



## FOR 2011

# Changes to the CPT code set and Medicare billing

➡ Important changes went into effect on January 1st, including a major overhaul of codes for observation care and labor and delivery. Has your practice kept up?

The Current Procedural Terminology (CPT) code set for 2011 includes several changes of interest to ObGyns. These include **1)** guideline clarifications regarding wound debridement and obstetric care codes; **2)** new codes for subsequent observation care; micro-remodeling of the bladder neck; insertion of a vaginal after-loading device; and **3)** a lab code for detecting amniotic fluid in cervicovaginal secretions (using the AmniSure kit).

There is also a new code for vaccine counseling that will have an impact on you if

your practice offers the human papillomavirus (HPV) vaccine to patients younger than 19 years.

There are changes to Medicare this year that you should take note of if you care for these patients, particularly in the area of preventive visit billing.

CPT and Medicare changes both took effect on January 1. The Health Insurance Portability and Accountability Act (HIPAA) requires that insurers accepted the new codes on that date.

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## Changes to the CPT code set

### OBSERVATION CARE

One of the biggest headaches for medical practices has been standardized coding and billing for observation care that lasts more than 1 day. In the past, payers accepted a problem E/M for Day 2 of observation care, or instructed practices to code an unlisted E/M service. Now, **you may report all care rendered in the observation setting with the addition of three new codes for subsequent care:**

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**99224** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: problem focused interval history, problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient's



**FAST  
TRACK**

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hospital floor or unit.

**99225** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

**99226** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

Note that each of these codes **1**) "suggests" the status of the patient for each level of billing, and **2**) includes a typical time. This means that, unlike the observation care admission codes or the observation admission/same-day discharge codes, time that is spent with the patient, or on the unit, may be used to select the code—if you document **1**) the requirement that more than 50% of the typical time was spent on counseling or coordination of care, or both, and **2**) a detailed description of this activity.

**WOUND MANAGEMENT**

Codes for wound debridement were given a facelift with the addition of a new guideline that addresses both surgical and medical debridement. The surgical debridement codes, **(11042–11047)** are now reported on the basis of the depth of tissue removed and the surface area of the wound. This means that codes **11040** and **11041** were deleted to make room for new and revised codes.

This change will mean that, when you report these codes, you will need to document more information to bill. It's also understood that coding separately for debridement of dermis or epidermis at the same time you code for debriding underlying structures would be inappropriate.

CPT has also indicated that active wound management codes **97597** and **97598** can now be reported by physicians or nonphysician providers as long as the provider has direct (one-on-one) contact. These codes should be reported for skin-surface debridement only.

The new and revised codes (some of which have been published in CPT in nonsequential order) are:

- 11042** Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
- +11045** (new add-on code reported with **11042** only) each additional 20 sq cm or part thereof
- 11043** Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less
- +11046** (new add-on code reported with **11043** only) each additional 20 sq cm or part thereof
- 11044** Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less
- +11047** (new add-on code reported with **11044** only) each additional 20 sq cm or part thereof
- 97597** Debridement (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open



wound (e.g., fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less

**+95798** (add-on code reported with **97597** only) Each additional 20 sq cm, or part thereof.

### TRANSURETHRAL RADIOFREQUENCY

Category III code **0193T**, which described transurethral radiofrequency micro-remodeling for stress urinary incontinence, has been deleted and converted to a Category I CPT code, **53860** (*Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence*). The procedure includes a periurethral block and flushing the bladder with a lidocaine slurry, and can be performed in the office.

In all, the procedure requires nine treatment cycles during the session, but the code is billed only once. Catheterization and measurement of a voiding sample after the procedure are included in the code.

### AFTER-LOADING DEVICES FOR CLINICAL BRACHYTHERAPY

CPT revised—slightly—existing code **57155**, and added code **57156** (*Insertion of a vaginal radiation after-loading apparatus for clinical brachytherapy*).

- Code **57155** was revised to clarify that only a single tandem is inserted into the uterus. There had been confusion earlier in this regard.
- The new code describes a procedure that may also include dilation of the vaginal canal to remove postradiation adhesions. That procedure also involves **1**) placement of bladder and rectal catheters and **2**) radiographic imaging to confirm placement, which are *not* coded separately.

### CLARIFICATION OF OBSTETRIC GUIDELINES

Been having problems with payers and their interpretation of the delivery only, postpar-

tum only, and delivery with postpartum care codes? CPT has, at last, clarified what you can, and cannot, bill in those circumstances. (Keep in mind, however, that you may not unbundle these procedures if more extensive care is provided: Most payers want you to bill the global OB care code that includes antepartum, intrapartum, and postpartum care.)

In some cases (such as Medicaid), the payer stipulates that only the physician who actually performed the delivery may bill for it, even if the delivering physician is covering for, or is a member of, the same group practice as the primary attending of record. The “delivery-only” codes should be reported when **1**) an unaffiliated physician has delivered the baby but will not be providing any outpatient postpartum care or **2**) the payer has specified this method of billing for the covering or affiliated provider.

CPT has clarified that delivery-only codes (**59409**, **59514**, or **59612**, **59620**) include admission to the hospital, the admission history and physical exam, uncomplicated labor and delivery (including delivery of the placenta, or use of forceps or vacuum extraction). These codes *do not* include inpatient rounding or discharge day care after delivery (and, of course, include *no* outpatient postpartum care). When, as the delivering physician, you also provide *inpatient* postdelivery care, therefore, you may additionally bill subsequent hospital care codes and discharge day management codes (**99231–99233**, **99238–99239**).

If the unaffiliated physician performs the delivery and also intends on providing outpatient postpartum care, the CPT codes for delivery with postpartum care are to be reported (**59410**, **59515**, **59614**, **59622**). In addition to the delivery, these codes include all inpatient and outpatient postpartum care. And finally, for those physicians who are only providing outpatient postpartum care, the code **59430**, *Postpartum care only*, should be reported.

### PLACENTAL ALPHA MICROGLOBULIN-1

A new code, **84112** (*Placental alpha microglobulin-1 [PAMG-1], cervicovaginal secretion, qualitative*), has been added to allow the



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clinical laboratory to bill for this immunoassay that detects amniotic fluid in the secretions. Physician work involves collection of the specimen but, under CPT rules, collection is included as part of any E/M service.

Note: An existing code for this test that is used by Blue Cross/Blue Shield payers (**S3628**) remains valid in 2011.

#### HPV VACCINE COUNSELING

Before January 1, 2011, if you counseled a patient about the HPV vaccine, you could report preventive counseling codes, such as **99401–99404**, in addition to the vaccine administration code, **90471** (*Immunization administration, 1 vaccine*). Now, however, you have a new code for counseling *and* vaccine administration for a patient who is younger than 19 years—the age group most likely to be counseled about this vaccine. When you see, and counsel, such a patient before administering the vaccine, on the same date of service, code **90460** (*Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care profession; first*

*vaccine/toxoid component*), and **90649** for the quadrivalent or **90650** for the bivalent HPV vaccine.

If your patient is 19 years or older and requires counseling, continue to bill **99401–99404** for counseling, with **90471** for immunization and **90649** or **90650** for the vaccine. Keep in mind: Whether you report **90460** or the **9940X** codes, **you are required to document the content of the counseling**. Codes **9940X** also require documentation of the duration of counseling.

#### INFLUENZA VACCINE

New codes have been established for the flu vaccine, but you won't be using them: They are intended to address future **pandemic strains** of influenza. This year's vaccine contains the H1N1 strain, but is coded as the normal seasonal flu vaccine, based on the type given:

- 90656** (preservative-free)
- 90658** (split virus)
- 90660** (intranasal)
- 90662** (enhanced vaccine for patients older than 65 years).



**You have a new HPV vaccine code for counseling and administration for a patient who is younger than 19 years—the age group most likely to be counseled about this vaccine**

## Changes to Medicare billing

Some of the coding and billing changes this year that have an impact on ObGyn practice come from the Centers of Medicare and Medicaid Services (CMS) and the Affordable Care Act.

#### TIMELY FILING

The Affordable Care Act calls for a reduction in the maximum time period for submission of Medicare fee-for-service claims. Before January 1, a provider had 15 to 27 months to submit first-time claims to Medicare. Now, these claims must be filed within a calendar year of the date of service. Exceptions can be made for retroactive entitlement or in situations in which there is a secondary payer.

#### PAYMENTS TO CERTIFIED NURSE MIDWIVES

Next, more good news—if you employ a certified nurse midwife (CNM) in your practice. Before January 1, Medicare reimbursed direct billing from a CNM at only 65% of the Medicare Physician Fee Schedule. Now, a CNM is paid the same as a physician when she (he) bills under her own number.

In the past, some practices billed for the services of a CNM under “incident to” rules, to capture the physician payment—but this also meant that the CNM could not see a new patient. Under the change I’m describing, all CNMs can bill Medicare directly; see new patients; and be paid the same as the physician is paid. In addition, CNMs are no longer re-



quired to be supervised by a physician when they perform diagnostic tests that fall under the scope of their practice.

#### ANNUAL WELLNESS VISIT

The Affordable Care Act extended preventive coverage to Medicare beneficiaries in the form of an annual wellness visit. The two new codes here have been valued based on a level 4-problem new and established E/M service:

**G0438** *Annual wellness visit, including personalized prevention plan services, first visit*

**G0439** *Annual wellness visit, including personalized prevention plan services, subsequent visit*

Payment for the initial visit is made only beginning the second year the patient is eligible for Medicare Part B—during the first year of coverage, only the Initial Preventive Physical Examination (IPPE) (the “Welcome to Medicare”) exam will be covered.

CMS has stated that only one physician will be paid for the initial visit; when the patient returns to the same or a new physician in the third year, only a subsequent visit will be paid. It is, therefore, important that this information be conveyed to any new physician who sees the patient.

The annual codes can be billed in addition to any other preventive service, such as **G0101** or **Q0091**; no modifier is needed for this combination. Medicare has waived both the copayment and the deductible for the annual wellness visit, as well as all Medicare-covered preventive services that have been recommended with a grade of “A” (“strongly recommends”) or “B” (“recommends”) by the

US Preventive Services Task Force.

The annual wellness visit requires seven elements at a minimum (i.e., you may document and perform more elements than this, but not fewer):

- Establish or update the patient’s medical and family history
- List her current medical providers and suppliers and all prescribed medications
- Record measurements of height, weight, body mass index (initial visit only), blood pressure, and other routine measurements
- Detect any cognitive impairment
- Establish or update a screening schedule for the next 5 to 10 years, including screenings appropriate for the general population, and any additional screenings that may be appropriate because of her particular risk factors
- Review the patient’s **1)** potential (i.e., risk factors) for depression, based on use of an appropriate screening instrument, and **2)** functional ability and level of safety based on direct observation or screening questions
- Furnish **1)** personalized health advice and **2)** refer her appropriately to health education or preventive services.

CMS has also indicated that, although they will pay for a problem E/M service and the annual wellness visit on the same date of service with a **modifier -25** added to the E/M service, they expect this type of billing to be rare—because of the nature of the wellness visit, which is time-intensive. They also expect that, given these requirements, the patient will not be billed additionally for a noncovered preventive service. ❌