INGENIX®

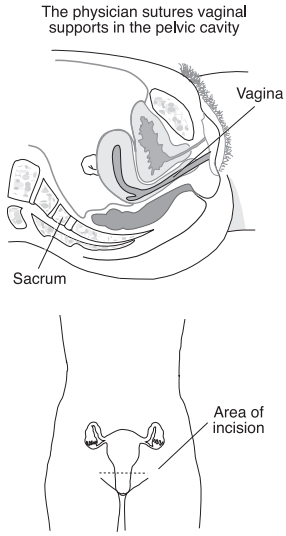
Coding Companion for OB/GYN

A comprehensive illustrated guide to coding and reimbursement

Contents

57280

57280 Colpopexy, abdominal approach



Explanation

Through a lower abdominal incision, the physician attaches the vault of the vagina to the prominent point of the sacrum. This is accomplished by suturing surgical fabric or a strip of abdominal wall fascia to the tissue in front of the internal sacral wall inside the pelvic cavity forming a bridge. The apex of the vagina is firmly sutured to this bridge. This stabilizes the vaginal vault and prevents prolapse of the vagina. The abdominal incision is closed with sutures.

Coding Tips

Transvaginal colporrhaphy often accompanies this procedure and should not be reported separately. For laparoscopic repair of stress incontinence only, see 51990 and 51992. For colpopexy by extra-peritoneal approach, see 57282. For colpopexy by intra-peritoneal approach, see 57283.

ICD-9-CM Procedural

70.77 Vaginal suspension and fixation

Anesthesia

57280 00840

ICD-9-CM Diagnostic

618.00 Unspecified prolapse of vaginal walls without mention of uterine prolapse — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.01 Cystocele without mention of uterine prolapse, midline — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.02 Cystocele without mention of uterine prolapse, lateral — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.03 Urethrocele without mention of uterine prolapse — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.04 Rectocele without mention of uterine prolapse — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.05 Perineocele without mention of uterine prolapse — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.09 Other prolapse of vaginal walls without mention of uterine prolapse — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.1 Uterine prolapse without mention of vaginal wall prolapse — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.2 Uterovaginal prolapse, incomplete — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.3 Uterovaginal prolapse, complete — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.4 Uterovaginal prolapse, unspecified — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.5 Prolapse of vaginal vault after hysterectomy — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.81 Incompetence or weakening of pubocervical tissue — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.82 Incompetence or weakening of rectovaginal tissue — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.83 Pelvic muscle wasting — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.84 Cervical stump prolapse — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

618.89 Other specified genital prolapse — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)

625.6 Female stress incontinence

Terms To Know

colpopexy. Suturing a prolapsed vagina to its surrounding structures for vaginal fixation.

colporrhaphy. Plastic repair or reconstruction of the vagina by suturing the vaginal wall and surrounding fibrous tissue.

female stress incontinence. Involuntary escape of urine at times of minor stress against the female bladder, such as coughing, sneezing, or laughing. ***NCD Reference:*** *30.1.1.*

prolapse. Falling, sliding, or sinking of an organ from its normal location in the body.

uterovaginal prolapse. Uterus displaces downward and is exposed in the external genitalia.

CCI Version 15.3

00940, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 44005, 44180, 44850, 44950, 49000-49010, 49255, 49570, 50715, 51701-51703, 57100, 57180, 57268-57270, 57282-57283❖, 57410, 57420, 57425, 57452, 57500, 57800, 62310-62319, 64400-64435, 64445-64450, 64470, 64475, 64479, 64483, 64505-64530, 69990, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150, P9612

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Assist
57280	26.47	26.47	90	80

Medicare References: None

0071T-0072T

0071T Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue

0072T total leiomyomata volume greater or equal to 200 cc of tissue

Explanation

Focused ultrasound ablation is a noninvasive surgical technique that uses thermal ablation to destroy uterine leiomyomata. In focused ultrasound ablation the ultrasound beam penetrates through soft tissues causing localized high temperatures for a few seconds at the targeted site, in this case the uterine leiomyomata. This produces thermocoagulation and necrosis of the uterine leiomyomata without damage to overlaying and surrounding tissues. Magnetic resonance (MR) guidance is used in conjunction with focused ultrasound ablation to provide more precise target definition. Since certain MR parameters are also temperature sensitive, MR guidance also allows estimation of optimal thermal doses to the uterine leiomyomata and detection of relatively small temperature elevations in surrounding tissues thereby preventing any irreversible damage to surrounding tissues. Report 0071T for total leiomyomata tissue volume less than 200 cc. Report 0072T for leiomyomata tissue volume equal to or greater than 200 cc.

0193T

0193T Transurethral, radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence

Explanation

The physician uses radiofrequency energy to treat female stress urinary incontinence, the involuntary loss of urine from the urethra due to increased intra-abdominal pressure. Using a small transurethral probe, the physician applies low temperature radiofrequency energy to targeted submucosal areas of the bladder neck and urethra. This results in minute structural alterations to the collagen which, upon healing, make the tissues firmer and increase their resistance to involuntary leakage.

71010

71010 Radiologic examination, chest; single view, frontal

Explanation

A radiograph is taken of the patient's chest from front to back (AP). Typically, this is done when the patient is too ill to stand or be turned to the prone position. The key element of this code is that it reports a single, frontal view.

71020

71020 Radiologic examination, chest, 2 views, frontal and lateral;

Explanation

Films are taken of the patient's chest to include a frontal and side to side (lateral) view. This code specifically reports these two views.

72170

72170 Radiologic examination, pelvis; 1 or 2 views

Explanation

One or two views are taken of the pelvis. The most common view is from front to back (AP) with the patient lying supine with feet inverted 15 degrees to overcome the anteversion (or rotation) of the femoral necks. The pelvic girdle, femoral head, neck, trochanters, and upper femurs are also shown.

72190

72190 Radiologic examination, pelvis; complete, minimum of 3 views

Explanation

A minimum of three films are taken of the pelvis, typically front to back (AP) with the patient lying supine. The patient's legs are placed in what is termed a "frogleg" lateral position, wherein the patient's feet are drawn up toward the buttocks, at which point the knees are allowed to drop down to the table with feet together. A third film may be taken with the patient lying on his or her side for a lateral view of the pelvis, as well as unilateral views of the hips, if necessary.

72191

72191 Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing

Explanation

Computed tomographic angiography (CTA) of the pelvis is performed with contrast materials and image postprocessing. CTA produces images of vessels to detect aneurysms, blood clots, and other vascular irregularities. Contrast medium is rapidly infused intravenously, at intervals, usually with an automatic injector, and the patient is scanned with thin section axial or spiral mode x-ray beams. The images are acquired with narrower collimation and reconstructed at shorter intervals than standard CT images. Three-dimensional images are generated and postprocessing reconstruction is done at a workstation on the scanner. CTA also provides information unavailable with conventional angiography, such as vessel wall thickness (mural thrombus) and the venous anatomy of a target organ and/or associated organs within the scan range. Noncontrast images, if performed, are also included in this procedure.

72192-72194

72192 Computed tomography, pelvis; without contrast material

72193 with contrast material(s)

72194 without contrast material, followed by contrast material(s) and further sections

Explanation

Computed tomography directs multiple narrow beams of x-rays around the body structure being studied and uses computer imaging to produce thin cross-sectional views of various layers (or slices) of the body. It is useful for the evaluation of trauma, tumor, and foreign bodies as CT is able to visualize soft tissue as well as bones. Patients are required to remain motionless during the study and sedation may need to be administered as well as a contrast medium for image enhancement. These codes report an exam of the pelvis. Report 72192 if no contrast is used. Report 72193 if performed with contrast and 72194 if performed first without contrast and again following the injection of contrast.

72195-72197

72195 Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)

72196 with contrast material(s)

72197 without contrast material(s), followed by contrast material(s) and further sequences

Explanation

Magnetic resonance imaging (MRI) is a radiation-free, noninvasive, technique to produce high quality sectional images of the inside of the body in multiple planes. MRI uses the natural magnetic properties of the hydrogen atoms in our bodies that emit radiofrequency signals when exposed to radio waves within a strong electro-magnetic field. These signals are processed and converted by the computer into high-resolution, three-dimensional, tomographic images. Patients with metallic or electronic implants or foreign bodies cannot be exposed to MRI. The patient must remain still while lying on a motorized table within the large, circular MRI tunnel. A sedative may be administered as well as contrast material for image enhancement. These codes report an exam of the pelvis. Report 72195 if no contrast is used. Report 72196 if performed with contrast and 72197 if

Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $29 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services
- Hospital inpatient services—initial care
- Hospital inpatient services—subsequent care
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician's office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the same specialty has seen the patient within three years, the patient is considered established.

If a physician is on call or covering for another physician, the patient's encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient's attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as "observation status" in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician "admitting" the patient for observation.

Codes 99234-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and