Challenges in FPMRS Surgical Coding for 2017 and Beyond

PFD Week 2017
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Faculty

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Learning Objectives

• After attending this session, attendees should be able to:
  ▪ Understand what services are included in the Global Surgical Package under CPT and how to use modifiers appropriately
  ▪ Understand how 2017 changes to ICD-10 CM effect how we bill for diagnosis
  ▪ Understand how to use surgical modifiers appropriately to bill for surgical services (-54, -53, and others)
  ▪ Construct documentation that supports complex surgical service billing
  ▪ Understand how recent changes to NCCI pair edits have changed how we bill for common procedures
I have no relevant financial relationships to disclose for any of my talks today
Coding Resources

We are the premier non-profit organization representing more than 1,900 members all dedicated to treating female pelvic floor disorders.

Learn More
AUGS Coding Resources

Coding Fact Sheets
- N99 Coding
- Pessary Coding
- Sling Revision and Urethrolysis
- E&M Form (Sample): Initial Exam
- Coding for Robotic Surgery
- Coding for Urodynamic Procedures
- Posterior Tibial Nerve Stimulation (PTNS) Therapy
- Urethral Bulking
- Sacral Neuromodulation
- Coding for Laparoscopic Sacral Colpopexy
- Coding for Botox Injections

Answers to Your Coding Questions
AUGS Coding Today

AUGSCodingToday Includes

- Advanced Code Checking Technology - Bundling Matrix. Enter up to 20 codes and check to see if they can be billed together and the order they should be submitted. Includes what modifiers may or may not be used. All information is displayed in a user friendly matrix with verbal explanation
- New ICD-10 tools are here!
- Current Medicare Correct Coding Initiative (CCI) edits
- National and local Fee Schedules, and Medicare Policy information
- Medicare information on global fee days and modifier usage
- Full LCDs
- PQRS
- MUEs
- 24/7 availability and real-time updates via Web site
- User friendly format with rules, regulations, and related information organized by code
- Powerful search engine for speedy look ups
- Free technical support and phone training
- AWP
- Laboratory Fees

Physician Reimbursement Systems 12300 Grant St. Unit 238 Thornton, CO 80241
Phone: 303-971-9749 Fax: 303-974-8377 PMNetwork.com
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Other Coding Resources
NOT Coding Resources (but highly recommended)
What is your role in the practice?

- Physician or other clinical practitioner
- Administration
- Clinical support staff (e.g. RN, MA, etc.)
- Billing/Coding personnel
- Other

Start the presentation to activate live content
If you see this message in presentation mode, install the add-in or get help at PollEv.com/app
What is your assessment of your level of coding knowledge?

- Significantly above average
- Above average
- Average
- Below average
- I don’t know anything about coding
ICD-10
How it Changes Coding and Billing for Surgical Procedures

Janet Tomezsko, MD
Disclosure

Janet Tomezsko, M.D.

Has NO relevant financial conflicts or any other conflicts of interest related to the topic(s) of today’s presentations.
ICD-10-CM

- ICD-10-CM replaced ICD-9 on 10/1/15
- Significantly changed the structure and guidelines to allow for increased levels of specificity and helps to improve tracking of outcome of care
- Significantly increases the reporting responsibilities for providers
  - Up to seven alphanumeric characters
  - Does not directly impact reimbursement
- ICD10 introduces several new categories for reporting pre-operative care, postop complications, and other healthcare encounters
ICD-10-CM

While ICD-10 has the basic hierarchical structure of ICD-9, ICD –10 introduces:

- Higher levels of specificity
- Reporting of laterality
- Combination codes to describe conditions with common symptoms
- New sections for postoperative complications with greater levels of specificity
ICD-10-CM: after October 1, 2016

- CMS allowed a grace period for the first 12 months after the initial rollout on 10/1/15
- An updated version was released on 10/1/16 containing over 3,000 revisions
- CMS now requires providers use highest level of specificity (including laterality)
- CMS has stated that there could be financial penalties for not using the most specific code
ICD-10-CM & FPMRS

- AUGS website contains a wealth of information regarding ICD-10
- Educational materials also available through ACOG and CMS
- Be familiar with important changes!
  - Conditions that are cured should not be coded
  - Be specific – report diseases not symptoms, once diagnosis made
- ICD-10 Organized by chapters
ICD-10-CM Coding

- 3 character codes:
  - N86 Erosion and ectropion of cervix

- 4 character codes:
  - N76.0 Acute vaginitis

- 5 character codes:
  - N85.01 Benign endometrial hyperplasia

- Some codes have 6th and 7th characters
- Must report maximum number of available characters for diagnosis
Conventions for ICD-10-CM

- First character is always alphabetic letter
  - Chapter 14 Diseases of the GU system (N00-N99)
  - Chapter 15 Pregnancy, Childbirth and Puerperium (O00-O9A)
- Second character is always a number
- Characters 3-7 alpha or numeric
  - O9A.311: Physical abuse complicating pregnancy, first trimester
Conventions for ICD-10-CM

- **Code Format:** `XXX.XXX X`
  - `XXX` = Category
  - `XXX` = Etiology, anatomic site, severity
  - `X` = Extension

- **Placeholder Character `X`**
  - Used with certain codes for potential future expansion or
  - Used to expand code when 7th digit extension required
    - Failure to use the 7th character can result in non-payment
Conventions for ICD-10-CM

- **Combination code**
  - Additional codes may be reported if needed to describe full clinical picture
  - Identified by referring to subterm entries in Index and reading notes in Tabular List

- **N83.51** Torsion of ovary and ovarian pedicle
- **N83.52** Torsion of fallopian tube
- **N83.53** Torsion of ovary, ovarian pedicle and fallopian tube
Conventions of ICD-10: Specificity

- ICD 9 = vulvovaginitis (616.10)
- ICD 10
  - N76.0 Acute vaginitis
  - N76.1 Chronic vaginitis
  - N76.2 Acute vulvitis
- Cystitis
  - N30.00 Acute cystitis without hematuria
  - N30.01 Acute cystitis with hematuria
Conventions for ICD-10-CM

• Laterality
  ◦ Some codes indicate whether condition is right, left, or bilateral
  ◦ If no bilateral code exists, then report code for right and left (two codes)
  ◦ If site not identified, then report code for unspecified side
Conventions for ICD-10-CM

- **N60.0** Solitary cyst of breast
  - N60.01 Solitary cyst of right breast
  - N60.02 Solitary cyst of left breast
  - N60.09 Solitary cyst of unspecified breast

- **N83** Non Inflammatory disorders of ovary, etc
  - N83.01 Follicular cyst of right ovary
  - N83.02 Follicular cyst of left ovary
Defining the 7th character

- **A** = initial encounter
  - Actually refers to the entire procedure of active treatment
    - Used for all encounters, any and all providers, subsequent visits as long as active treatment occurs
    - A means Active treatment (ongoing)

- **D** = subsequent encounter
  - Any encounter after the active treatment during which patient receives routine care during the healing or recovery phase
  - Used as long as the injury is healing normally

- **“S”** = Sequela encounter
  - Describes complications of the complication
    - eg pain after a fracture heals
    - Bleeding/dyspareunia after mesh is removed
    - Urinary retention after a sling is revised
  - Sequelae are often late effects of an injury due to a procedure (like chronic pain)
Examples for FPMRS

• T83.59 Infection due to prosthetic device, implant, and graft, GU
  ◦ T83.59XA – active treatment
  ◦ T83.59XD – encounters during healing
  ◦ T83.59XS – sequelae

• T83.6 Infection due to device…genital tract
  ◦ T83.6XXA
  ◦ T83.6XXD
  ◦ T83.6XXS
Chapter 14: Diseases of the Genitourinary System (N00-N99)

- **11 “Blocks”**
  - N00-N08 Glomerular diseases
  - N10-N16 Renal tubulo-interstitial diseases
  - N17-N19 Acute kidney failure and chronic kidney disease
  - N20-N23 Urolithiasis
  - N25-N29 Other disorders of kidney and ureter
  - N30-N39 Other diseases of the urinary system
  - N40-N53 Diseases of male genital system
Chapter 14: Diseases of the Genitourinary System (N00-N99)

- **N30-N39** Other disorders of urinary system
  - **N39.3-N39.9** Urinary incontinence
- **N60-N65** Disorders of breast
- **N70-N77** Inflammatory diseases of female pelvic organs
- **N80-N98** Non-inflammatory disorders of female genital tract
  - **N81.0-81.9** Prolapse codes
- **N99** Intraoperative and postprocedural complications and disorders of genitourinary system, not elsewhere classified
Chapter 19: Complications of Medical And Surgical Care, NEC (T80-T88)

- Other complications of surgical and medical care, not elsewhere classified
  - T81 Complications of procedures, not elsewhere classified
  - T83 Complications of genitourinary prosthetic devices, implants and grafts
  - T85 Complications of other internal prosthetic devices, implants and grafts
  - T88 Other complications of surgical and medical care, not elsewhere classified
Chapter 19: Complications of Medical And Surgical Care, NEC (T80-T88)

- **T81 – Post procedural complications**
  - T81.3XX Disruption of wound
  - T81.4XX Infection post procedure

- **T83 – Complications of genitourinary prosthetic devices, implants and grafts**
  - T83.2 Mechanical complication of graft of urinary organ
  - T83.4 Mechanical complication of other prosthetic devices, implants and grafts of genital tract
  - T83.5 Infection and inflammatory reaction due to prosthetic device, implant and graft in urinary system
  - T83.6 Infection and inflammatory reaction due to prosthetic device, implant and graft in genital tract
  - T83.7 Complications due to implanted mesh and other prosthetic materials
  - T83.8 Other specified complications of genitourinary prosthetic devices, implants and grafts
  - T83.9 Unspecified complication of genitourinary prosthetic device, implant and graft

- Remember to use sixth character placeholder “X”
- Followed by 7th character extension “A”, “D” or “S”
Chapter 19: Complications of Medical And Surgical Care, NEC

- Surgical treatment for patient previously seen in office with exposure of vaginal mesh into vagina
- T83.721D Exposure of implanted mesh and other prosthetic materials into surrounding organ or tissue, subsequent encounter
  - T83.721 = Exposure
  - D = Subsequent encounter
- Placeholder X is not required since code has 6 meaningful characters
T83.7
Erosions and Exposure of mesh/prosthetic materials

- T83.71 1
  - Erosion of implanted vaginal mesh to surrounding organ or tissue
  - Includes pelvic floor muscles
- T83.72 Exposure of mesh
  - T83.721 Exposure of mesh into vagina
  - T83.728 Exposure to surrounding tissue
- Remember to include 7th digit extension
T85 – new codes to describe complications of sacral neuromodulation

- T85.111 mechanical breakdown of neurostimulator lead
- T85.113 mechanical breakdown of neurostim device
- T85.121 Displacement of peripheral nerve lead
- T85.123 Displacement of neurostim device
- T85.732 Infection of neurostimulator lead
- T85.734 Infection due to neurostim device
  - e.g. generator pocket infection
- Remember to add 7th character (A,D,S)
Chapter 14: 
N99 Intraoperative and post procedural complications and disorders of genitourinary system, not elsewhere classified

- Category created in ICD-10 by WHO to capture Postprocedural disorders of the GU tract
- Contains disorders not elsewhere classified
- This includes conditions that occur as a result of a prior surgery
  - i.e. pelvic adhesions, ovarian remnant and vaginal vault prolapse after hysterectomy
  - Includes Postprocedural disorders N99.0-N99.4
  - Intraoperative hemorrhage and hematoma of GU organ complicating a procedure (NEC) N99.6
  - Accidental puncture and laceration of a GU organ during a procedure N99.7
  - Other intraoperative and Postprocedural complications and disorders N99.82
Chapter 14: N99 Intraoperative and post procedural complications and disorders of genitourinary system, not elsewhere classified

- Category somewhat confusing as it describes both chronic conditions diagnosed remote from procedure as well as immediate complications.
- Specifically list codes Not Elsewhere classified.
  - Look elsewhere for surgical site infection, etc.
- Category can contain up to six alphanumeric characters.
- Category includes certain complications that directly involve the GU system (bleeding, injury).
- Other complications of GU surgery are classified elsewhere (ie mesh complication, SSI).
Understanding N99

• Late or chronic occurrences are described first:
  ◦ N99.2 Post procedural adhesions of the vagina
  ◦ N99.3 Prolapse of the vaginal vault after hysterectomy
  ◦ N99.4 Postprocedural pelvic peritoneal adhesions
  ◦ N99.83 Residual ovary syndrome
Understanding N99

- N99.6 – Intraoperative hemorrhage of a GU organ/structure complicating any procedure
  - N99.61 – bleeding during a GU procedure
  - N99.62 – bleeding of a GU structure resulting from a non-GU procedure
Understanding N99

- N99.7 accidental puncture of a GU system organ/structure
  - N99.71 – injury occurs during a GU procedure (ie TVT sling, Vaginal hysterectomy)
  - N99.72 – injury occurs during a non GU procedure (ie laparoscopy for colorectal procedure)
N99: 2017 ICD-10 Changes

- Codes revised to provide separate reporting for post-op hemorrhage and hematoma
- N99.820 – bleeding of a GU organ following a GU procedure
  - e.g. hematoma after TVT
- N99.821 – GU bleeding following an unrelated procedure
- N99.840 - postop hematoma of GU system after GU surgery
- N99.842 - postop seroma of GU system after GU surgery
Z Codes

- Latest ICD-10-CM version adds back reporting of endoscopic procedures converted to open procedure
- Z53.31 - Laparoscopic surgical procedure converted to open procedure
- Z09 – Postop Visit – for when treatment is completed and condition no longer exists
- Z48.816 Encounter for surgical aftercare following genitourinary surgery
Linkage and Medical Necessity

- ICD codes “justify” the services provided
- Important to “link” the ICD code to the CPT code on the claim form
- Failure to appropriately link may result in denials
- Physicians should provide the linkage
Finally....

- We are held to greater specificity
- There may be financial downfalls to not being as specific as possible
- There were significant revisions to ICD-10 since our last workshop
- Everyone needs to have an updated ICD-10 book!
QUESTIONS?
SURGICAL MODIFIERS

Brad Hart, MBA, MS, CMPE, CPC, CPMA, COBGC
Disclosure

Brad Hart, MBA, MS, CMPE, CPC, CPMA, COBGC

Has NO relevant financial conflicts or any other conflicts of interest related to the topic(s) of today’s presentation.
Why do I have to know this???
Surgical Modifiers

- **Definition:**
  - Two digit numeric codes that indicate a basic service has been altered by particular circumstance

- **Purpose:**
  - Identify “excluded” services for Medicare
  - Provide additional information about services provided
Surgical Responsibility Modifiers

- 80  Assistant at surgery
- 82  Assistant at surgery (academic)
- 62  Co-surgeon
- 66  Surgical Team
80- Assistant Surgeon

- Actively “assists” in the performance of a surgical procedure
  - Does not dictate op report
  - Does not admit or follow patient
  - Does not perform distinct part of surgery
- Both surgeons report *same* CPT code
- Only assistant reports modifier
Payers’ Response

- **Medicare:**
  - Pays if designated as “medically necessary”
  - Payment is 16% of the allowable amount paid to primary surgeon
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<td>0.14</td>
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<td>Maybe</td>
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Reviewing Explanation of Benefits (EOBs)

- Medicare divides CPT into 3 Co-surgeon categories
  - Not permitted
  - Permitted without documentation
    - Different Board-Certified specialties
    - Currently only GYN Oncology is recognized as a subspecialty of Ob/GYN
  - Permitted with additional documentation
    - Some codes “maybe” considered for Co-surgeons. Look at your EOB’s.
      - Paravaginal defect repairs
      - Colpopexy, intra and extraperitoneal
Payers’ Response

**Other Payers:**
- Medical Necessity must be established
- Maintain lists of surgical procedures for which assist is paid
Surgical Responsibility Modifiers

- TVH WITH ENTEROCELE REPAIR (58270)
  - Primary surgeon receives $899.02
  - Assistant surgeon typically paid 16% of allowable reimbursement for procedures approved by CMS
  - $143.84
Why this is important...

- The only documentation of the assistant’s presence is the indication in the primary surgeon’s operative report
  - Some payers are requiring specific note concerning the portion(s) in which the assistant participated
- Is there a better way to use the assistant’s time?
  - Will they earn more money seeing patients in the office?
82 Assistant at surgery (academic)

- CMS will not reimburse for an assistant in surgery at a teaching institution with a residency program unless a special circumstances statement is submitted
  - Resident not available, emergency
  - Attending who universally will not allow residents to operate with him
  - Use code 82 modifier with explanation letter as well
  - Could possibly affect revenue cycle
This must appear in the operative report

• “I understand that section 1842(b)(7)(D) of the Social Security Act generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the Medicare carrier.”
Surgical Responsibility Modifiers

- **TVH WITH ENTEROCELE REPAIR (58270)**
  - Attending surgeon receives $899.02
  - Resident receives $0.00
  - But, your partner may be more productive elsewhere
62- Two Surgeons

- Surgeons working together to perform *distinct parts of a single procedure*
- Each surgeon has key role in the performance of the procedure
- Both surgeons report *same CPT code and same modifier*
62- Two Surgeons

- If a single code is available that describes all the elements, then it must be used.
- It is considered unbundling for the surgeons to report separate codes for the individual portions of the procedure.
Dr. Jones, a general gynecologist, plans to do a TVH of a large uterus (> 250 gms) w/removal of tubes and ovaries (58291). After completing the TVH with some difficulty, the physician determines that assistance is needed with the salpingo-oophorectomy. Dr. Masters, a urogynecologist, presents and completes the BSO.
Financial Ramifications

• If Dr. Jones had done the entire procedure, she would have received $1,265.12

• In the shared case, Medicare would increase payment by 25% ($1,581.40) and split the payment in half
  ◦ Dr. Jones  58291-62  $790.70
  ◦ Dr. Masters  58291-62  $790.70
Payers’ Response

- Medical necessity requirement
- Pays 125-130% of the primary procedure
- Payment divided evenly between surgeons
- Documentation for *both* surgeons may be requested
- Some payers may not pay surgeons of the same specialty as co-surgeons
Two separate procedures

- Surgeon A performs a LAVH with BSO. During the procedure, the ovary looked suspicious so Surgeon B, a GYN oncologist, presents to perform a laparoscopic lymph node dissection. Both physicians will be seeing the patient post-operatively.
Financial Ramifications

- Completely separate
  - Dr. A (58552) $1,008.87
  - Dr. B (38571) $703.08

- Assist each other
  - Dr. A (58552, 38571-80) $1,121.36
  - Dr. B (38571, 58552-80) $864.50
Surgical Work Modifiers

- 54 Operative care
- 55 Postoperative care
- 56 Preoperative care
Modifiers 54, 55, 56

- Used when the surgical components are broken out to preoperative management, operative management, and postoperative management
- Surgeon A becomes ill at the initiation of anesthetic for the case. Surgeon B, from another group, performs the case. Surgeon C, from the patient’s home town, provides post-operative care of the patient.
  - 54 Operative care (Dr. B)
  - 55 Postoperative care (Dr. C)
  - 56 Preoperative care (Dr. A)
57265  Combined Anteroposterior colporrhaphy with enterocele repair
Reimbursement

- Total for 57265 (25.94 RVUs) $930.99
  - Dr. A $111.72
  - Dr. B $688.93
  - Dr. C $130.34
Surgical service only

- Surgeon A performs a vaginal hysterectomy. Dr. A asks Dr. B to come in during the procedure to do a sling during the same encounter. Dr. B does not plan on seeing the patient in the hospital or in follow up
Financial Ramifications

- Total compensation
  - Dr. A (58260) $849.52
  - Dr. A (57288-51) $366.62
  - TOTAL $1,216.14

- Two different physicians, not working together
  - Dr. A (58260) $849.52
  - Dr. B (57288-54) $542.59
Unusual circumstance modifiers

- 53  Discontinued procedure
- 22  Increased procedural services
53- Discontinued Procedure

- Terminated surgical or diagnostic procedure after anesthesia induction or surgical prep
- Physician decision due to:
  - Extenuating circumstances
  - Threat to well-being of patient
- Intent to provide way to seek partial payment for service/assure future payment
53- Discontinued Procedure

- Modifier not used if:
  - Two approaches used during same surgical session
    - Attempted vaginal hysterectomy followed by abdominal hysterectomy
  - Elective cancellation prior to induction or prep
Payers’ Response

- **Medicare:**
  - Recognizes modifier
  - Reimbursement rate set at 50% of usual payment

- **Other Payers:**
  - Internal payment policy
  - Documentation review
Rebecca

- **Surgeon:** Dr. Danvers
- **Preop Dx:** Postmenopausal bleeding
- **Postop Dx:** Postmenopausal bleeding
  Stenotic cervix
- **Procedure:** Attempted endometrial biopsy, discontinued after surgical prep
Rebecca

- **Background:** Rebecca is a 64 year old new patient, not on HT, who presents with unexplained vaginal bleeding. She has had four recent episodes, one lasting for several days.
- After obtaining additional history and performing a limited examination, it was decided that an endometrial biopsy should be performed on the same day. Rebecca’s questions were answered and a consent signed.
Rebecca

• **Procedure Note:** A small Pederson speculum was inserted and the cervix identified. No vaginal lesions were noted. *The os was quite stenotic.* *Multiple attempts were made to insert the endometrial aspiration device. It was decided to schedule her for a D&C the next day.*
Rebecca

- Service Billed on Day 1
  - 9920X-25
  - 58100-53
- Service Billed on Day 2
  - 58120
22- Increased Procedural Services

- CPT codes based on typical patient and typical work
- Modifier added only if work of the procedure is **substantially greater** than typically required
- Documentation important and must:
  - Support the substantial additional work
  - Indicate the reason for the additional work
22- Increased Procedural Services

Criteria for increased work:
- Increased intensity
- Increased time
- Technical difficulty of procedure
- Severity of patient’s condition
- Physical and mental effort required
22- Increased Procedural Services

- Examples:
  - Extensive lysis of adhesions
  - Morbid obesity
  - Increased time or intensity to complete procedure
    - Time alone not sufficient-need to reflect additional work
Documentation and Reimbursement

- Clear and precise documentation improves the appeal process and reviews
  - Use “coding language”:
    - Sling procedure vs. TVT
    - Intra-peritoneal colpopexy vs. vaginal vault suspension
Documentation and Reimbursement

- Document all findings/procedures
  - Clearly document procedure and diagnosis
    - Appendectomy for endometriosis
    - Procedure(s) in header must be in body of operative report
Writing a Special Report for Additional Reimbursement

- Distinct document used in conjunction with operative report
- Should be a brief, summary statement of the service and the unusual circumstance
- Best if written by the surgeon
Special Reports and Unlisted Procedures

- Service not identified by a specific CPT code
- Unlisted procedure codes found in all anatomical sections of CPT
- Documentation required
  - Special report
  - Operative report
- Payment varies and may be delayed
QUESTIONS?
SURGICAL MODIFIERS: Billing for related and unrelated services during the global surgical period

Alison Weidner, M.D.
Disclosure

Alison Weidner, M.D.

Has NO relevant financial conflicts or any other conflicts of interest related to the topic(s) of today’s presentation.
Surgical Modifiers

- **Who?**
  - 80, 82, 62, 66

- **When?**
  - 54, 55, 56

- **Why?**
  - 58, 78, 79

- **Others**
  - 22, 24, 25, 51, 52, 53, 57, 59
Surgical Modifiers

- **Who?**
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- **When?**
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- **Why?**
  - 58, 78, 79

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- **Others**
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- **When?**
  - 54, 55, 56

- **Why?**
  - 58, 78, 79

- **Others**
  - 22, 24, 25, 51, 52, 53, 57, 59

The Unrelated, Related, & the Staged
Modifier 58

- Staged or Related procedure by the Same physician during the post op period
  - Three indications:
    - Planned prospectively or at the time of the original procedure; or
    - More extensive than the original procedure; or
    - For therapy following a diagnostic surgical procedure.
  - Is NOT an unanticipated return to the OR
  - NOT used for a surgical complication
  - A new post-operative period begins when the next procedure in the series is billed
  - Both procedures same indication/Dx
## Modifier 58: Sacral neuromod

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<thead>
<tr>
<th>&quot;Basic test&quot; (PNE)</th>
<th>Global</th>
<th>“Advanced Test” (Stage I)</th>
<th>Global</th>
</tr>
</thead>
<tbody>
<tr>
<td>64561</td>
<td>10 days</td>
<td>64581</td>
<td>90 days</td>
</tr>
<tr>
<td>Percutaneous electrode</td>
<td></td>
<td>Incision for electrode</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>76000-26</td>
<td></td>
</tr>
</tbody>
</table>

### Full System Implant

<table>
<thead>
<tr>
<th>Full System Implant</th>
<th>IPG Implant (Stage II)</th>
</tr>
</thead>
<tbody>
<tr>
<td>64581 (incision for elec)</td>
<td>64590-58 (10 days)</td>
</tr>
<tr>
<td>64590-51</td>
<td>95972-51</td>
</tr>
<tr>
<td>95972-51</td>
<td></td>
</tr>
<tr>
<td>76000-26</td>
<td>76000-26</td>
</tr>
</tbody>
</table>
Modifier 58: Sacral neuromod

- This modifier communicates relatedness between 64581 and 64590
- Allows for billing of the second code (64590) during the global period of the first (64581)
- The second procedure completes the first
- Both procedures are for the same indication/diagnosis
Modifier 78

- Unplanned Return to the OR by the same physician following initial procedure for a related procedure during the post-operative period
- Related to the first procedure
- Physician is reimbursed only for the intraoperative portion of the procedure by CMS
- E.g., revision of mesh granulation
Modifier 78: other examples

- Revision/loosening of a midurethral sling within the global period
  - 57288
  - 57287-78

- Revision of USLS sutures due to pain within the global period
  - 57283
  - 58999-78

- Return to OR for debridement of wound infection after TAH within the global period
  - 58150
  - 11043-78 (debridement, skin/subcut tissue)
Modifier 79

- 79: Unrelated Procedure by the same physician or other qualified provider during the Postop period
- The physician may need to indicate that a procedure or service furnished during a post-operative period was unrelated to the original procedure.
- A new post-operative period begins when the unrelated procedure is billed.
Modifier 79

- A new post-operative period begins when the unrelated procedure is billed.
- Unlike 78, you will be reimbursed for more than intra-service time because the procedures are unrelated.
- Appropriate, different diagnoses are associated with each surgical code.
Modifier 79: example

- Your patient is a teacher who wishes surgery for both SUI and FI during the summer break
- You do not feel comfortable doing both procedures during same surgery
- 1st surgery is the sling for N39.3:
  - 57288
- 2nd surgery 30 days later within the global
  - 46750-79 (sphincteroplasty) for R15.9
Some Case Examples to illustrate...
Lisa

- Lisa is referred to you for stress incontinence symptoms. She is not reporting urgency symptoms and PVR by bladder scan was 125 cc. Decision was made for RP sling placement and it was not felt that UDS needed to be performed based on her history and exam.

- 57288 (sling) was completed without difficulty but the patient did not pass her voiding trial. At 7 days, she still was unable to void at all and decision was made to revise the sling. She is taken back to the OR POD 8 and the sling is cut but not removed.
How do you code the second operation of sling revision?

57287 (sling revision or removal)

57287 with 78 modifier.

You don't code the second operation because it is in the 90 day global.

57287 with the 55 modifier (Postoperative Care)

57287 with the 58 modifier (Staged or repeated procedure by the same physician)
### ICD-10 Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R33.8</td>
<td>Other retention of urine</td>
</tr>
</tbody>
</table>

### CPT Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>57287-78</td>
<td>Removal or revision of sling for SUI (fascia or synthetic)</td>
</tr>
</tbody>
</table>
Beverly

- Beverly undergoes Stage I electrode placement (64581) for refractory severe UUI (N39.41) and 14 days later you do Stage II/IPG placement (64590) with a 10 day global period
- How do you bill her procedure?
### ICD-10 Codes

| N39.41 | Urge urinary incontinence |

### CPT Codes

| 64581 | Incision for implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) |
### ICD-10 Codes

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>ICD-10 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N39.41</td>
<td>Urge urinary incontinence</td>
</tr>
</tbody>
</table>

### CPT Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64590-58</td>
<td>Insertion or replacement of peripheral or gastric neurostimulator pulse generator</td>
</tr>
<tr>
<td></td>
<td>or receiver, direct or inductive coupling</td>
</tr>
<tr>
<td>95972-58, 51</td>
<td>Electronic analysis of implanted neurostimulator pulse generator system; complex</td>
</tr>
<tr>
<td></td>
<td>spinal cord, or peripheral, with intraoperative or subsequent programming</td>
</tr>
</tbody>
</table>

### Diagnosis and Nature of Illness or Injury

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N39.41</td>
<td>Urge urinary incontinence</td>
</tr>
</tbody>
</table>

#### Procedures, Services or Supplies

<table>
<thead>
<tr>
<th>Procedure</th>
<th>MODIFIER</th>
<th>Description</th>
<th>NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>64590-58</td>
<td></td>
<td>Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling</td>
<td>22 64590 58 A 1 NPI</td>
</tr>
<tr>
<td>95972-58</td>
<td>58</td>
<td>Electronic analysis of implanted neurostimulator pulse generator system; complex spinal cord, or peripheral, with intraoperative or subsequent programming</td>
<td>22 95972 58, 51 A 1 NPI</td>
</tr>
<tr>
<td>76000-26</td>
<td></td>
<td></td>
<td>22 76000 26 A 1</td>
</tr>
</tbody>
</table>
Beverly

- Beverly undergoes Stage I electrode placement (64581) for refractory severe UUI (N39.41) and 14 days later you do Stage II/IPG placement (64590-58) with a 10 day global period.

- 12 days later she presents to your office febrile with pus draining from her wound. She is taken to the OR that same day to remove it.

- How do you bill her services?
How do you code the second operation of removal of the IPG?

5 (doesn’t need the modifier because it is outside the 10day global)

64595 with 78 modifier

You don't code the second operation because it is a complication

64595 with the 58 modifier (Related procedure by the same physician)
## ICD-10 Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T85.734A</td>
<td>Infection/inflammatory rxn due to implanted electronic neurostimulator, generator, initial (active) encounter</td>
</tr>
<tr>
<td>N39.41</td>
<td>Urge urinary incontinence</td>
</tr>
<tr>
<td>Z09</td>
<td>Encounter for follow up examination</td>
</tr>
</tbody>
</table>

## CPT Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99024</td>
<td>Postoperative follow up visit</td>
</tr>
<tr>
<td>64595-78</td>
<td>Revise/remove peripheral neurostimulator</td>
</tr>
</tbody>
</table>
Coding for Sacral Neuromodulation

Sacral Neuromodulation (SNS) is a widely used technique in FPMRS, with several FDA-approved indications. Unlike more traditional FPMRS procedures, SNS is not a single-event procedure but is typically done as a staged procedure. Additionally, future interventions, including programming, monitoring and revision surgery is often indicated. Because of this, practitioners who utilize this therapy frequently have concerns about the proper coding for each portion of the therapy both for purposes of complete and accurate documentation, as well as appropriate coding. The purpose of this document is to provide an overview as well as a detailed understanding of the components of SNS coding to assist in accurate and reproducible coding for the therapy. Currently there is a single SNS device available on the market in the US, the InterStim® system which is manufactured and marketed by Medtronic, Inc.

ICD-10-CM Diagnosis Codes
From the perspective of FPMRS, there are two FDA approved indications for the use of SNS: urinary control, and bowel control. These general indications each include a variety of different diagnoses and therefore a variety of ICD-10-CM codes to describe them.
Surgical Modifiers

• Who
  ◦ 80, 82, 62, 66

• When
  ◦ 54, 55, 56

• Whether
  ◦ 58, 78, 79

• Others
  ◦ 22, 24, 25, 51, 52, 53, 57, 59
Modifier 24

- Unrelated E/M service by the same provider or other provider during a post operative period
- Need to document that the E/M service was for reason unrelated to the original procedure
- The 24 modifier goes on the E/M code
Modifier 24

- You perform A&P repair (57260) and 2 wks post op pt returns to office with a Bartholin’s cyst
  - Diagnose N75.0 with E/M 9921X-24 as well as 99024 for post operative visit

- You do 57260 and during post op period patient returns with bleeding and you:
  - Diagnose N95.0 with E/M 9921X-24 as well as 99024 for post operative visit
  - Do endometrial biopsy (58100-79) associated with N95.0
Modifier 24

- You do a colpocleisis but she has mental status changes with hyponatremia 4d post op and is admitted to your service
  - 57120 is your outpatient surgery
  - Inpatient E/M code has 24 and associated dx of R41.82 and E87.1
QUESTIONS?
Understanding NCCI edits, Surgical Bundling and Coding for Multiple Surgical Procedures

Janet E. Tomezsko MD
History of Correct Coding Initiative (CCI):

- The Medicare National Correct Coding Initiative (NCCI) was implemented in 1995 to promote correct coding and prevent improper coding that leads to inappropriate payment.
- Procedure-to-Procedure (PTP) code pair edits are created to prevent similar or overlapping services from being paid separately:
  - e.g. you don't bill TAH separate from BSO, you bill TAH-BSO
- Some pair codes are obvious because the procedures are mutually exclusive:
  - e.g. you can't bill vaginal and abdominal hysterectomy in the same patient
- Codes that are "bundled" under a pair edit will be declined for reimbursement:
  - e.g. the "lesser" of the two procedures will not be paid
- However, some pair edits can be "unbundled" under certain circumstances:
  - This will require the use of specific modifiers in order for the pair to be accepted
CCI Code Pairs:

- The CCI presents "code pairs," procedure codes that may not be reported if performed at the same operative session by the same surgeon. That is, the codes are considered bundled.
- Mutually exclusive code pairs cannot reasonably be done in the same session. Some examples are:
  - A code that is performed only on females and a code that is performed only on males
  - Multiple approaches to the same procedure
  - An initial service and a subsequent service
- Column 1/Column 2 code pairs include a comprehensive code (column 1) and a code that is considered a component of that code (column 2). In most cases, the column 2 code will not be reimbursed when reported with the column 1 code.
Pair Edits and Modifier Indicators:

- NCCI classifies pair edits in published tables to designate which code pairs can and cannot be "unbundled" and paid separately.
- "0" means you can never override the edit with a surgical modifier.
  - e.g. the two procedures are never paid together in the same setting.
- "1" indicates that an appropriate modifier can be used, when clinically appropriate to override the edit.
  - May require additional documentation within the Op note.
  - May not be recognized by all Payers.
NCCI Edits

Historically known edits

- Pubovaginal sling and cystoscopy
- Oophorectomy and ureterolysis
- TAH and lysis of adhesions
- Laparotomy and TAH

If a more comprehensive code exists, you must use it, rather than attempt to un bundle:
- TAH+Burch (58152), not TAH (58150) and Burch (51840)
- AP repair (57260); not anterior repair (57240) and posterior repair (57250)
NCCI Process

- NCCI updates new pair edits quarterly, and post them on the CMS website under PTP Coding edits - Practitioner
- NCCI analyzes coding conventions, standard practices, and national guidelines in making these determinations
- Engages interested parties (including ACOG, AUGS) for feedback for proposed new edits
<table>
<thead>
<tr>
<th>Column 1 CPT code</th>
<th>COLUMN 1 CODE DESCRIPTOR</th>
<th>Column 2 CPT Code</th>
<th>COLUMN 2 CODE DESCRIPTOR</th>
<th>CMS DECISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>58290</td>
<td>Vaginal hysterectomy, for uterus greater than 250g;</td>
<td>57282</td>
<td>Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococygeus)</td>
<td>On April 1, 2015, CMS will change the modifier indicator on this PTP edit from 0 to 1 retroactive to October 1, 2014, allowing NCCI-associated modifiers to be used to bypass the edit.</td>
</tr>
<tr>
<td>58290</td>
<td>Vaginal hysterectomy, for uterus greater than 250g;</td>
<td>57283</td>
<td>Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)</td>
<td>On April 1, 2015, CMS will change the modifier indicator on this PTP edit from 0 to 1 retroactive to October 1, 2014, allowing NCCI-associated modifiers to be used to bypass the edit.</td>
</tr>
<tr>
<td>58290</td>
<td>Vaginal hysterectomy, for uterus greater than 250g;</td>
<td>57284</td>
<td>Paravaginal defect repair (including repair of cystocele, if performed); open abdominal approach</td>
<td>On April 1, 2015, CMS will change the modifier indicator on this PTP edit from 0 to 1 retroactive to October 1, 2014, allowing NCCI-associated modifiers to be used to bypass the edit.</td>
</tr>
<tr>
<td>58291</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
<td>57260</td>
<td>Combined anteroposterior colporrhaphy;</td>
<td>On April 1, 2015, CMS will delete this PTP edit retroactive to October 1, 2014.</td>
</tr>
</tbody>
</table>
### CCI FORMAT

The first two unshaded rows list the bundles for comprehensive code 57550. The two shaded rows list the codes bundled into comprehensive code 57555. An example follows:

<table>
<thead>
<tr>
<th>CCI CODE</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>57550</td>
<td>Excision residual cervix</td>
</tr>
<tr>
<td>57555</td>
<td>Excision residual cervix, repair of vagina</td>
</tr>
</tbody>
</table>

#### ACOG format

**57550-** Excision residual cervix  
**57555—** Excision residual cervix, repair of vagina
NCCI Pair Edit resources for the Provider

- ACOG Coding Manual will list bundled services (e.g. pair edits) for common gyn surgical procedures
- ACOG coding course covers common pair edits
- PMIC Coding Guide publishes specialty specific Coding books that will list both Column 1 and Column 2 pair edits
- CMS Website, under PTP coding edits – Practitioner
  - You can download exhaustive list of all PTP edits, or the quarterly updates
NCCI Updates 2014 and 2015 Significantly Impacted FPMRS and Gyn Surgical Coding

- New PTP edit does not allow cystoscopy to be billed separately from most gyn surgical procedures for the purpose of checking ureteral patency
- NCCI implemented an extensive list of pair edits concerning reconstructive vaginal surgical procedures in October 2014
  - Did not allow colporrhaphy or apical vaginal suspensions (57282, 57283, 57280) from being billed at the same time as vaginal or laparoscopic hysterectomy
- TVH + AP Repair + vaginal suspension was reduced to TVH only
  - e.g. 58260 + 57260 + 57283
ACOG/AUGS/SGS Task Force petitioned NCCI

• A task force, under leadership of AUGS, engaged NCCI in a series of discussions regarding our objections
• NCCI “listened” to these objections and April 2015 made significant changes to the list of pair edits, retroactive to 10/1/14
• Vaginal hysterectomy + colporrhaphy no longer bundled
  ◦ 58260; 57260-51
• Remaining edits were maintained, but changed to allow modifier –59 to override, when the surgeon documents that substantial additional work was required
Procedures that need modifier -59 with TVH(58260-58294) retroactive to 10/1/14

- 57260 AP repair
- 57280 sacral colpopexy, open
- 57282 colpopexy-extraperitoneal-SSVVS
- 57283 colpopexy-intraperitoneal-high US suspension
- 57284 paravaginal repair, abdominal
TVH-APR-US suspension
Effective 4/1/15 (retroactive to 10/1/14)

- 58260
- 57260 -51
- 57283 -59

Be sure to document the substantial separate work done (i.e. high uterosacral suspension)

Must distinguish from the normal fixation of vagina to surrounding tissue at conclusion of the procedure
LAVH + 57260, 57280, 57283

- A few pair edits that were presumed to be included in the reversal were missed with the NCCI decision
- 2nd AUGS letter was successful in changing the above, effective 4/1/16 forward (but not retroactive)
- This means procedures done between 10/1/15 and 4/1/16 could not be reimbursed together
Procedures need modifier -59
LAVH (58550-58552) effective 4/1/2016

- 57260  AP repair
- 57280  sacral colpopexy, open
- 57282  colpopexy-extraperitoneal-SSVVS
- 57283  colpopexy-intraperitoneal-high US suspension
- 57284  paravaginal repair, abdominal
TVH OR LAVH CODES

- TVH (58260 – 58294)
- LAVH (58541 - 58544)
- Use -59 modifier w/
  - 57282/57283 apical suspension
  - 57280 ASC
- Prior NCCI edits had already bundled codes that include enterocele with apical suspension codes, and cannot be modified
  - e.g. never bill 57282/57283 with 57265 (AP w enterocele) or 58263 (TVH w enterocele)
NCCI Pair Edit Summary

- Colporrhaphy can be billed with -51 modifier
- Cystoscopy cannot be separately billed to “check your work”
- Apical suspension codes (57283, 57282, 57280) require -59 modifier with TVH, LAVH
- Resources for NCCI edits:
  - AUGS coding website
  - ACOG Coding Manual 2017
  - ACOG coding website
QUESTIONS?