All About the Benjamins!

How to maximize billing and coding for PAG

Learning objectives

- Explain how medical care is reimbursed to providers via the Medicare Fee Schedule.
- Demonstrate outpatient and inpatient coding for pediatric and adolescent gynecology.
- Examine the most effective utilization of procedural codes for pediatric and adolescent gynecology.

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Outline

- Outpatient billing
- Multi-disciplinary billing
- Inpatient billing
- Surgical billing and coding
- Discussion time

We know everyone will have a LOT of questions but in order to get through the material, we are going to hold questions until the end of the lecture.
We will ensure there is time for questions.

Outpatient billing

Major changes happened in 2021!

- Level of service determined by either:
  - Total time for services on the date of encounter
  - Level of medical decision making
- Medically appropriate history and exam are required – but the extent of your history and exam are no longer components for the selection of E&M codes
- You may select the code based on the highest component documented (time vs decision making).
- Times for the time based codes increased
- Changes to how to code for prolonged services
- WRVUs increased

Coding based on time

- Time personally spent by the provider ***on the day of the encounter***
- Includes both:
  - Face-to-face time
  - Non face-to-face time
- No longer needs to include “>50% of time spent in counseling and/or coordination of care”, time based billing can be used regardless of which component dominates the service

Coding based on time

Face-to-face time

- Obtaining history
- Performing exam
- Counseling and educating patient/family/caregiver
- Time spent communicating with the patient/family/caregiver through an interpreter

Non face-to-face time

- Preparing for the visit - records review, review of labs/imaging
- Ordering tests, sending prescriptions
- Documenting
- Referring and communicating with other health care providers
- Care coordination

Billing based on time: does not include

- Time spent in activities normally performed by clinical staff
- Time spent on services that are separately reported or billed
  - Example: same day IUD placement that is separately billed as a procedure
- Time spent on another date

Time based billing: new patient visit

Previous

Code	Time	wRVUs
99202	20 mins	0.93
99203	30 mins	1.42
99204	45 mins	2.43
99205	60 mins	3.17
99354-99357 Prolonged services	Extra 30-74 minutes above time allotted for visit	

2021/New

Code	Time	wRVUs
99202	15-29 mins	0.93
99203	30-44 mins	1.6
99204	45-59 mins	2.6
99205	60-74 mins	3.5
99417 Prolonged services	≥75 mins, each 15 mins	

Time based billing: established patient visit

Previous

Code	Time	WRVUs
99212	10 mins	0.48
99213	15 mins	0.97
99214	25 mins	1.5
99215	40 mins	1.92
99354-99357 Prolonged services	Extra 30-74 mins above time allotted for visit	

2021/New

Code	Time	WRVUs
99212	10-19 mins	0.7
99213	20-29 mins	1.3
99214	30-39 mins	1.92
99215	40-54 mins	2.8
99417 Prolonged services	≥55 mins, each 15 mins	

Prolonged time

- New code 99417
- Can only be used when using time based billing, and only after the total time of the highest level service (99205 or 99215)
  - ≥75 minutes for new patient (99205)
  - ≥55 minutes for established patient (99215)
- For each additional 15 minutes – can use multiple times

Prolonged time

Total duration of new patient office visit	Code
Less than 75 minutes	99205, not reported separately
75-89 minutes	99205 + 99417x1
90-104 minutes	99205 + 99417x2
105 or more minutes	99205 + 99417x3, or more for each additional 15 mins

Total duration of established patient office visit	Code
Less than 55 minutes	99215, not reported separately
55-69 minutes	99215 + 99417x1
70-84 minutes	99215 + 99417x2
85 or more minutes	99215 + 99417x3, or more for each additional 15 mins

Prolonged services: not on date of service

- Non face-to-face prolonged services (medical record review) billed when done on a day ***OTHER*** than the office visit
  - CPT codes 99358-99359
- All records review that occurred on the date of the encounter should be included in the time for the office visit (whether before or after) and would not be billed separately

Documenting your time

- Can only include time you PERSONALLY spent, cannot include time spent by learners
- Document the total time spent on the date of service
  - Example 1: “I spent 35 minutes on the date of service in evaluation and management of her menorrhagia.”
  - Example 2: “I spent a total of 35 minutes today preparing to see the patient (reviewing records/tests/images), obtaining my own history & performing a medically appropriate exam, counseling and educating the parent/family/caregiver, documenting in the electronic medical record, and coordinating care of the patient. This time is exclusive of any separately reported procedures.”
  - Example 3: “I spent a total of 35 minutes for “patient’s name” visit today, 2/23/2023; during which I was obtaining and/or reviewing separately obtained history, performing a medically appropriate examination and/or evaluation, forming my assessment and plan, reviewing assessment and treatment plan with patient/family/caregiver.”

Documenting your time

- Medicaid: need to document the specific start/stop times for any non face-to-face and the time in/out of the room for face-to-face
  - Example: “Time in: 9:00
    Time out: 9:33
    Time spent documenting and coordinating care: 9:33 – 9:35
    I spent 35 minutes on the date of service in evaluation and management of her menorrhagia.”
- This may differ by state, so always check with your billing department to make sure you are meeting all necessary requirements!
- In my state, if the time in/time out is not documented then Medicaid will not allow billing based on time and will revert to billing on complexity instead.

Examples of time based billing

- A new patient is here to see you in clinic. You spend 10 minutes on the day of her clinic visit reviewing the referring provider's records prior to seeing her. The patient visit including history, physical exam, and counseling takes 45 minutes. You spend 10 minutes after the patient leaves sending her prescription and documenting in EMR.
  - How would you bill based on time?
  - You spent a total of 65 minutes on the date of service
  - 99205 (60-74 mins)

Examples of time based billing

- An established patient comes in for a problem visit. Her mother only speaks Spanish so you use an interpreter for the entire visit. She has multiple concerns and her visit ends up taking 70 minutes. After her visit, you spend 15 minutes documenting. At the end of the day, you call her pediatrician to update them on your plan of care, which takes you 8 minutes. The following day, you speak to her other 3 sub-specialist providers to ensure everyone is on the same page, which takes you about 20 minutes in total.
  - How would you bill based on time?
  - You spent 93 minutes on the date of service
  - The 20 minutes the next day do not count toward your total
  - 99215 (40-54 mins) + 99417 (15 mins) + 99417 (15 mins) + 99417 (15 mins)

Examples of time based billing

- You have a 4th year medical student rotating in your clinic today. They go in to see an established patient of yours who has endometriosis, heavy menstrual bleeding due to von Willebrand disease, and is on OCPs for management of her menstrual symptoms. The medical student spends 40 minutes taking a thorough history. They spend 5 minutes presenting the patient to you, and then you spend 10 minutes with the patient discussing her management. You spend 10 minutes documenting the following day.
  - How would you bill based on time?
  - Can't include time spent by the student, or the time documenting the next day. Your total time is only 15 minutes = 99212 (10-19 mins).
  - Better to bill based on complexity! Would get you to 99214.

Examples of time based billing

- You see a new patient for contraception counseling. You spend 5 minutes on the same day reviewing her pediatrician's referral notes. You discuss contraception options with her and she is considering a LARC, and wants it placed before she leaves. You spend quite a bit of time going through the arm implant versus the intrauterine device, and she ultimately chooses the arm implant. Your counseling discussion took 40 minutes. You then spend 15 minutes consenting for the procedure and placing the arm implant. At the end of the day, you spend 5 minutes documenting.
  - How would you bill based on time?
  - Procedure is separately billed, so that time is not included.
  - You spent 50 minutes on the date of service, not including the procedure.
  - 99204 (40-59 mins)

Billing based on medical decision making

- Decision making component
- Specific number of history and physical exam components no longer part of this
- 3 components:
  - Number and complexity of problems addressed
  - Amount and complexity of data
  - Risk of complications
- 2 out of 3 components need to be met to bill for that level

Billing based on medical decision making

Code	Level of MDM Based on 2 out of 3 elements	Elements of Medical Decision Making		
		Number and complexity of problems addressed	Amount and/or complexity of data to be reviewed and analyzed *Each unique test, order, or document contributes to the combination of 2 or 3 in category 1 below	Risk of complications and/or morbidity or mortality of patient management
99211	**N/A**	**N/A**	**N/A**	**N/A**
99202 **99212**	**Straightforward**	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 **99213**	**Low**	**Low** • 2 or more self-limited or minor problems or • 1 stable chronic illness or • 1 acute, uncomplicated illness or injury	**Limited** (Must meet the requirements of at least 1 of the 2 categories) **Category 1: Tests and documents** • Any combination of 2 from the following: 1. Review of prior external note(s) from each unique source* 2. Review of the result(s) of each unique test* 3. Ordering of each unique test* or **Category 2: Assessment requiring an independent historian{s)**	**Low risk of morbidity from additional diagnostic testing or treatment**

99204 **99214**	**Moderate**	**Moderate** • 1 or more chronic illness with exacerbation, progression, or side effects of treatment or • 2 or more stable chronic illnesses or • 1 undiagnosed new problem with uncertain prognosis or • 1 acute illness with systemic symptoms or • 1 acute complicated injury	**Moderate** (Must meet the requirements of at least 1 out of 3 categories) **Category 1: Tests, documents, or independent historian(s)** • Any combination of 3 from the following: 1. Review of prior external note(s) from each unique source* 2. Review of the result(s) of each unique test* 3. Ordering of each unique test* 4. Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 **99215**	**High**	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment or • 1 acute or chronic illness or injury that poses and threat to life or bodily function	**Extensive** (Muse meet the requirements of at least 2 out of 3 categories) **Category 1: Tests, documents, or independent historian(s)** • Any combination of 3 from the following: 1. Review of prior external note(s) from each unique source* 2. Review of the result(s) of each unique test* 3. Ordering of each unique test* 4. Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding major elective surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care due to poor prognosis

Documenting level of complexity

- List the specific orders (3 or more!) in your note
- Help your billing team out! Include specific verbiage that matches what is in the MDM guidelines
  - “I discussed the plan of care with patient’s pediatric endocrinologist Dr. Smith on the same date of service.”
  - “Labs ordered during today’s visit: CBC, coagulation profile, fibrinogen, and von Willebrand panel.”
  - “Due to **side effects** of mood swings on her current OCPs, alternative options were reviewed and patient elects to switch to patches.”
  - “I personally reviewed the ultrasound images on the same date of service. **My own interpretation**: normal anteverted uterus and normal bilateral ovaries.”
  - “Patient with known endometriosis, experiencing **exacerbation** of her chronic pelvic pain.”

Examples of medical decision making billing

- You see a new patient for secondary amenorrhea of unknown etiology. You obtain a history and perform a physical exam, and order a panel of labs for work up: HCG, thyroid studies, prolactin, LH, FSH, estradiol, free/total testosterone, and DHEA-S. You schedule her to come back to see you in 1 month to review results and discuss treatment options. The visit takes you 20 minutes.
  - How would you billed based on medical decision making?
  - 1 undiagnosed new problem + ≥3 lab orders
  - 99204 (new patient, moderate complexity)
  - You get a higher level of billing based on complexity instead of time (which would only get you 99202)

Examples of medical decision making billing

- You are seeing patients in a multidisciplinary clinic with hematology. You see an established patient who has von Willebrand disease and is doing well on her OCPs. You send refills to the pharmacy. Her visit with you takes 10 minutes. At the end of the clinic, you and the hematologist review each of the patients seen that day and discuss their management plans.
  - How would you bill based on medical decision making?
  - Discussion of management with external physician + prescription drug management
  - 99214 (established patient, moderate complexity)

Examples of medical decision making billing

- You see an established patient for follow up of her dysmenorrhea. 2 months ago you had initiated her on OCPs, however today she reports side effect of nausea and mood swings since starting the pills. After discussion, she elects to switch to Depo Provera.
  - How would you bill based on medical decision making?
  - 1 chronic illness with side effect of treatment + prescription drug management
  - 99214 (established patient, moderate complexity)

Examples of medical decision making billing

- You see a patient in your clinic for fertility preservation counseling. She was recently diagnosed with leukemia and will be starting chemotherapy in 2 days. Before heading into the exam room you call her oncologist to review her treatment plan, and determine that she is at high risk for negative impact on future fertility. You counsel the patient about her options, and order baseline estradiol, LH, FSH, and AMH. She elects to start depot leuprolide.
  - How would you bill based on medical decision making?
  - 1 acute/chronic illness that poses threat to life/bodily function + [discussion of management with external physician + ≥3 lab orders] + drug therapy requiring monitoring for toxicity
  - 99205 (new patient, high complexity)

Billing code 96217

- “Brief emotional/behavioral assessment, with scoring and documentation”
- Are you giving patients depression screening with PHQ9? You can bill for this!
- Insurance will typically pay for this 3x per year
- The screener must be documented (either in your note, or scanned into EMR) and include the scoring/results and your treatment recommendation (even if it is neg/no treatment needed)
  - Depression screen results: negative
  - Intervention: reviewed results with patient and family
  - Referral: no referral made at this time

Office procedures

- Typically billed separately from the clinic visit, unless the visit was only for the procedure
  - Example 1: Patient seen for contraception counseling, elects for same day IUD placement. Billing would include the visit (typically 99203/99213, include modifier -25 for separately identifiable service) + IUD placement procedure (58300).
  - Example 2: Patient seen in clinic on Monday for contraception counseling, elects for IUD placement but prefers to come back on a different day, then comes in on Wednesday for IUD placement procedure. Billing for the visit on Wednesday would only be the procedure.
  - Example 3: Patient presents for contraception visit, and states at the beginning of the visit that she wants an IUD. You don't discuss other options, simply review the procedure and sign consents then place the IUD. Billing would only be for the procedure.

Office procedure codes

Procedure	CPT code
Biopsy vulva: 1 lesion	56605
Biopsy vulva: each additional lesion	56606
I&D vulva	56405
I&D Bartholin gland	56420
Vaginal irrigation	57150
Subdermal implant insertion removal removal/re-insertion	11981 11982 11983
Intrauterine device insertion removal	58300 58301
Ultrasound guidance (ie, during IUD insertion)	76998
Ultrasound (ie, after difficult IUD insertion) Transvaginal Pelvic (non-OB)	 76830 76857

Office procedure coding

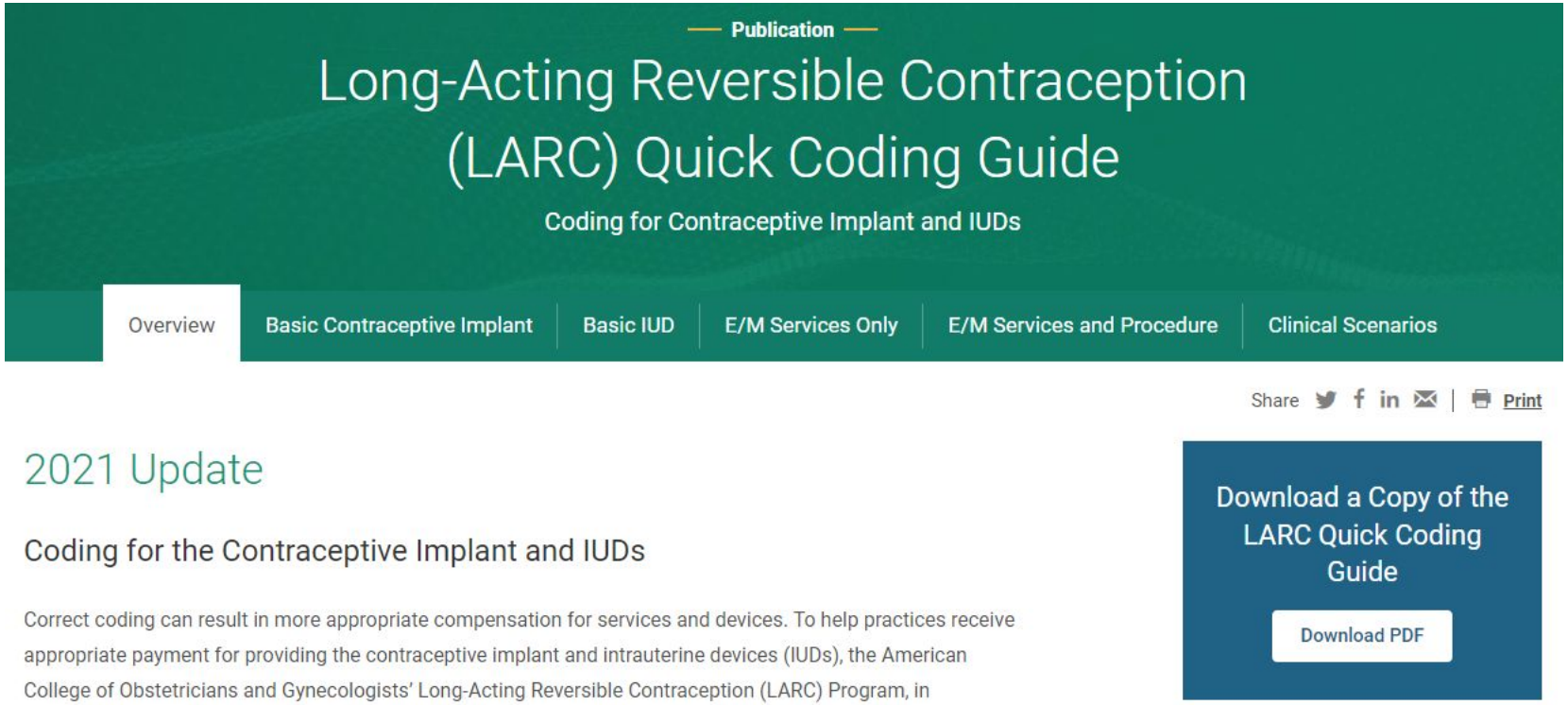
Modifier codes	
Increased difficulty	-22
Significant, separately identifiable E/M service on same day as procedure	-25
Multiple procedures	-51
Aborted procedure	-53

HCPCS codes

- Remember to bill for the device that was placed! This helps to make sure your clinic gets re-imbursed correctly
- The procedure codes do not include the cost of the device, needs to be reported separately
  - Etonorgestrel implant HCPCS code: J7307
  - Example: patient seen for subdermal contraceptive implant placement procedure. Billing would include: 11981 (insertion procedure) + J7307 (HCPCS code for the device)

ACOG LARC coding guide

- https://www.acog.org/education-and-events/publications/larc-quick-coding-guide



Multi-disciplinary billing

Multi-D Clinics

- Visit type: multidisciplinary visit
- “I spent a total of 90 minutes with the patient and their family today. The first 60 minutes was during the initial intake and the second 30 minutes was during the feedback session”
- Time prepping for visit, collaboration with other providers, documentation
- First specialty to see the patient picks new patient LOS, subsequent providers select established LOS

Multi-D Surgeries

- Assistant
  - No qualified resident available
    - Modifier 62
  - The complexity requires another teaching physician to assist
  - Assistant does not need to write an op note
  - Reimburses at 16% the maximum of procedure
- Co-surgeon
  - Reimburses 62.5% of the global surgery fee
  - Separate op note
- If a patient refuses to allow a resident to participate in their surgery & another physician acts as an assistant due to request/demand, those services cannot be billed to any payer or the patient

Examples

- Lscope USO and staging done with GYN onc
- Complex vaginoplasty with bladder mobilization and buccal graft done with Urology
- EUA, cystoscopy, rectal exam, vaginoscopy done with Urology and Pediatric Surgery
- Discuss who will bill for what it ahead of time!

Inpatient billing

Inpatient Changes as of January 2023

- “Patients over paperwork”
- Goal is for documentation reduction
- Mirrors 2021 Office/Outpatient changes to E/M
- Service levels will be determined by MDM or time only
- MDM requirements same for all patients
  - New/established (outpatient)
  - Initial/subsequent (inpatient)
- Time = total time on of day of service
  - No longer requires 50% of encounter spent counseling & coordinating of care

H&P

- History & exam are no longer required components in selecting level of billing but this differs from hospital requirements for H&P.
- H&P must be completed within 24 hrs of admission by admitting physician
- Anyone else seeing the patient for the first time that hospitalization should bill for an initial inpatient service.
- Hospital requirements for an H&P should include (at a minimum):
  - History
  - Physical Exam
  - Pertinent lab results and studies
  - Assessment
  - Plan

Medical Decision Making (MDM)

- Two of the three elements must be met or exceeded
- Tell the story: Give a brief description of the problem(s), complexity, and risk rather than checking off points
- Comorbidities are only considered if they address and impact the MDM

MDM Example

- Heavy menstrual bleeding (AUB-I/C)
  - Patient's current menstrual cycle exacerbated by anticoagulation
  - H/H stable, no recent transfusions
  - continue daily pad weights, please call Gyn for bleeding >20cc/day
  - s/p Depo Provera on 12/31/22, followed by Provera taper.
  - Currently on Provera 20mg TID. Plan to down titrate to 20mg BID (1/8-14), 20mg daily (1/15-21) then 10mg daily 1/22 until seen by Gynecology as outpatient
- Heterozygous Factor V Leiden, Protein S deficiency
  - Management per Hematology
  - Avoid estrogen containing compounds
- Extensive RLE thrombus
  - s/p IR thrombolysis and bilateral iliac stents
  - Currently on Bivalrudin with plans to transition to Lovenox prior to discharge
  - Anticipate long term need for anticoagulation

CPT E/M MDM Table effective January 1, 2023

Levels of MDM	Elements of MDM		
(based on 2 out of 3 elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed (each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment

Low	Low
	• 2 or more self-limited or minor problems; OR
	• 1 stable chronic illness; OR
	• 1 acute, uncomplicated illness or injury; OR
	• **1 stable, acute illness**; OR
	• **1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care**
		Limited
		(Must meet the requirements of at least 1 of the 2 categories)
		Category 1: Tests and documents
		• Any combination of 2 from the following:
		  • Review of prior external note(s) from each unique source*;
		  • review of the result(s) of each unique test*;
		  • ordering of each unique test*
		or
		Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
			Low risk of morbidity from additional diagnostic testing or treatment

CPT E/M MDM Table effective January 1, 2023

Levels of MDM	Elements of MDM		
(based on 2 out of 3 elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed (each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Patient Management
Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; OR • 2 or more stable chronic illnesses; OR • 1 undiagnosed new problem with uncertain prognosis; OR • 1 acute illness with systemic symptoms; OR • 1 acute complicated injury	Moderate (Must meet the requirements of at least 1 out of 3 categories) Category 1: Tests, documents, or independent historians(s) Any combination of 3 from the following: • Review of prior external note(s) of each unique test* • Review of the result(s) of each unique test* • Ordering of each unique test* Or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reporting) Or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	Moderate Risk of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

CPT E/M MDM Table effective January 1, 2023

Levels of MDM	Elements of MDM		
(based on 2 out of 3 elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed (each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Patient Management
High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; Or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (Must meet the requirements of at least 2 out of 3 categories) Category 1: Tests, documents, or independent historians(s) Any combination of 3 from the following: • Review of prior external note(s) from each unique source* • Review of the result(s) of each unique test* • Ordering of each unique test* • Assessment requiring an independent historian(s) Or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified healthcare professional (not separately reported) Or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified healthcare professional/appropriate source (not separately reported)	High Risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization **or escalation of hospital level of care** • Decision not to resuscitate or to de-escalate care because of poor prognosis • **Parenteral controlled substances**

Time based billing

- Consider adding a time statement to your notes
- Time the the day of encounter only
  - If this is overnight, bill as the day it began
- Total time will include both face-to-face and non-face-to-face time **personally provided** by the billable practitioner
- Inpatient prolonged services: 99418 (15 min)
- Only able to use this when billing on time, in conjunction with highest-level inpatient/observation level of service
  - AMA/CPT: add 99418 to minimum time
  - CMS: add 99418 to maximum time
- Depends in insurance

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▲**99221** **Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making.

When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

▲**99222** **Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.

▲**99223** **Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.

►(For services of 90 minutes or longer, use prolonged services code 993X0)◄

►Subsequent Hospital Inpatient or Observation Care◄

★▲**99231** **Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.

When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.

★▲**99232** **Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.

★▲**99233** **Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

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When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.

►(For services of 65 minutes or longer, use prolonged services code 993X0)◄

Consults

- Consultation requirements have been revised to reflect the same 4 levels of MDM, and time(s) for each level have been changed
- Link note to consultation order (initial inpatient encounter)
- Follow-up consult notes: subsequent inpatient encounter

Surgical billing and coding

Medicare Global Package

- Pre-operative Work
- Intra-operative Work
- Post-operative Work

- Minor procedures
  - 0 or 10 day global period
- Major procedures
  - 90 day global period

CPT Global Package

- Includes:
  - Operation
  - Local infiltration, topical anesthesia, blocks, etc.
  - Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (includes H&P)
  - Typical supplies and materials
  - Immediate postoperative care, dictating operative notes, talking to family and other providers
  - Writing orders
  - Evaluating patient in PACU
  - Typical postoperative follow-up care

CPT Global Package

- Does Not Include:
  - Administration of regional anesthesia or conscious sedation (unless specifically noted)
  - Care provided for complications, exacerbations, recurrence, or other diseases or injuries
  - Supplies and materials provided by the physician ***over and above*** those usually included
  - Care provided **outside** the group or by **other specialties** within the same group

Minor Surgical Procedures

- Include:
  - Preoperative: E/M services same day
  - Intra-operative:
    - All integral procedures including supplies usually used
    - Anesthesia by surgeon
  - Postoperative:
    - 0 day global: Related visits on same day
    - 10 day global: Follow-up visits for 10 days that are related to recovery from surgery

Major Surgical Procedures

- Include:
  - Preoperative: E/M services beginning one day prior
  - Intra-operative:
    - All usual intra-operative procedures
    - Anesthesia administered by surgeon
  - Postoperative:
    - Complications treated outside the operating or procedure room
    - Related visits for 90 days
    - Post-surgical pain management by surgeon
- Does not include:
  - E/M services which the decision to perform the surgery was made
  - Treatment for post operative complications that require a return trip to the OR

CPT Surgery Section

Female Genital Section

- Vulva, Perineum, Introitus (56405-56821)
- Vagina (57000-57462)
- Cervix Uteri (57452-57800)
- Corpus Uteri (58100-58579)
- Oviduct/Ovary (58600-58770)
- In Vitro Fertilization (58970-58976)
- Other Procedures (58999)

Divided by Incision, Destruction, Excision, Repair, Endoscopy/Laparoscopy/Hysteroscopy, Manipulation

Medicare Global Periods

CPT Code	General Description	Global Period
57452	Colposcopy of the cervix/upper vagina	0
58120	D&C	10
58661	Laparoscopy with removal of adnexal structures	10
58662	Laparoscopy with excision of lesions of the ovary/pelvic viscera, peritoneum	90
58720	Open salpingo-oophorectomy	90
49320	Diagnostic laparoscopy	10
49321 or 49321	Laparoscopy with biopsy or aspiration of cyst	10

Surgical Bundling

- Inclusion of lesser procedures in the payment for a more comprehensive procedure performed during the same session
  - Example: Pelvic examination under anesthesia (57410) is commonly performed and included in many OB-Gyn CPT codes
  - Medicare's Correct Coding Initiative (CCI) sets guidelines
- Exceptions to CCI
  - Different sides of the body (procedures are assumed to be on one organ)
  - Biopsy of lesions may be bundled but sometimes they are not
  - Endoscopy at the time of open procedure may be bundled but sometimes they are not

Surgical Modifiers

- Definition:
  - Two digit numeric codes that indicate a basic service has been altered by particular circumstance
  - Medicare also has developed alphanumeric modifiers such as RT/LT

Surgical Modifiers

- Preoperative
  - -25: E/M *above and beyond* the usual pre- and post-procedure care (typically for “minor” surgery
  - -57: E/M service resulted in *initial* decision to perform “major” surgery
- Intraoperative
  - -50: Procedure was done *bilaterally* (used for codes that are unilateral typically)
  - -51: More than one procedure performed at the same session (*procedures not typically bundled*)
  - -59: Unusual circumstances involving multiple procedures performed together (*typically procedures that are bundled*)

Surgical Modifiers

- Intraoperative
  - -80 or -82: Assistant at surgery (depends on *teaching hospital/Medicare status*)
  - -62: Two primary surgeons (2 operative reports required)
- Postservice
  - -78: Unplanned return to the OR: Complication requiring return to OR
  - -58: Staged or related procedure during the global period
  - -24 or -79: Unrelated E/M or procedure during global period that is independent of original procedure

Modifier 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
- Providing a cover letter along with a copy of the operative report indicating the additional time/effort/services provided is recommended

Special Issues in Gynecology Surgery

- Endoscopy versus open procedure
  - The only endoscopy codes are under the endoscopy categories otherwise all other codes are assumed to be open procedures
  - If no specific endoscopy code exists, should bill for unlisted endoscopy code
- Endoscopy followed by open procedures
  - The rules are complex and CPT/Medicare rules are not always consistent
  - Discuss with biller if adding a modifier -22 (increased procedure time) versus modifier -59 (distinct service) is most appropriate
- Lysis of adhesions code may be a independent procedure, component of another procedure or independent but distinct from other procedures
  - Discuss with biller if adding a modifier -22 (increased procedure time) versus modifier -59 (distinct service) is most appropriate

PAG Procedures without CPT Codes

How do you code for these procedures?

Vaginoscopy

CPT Code	Procedure Description	wRVU	Global
57452	Colposcopy of the cervix including upper vagina	1.5	0

- Consider billing for 57150- irrigation of the vagina and/or application of drug to treat??

Labiaplasty for labia minora hypertrophy

CPT Code	Procedure Description	wRVU	Global
56620, -50	Vulvectomy simple, partial	7.53	90

Torsion of adnexa

CPT Code	Procedure Description	wRVU	Global
49320	Diagnostic laparoscopy with or without collection of washings	5.14	10

- Could also consider coding as 58679-unlisted laparoscopy procedure??

Laparoscopic paratubal cystectomy

CPT Code	Procedure Description	wRVU	Global
58662	Laparoscopic, surgical; excision of lesions of the ovary, pelvic viscera or peritoneal surface	12.15	90

- Could debate 58661-Laparoscpic, surgical; with removal of adnexal structures??

Laparoscpic salpingo-oophorectomy

CPT Code	Procedure Description	wRVU	Global
58661	Laparoscopic, surgical; with removal of adnexal structures	11.35	10

- Could debate 58662-Laparoscpic, surgical; excision of lesions of the ovary, pelvic viscera or peritoneal surface??

Laparoscopy for endometriosis

CPT Code	Procedure Description	wRVU	Global
49320	Diagnostic laparoscopy with or without collection of washings	5.14	10
49321	Laparoscopy, surgical; with biopsy (single or multiple)	5.44	10
58662	Laparoscopic, surgical; fulguration or excision of lesions of the ovary, pelvic viscera or peritoneal surface	12.15	90

- Per AAGL recommendations, if minimal work involved, use 49320 or 49321. If operative time is ~ 80 minutes, use 58662. If > 80 minutes, use -22 modifier.

Repair of Imperforate Hymen

CPT Code	Procedure Description	wRVU	Global
56700	Partial hymenectomy or revision of hymenal ring	2.84	10

- Could debate 56442-Hymenotomy, simple incision

Excision of longitudinal septum

CPT Code	Procedure Description	wRVU	Global
57130	Excision of vaginal septum	2.46	10

Excision of transverse septum

CPT Code	Procedure Description	wRVU	Global
57130	Excision of vaginal septum	2.46	10

- Definitely consider a -22 modifier since it is a more complicated procedure??

OHVIRA Repair

CPT Code	Procedure Description	wRVU	Global
57130 -22	Excision of vaginal septum	2.46	10

- Consider adding 57291- Construction of artificial vagina; without graft??
- Definitely consider a -22 modifier since OHVIRA is a more complicated procedure??

Lower vaginal atresia repair

CPT Code	Procedure Description	wRVU	Global
57291	Construction of artificial vagina; without graft	8.64	90

- If using a graft, can use 57292-Construction of artificial vagina; with graft

Removal of Mullerian remnant

CPT Code	Procedure Description	wRVU	Global
58541	Laparoscopic, surgical, supracervical hysterectomy, for uterus 250 g or less	12.29	90

- If small, would code 58661
- If large, would code as hysterectomy

Discussion and Questions