FOR 2012

Changes to the CPT code set and Medicare billing

Revisions to codes and guidelines and new codes came into force on January 1. They regard the services you provide for contraceptive implants, injection of denosumab, and enterocele repair, among others.

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The code set of the 2012 Current Procedural Terminology (CPT) includes changes of interest to ObGyns, including 1) clarification of guidelines for evaluation and management (E/M) services and 2) bundling problems in regard to vaginal hysterectomy and enterocele repair.

Coding for insertion and removal of contraceptive implants also became a little more ... interesting.

The changes to the CPT code set took effect January 1. Because of Health Insurance Portability and Accountability Act (HIPAA) requirements, insurers were required to accept new codes on that date.

Note also that, this year, several changes have been made to Medicare billing rules, particularly in regard to 1) payment levels and 2) new “J” codes to report drug injections.

EVALUATION AND MANAGEMENT SERVICES

This year, it won’t be code changes that might trip you up; rather, revision of some guidelines—particularly for E/M services—might cause problems.

The American Medical Association’s Editorial Panel has clarified that a “new patient visit” means that the patient has not received any professional services from the physician, or another physician of the same specialty and subspecialty who belongs to the same group practice, within the past 3 years.

This particular clarification might (or might not) improve your ability to bill new patient services for subspecialty groups within the practice, because it will be the payer who decides which subspecialties they recognize above the general ObGyn classification. For example, urogynecologists are seldom recognized as a distinct subspecialty from general ObGyn, whereas...
Consequently, this might be a good time to revise existing contracts with payers to add subspecialty groups for additional recognition.

**Prolonged services.** The Editorial Panel also revised descriptors for the prolonged physician codes 99354 to 99359. The change involves two actions:

- deleting the word “physician,” which opens the door for other qualified health-care professionals to submit the codes when appropriate
- substituting “direct patient contact” for “face-to-face” requirements from the descriptors to incorporate unit/floor time into the definition, when it is appropriate to provide prolonged services in a facility.

In other words, “direct patient contact” still means that a “face-to-face” service has been provided, but also incorporates unit/floor time when appropriate. For example: 99354 reads: *Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (list separately in addition to code for office or other outpatient E/M service).*

This revision leads to an additional change for 2012: addition of typical times to initial observation codes 99218 to 99220. These typical times match those assigned to initial hospital visits, for which: 99218 is 30 minutes 99219 is 50 minutes 99220 is 70 minutes. Because observation care takes place in a facility, not in an office, unit/floor time may be counted toward the typical time in addition to any prolonged face-to-face service (except, as noted, for Medicare patients).

**Implantable contraceptives**

With the deletion of CPT codes 11975 and 11977, you now have to look to the existing code 11981 (*Insertion, non-biodegradable drug delivery implant*) when you insert an implantable contraceptive. Code 11976 (*Removal, implantable contraceptive capsules*) remains a valid CPT code, however, because some patients still have the older Norplant capsule systems that will need to be removed.

For a patient who comes to the office to have Norplant capsules removed and has a contraceptive rod inserted at the same visit, CPT instructs you to report 11976 and 11981: Submit the claim as 11976, 11981-51 (*Multiple procedures*). Note: The diagnosis code for this combination service is V25.13 (*Encounter for removal and reininsertion of intrauterine contraceptive device*).

When a patient visits your office to have a contraceptive rod removed, report 11982 (*Removal of a non-biodegradable drug delivery implant*) or 11983 (*Removal with reininsertion of a non-biodegradable drug delivery implant*).

**Repair of an Enterocele**

An existing parenthetical note for code 58263 (*Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(ies), with repair of enterocele*) instructed coders not to report code 58263 with code 57283 (*Colpopexy, vaginal; intraperitoneal approach [uterosacral, levator myorrhaphy]*) because a vaginal hysterectomy with enterocele would not be an integral part of an intra-peritoneal procedure, the note was revised to indicate that 57283 should not be reported with any CPT combination code that includes enterocele repair. Codes affected are: 57556, 58263, 58270, 58280, 58292, and 58294.

**Wound Repair**

CPT has revised the instructions for listing services at the time of wound repair. In 2011, you would have reported each separate repair with a modifier -51 (*Multiple procedures*); in 2012, however, you report modifier -59 (*Distinct procedural services*) instead when you have repaired multiple wounds.
Relative value units (RVUs) for most obstetric codes were increased effective January 1. This revaluation was done to keep up with increases in the RVUs for individual E/M codes that make up part of the global obstetric services.

Changes to Medicare billing

72-HOUR PAYMENT WINDOW
If your practice is wholly owned or operated by a hospital and you provide any service, including E/M services, that are related to an admission to the hospital within a 72-hour period of the initial service, you will have to start adding a modifier –PD (from physician’s office to diagnostic or therapeutic site) to your services to have them paid. This modifier will reimburse you at the lower facility rate, however, even if your practice is not located anywhere near the hospital proper. Be aware that the diagnosis listed for preadmission services does not have to be identical to the one listed for admission for this rule to apply; Medicare is looking for related services.

Best advice. Hold a claim for 3 days if you think it’s possible that the patient will be admitted.

OBSTETRIC SERVICES
Good news. Relative value units (RVUs) for most obstetric codes were increased effective January 1. This revaluation was done to keep up with increases in the RVUs for individual E/M codes that make up part of the global obstetric services.

VACCINATION
A new influenza vaccine code has been added to CPT: 90654 (Influenza virus vaccine, split virus, preservative free, for intradermal use)

Two older codes, put into CPT to address last year’s H1N1 flu strain, have been deleted. Those codes are:

90470 H1N1 immunization administration (intramuscular, intranasal), including counseling when performed

90663 Influenza virus vaccine, pandemic formulation, H1N1.

PARACENTESIS AND LAVAGE
Gynecologic oncologists who see patients who have ascites should be aware that codes 49080 and 49081 (Peritoneocentesis, abdominal paracentesis, or peritoneal lavage; initial [...] subsequent) have been deleted. Three new codes have been created to replace them:

49082 Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance

49083 Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance

49084 Peritoneal lavage, including imaging guidance, when performed.

The precise changes to selected OB RVUs are listed in the TABLE that appears in the Web archive version of this article at obgmanagement.com. Check your contracts with payers to ensure that those who are using the resource-based relative value scale (RBRVS) system to set fee allowances are increasing the amounts that you are being reimbursed in 2012.

CHANGES TO HCPCS J CODES
Two changes to the Healthcare Common Procedure Coding System (HCPCS) “J”-code bank might have an impact on your practice:

C9272 has been replaced by J0897 (injection, denosumab, 1 mg)

Q2042 has been replaced by J1725 (injection, hydroxyprogesterone caproate, 1 mg).

CMS error? Note, however, that the hydroxyprogesterone code is defined as 1 mg even though the typical dosage is 250 mg/mL. It might be that CMS misstated the dosage, and meant to write “1 mL.” Always check with your payer before billing this drug, because billing it with the quantity of “250” might trigger a denial.
Relative value units for most OB codes have gone up in 2012

<table>
<thead>
<tr>
<th>CPT code</th>
<th>2011 work RVUs</th>
<th>2012 work RVUs</th>
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</thead>
<tbody>
<tr>
<td>59400  Global vaginal delivery</td>
<td>28.69</td>
<td>32.16</td>
</tr>
<tr>
<td>59409  Vaginal delivery only</td>
<td>12.82</td>
<td>14.37</td>
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<tr>
<td>59410  Vaginal delivery with PP only</td>
<td>16.07</td>
<td>18.01</td>
</tr>
<tr>
<td>59412  External cephalic version</td>
<td>1.53</td>
<td>1.71</td>
</tr>
<tr>
<td>59414  Delivery of placenta</td>
<td>1.44</td>
<td>1.61</td>
</tr>
<tr>
<td>59425  Antepartum care only (4-6 visits)</td>
<td>5.63</td>
<td>6.31</td>
</tr>
<tr>
<td>59426  Antepartum care only, (7+ visits)</td>
<td>9.96</td>
<td>11.61</td>
</tr>
<tr>
<td>59430  PP care only</td>
<td>2.20</td>
<td>2.47</td>
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<tr>
<td>59510  Global cesarean delivery</td>
<td>31.80</td>
<td>35.64</td>
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<td>59514  Cesarean delivery only</td>
<td>14.39</td>
<td>16.13</td>
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<td>59515  Cesarean delivery w/PP care only</td>
<td>19.15</td>
<td>21.47</td>
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<tr>
<td>59610  Global VBAC delivery</td>
<td>30.22</td>
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<td>59612  VBAC delivery only</td>
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<td>59614  VBAC delivery w/PP care only</td>
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<td>19.73</td>
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<td>59618  Global cesarean delivery (failed VBAC)</td>
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<td>59620  Cesarean delivery only (failed VBAC)</td>
<td>14.86</td>
<td>16.66</td>
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<td>59622  Cesarean delivery w/PP care only (failed VBAC)</td>
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