



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.

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## Changes to CPT code set

### 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

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*The author reports no financial relationships relevant to this article.*

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for OB work in 2012, at  
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maternal-fetal medicine physicians often are.

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)*. Note, however, that, if you are seeing a Medicare patient, prolonged services continue to require documentation of face-to-face work, not unit/floor work. Prolonged services are add-on codes that can be reported only with a basic E/M service that has a time component assigned to it.

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: You will have to report two diagnostic codes for this combination service; V25.5 (*Insertion of implantable subdermal contraceptive*) and V25.43 (*Surveillance of previously prescribed contraceptive methods; implantable subdermal contraceptive*).

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 reinsertion 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** (*colpexy, 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



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2012, however, you report **modifier -59** (*Distinct procedural services*) instead when you have repaired multiple wounds.

### 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.

### 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.

## 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.

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 (RVUs) for most obstetric codes were increased effective January 1**



## Relative value units for most OB codes have gone up in 2012

CPT code	2011 work RVUs	2012 work RVUs
59400 Global vaginal delivery	28.69	32.16
59409 Vaginal delivery only	12.82	14.37
59410 Vaginal delivery with PP only	16.07	18.01
59412 External cephalic version	1.53	1.71
59414 Delivery of placenta	1.44	1.61
59425 Antepartum care only (4-6 visits)	5.63	6.31
59426 Antepartum care only, (7+ visits)	9.96	11.61
59430 PP care only	2.20	2.47
59510 Global cesarean delivery	31.80	35.64
59514 Cesarean delivery only	14.39	16.13
59515 Cesarean delivery w/PP care only	19.15	21.47
59610 Global VBAC delivery	30.22	33.87
59612 VBAC delivery only	14.35	16.09
59614 VBAC delivery w/PP care only	17.60	19.73
59618 Global cesarean delivery (failed VBAC)	32.26	36.16
59620 Cesarean delivery only (failed VBAC)	14.86	16.66
59622 Cesarean delivery w/PP care only (failed VBAC)	19.63	22.00
59400 Global vaginal delivery	28.69	32.16
59409 Vaginal delivery only	12.82	14.37