in a few short years.

Starting in 2017, the Centers for Medicare and Medicaid Services (CMS) has indicated that it will change all surgical codes to 0-day global periods. They plan on starting by converting 10-day global codes to 0-day codes in 2017, and then move on to the conversion of 90-day global codes in 2018. This is being proposed because of an Office of Inspector General (OIG) finding that many surgeons are not providing the evaluation and management (E/M) services included in the surgical code; therefore, Medicare is reimbursing for surgical procedures at a higher rate than warranted. In addition, the number of assigned visits may no longer reflect current care protocols, which again may mean that Medicare is not paying appropriately.

The immediate effect of this proposal—which has been adopted in the final rule published in the November 13, 2014, Federal Register—would be a reduction in payment for the converted codes due to a decrease in the assigned relative value units (RVUs). In addition, surgeons would need to document and provide the level of service for all preoperative and postoperative care, which may

At least one, if not many, of the coding changes highlighted below is likely to modify the incomes of ObGyns in the upcoming year. Here, I outline the 2015 changes that are most likely to affect your practice to some degree.

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lead some payers to begin scrutinizing both levels of service billed and frequency of visits before and after surgical procedures.

CMS is still looking for any additional comments from physicians on this conversion process and such comments can be submitted electronically through a link at www.regulations.gov. Reference the final rule as CMS-1612-FC in your reply.

Medicare reimbursements poised to decrease in April

The calendar year 2015 conversion factor will remain at \$35.80 from January 1 through March 31, 2015, as mandated by section 101 of the Protecting Access to Medicare Act of 2014. This represents the amount that will be multiplied by the geographically adjusted RVU for a code to determine the final Medicare allowable per procedure or service billed. Effective April 1, 2015, the conversion factor based on the sustainable growth rate (SGR) formula will be only \$28.22—representing a 21.2% decrease—unless Congress acts to override this mandate.

Code bundling leads to lost Medicare compensation

Hysterectomy bundling. Effective October 1, 2014, CMS began permanently bundling anterior/posterior colporrhaphy and colpexy procedures into all vaginal and laparoscopic-assisted hysterectomy codes. By *permanently*, CMS means that no modifier can be used to report Current Procedural Terminology (CPT) code 57260 (*anterior and posterior [A&P] repair*) or codes 57280, 57282, 57283 (*abdominal, and vaginal approach colpexy procedures*) separately when performed with a vaginal or laparoscopic-assisted hysterectomy.

The American Congress of Obstetricians and Gynecologists (ACOG) and the American Urogynecologic Society (AUGS) wrote to CMS in May with regard to these edits and objected to them strongly. These organizations will continue to work with CMS to get them removed. Until then, physicians who perform anterior/posterior colporrhaphy and colpexy procedures with a vaginal

or laparoscopic-assisted hysterectomy will need to clearly make a case in the operative report for the need to perform the additional procedures in order to add a **modifier -22** (*Increased procedural services*) to the hysterectomy code for consideration of additional payment. If an A&P repair is performed, it would not be appropriate to bill only an anterior repair (CPT code **57240**) or a posterior repair (CPT code **57250**) to obtain some separate reimbursement as this would represent inaccurate coding.

Hysteroscopy bundling. Another edit that will affect ObGyns is the bundling of CPT code 58558 (*Hysteroscopy, surgical; with sampling [biopsy] of endometrium and/or polypectomy, with or without D&C*) into codes for hysteroscopic removal of a fibroid (**58561**) and the removal of an impacted foreign body (**58562**).

Previously, these codes could have been billed together, but now only the addition of a modifier -22 to the primary procedure (*myomectomy or foreign body removal*) presents any chance for additional reimbursement. In order to report the modifier, Medicare has indicated that the documentation must clearly support the additional work in accomplishing the primary procedure, including a statement of how much time it added to the normal procedure.

Awareness of new or revised CPT codes could benefit your earnings

The 2015 CPT code set includes several changes, including laboratory and vaccination codes, which may be of interest to your practice. Because of Health Insurance Portability and Accountability Act (HIPAA) requirements, insurers were required to accept new codes on January 1, 2015.

Added: Fetal chromosomal aneuploidy code for genomic sequencing

On January 1, 2014, CPT added a new code to report cell-free DNA to screen for fetal aneuploidy. This new code is 81507 (*Fetal aneuploidy [trisomy 21, 18, and 13] DNA sequence*



CPT has added a new code (81507) to report cell-free DNA to screen for fetal aneuploidy

analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy), and it was added to report the Harmony™ Prenatal Test.

For 2015, another new code, **81420** (*Fetal chromosomal aneuploidy [eg, trisomy 21, monosomy X] genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21*), was added. This code represents a more comprehensive analysis and would therefore not be reported or ordered with code 81507. This new code requires a genomic sequence analysis panel.

HPV revisions extend beyond new codes

The codes for HPV testing have been redefined. These codes have been deleted: 87620-87622 (*Infectious agent detection by nucleic acid [DNA or RNA]; papillomavirus, human, direct probe technique/amplified probe technique/quantification*). In their place are three new codes to choose from:

- **87623**, *Human papillomavirus (HPV), low-risk types (eg, 6, 11, 42, 43, 44)*
- **87624**, *Human papillomavirus (HPV), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)*
- **87625**, *Human papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed.*

This coding change may be significant for payment as some payers will cover testing for high-risk HPV types only, so be sure your practice management team is aware of the latest rules for ordering HPV testing for your patients. Otherwise, patients could be faced with unexpected out-of-pocket expenses.

Egg freezing recognized as mainstream

- Infertility laboratories will be pleased to learn that CPT has changed the status of the code for cryopreservation of oocytes from a Category III to a Category I code. This means that this technology has now proven itself as a mainstream procedure, warranting a Category I CPT code. The new code is **89337** (*Cryopreservation, mature oocyte[s]*), which replaces the deleted code 0059T (*Cryopreservation; oocyte[s]*).

Vaccination codes for 2015

Almost every year new codes are added, and 2015 is no different. This year, you will see codes for:

- **90651**, *Human papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, non-avalent (HPV), 3 dose schedule, for intramuscular use*
- **90630**, *Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use.*

There is also a revision to the flu virus vaccine code 90654 to indicate that it represents a trivalent preservative-free vaccine. See page 22 for a complete list of all the vaccines by trade name and CPT/Medicare *Healthcare Common Procedure Coding System* (HCPCS) codes for the 2014–2015 flu season.

Keep in mind that reporting administration of the flu vaccine is different for Medicare than for private payers. Administration code G0008 and diagnosis code V04.81 (*Need for prophylactic vaccination and inoculation against influenza*) would be reported in conjunction with the appropriate vaccine code for Medicare, while CPT instructs you to report 90471 instead for the administration. When we switch to ICD-10 diagnostic coding on October 1, 2015, the code V04.81 becomes Z23 (*Encounter for immunization*).

Three new codes for anoscopy

The first two codes were formerly Category III codes representing new technology, but now have proven to be more mainstream.

- **46601**, *Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed*
- **46607**, *Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple*
- **0377T**, *Anoscopy with directed submucosal injection of bulking agent for fecal incontinence.*

Three new codes have been added for anoscopy (46601, 46607, and 0377T), reflecting more mainstream use of the technology

Replacement codes for vertebral fracture assessments

If your practice is performing or ordering vertebral assessments for patients, there are two new codes to report. The old code, 77082 (*Dual-energy X-ray absorptiometry [DXA], bone density study, 1 or more sites; vertebral fracture assessment*) for vertebral fracture assessment has been deleted and replaced with:

- **77085**, *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment*
- **77086**, *Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA).*

Coding for breast ultrasound and tomosynthesis get more descriptive—at least for private insurance

The CPT Editorial Panel created three codes

to describe digital breast tomosynthesis services and two new codes for a breast ultrasound.

- **77061**, *Digital breast tomosynthesis; unilateral*
- **77062**, *Digital breast tomosynthesis; bilateral*
- **77063**, *Screening digital breast tomosynthesis, bilateral* (List separately in addition to the code for the primary procedure.)
- **76641**, *Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete*
- **76642**, *Ultrasound, breast, unilateral, ... ; limited.*

Medicare, on the other hand, has decided to create a G code for tomosynthesis, which is the only code that will be accepted for payment if the patient meets her high-risk criteria for performance of this test.

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Under Medicare rules you would report/order the following codes for mammographic services:

- Film (use CPT codes)
 - **77055**, Mammography; unilateral
 - **77056**, Mammography; bilateral
 - **77057**, Screening mammography, bilateral (2-view film study of each breast)

- 2D digital (use G0202, G0204, and G0206)
 - **G0202**, Screening mammography, producing direct digital image, bilateral, all views
 - **G0204**, Diagnostic mammography, producing direct digital image, bilateral, all views
 - **G0206**, Diagnostic mammography,

Coding Table for 2014–2015 Flu Season

| Trade name (vaccine abbreviation) | How supplied | Age group | CPT/HCPCS product code |
|--------------------------------------|--------------------------------------------|---------------------|------------------------------------|
| Afluria (IIV3) | 0.5 mL (single-dose syringe) | ≥9 years | 90656 |
| | 5.0 mL (multi-dose vial) | | 90658 Q2035 (Medicare) |
| Fluarix (IIV3) | 0.5 mL (single-dose syringe) | ≥3 years | 90656 |
| Fluarix (IIV4) | 0.5 mL (single-dose syringe) | ≥3 years | 90686 |
| FluLaval (IIV3) | 5.0 mL (multi-dose vial) | ≥3 years | 90658 Q2036 (Medicare) |
| | 5.0 mL (multi-dose vial) | | 90688 |
| FluMist (LAIV4) | 0.2 mL (single-use nasal spray) | 2 through 49 years | 90672 |
| Fluvirin (IIV3) | 0.5 mL (single-dose syringe) | ≥4 years | 90656 90658 Q2037 (Medicare) |
| | 5.0 mL (multi-dose vial) | | |
| Flucelvax (ccIIV3) | 0.5 mL (single-dose syringe) | ≥18 years | 90661 |
| Flublok (RIV3) | 0.5 mL (single-dose vial) | 18 through 49 years | 90673 |
| Fluzone (IIV3) | 0.25 mL (single-dose syringe) | 6 through 35 months | 90655 |
| | 0.5 mL (single-dose syringe) | ≥3 years | 90656 |
| | 0.5 mL (single-dose vial) | ≥3 years | 90656 |
| | 5.0 mL (multi-dose vial) | 6 through 35 months | 90657 |
| | 5.0 mL (multi-dose vial) | ≥3 years | 90658 Q2038 (Medicare) |
| Fluzone (IIV4) | 0.25 mL (single-dose syringe) | 6 through 35 months | 90685 |
| | 0.5 mL (single-dose syringe) | ≥3 years | 90686 |
| | 0.5 mL (single-dose vial) | ≥3 years | 90686 |
| Fluzone intradermal | 0.1 mL prefilled microinjection system | 18 through 64 years | 90630 |
| Fluzone High-Dose (IIV3) | 0.5 mL (single-dose syringe) | ≥65 years | 90662 |
| Fluzone Intradermal (IIV3) | 0.1 mL (single-dose microinjection system) | 18 through 64 years | 90654 |

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producing direct digital image, unilateral, all views

- 3D screening (use G0202 for 2D digital plus the new CPT code 77063 for 3D)
 - **77063**, *Screening digital breast tomosynthesis, bilateral* (List separately in addition to the code for the primary procedure.)
- 3D diagnostic (use G0204 or G0206 for the 2D digital plus the new G code G0279 for 3D)
 - **G0279**, *Diagnostic digital breast tomosynthesis, unilateral or bilateral*.

Modifier 59 becomes more specific

Another Medicare coding change that may affect ObGyns is the addition of new Medicare modifiers that are intended to eventually replace the modifier -59. This new list of modifiers will need to be appended to bundled procedures to more clearly explain why the secondary procedures should be paid separately. At the most recent American Medical Association (AMA) CPT symposium in Chicago, Illinois, CMS medical directors indicated that the new modifiers should be used only when the clinician is given instructions to do so by the carrier. Until then, the modifier -59 should continue to be used by most clinicians.

Here are the new modifiers, with an example of their use with currently bundled procedures that allow a modifier -59 to be used under certain circumstances:

- **-XE: Separate encounter** (A service that is distinct because it occurred during a separate encounter.) For instance, a patient presents to the office in the morning to have an abscess on her labia near her urethra incised and drained (56405). She returns in the afternoon to have a temporary catheter inserted because she states she cannot urinate and you decide to put in a temporary Foley catheter (51702) until the swelling has gone down. Add the modifier XE to 51702 to indicate it was performed at a different patient encounter.
- **-XP: Separate practitioner** (A service that is distinct because it was performed by a

different practitioner.) Normally, Medicare will reimburse an unaffiliated clinician for performing a procedure that is bundled, since the bundling edits apply to the billing surgeon. But when two physicians from the same practice each are performing a different procedure at the same operative session that would otherwise be bundled, this new modifier will make that clear.

For example, Dr. Bates is performing a laparoscopic paravaginal defect repair (57423) and calls Dr. Clark, a urogynecologist in his practice, to remove severe adhesions from the ureters. The claim should go in under the same tax ID number, with the code 50715 listed first (as it has greater RVUs) and code 57423 reported with the -XP modifier.

- **-XS: Separate structure** (A service that is distinct because it was performed on a separate organ/structure.) Dr. Scott is performing the removal of endometrial implants around the left fallopian tube and in the cul-de-sac and notices that the right fallopian tube appears closed. He performs chromotubation on the right fallopian tube and notes that the right tube is blocked.
- **-XU: Unusual non-overlapping service** (The use of a service that is distinct because it does not overlap usual components of the main service.) Mary has Medicare coverage and presents at 20 weeks 4 days gestation with bleeding and labor pains. Her examination shows bulging membranes that rupture when you attempt to remove the cerclage suture. You note a large rent in the cervix, but cannot get to the cerclage sutures as the patient is in active labor and beginning to bear down. The fetus and placenta are delivered a short time later through the rent in the cervix. You repair the rent in the cervix following delivery.

In this case, code 59400-52 (reduced services since the patient delivered at 20 weeks and there were reduced antepartum services), and 57720-XU because the repair of the cervix is not part of the usual services for a vaginal delivery. ❌



New Medicare modifiers to augment -59 should be used only when the carrier specifically requests them