Keeping up with CPT 2003

What do obstetric ultrasounds, large-uterus vaginal hysterectomies, and body-fat-composition tests have in common? They all got coding makeovers for 2003. Read on for details on these and more OBG-specific changes.

There’s good news and bad news for OBG coders in 2003. The bad news is that the wealth of new Current Procedural Terminology (CPT) codes means practices must make some serious changes to their office procedures encounter form. The good news is that these long-awaited changes should make it easier for physicians to communicate to insurers the type and difficulty of many routine procedures.

In addition to the OBG-relevant changes highlighted in this article, a wide range of other code and editorial updates have been made. For instance, CPT has deleted the optional 5-digit modifier codes that could have been used instead of the 2 digit modifier. (For example, CPT defined that the modifier to signify a separate and significant E/M service could be reported as either modifier -25 or by using the code 09925. With CPT 2003, only the modifier would be reported.) This change was necessary because the uniform electronic claim set up as a result of Health Insurance Portability and Accountability Act regulations can only accommodate 2-character modifiers. Coders should therefore review CPT 2003 in full to ensure that all relevant changes are captured.

A note about formatting: Codes marked in red are new in CPT 2003, while blue codes have been revised since the last edition. When a code has 1 or more indented codes following it, the indented text replaces everything following the semicolon in the initial code.

Updated Pap smear codes

Pap smear codes have been revised to more clearly represent current screening techniques. Codes 88144 and 88145—which described the ThinPrep (Cytyc Corporation, Boxborough, Mass) manual screening and computer-assisted rescreening—have been deleted, but 2 new codes have been added:

- **88174** Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation;

- Ms. Witt, former program manager in the department of coding and nomenclature at the American College of Obstetricians and Gynecologists, is an independent coding and documentation consultant.
Keeping up with CPT 2003

screening by automated system, under physician supervision
88175 with screening by automated system and manual rescreening, under physician supervision
For manual screening, coders should refer to codes 88142 and 88143.

Counting leukocytes, testing semen 89055 leukocyte count, fecal
This new code, added to describe laboratory testing for fecal leukocytes, replaces the Health Care Financing Administrators Common Procedure Coding System (HCPCS) Level II G code G0026 (fecal leukocyte examination).

89300 Semen analysis; presence and/or motility of sperm including Huhner test (post coital);
89310 Motility and count, not including Huhner test.
While 89300 has not changed, 89310 was revised to specifically exclude Huhner testing. It will replace the HCPCS Level II G code G0027 (semen analysis presence and/or motility of sperm excluding Huhner test).

The biggest change: diagnostic ultrasound codes
Possibly the most significant change in CPT coding comes in the area of obstetric ultrasound. These codes have been revamped to allow maternal-fetal specialists to report accurately the ultrasound procedures they perform. A new guideline note that precedes this section gives a clear definition of what the codes in that section include. For instance, the guidelines state regarding 2 of the codes:
“Codes 76801 and 76802 include determination of the number of gestational sacs and fetuses, gestational sac/fetal measurements appropriate for gestation (<14 weeks 0 days), survey of visible fetal and placental anatomic structure, qualitative assessment of amniotic fluid volume/gestational sac shape and examination of the maternal uterus and adnexa.”

Coders should spend time reviewing this section to ensure correct billing. Please also note that the codes 76802, 76810 and 76812 are designated by CPT as “add-on” codes. This means that they do not require a modifier to indicate a multiple procedure (i.e., modifier -51):
Keeping up with CPT 2003

Keeping up with CPT 2003
time with image documentation,limited (e.g., fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses
(Use 76815 only once per exam, not per element.)

**76816** Ultrasound, pregnant uterus, real
time with image documentation,
follow-up (e.g., reevaluation of
fetal size by measuring standard
growth parameters and amniotic fluid volume, reevaluation of
organ system[s] suspected or
confirmed to be abnormal on a
previous scan), transabdominal
approach, per fetus
(Report 76816 with modifier -59 [distinct pro-
cedure] for each additional fetus examined in a
multiple pregnancy.)

**76817** Ultrasound, pregnant uterus, real
time with image documentation,
transvaginal
(If transvaginal examination is done in addition
to transabdominal obstetrical ultrasound exam,
use 76817 as well as the appropriate transabdom-
inal exam code. For nonobstetrical transvaginal
ultrasound, use code 76830 [ultrasound, trans-
vaginal].)

**Multiple births.** There has also been
a change in CPT instructions for coding mul-
tiple fetuses when performing a fetal biophysical
profile (BPP). In the past, CPT instructed
coders to use modifier -51 (multiple proce-
dures) with each BPP code reported at that
session after the first fetus (e.g., 76818, 76818-
51 for twins). Now CPT indicates that a BPP
done on additional fetuses should be reported
separately by adding the modifier -59 (distinct
procedure) to code 76818 (fetal biophysical
profile; with non-stress testing) or 76819 (fetal
biophysical profile without non-stress testing).

**Transvaginal examination.** CPT now
explicitly states that if a transvaginal examina-
tion is done in addition to a transabdominal
gynecologic ultrasound exam, coders should
use code 76830 in addition to the appropriate
transabdominal exam code (76856-76857).

**Bone density studies**

CPT now differentiates between a study
done on the axial skeleton and one done
on the peripheral skeleton, thanks to the revi-
sion of 1 code and the addition of a second:

**76070** Computed tomography, bone
mineral density study, 1 or more
sites; axial skeleton (e.g., hips,
pelvis, spine)

**76071** appendicular skeleton
(peripheral) (e.g., radius,
wrist, heel)

**Vaginal hysterectomy**

The codes listed below were revised or
added to account for the additional work
involved in removing a large uterus vaginally.
Report these new codes when the operative
report includes a description of how the
uterus was removed—by bisection, morcella-
tion, or myomectomy and coring—and con-
ffirms the weight of the uterus. As with an
abdominal hysterectomy, fibroid removal
prior to uterus removal is considered an inte-
gral part of the procedure, and therefore is not
reported separately. Note that if the weight of
the uterus is not known at the time the proce-
dure is coded, the default would be to code for
the uterus that weighs 250 g or less.

**58550** Laparoscopy, surgical, with vagi-
nal hysterectomy, for uterus 250
grams or less;

**58552** with removal of tube(s)
and/or ovary(s)

**58553** Laparoscopy, surgical, with vaginal
hysterectomy, for uterus greater
than 250 grams;

**58554** with removal of tube(s)
and/or ovary(s)
Vaginal hysterectomy for uterus 250 grams or less; with removal of tube(s) and ovary(s) with removal of tube(s), and/or ovary(s), with repair of enterocele with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control with repair of enterocele Vaginal hysterectomy for uterus greater than 250 grams, abdominal approach

Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas

5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams

Coders should note that code 58551 (laparoscopy, surgical; with removal of leiomyomata [single or multiple]) has been deleted. In its place coders would report either 58545 or 58546. CPT has also clarified that the “abdominal approach” myomectomy codes should not be reported in addition to the abdominal hysterectomy codes (58150-58240).

Colposcopy procedures

CPT 2003 contains new and revised codes for colposcopy of the vulva, cervix, and vagina:

Colposcopy of the vulva;

Colposcopy of the entire vagina, with cervix if present;

Colposcopy of the cervix including upper/adjacent vagina;

Colposcopy of the cervix and endocervical curettage

Colposcopy of the cervix with biopsy(s) of the cervix and endocervical curettage

Colposcopy of the cervix with loop electrode biopsy(s) of the cervix

CONTINUED
Coders should note the following guidelines:

- If colposcopy is performed on both the vagina and vulva, both procedures may be reported, with modifier -51 added to the code of lesser relative value.
- A superficial cervical examination is considered part of a complete vaginal examination (codes 57420 and 57421), if performed.
- If the main purpose of the examination is to evaluate the cervix, not the vagina, only the cervical colposcopy codes (54452-57461) would be reported.
- Colposcopy of the cervix codes (54452-57461) include an examination of the entire cervix as well as the upper/adjacent portion of the vagina.
- Code 57460 has been revised and code 57461 added to clarify the 2 different cervical loop electrode excision procedures that might be done in conjunction with colposcopy. Code 57460 includes removal of the exocervix and a portion of the transformation zone, if necessary. Code 57461 represents a conization procedure that takes all of the exocervix, the transformation zone, and some or all of the endocervix.
- An endocervical curettage is included as part of a conization; therefore code 57456 would not be reported in addition to code 57461.

**Bladder procedures, incontinence testing**

Three new codes were developed to replace HCPCS code G0002 (office procedure, insertion of temporary indwelling catheter, Foley type [separate procedure]). These would be reported only when the catheter insertion is an independent procedure, not part of another procedure.

Codes 53670 and 53675 (both catheterization procedures listed under the heading "urethra") have been deleted. In their place are new codes that are more appropriate.

**Urodynamics.** Code 51798 (measurement of postvoiding residual urine and/or bladder capacity by ultrasound, nonimaging) replaces code 78730, which had been inaccurately placed in CPT’s nuclear medicine section, as well as the HCPCS Level II G code G0050 (measurement of postvoiding residual urine and/or bladder capacity by ultrasound, nonimaging). The new code represents a more accurate description of this noninvasive procedure, which uses a handheld Doppler ultrasonic device. This code represents only the technical component of the procedure, and is not associated with physician work that involves interpretation because the device gives a numeric result.

**Abdominal procedures**

**49419** Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (i.e., totally implantable)

This would be reported by gynecologic oncologists who want to provide intraperitoneal chemotherapy in women with ovarian or primary peritoneal cancer. The procedure requires an incision and the creation of a pocket for the reservoir.

For the removal of these devices, use code 49422.

**Blood collection**

**36415** Collection of venous blood by venipuncture
36416  Collection of capillary blood specimen (e.g., finger, heel, ear stick)

Code 36415 was revised and code 36416 was added to better assign blood collection methods, and so that HCPCS Temporary G code G0001—routine venipuncture for collection of specimen(s)—could be deleted.

Excising skin lesions

Coders now choose which skin-lesion code to report based on the total amount of tissue removed at the site during the operative session, not just lesion size. These codes were revised so it’s clear they describe a full-thickness removal of the lesion, including the margin, along with simple closure (if performed).

11420  Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less

11421  excised diameter 0.6 to 1.0 cm

11422  excised diameter 1.1 to 2.0 cm

11423  excised diameter 2.1 to 3.0 cm

11424  excised diameter 3.1 to 4.0 cm

11426  excised diameter over 4.0 cm

11620  Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less

11621  excised diameter 0.6 to 1.0 cm

11622  excised diameter 1.1 to 2.0 cm

11623  excised diameter 2.1 to 3.0 cm

11624  excised diameter 3.1 to 4.0 cm

11626  excised diameter over 4.0 cm

When a Category III code accurately describes the procedure or service performed, use that code rather than an unlisted code. CPT adds Category III codes to its database in January and July. To check on any Category III code updates, go to www.ama-assn.org/ama/pub/article/3885-4897.html:

0028T  Dual energy x-ray absorptiometry (DEXA) body composition study, 1 or more sites

This code represents the assessment of body fat composition—a procedure popular with athletes, but one unlikely to be covered by insurers in most cases. Its medical indications are generally children with growth disorders; adults with growth hormone deficiency; and patients with eating disorders, with rapid intervention or unintentional weight loss, or on long-term total parenteral nutrition.

0029T  Treatment(s) for incontinence, pulsed magnetic neuromodulation, per day

This code would be used to report treatment with the NeoControl system (Neotonus, Inc., Marietta, Ga), in which the patient sits in a chair designed to induce contractions in the pelvic floor and urinary sphincter muscles via a pulsed magnetic field.

0030T  Antiprothrombin (phospholipid cofactor) antibody, each Ig class

Code 0030T represents an antibody test to assess patients who may be at risk for, among other things, fetal loss.

0031T  Speculoscopy;

0032T  with directed sampling

These were added to report procedures, such as PapSure (Watson Diagnostics, Corona, Calif), in which light is used to examine the cervix for abnormal lesions and aid in specimen collection.

Ms. Witt reports no financial relationship with any companies whose products are mentioned in this article.