The 2014 CPT and Medicare code changes affecting ObGyn practice

Here you'll find new codes for noninvasive prenatal testing and your peer-to-peer consultation time, as well as information on which ObGyn services are likely to be hardest hit by decreased RVUs in 2014

Melanie Witt, RN, CPC, COBGC, MA

The code set of the 2014 Current Procedural Terminology (CPT), which took effect on January 1, includes several changes that affect all women's health-care providers, including:

- a clarification of who should bill discharge-day management
- the addition of interprofessional telephone and Internet consultations
- new codes for image-guided fluid drainage
- new codes for fibroid embolization and laparoscopic ablation of fibroids.

There are also some new laboratory codes: one that captures the work of the noninvasive prenatal DNA test Harmony, and one to test for *Trichomonas vaginalis*. Finally, the code for anogenital examinations was revised to reflect current practice.

Medicare also has made some changes you should note, related to the levonorgestrel-releasing intrauterine system Skyla and billing for "incident to" services, and the type of provider who can order a fecal occult blood test. In addition, Medicare changes to some of the practice expense relative value units (RVUs) and geographic payment adjustor values will have an impact on some frequently used ObGyn services.

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.

Ms. Witt is an independent coding and documentation consultant and former program manager, department of coding and nomenclature, American Congress of Obstetricians and Gynecologists.

Ms. Witt reports no financial relationships relevant to this article.

CPT code changes

Discharge-day management coding clarified

Codes **99238** and **99239** should be reported by the admitting provider for all services rendered on the date of discharge as long as the admission and discharge were not on the same date of service. Concurrent hospital services performed by the nonadmitting clinician on the date of discharge should be billed instead as a subsequent inpatient hospital encounter (codes **99231–99233**).

Interprofessional phone and Web consultations now reimbursed

Most clinicians at one time or another end up giving advice to another health-care provider about the care of a patient he or she never sees and, up until 2014, there was no way to ask for reimbursement for this additional work. Starting on January 1, however, there were four new codes to allow a consultant clinician to report this

IN THIS ARTICLE

work. These services, of a consulting physician who has specific specialty expertise, typically will be provided in complex or urgent situations where a timely face-to-face service with the patient may not be feasible.

The new codes are billed based on total documented cumulative time spent (to account for more than one telephone/Internet contact to complete the consultation request). The codes are for *interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health-care professional,* with varying time intervals for *medical consultative discussion and review*:

- **99446** 5–10 minutes
- **99447** 11–20 minutes
- **99448** 21–30 minutes
- **99449** 31 minutes or more

Like all new codes, these have some very specific requirements:

- The billing physician cannot have had a face-to-face encounter with the patient within the past 14 days. If the consultation leads to scheduling a face-to-face appointment or surgery within 14 days, these codes cannot be reported.
- If the consultation is to accept transfer of care or arrange for an immediate face-to-face encounter with the consulting physician, these codes should not be billed.
- The documentation must include a review of all pertinent medical records, studies, medications, etc., that may be required to render an opinion on how to proceed with care of the patient, and reviewing of any data is not reported separately.
- The patient either can be new to the consultant or can be established (with a new or an exacerbated problem).
- The majority of the service (more than 50%) must be devoted to the medical consultative verbal/Internet real-time discussion, and not be reported more than once within a 7-day interval.
- The request for advice by the qualified health-care professional must be documented in the patient's medical record, including the reason for the request.
- There must be a verbal opinion report and written report from the consultant to the treating physician.
- The treating physician who asks for the telephone/Internet advice can report a prolonged services, non–face-to-face code if the time exceeds the typical time of a problem E/M service by 30 minutes to get credit for the discussion with the consultant.

CASE As an example, Dr. Moody, Mary's primary care physician, has ordered a computed tomography scan for her due to reports of sharp epigastric pain. A large mass in the area of the right ovary is detected. Dr. Moody phones Dr. Gerard, the patient's ObGyn of record, for an opinion about additional testing for this mass. Mary was last seen by Dr. Gerard at her well-woman visit 8 months ago; there were no complaints reported or problems detected.

Dr. Gerard recommends that additional views of the mass be obtained and that a CA-125 test be performed due to Mary's family history of ovarian cancer. He also recommends that Mary be sent for a consultation with a gynecologic oncologist as soon as possible. The total time spent on this consultation is 15 minutes, and Dr. Gerard reports Mary's consultative session to her insurance company with CPT code 99447.

FAST TRACK

Your peer-to-peer consultations of 5 minutes or longer are now reimbursable as long as you review all of the patient's medical records and don't see her in the office within the next 14 days

Image-guided drainage of a fluid collection

CPT code **10030** has been added to report image-guided drainage of a fluid collection using a catheter for areas just under the skin. This code would be used if the patient had an abscess, hematoma, seroma, lymphocele, or cyst that was drained percutaneously. For instance, this code could be reported for a hematoma located in the abdominal wall or just under the skin. The code bundles image guidance, but it can be reported more than once if there is more than one collection drained with a separate catheter.

CPT also has added additional codes for *image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma,*

lymphocele, cyst) of visceral, peritoneal, or retroperitoneal collections. The codes for these procedures are:

- **49405**...; visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous
- **49406**...; peritoneal or retroperitoneal, percutaneous
- **49407**...; peritoneal or retroperitoneal, transvaginal or transrectal

With the addition of these new codes, the old code **58823** has been eliminated.

Uterine fibroid treatment

There are two changes with regard to the treatment of uterine fibroids. First, CPT code **37210** (*Uterine fibroid embolization [UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata], percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiologic supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure*) has been eliminated and replaced by a more general code that will apply to any tumor or organ. This new code is **37243** (*Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction*).

Second, there is now a Category III code for the laparoscopic ablation of uterine fibroids: **0336T** (*Laparoscopy, surgical, ablation of uterine fibroid[s], including intraoperative ultrasound guidance and monitoring, radiofrequency*). Clinical research has shown that radiofrequency ablation (RFA) is effective in treating fibroids, resolving associated symptoms in more than 80% of treated patients. Because RFA is not yet a standard of care, this Category III code must be reported in order for data on its use to be collected. Under CPT rules, you may not use an unlisted code in place of the Category III code for this procedure. If you are performing RFA, it may be considered experimental by some payers, but you can still make a case for payment with

SGR fate, and your reimbursement, unknown at this time

At the time this article was finalized, there was no information about the fate of the Medicare payment mechanism for 2014. If the sustained growth formula used to calculate the Medicare conversion factor for physician reimbursement is not fixed by Congress, the projected 2014 conversion factor will be $27.2006, a decrease from the current conversion factor of $34.023.

But even without concrete, final information on this complicating factor, changes to the geographic adjustment units (which in turn determine the payment allowance for physicians based on their practice location), as well as changes to the practice expense RVUs for such office procedures as urodynamic testing, may spell decreased payments in 2014 from Medicare or payers who use Medicare as the basis for reimbursement.

Some states will fare better than others. The geographic payment cost index for all but a handful of states will be adjusted downward. The good news is that if you practice in Alabama, Alaska, Colorado, Connecticut, Delaware, Louisiana, Minnesota, New Hampshire, New Mexico, New York, Virginia, certain areas of California (San Francisco, Los Angeles, Marin County), and the Washington DC area, your geographic factors will increase. This increase may offset any decrease in the RVUs.

ObGyn reimbursements hardest hit by decreased RVUs. The RVUs for 2014 for the technical component of all the urodynamic testing codes will be reduced by 6% to 40%, with the biggest hit coming to codes **51726-51727** (complex cystometrogram with urethral and voiding pressure studies). In-office procedures such as endometrial ablation, endometrial cryoablation, and hysteroscopic sterilization will see around an 8% decrease to the practice expense RVUs. This same reduction will be noticed in the technical-component reimbursement for gynecologic and obstetric ultrasounds, with the notable exception that the RVUs were increased for umbilical artery Doppler.

The final result for increased or decreased payments via the relative value system will therefore depend on your practice location, and whether you are billing the technical component only for many of these procedures (and, of course, the final outcome of the SGR).

the submission of adequate documentation with the claim in the form of peer-reviewed articles and the patient's circumstances that preclude more standard surgeries.

Anogenital examination coding

Code **99170** was revised to reflect current practice. The procedure is not always performed with a colposcope, but usually requires digital imaging for legal recoding and documentation. The revised code reads "*anogenital examination, magnified, in childhood for suspected trauma, including image recording when performed.*" Moderate sedation, if performed, may be billed separately using code **99143-99150**.

Laboratory code changes

Cell-free DNA testing code added

As of January 1, there is a new code to report cell-free prenatal DNA testing to screen for fetal aneuploidy. This new code is **81507** (*Fetal aneuploidy [trisomy 21, 18, and 13] DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy*).

In addition, the code **84112**, which used to be defined as "*placental alpha microglobulin-1 (PAMG-1), cervicovaginal secretion, qualitative,*" has been revised. The revision was done to make it clear that it can be ordered for other proteins that are tested in amniotic fluid. Code 84112 is now defined as follows: *Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (eg, placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen.*

This test is normally ordered to determine whether the fetal membranes have ruptured, but this is not a Clinical Laboratory Improvement Amendments (CLIA) waived or Provider Performed Microscopy Procedures (PPMP) test. Therefore, only the laboratory with the applicable CLIA certificate can bill for it.

There are now two code options for *T vaginalis* testing

To the existing code **87660** (*direct probe technique*) is added the new code **87661**, *T vaginalis*, amplified probe technique.

Three new codes for the flu vaccine

- **90673**, Flublok (effective January 2013)
- **90686**, Fluzone, preservative-free (effective December 2012)
- **90688**, FluLaval (effective August 2013)

In addition, Medicare has deleted code G2033, which was used to report Flublok. It will now accept the CPT code 90673 for this influenza product.

Keep in mind that reporting the administration of the influenza vaccine is different for Medicare than private payers. Administration code G0008 and diagnosis code V04.81 would be reported in conjunction with the appropriate vaccine code for Medicare, while CPT instructs you to report 90471 instead for the administration.

Medicare coding changes

Skyla. The new code is **J7301**, *levonorgestrel-releasing intrauterine contraceptive, 13.5 mg.* This replaces the temporary code Q0090, which was added by Medicare on July 1, 2013.

More providers can order fecal occult blood tests. To expand access to screening fecal occult blood testing, Medicare has revised the rules on who can order these tests. Effective January 1, 2014, not only a physician but also the billing physician's assistant (PA), certified nurse specialist (CNS), or nurse practitioner (NP) can order the test. But as before January 1, the physician, PA, CNS, or NP is responsible for using the results of the screening test in the overall management of the patient's medical care.

"Incident to" providers must be state-licensed. Medicare recently became aware that it was being billed in several situations for "incident to" services that were provided by auxiliary personnel (rather than the physician or practitioner billing for the services) who did not meet the state standards for those services. For this reason, Medicare has revised the "incident to" rules to make it clear that the person who is assigned to provide the aspect of the service must be licensed within their state to provide the services performed.