

CPT codes diversify for hysterectomy and repair of paravaginal defects

In 2008, long-awaited surgical codes are being added to Current Procedural Terminology (CPT) for **total laparoscopic hysterectomy** and **repair of a paravaginal defect**. Pay attention to code renumbering and revisions in the New Year, too: **Bladder aspiration** codes have new numbers, and **removal of an intra-abdominal tumor** will require more careful documentation, to cite two changes.

There's more: If you've been spending time on telephone or on-line **counseling**, codes that may get you paid for that service are about to make their debut.

Key additions and revisions to CPT for the new year are detailed in this article and in next issue's Reimbursement Adviser.

Specify repair of paravaginal defect

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*

You'll now have to carefully document your surgical approach to repairing a paravaginal defect, thanks to creation of two new codes and revision of the existing 57284.

Several bundles are still attached to the new codes, however. CPT did remove references to "stress urinary incontinence, and/or incomplete vaginal prolapse" from the revised and new codes, but repair of a cystocele, by any method, is still included.

CPT 2008 is, therefore, listing codes that cannot be reported additionally. In general, urethropexy codes **51840**, **51841**, **51990**, **58152**, and **58267** and cystocele repair codes **57240**, **57260**, and **57265** should not be reported when a paravaginal defect repair is performed.

Also, be alert for any National Correct Coding Initiatives (NCCI) bundles assigned by Medicare to these new codes if they are different from the ones that will be listed by CPT. In particular, **57288** [*sling operation for stress incontinence (e.g., fascia or synthetic)*] was permanently bundled into **57284**. (If that bundle isn't removed in 2008, I encourage you to contact ACOG and urge the College to discuss this inappropriate bundle with Medicare administrators.)

Total lap hysterectomy

58570 *Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less*

58571 *Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(ies)*

58572 *Laparoscopy, surgical, with total*

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FAST TRACK

Code 57288—fascial or synthetic sling operation for stress incontinence—is now permanently bundled into code 57284

hysterectomy, for uterus greater than 250 g

58573 *Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(ies)*

For some time, surgeons have been able to perform a hysterectomy by completely detaching both the uterine cervix and the body of the uterus from their surrounding support structures laparoscopically, then closing the vaginal cuff via this approach as well. Before 2008, the only coding choices were laparoscopic-assisted hysterectomy codes (58550–58554) or the unlisted laparoscopic code 58578. The new codes—as with codes for any vaginal or laparoscopic approach—are selected based on 1) the documented weight of the uterus and 2) whether the fallopian tubes or ovaries have been removed.

Intraperitoneal tumors, coded by size

49203 *Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less*

49204 *...largest tumor 5.1–10.0 cm diameter*

49205 *...largest tumor greater than 10.0 cm diameter*

In 2007, documenting the removal of intraperitoneal or retroperitoneal tumors, cysts, and endometriomas via abdominal incision was fairly simple: There were two codes and you had only to decide if removal was extensive or not.

In 2008, codes 49200 and 49201 are deleted and replaced by three new codes—each of which requires you to document the size of the largest tumor or lesion removed.

The new codes will come in handy during surgery in which the originating organ has been removed but the patient is found to have additional tumors. For

example: A patient had ovarian cancer and now there are additional tumors in the abdominal cavity, but an omentectomy is not being performed. Of course, the new codes can still be used for excision or destruction of cysts or endometriomas, as well. But CPT has also listed codes that *cannot* be billed with the new codes: Among them are 38770 [*pelvic lymphadenectomy*] and 58900–58960 [*surgeries performed on the ovaries*]. If the new codes don't fit the surgery, the other option for tumor debulking after the organ has been removed is to report 58957 or 58958; note, however, that these codes include omentectomy and optional pelvic lymph node sampling.

Bladder aspiration is renumbered

51100 *Aspiration of bladder; by needle*

51101 *...by trocar or intracatheter*

51102 *...with insertion of suprapubic catheter*

If you have the old codes for bladder aspiration memorized, relearn them. Once again, CPT tinkered with placement of codes and decided that bladder aspiration codes are placed more appropriately under “Bladder, Removal” than “Bladder, Incision.” The uses of those codes are unchanged.

Giving flu, HPV vaccines

90661 *Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use*

90662 *Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use*

90663 *Influenza virus vaccine, pandemic formulation*

90650 *Human papillomavirus (HPV) vaccine, types 16 and 18, bivalent, 3-dose schedule, for intramuscular use*

Four new codes for vaccines can be

FAST TRACK

Codes 51100–51102 for bladder aspiration now appear under “Bladder, Removal” rather than “Bladder, Incision”

A few “clarifications” may simplify coding in 2008

Fecal blood testing

If you bill 82272 [*blood, occult, by peroxidase activity (e.g., guaiac), qualitative, feces, single specimen (e.g., from digital rectal exam)*] for the annual fecal occult blood screening test, CPT has revised the code to make it clear that this code is not to be reported for a screening test.

The only two CPT codes that can be reported for the screening fecal occult blood test are 82270 [*blood, occult, by peroxidase activity (e.g., guaiac), qualitative, feces, consecutive collected specimens with single determination, for colorectal neoplasm screening*] (that is, the patient was provided three cards or a single triple card for consecutive collection) or 82274 [*blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1–3 simultaneous determinations*].

Note: The physician may collect the specimen for an immunoassay (except on a Medicare patient), but a guaiac test specimen must be collected by the patient.

Cervical biopsy

The descriptor for 57500 will now specifically refer to the cervix as the location for biopsy or excision of a lesion.

Before this change, only the subheading title gave any indication of anatomic location.

Hysterectomy

If you perform a laparoscopic-assisted (58550–58554), total (58570–58573), or supracervical (58541–58544) hysterectomy, CPT has added a list of codes that you may not report as well. These include:

- 49320 [*diagnostic laparoscopy*]
- 57000 [*colpotomy*]
- 57180 [*hemostatic vaginal packing*]
- 57410 [*EUA*]
- 58140–58146, 58545–58546, 58561 [*myomectomy*]
- 58661 [*removal of tubes and/or ovaries*]
- 58670, 58671 [*tubal ligations*]

Vascular ultrasound

Last, CPT has clarified that, to bill 93975 or 93976 [*duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs*], the purpose of the exam must be to evaluate **vascular structures**. If color Doppler ultrasound is used to identify **anatomic structures** at the time of US scan, neither of those two codes may be billed additionally.

reported beginning January 1, but only those for the influenza vaccine appear in the CPT 2008 book. The code for the new bivalent HPV vaccine is a valid code for 2008 but will not appear in print until CPT 2009.

Changes made to “modifier -51” exemptions

CPT 2008 also reassessed codes that have been designated as “modifier -51 exempt.” Typically, these are codes that do not involve significant preoperative or postoperative work. 36660 [*catheterization, umbilical artery, newborn, for diagnosis or therapy*] now requires a modifier when performed with other procedures, whereas 51797

[*voiding pressure studies (VP); intra-abdominal voiding pressure (AP) (rectal, gastric, intraperitoneal)*] becomes an add-on code that does *not* take a modifier -51. Beginning January 1, 51797 can be billed only if 51795 [*voiding pressure studies (VP); bladder voiding pressure, any technique*] has also been reported. ■

More on CPT 2008

Ms. Witt’s roundup of new and revised CPT codes for 2008 in ObGyn practice—including for telephone and online counseling and semen analysis—continues in the **January 2008 issue of OBG MANAGEMENT**.