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Pelvic repair: Update on correct coding

CPT codes that cover many aspects of pelvic prolapse surgery have changed—in ways that significantly influence how payers reimburse you. Here are the details.

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In a September 2007 supplement to OBG Management, "Best options, techniques, and coding tips for pelvic prolapse repair," I answered frequently asked questions about Current Procedural Terminology (CPT) codes and documentation for these procedures. In this follow-up supplement, I explain a number of changes to those codes that have occurred in the interim and that appear in the CPT 2010 Professional Edition, and answer relevant questions that have been posed by gyn surgeons and by billing staff in their practices.

Q I've been told that CPT codes relating to the repair of paravaginal defects have changed since the 2007 supplement to OBG Management on pelvic prolapse repair was published. What are those changes? And what are the implications of the new codes for my practice?

A CPT now includes three distinct codes for repairing a paravaginal defect. The correct CPT code (I'll simply say "code" throughout this supplement) is selected based on the approach you've taken:

57284 Paravaginal defect repair (including repair of cystocele, if performed); open abdominal approach
57285 Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach
57423 Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach

The first thing you'll notice is that each code explicitly states that the paravaginal defect repair also repairs a cystocele; this means that you are not able to bill a cystocele repair separately from the paravaginal repair. Code **57240** (*anterior colporrhaphy, repair of cystocele with or without repair of urethrocele*), therefore, will always be bundled.

CPT also now includes notes after each of these codes that indicate which codes should *not* be billed additionally. These bundled codes are, predominantly, those that include urethropexy (e.g., a Marshall-Marchetti-Krantz or Burch procedure) as well as combination codes that include an anterior colporrhaphy.

The good news? With the addition of a code for the vaginal approach to paravaginal defect repair, the sling procedure for stress urinary incontinence (**57288** [*sling operation for stress incontinence (e.g., fascia or synthetic*]) can be reported separately, no matter which approach is performed. If mesh is used during the repair to support weakened or attenuated pubocervical tissue, the add-on mesh code **57267** can be reported additionally, as long as you are reporting the vaginal approach to paravaginal repair. CPT does *not* include abdominal or laparoscopic paravaginal defect repair among the list of procedures for which **57267** may be reported additionally.

Q Post-hysterectomy, a patient in our practice returned for follow-up with vaginal vault prolapse. My physician dictated that she performed a sacrospinous ligament fixation to restore the apex/vault of the vagina using a mesh system. In that dictation, she described placing and suturing mesh over the apex of the vagina as well as along the posterior vaginal wall. We billed the following codes; can you confirm that these are correct?

57282 Colpopexy, vaginal
57250 Repair of rectocele
57267x1 Insertion of mesh

A The main coding issue here is whether your physician has provided medical justification for all the procedures you intend to report. Mesh systems can be used to repair multiple

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prolapse problems that a given patient can have. The systems are versatile: They can be custom-fitted to the patient's needs or can be used as is, with the additional mesh simply being tacked in place.

From your question, it appears that the physician documented only vaginal vault prolapse (International Classification of Diseases, 9th Revision, Clinical Modification [ICD-9-CM] code **618.5** [*vaginal vault prolapse after hysterectomy*]). To bill a rectocele repair, she must have dictated that one was present, and she must also have indicated why additional mesh was required to reinforce the repair of the posterior vaginal wall. In other words, you would have to link code **57250** to a diagnosis of **618.04** (*rectocele*) and the add-on code, **57267**, to a diagnosis of **618.82** (*incompetence or weakening of rectovaginal tissue*). The reverse would also be true.

In some cases, a mesh system is used to repair an existing rectocele; excess mesh is then tacked to the vaginal vault. Because a colpopexy cannot be reported without the presence of vault prolapse, documentation by the physician is crucial to getting all the surgical procedures that were performed reimbursed.

Q Examination of my patient revealed cystocele, rectocele, vaginal vault prolapse, and stress urinary incontinence. I performed a urinary sling procedure with mesh (code **57288**); a vaginal paravaginal defect repair with mesh (codes **57285** and **57267**); rectocele repair with mesh (**45560** and **57267**); and vaginal vault repair with mesh (**57282**).

Is this coding correct?

Also, does the order in which one lists codes matter?

A First, I assume that you performed an extraperitoneal colpopexy, because you indicate that you reported 57282 for the vault repair. Reporting **45560** for the rectocele repair, however, will depend on your documentation of how you performed the procedure. Note that **45560** represents a gastrointestinal system procedure—*not* a female genitourinary surgical procedure. In the CPT book, **45560** appears under the heading "Rectum, repair"; a note after this code states that, for repair of a rectocele with a posterior colporrhaphy, the correct code is **57250** (*posterior colporrhaphy, repair of rectocele with or without perineorrhaphy*). Code **45560** represents a procedure that repairs a rectocele by plicating rectal mucosa; typically, this is performed on a patient who complains of fecal incontinence.

Second, the order in which codes are placed on a claim form *does* matter: Most payers pay the full allowable amount for the first listed procedure and discount any procedures listed after it. In the scenario you describe (assuming that you documented a posterior colporrhaphy and established medical need for the mesh add-on), codes should be entered as follows, in this order:

57288
57285-51
57250-51
57282-51
57267 x 2

Q Looking at codes **57282** (*colpopexy, vaginal; extraperitoneal approach*) and **57283** (*colpopexy, vaginal; intraperitoneal approach*), what is the difference between "intraperitoneal" and "extra-peritoneal"?

A CPT added **57283** because it noted that some surgeons preferred to attach the vaginal vault to the uterosacral or levator, rather than sacrospinous, ligaments. This type of attachment requires additional work by the surgeon to reach the ligament. The intraperitoneal approach requires:

- opening and entering the peritoneal cavity through the vagina
- packing bowel
- identifying both ureters.

The peritoneal cavity does not need to be entered in order to use the sacrospinous or ileococcygeal ligaments.

To capture this additional work, **57283** has greater relative value units assigned to it than **57282** does. For that reason, documentation by the physician is crucial in selecting and billing the correct code to ensure fair and timely reimbursement for the procedure performed.

Q I performed a cystocele repair with mesh approximately 10 weeks ago. I saw the patient today in the office, and she complained of discomfort in the vaginal area. During examination, I noted a piece of mesh extruding into the vagina. I trimmed the extruded mesh and prescribed a conjugated estrogens vaginal cream (Premarin).

I billed codes **57295** and **99213-25;** was that correct?

A Your main obstacle to reimbursement for the revision you performed is the *place of service*. Under the Resource-Based Relative Value Scale (RBRVS) system, The Center for Medicare & Medicaid Services (CMS) did not develop non-facility (i.e., office, etc.) practice expense relative value units for some services that, either by definition or in practice, are never (or rarely) performed in a non-facility setting.

Code **57295** (*revision [including removal] of prosthetic vaginal graft, vaginal approach*) represents such a service. You might receive a denial for having billed for this service performed in the office.

Look at the relative value assigned to **57295**: The work you performed trimming the excess mesh with scissors, without anesthesia, in the office does not equate to the estimated physician work required to perform such a revision in a facility, under anesthesia.

Assuming that the woman is not a Medicare patient, and that your payer accepts the office as the site of service, it would probably have been appropriate to add modifier **-52** (*reduced services*) to the procedure code.

Another coding option would have been for you to report the unlisted code **58999**, and compare the work to either **57130** (*excision of vaginal septum*) or **57135** (*excision of vaginal cyst or tumor*) so that the payer could more accurately assess the charge you billed for performing this procedure in the office.

One more point about your case: You say that the patient

was 10 weeks postop when you detected the extruded mesh. This means that she was still in the global period of the original surgery. Although what you found is certainly a complication of the original procedure, the office visit would not have been paid above the amount reimbursed for the original procedure for a Medicare patient. In the office place of service, they would also have denied the procedure code because, under their rules, the patient must be taken back to the hospital OR before they will reimburse for a complication during the global period. Some commercial payers may allow the office visit in addition to the procedure, but usually it will be bundled, since the complication was related to the original surgery, and the examination was related to performing the office procedure. Under CPT coding rules, you cannot bill an E/M service and a same-day procedure unless the E/M service is separate and significant from the procedure. Medicare will not pay at all for the E/M service if the evaluation was directly related to doing the procedure on the same day—that includes looking to see if there was a problem and then fixing it, with informed consent and instructions about care afterwards.

Whenever you report a "surgical" code within the global period of the original procedure, you must append a modifier. Modifier **-78** (*unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period*) would be appropriate if you performed this revision in a designated procedure room. Additional documentation and explanation may be required, however, because you performed it in the office.

Q Codes **57268** (*repair of enterocele, vaginal approach*) and **45560** (*repair of rectocele*) are each designated as a "separate procedure." What does "separate procedure" mean? What are its implications when coding these procedures?

A "Separate procedure" is not an easy concept to grasp. To keep it simple: CPT identifies certain procedures with this designation because they are commonly performed as an integral component of another total service or procedure. According to CPT guidelines, a code with a "separate procedure" designation should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

For example: It is obvious that the repair of an enterocele is an integral part of any CPT procedure that included enterocele repair (e.g., **58263** [*vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele*]). Billing **58262** (*vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)*) and **57268** for the "separate" enterocele repair would be equally incorrect, however, because you would be unbundling the more comprehensive procedure.

Your first solution is to bill the most extensive procedure, if such a code is available. When that isn't possible, you may have the option of letting the payer know that this "separate procedure" was done independently or considered to be unrelated or distinct from other procedures you performed at the time. This would be the case when the "separate procedure" represented a different session; a different procedure or surgery; a different site or organ system; a separate incision/excision; a separate lesion; or a separate injury. You would then add modifier **-59** (*distinct procedural service*) to the specific "separate procedure" code. Modifier **-59** must be supported by clear documentation, however, and should be considered the modifier of last, not first, resort.

Q I recently performed a cystocele repair with mesh and billed **57240** (*anterior colporrhaphy, repair of cystocele with or without repair of urethrocele*), **57267** (*insertion of mesh*) and ICD-9-CM code **618.01** (*cystocele without mention of uterine prolapse, midline*). Insertion of the mesh was denied by the patient's insurer for "lack of medical necessity." Why?

A You raise the very real issue of medical necessity and how best to establish it with payers for each procedure you perform.

A cystocele can usually be repaired with a standard colporrhaphy. On occasion, however, pubocervical tissue (or rectovaginal tissue when posterior colporrhaphy is performed) is judged to be weak and inadequate for repair, and the surgeon opts to insert an intervening prosthetic material, such as an autograft, allograft, xenograft, or synthetic mesh. Code **57267** is to be reported for this additional procedure and, like the surgery itself, requires its own ICD-9-CM diagnostic code to establish medical justification.

Simply reporting that the patient had a cystocele does not establish medical need for the graft; that is why the additional service was denied in the case you describe.

On the other hand, communicating to the insurer that the patient's weakened tissue necessitated adding the graft to the repair *does* establish medical need. Two ICD-9-CM diagnosis codes could apply should the surgeon document such weakness in the operative note:

618.81 Incompetence or weakening of pubocervical tissue

is reported when the mesh is added to an anterior wall.

618.82 Incompetence or weakening of rectovaginal tissue

clearly establishes the need for mesh when a posterior repair was performed. ■