

# Coding for Pelvic Reconstruction Surgery

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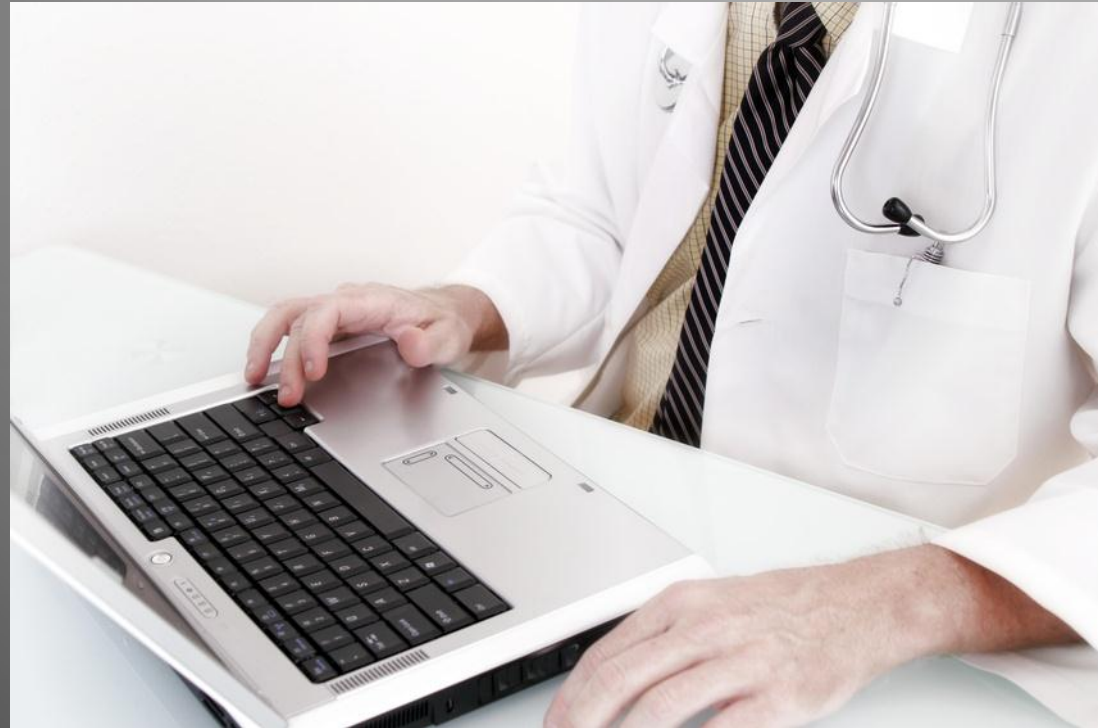
- ▶ Ms. Witt provides coding and reimbursement assistance to Boston Scientific Corporation relating to their products for female genitourinary conditions.
- ▶ The opinions and recommendations expressed in this presentation are those of the presenter and do not necessarily reflect those of Boston Scientific.

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# Webinar Learning Objectives

- ▶ Select appropriate CPT® Codes for each type of repair
- ▶ Understand the role of documentation to ensure fair and timely reimbursement
- ▶ Select appropriate diagnostic linkages in support of procedures performed
- ▶ Understand how payer billing rules can impact reimbursement
- ▶ Effectively report surgical complications

# Documentation: the Key to Reimbursement



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# What Payers Want

- ▶ Documentation of
  - What you did
  - How you did it
  - Why you did it



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# Sobering Facts

- ▶ An improperly filed claim for payment automatically adds another 30 days before you receive payment
  - It could be your fault, not the coders
- ▶ Large surgical practices can lose around 20% in revenue due to improperly coded claims
  - Smaller practices generally lose less revenue due to less volume of claims and more time by staff to investigate correct coding
    - This still assumes well trained coding/billing staff

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# Surgical Documentation Means Reimbursement

- ▶ The operative note represents the most important document for justification of reimbursement for surgical services
- ▶ Consider it a stand-alone document
- ▶ Surgeons should reassess the operative note as a billing document and provide the information necessary to expedite reimbursement

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# Surgical Documentation...

- ▶ Important elements
  - Pre- and postoperative diagnoses
  - Procedure performed
    - Try and use CPT® Code terminology
  - Indications statement
  - Findings statement
  - Description of each procedure performed in enough detail to support billing
    - If procedure is very difficult spend some time describing it and indicate time in comparison to normal time
  - Sponge count & patient status

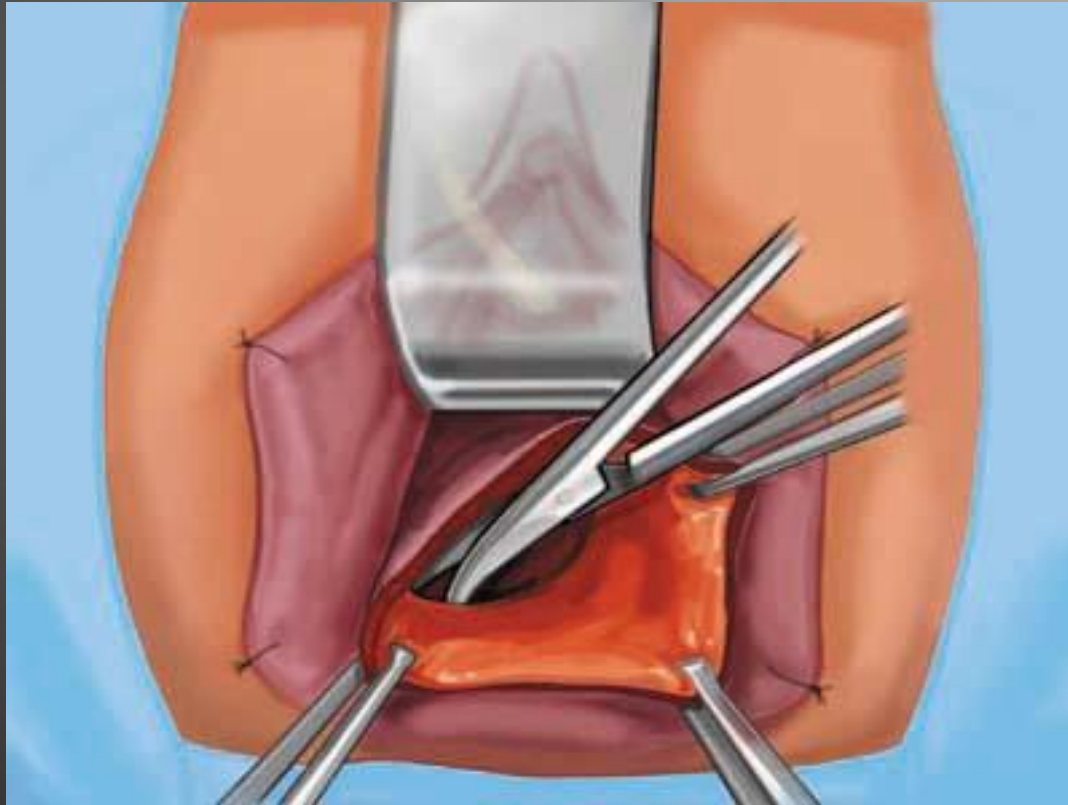
# Be Proactive

- ▶ Know your payers and their policies
  - Coding can't fix a bad contract
  - Negotiate for the things you want
- ▶ Work with your coders and billers
  - Be available and open for questions
  - Plan regular meetings to discuss problems
  - Make sure someone is watching denials and payer contracted payment amounts
- ▶ Be prepared to appeal denials – every time when right is on your side
  - May require writing letters or contacting the payer's medical director to resolve issues



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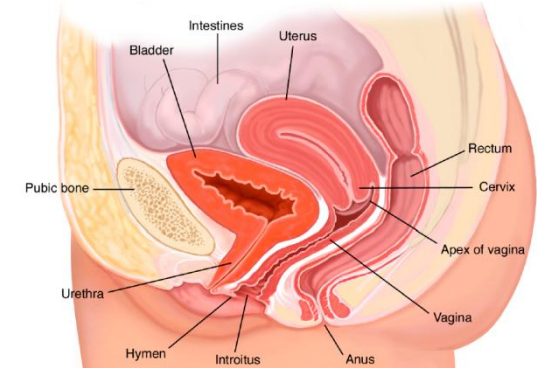
# Surgical Treatments



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# Anterior Wall Prolapse Surgery

- ▶ Anterior colporrhaphy—  
CPT® Code 57240:
  - Usually performed for midline cystocele or cystourethrocele
  - Basic description: open anterior wall, plicate excess tissue, suture closed, cut off excess
  - Includes repair of urethrocele if performed



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# Anterior Wall...

- ▶ Paravaginal defect repair
  - Repairs a lateral defect
  - All approaches include cystocele repair (anterior colporrhaphy)
  - Reattaches the lateral vagina to the ATRFP
  - All CPT® Codes for this repair involve entering the space of Retzius and using sutures to make the attachment
    - Abdominal (CPT Code 57284)
    - Vaginal (CPT Code 57285)
    - Laparoscopic (CPT Code 57423)

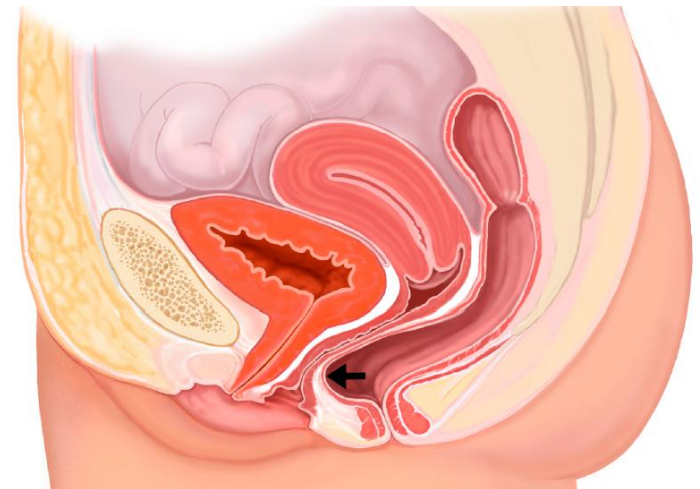
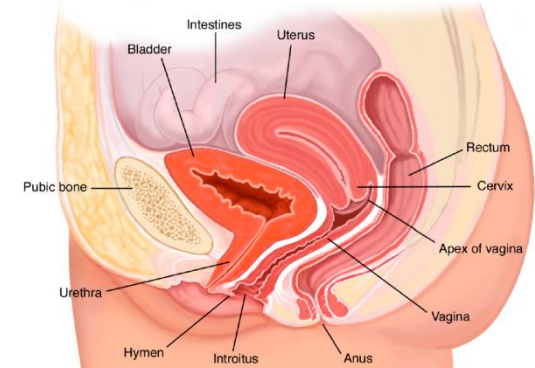
# Posterior Wall Prolapse

## ▶ Rectocele repair

- Without posterior colporrhaphy: CPT® Code 45560
  - Documentation will show rectal plication
  - Normally performed by a general surgeon for fecal incontinence
- With posterior colporrhaphy: CPT Code 57250
  - Includes perineorrhaphy
  - Open the posterior vaginal wall, plicate thickened tissue, suture to close defect, cut off excess

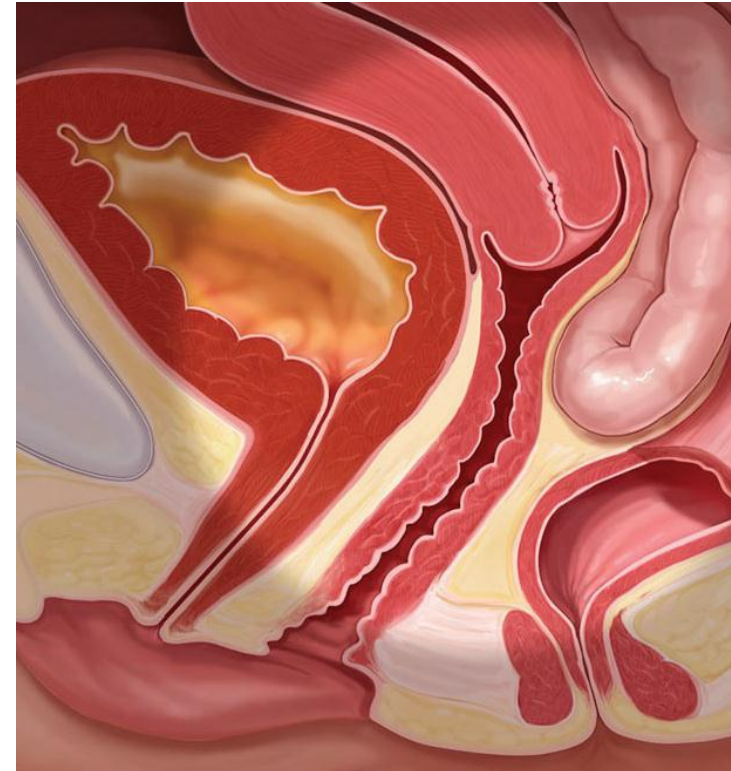
## ▶ Combined Procedures

- Each includes perineorrhaphy
- A&P: CPT Code 57260
- A&P & enterocele repair: CPT Code 57265



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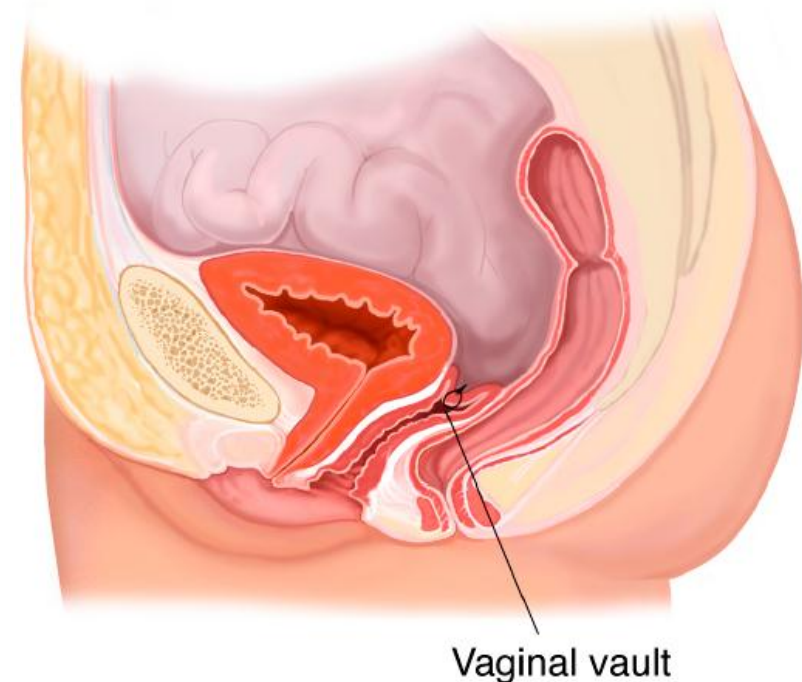
- ▶ Special case because the 2 stand-alone codes are always bundled (CPT® Codes 57268/57270)
  - Report inclusive codes only
    - CPT Codes 58263, 58270, 58280, 58292, 58294
- ▶ Can be repaired at the time of a vaginal hysterectomy
  - Report inclusive codes only
    - CPT Codes 58263, 58270, 58280, 58292, 58294
- ▶ Can be repaired at the time of colpexy
  - McCall culdoplasty to reduce the enterocele (CPT Code 57283) per ACOG
  - Do not bill for both an enterocele repair and colpexy at the same operative session



# Vaginal Vault Prolapse

## ▶ Colpopexy:

- Attach vaginal vault to a supporting structure usually using mesh
  - Use of mesh is not reported separately
- Laparoscopic—CPT® Code 57425
- Abdominal—CPT Code 57280
- Vaginal:
  - Sacrospinous or iliococcygeus ligament—CPT Code 57282
  - Uterosacral or levator myorrhaphy—CPT Code 57283
- Documentation of vault prolapse is required by most payers





# Use of Mesh for Prolapse Repairs

- ▶ Main rationale is to provide support to the already attenuated or absent connective pelvic floor tissues that have failed



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# Mesh System Repairs

- ▶ Vaginal mesh kits facilitate physician placement and may reduce operative time.
  - Mesh can be additionally cut or trimmed in OR to fit the patient
- ▶ Physicians often refer to procedures by the name of the product they use
  - E.g., Uphold® System, Elevate® Prolapse Repair System, Repliform® Matrix, etc.
    - These product names will not get the claim coded properly
      - It is what the surgeon documents that determines the code
  - The product is named by the company that developed it
    - May include one product or a combination of products within a single package (Kit/System) that includes special tools to accomplish an implants placement (introducers, obturators, needles, etc.)
    - Not all products are the same. Product selection is based on physician preference and desired outcomes for the patient

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# Mesh Repairs...

- ▶ You report the CPT® Code that best fits the repair type
  - Anterior repair
    - Note, even though some mesh systems may anchor the mesh at the arcus tendineus, this is not the same as the work for the paravaginal codes developed by CPT
  - Posterior repair
  - Vaginal vault repair
  
- ▶ Mesh may be bundled by the payer without establishing medical need for the augmentation to the anterior or posterior wall

# Mesh Systems

Name	Uses	Attachments	Add-on Mesh?
Uphold® Vaginal Support System	Anterior wall, and vaginal vault repair	Sacrospinous ligament, with overlay of anterior compartment	Yes, with documented pubocervical fascia weakness
Pinnacle® Posterior Pelvic Floor Repair Kit	Posterior wall repair	Sacrospinous ligament	Yes, if rectovaginal fascia weakness is documented
Elevate® Prolapse Repair System	Anterior wall, posterior wall and vault repair	Sacrospinous ligament and/or obturator internus muscle	Yes, if pubocervical or rectovaginal fascia weakness is documented

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# Diagnostic Coding: The Horse that Pulls the Cart

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# Diagnostic Coding

- ▶ Purpose
  - To provide medical indication for claim payment
  - Data collection
- ▶ The provider assigns the diagnosis, not the coder
- ▶ Link each procedure or service to it's own diagnosis
- ▶ Always code to the highest level of specificity
  - An unspecified code can cause a claim denial or delay of payment, especially for surgical cases

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# Diagnostic Coding...

- ▶ Payers reimburse for medically indicated procedures
  - The diagnosis codes reported establish medical indication and need to be as specific as possible
- ▶ Each surgical procedure performed must be supported by at least 1 diagnostic code that indicates the reason it is necessary for this patient

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# Non-Specific Terms ≠ Codeable Dx

Uncodeable Without More Info	Why?
Uterine prolapse	Is it only uterine prolapse or is there vaginal wall prolapse in addition?
Genital prolapse	What is prolapsing?
Uterovaginal prolapse	It is incomplete or complete prolapse?
Pelvic relaxation	Results from lax ligaments, fascia, and muscles supporting the pelvic organs (pelvic floor). So which ones?
Pelvic floor dysfunction	Refers to a wide range of problems that occur when the muscles of the pelvic floor are weak or tight. So what is the patient's specific problem that requires surgery to fix?
Urogenital prolapse	Can refer to displacement of the uterus, the bladder and the rectum with consequent dislocation of the vaginal walls. So which one(s)?

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# Non-Specific Terms...

Uncodeable Without More Info	Why?
Significant pelvic prolapse	What is significant? Which areas are prolapsing?
Pelvic organ prolapse	Which ones? How bad?
Vaginal vault prolapse	And does she still have her uterus?
Vaginal wall prolapse	Anterior or posterior wall?
Recurrent distal cystocele	Was it midline or lateral?
At risk for SUI	Possibly a V code. She either has it or she does not.

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# Match the diagnosis to the procedure

- ▶ Paravaginal defect repair  ◦ 618.02, lateral cystocele
- ▶ Colpopexy  ◦ 618.09, Vaginal vault prolapse with uterus in place  
◦ 618.2–618.4, Vaginal vault prolapse with uterine prolapse  
◦ 618.5, Vaginal vault prolapse after hysterectomy
- ▶ McCall, Halban, Moschowitz culdoplasties  ◦ 618.6, Vaginal enterocele

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# Diagnosis Matching...

## ▶ Anterior repair



- 618.01, Midline defect
- 618.2–618.4, With uterine prolapse

## ▶ Posterior repair



- 618.04, Rectocele
- 618.2–618.4, With uterine prolapse

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# Special Billing Issues



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# Mesh Add-On Code

- ▶ AMA's rationale for adding CPT® Code 57267
  - Native tissues are determined to be weak and inadequate for repair with reconstructive procedures performed for the anterior and posterior compartments of the vagina
  - The MD decides to insert an intervening prosthetic material (e.g., autograft, allograft, xenograft, synthetic)
  - The physician work includes insertion of prosthetic material, extra sutures as needed, and mesh sizing
    - This work is distinct from the physician work involved in performing the primary pelvic floor defect repair(s) which primarily involves re-approximation of pelvic fascial tissues only

# Mesh Add-On...

- ▶ CPT® Code 57267 can only be reported when performing a vaginal approach repair
  - CPT codes 45560, 57240–57265, 57285 only
    - Add-on mesh code is not reported with laparoscopic or abdominal paravaginal repairs, or colpopexy procedures
- ▶ Bill once per vaginal wall repair
  - Anterior x 1, posterior x 1
- ▶ Remember that medical need must be documented to report
  - Weakened pubocervical tissue (618.81) and/or
  - Weakened rectovaginal tissue (618.82)

# Documentation

- ▶ Does not establish medical need
  - “Discussed with patient use of mesh and she consented”
  - “Mesh was placed”
  - “anterior repair with mesh”
  
- ▶ Does establish medical need
  - “Patient’s native tissues were friable so decision was made to augment repair with mesh”
  - Findings: “Attenuated rectovaginal tissue”
  - “Pubocervical fascia was atrophic and required mesh repair”



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# Cystoscopy

- ▶ Cystoscopy is a frequently performed procedure after reconstructive surgery
  - Done to ensure bladder is not compromised by sutures, needles or mesh used in the repair
    - A procedure done by the surgeon to check his work is always included in the surgical procedure
- ▶ Can only be billed for a documented pre-existing condition that must be investigated at the time of the surgery

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# Checking Your Work

- ▶ “I then performed cystoscopy with above mentioned findings.”
  - Findings: “There was no trauma to the bladder as seen on cystoscopy at the conclusion of the procedure. Both ureters were seen to efflux clear indigo carmine stained urine.”
- ▶ “Cystoscopy was then done. There is clear urine effluxing from both ureters at the conclusion of the procedure. There was no trauma to the bladder or aberrant suture material present. We also looked at the urethrovesical angle and it coarcted nicely.”

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# But...

- ▶ Indications statement: On exam, she was noted to have a grade 3 cystocele, grade 2 uterine prolapse, and grade 1 rectocele. She also demonstrated urethral hypermobility and perineal laxity. Urodynamic testing revealed borderline bladder capacity without objective evidence of stress incontinence with the prolapse reduced. Her symptoms were more consistent with overactive bladder
  - Given the patient's symptoms of urinary frequency discussed above, attention was turned to the cystourethroscopy. A 70-degree cystoscopic telescope was inserted into the bladder lumen which was filled in a retrograde fashion. The bladder lumen was carefully visualized in its entirety. No bladder injury was noted. The trigone and both ureteral orifices were identified. The patient was given 5 mL of IV indigo carmine and both ureteral orifices were noted to spill dye confirming ureteral patency. The urethra was then visualized upon extraction of the cystoscope and found to be normal. Bladder lumen appeared normal without trabeculations, foreign body, masses/lesions, or abnormal vascular patterns. Bilateral ureteral patency was reconfirmed. The urethra was normal upon extraction of cystourethroscope.

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# Prophylactic Procedures

- ▶ Payers do not reimburse for procedures that fix a problem not yet in evidence
  - Many physicians believe that prophylactic repair will avoid future surgery for the patient
    - The payer is not interested in this argument, and
    - You cannot fix a coverage problem with coding
      - Reporting a diagnostic condition not documented to get this type of procedure paid can be considered fraud

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# Robot-Assisted Surgery

- ▶ Coded the same as laparoscopic procedures
  - No additional physician reimbursement for using robot, but you can report that you used the robot (e.g., robot-assistance sacrocolpopexy)
    - CPT® Code 57425, laparoscopic colpopexy
    - HCPCS Code S2900, Surgical techniques requiring use of robotic surgical system

# Mesh Erosion

- ▶ Dx 629.31 (mesh erosion)
- ▶ Revision of graft to repair or remove
  - CPT® Code 57295 (vaginal approach)
    - Caution! CPT Code 57295 has 13.13 RVUs and is appropriate only for a facility site of service, not office
    - Office removal of eroding mesh using forceps or scissors is CPT Code 58999 only
      - Comparison codes can be incision and removal of foreign body
        - CPT Codes 10120 (3.45 RVUs), or 10121 (6.68 RVUs)
  - CPT Code 57296 (abdominal approach)
  - CPT Code 57426 (laparoscopic approach)
  - Modifier –78 if return to OR in global period

# In the postoperative period

- ▶ You can bill for unexpected complications of the surgery that do not result in a return to the OR....maybe
  - “I can’t pee” would not be unexpected for many uro/gyn procedures
  - Wound dehiscence or infection would be unexpected
- ▶ Medicare always requires a return to the hospital OR to bill for complications

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# Case Examples



*Results from case studies are not predictive of results in other cases. Results in other cases may vary. See important notes on the uses and limitations of this information on slide 2.*

# Case 1

- ▶ 28 y/o g5 with a symptomatic vaginal bulge who desired permanent correction. She had documented stress and urge urine loss. She also had symptoms of interstitial cystitis.
- ▶ She was consented for and had a vaginal hysterectomy, BSO, anterior and posterior repair with synthetic graft kit, enterocele repair, perineal body reconstruction, suburethral sling, and cystoscopy.

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# Case 1 – Coding Staff Billed

- ▶ CPT® Code 58260, vaginal hysterectomy
  - linked to 618.3 (*uterovaginal prolapse, complete*)
    - Line item was paid at 100% of allowable
  
- ▶ CPT Code 57265–51, combined anterior/posterior repair with enterocele repair
  - linked to 618.01 (*Cystocele, midline*), 618.04 (*Rectocele*) and 625.6 (*Stress incontinence, female*)
    - Line item was paid at 50% of allowable

# Case 1 Billed...

- ▶ CPT® Code 57267 x 2, insertion of add-on mesh
  - linked to 625.6 (*stress incontinence, female*)
    - Line item was denied due to ICD9/procedure code mismatch
  
- ▶ CPT Code 52000–51, cystoscopy
  - linked to 625.6 (*stress incontinence, female*)
    - line item was denied as bundled

# Documentation Issues

- ▶ Does the method of billing capture the procedures performed?
  - Does the documentation support the procedures billed?
    - There is an anterior repair, but Monarc tape was also used. Where is the description of the sling procedure?
    - Where is the rectocele repair described?
- ▶ Which Dx for incontinence is documented?
- ▶ Is perineal body repair included?
- ▶ Is cystoscopy diagnostic and separate from routine surgical care?

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# Case 1: With Better Documentation

- ▶ CPT® Code 57265, combined A&P repair with enterocele repair
  - linked to 618.3 (*uterovaginal prolapse, complete*) – 27.15 RVUs
- ▶ CPT Code 58260–51, vaginal hysterectomy
  - linked to 618.3 (*uterovaginal prolapse, complete*) – 24.69 RVUs
- ▶ CPT Code 57288, sling procedure
  - linked to 788.33 (*mixed incontinence, urge and stress – male/female*) – 21.16 RVUs
- ▶ CPT Code 57283–51, uterosacral colpopexy (includes enterocele repair)
  - linked to 618.3 (*uterovaginal prolapse, complete*) – 20.59 RVUs
- ▶ CPT Code 57267, add-on mesh for posterior repair
  - linked to 681.82 – 7.67 RVUs

# Revenue Lost

## Without Good Documentation

- ▶ CPT® Code 58260 vaginal hysterectomy – 24.69 RVUs
- ▶ CPT Code 57265 combined A&P repair with enterocele repair – 50% of **27.15 RVUs**

**Total RVUs: 38.27 RVUs**

- ▶ CPT Code 57265 combined A&P repair with enterocele repair – 27.15 RVUs
- ▶ CPT Code 58260 vaginal hysterectomy – 50% of 24.69 RVUs

**Total RVUs: 39.50 RVUs**

## With Good Documentation

- ▶ CPT Code 57265 combined A&P repair with enterocele repair – 27.15 RVUs
- ▶ CPT Code 58260 vaginal hysterectomy – 50% of 24.69 RVUs
- ▶ CPT Code 57288 sling procedure – 50% of 21.16 RVUs
- ▶ CPT Code 57283 uterosacral colpopexy (includes enterocele repair) – 50% of 20.59 RVUs
- ▶ CPT Code 57267 insertion of add-on mesh– 7.67 RVUs

**Total RVUs: 68.05 RVUs**

# Case 2

- ▶ Stage III uterine prolapse, Urodynamic stress incontinence, vaginal outlet relaxation, cystocele
- ▶ Surgeon performs bilateral anterior sacrospinous fixation with Uphold<sup>®</sup> Mesh, anterior repair with Uphold Mesh, TVT-obturator sling system, perineorrhaphy, and cystoscopy

Products are labeled for individual use and concomitant repairs are at the discretion of the physician. See important notes on the uses and limitations of this information on slide 2.

# Documentation Issues

- ▶ Anterior pubocervical tissue weakness is not documented
- ▶ There is no indication of need for a diagnostic cystoscopy for any reason other than the surgeon checking his work

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# Correct Coding

- ▶ CPT® Code 57288 sling procedure
  - linked to 625.6 – 21.16 RVUs
  
- ▶ CPT Code 57240–51 anterior repair
  - linked to 618.3
    - 50% of 19.80 RVUs
  
- ▶ CPT Code 57282–51 vaginal colpopexy
  - linked to 618.3
    - 50% of 14.93 RVUs
  
- ▶ CPT Code 56810–51
  - linked to 618.89
    - 50% of 7.74 RVUs

**Total RVUs: 42.40 RVUs**

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# ICD9 and ICD10 Codes



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# Vaginal Wall Prolapse Only

ICD-9-CM	ICD-10-CM
618.00, Unspecified prolapse of vaginal walls	No ICD10 equivalent
618.01, Cystocele, midline	N81.10, Cystocele, unspecified
618.02, Cystocele, lateral	N81.11, Cystocele, midline N81.12, Cystocele, lateral <b>Includes cystourethrocele</b>
618.03, Urethrocele	N81.0, Urethrocele only
618.04, Rectocele	N81.6, Rectocele
618.05, Perineocele	N81.81, Perineocele
618.09, Other prolapse (e.g, cystourethrocele)	N81.89, Other female genital prolapse

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# Uterine and Vaginal Prolapse

ICD-9-CM	ICD-10-CM
618.2, uterovaginal prolapse, incomplete	N81.2, incomplete uterovaginal prolapse Includes 1 <sup>st</sup> & 2 <sup>nd</sup> degree uterine prolapse, cervical prolapse NOS, uterine prolapse with any form of vaginal wall prolapse
618.3, uterovaginal prolapse, complete	N81.3, complete uterovaginal prolapse 3 <sup>rd</sup> degree uterine prolapse, procidentia NOS, uterine prolapse with any form of vaginal wall prolapse
618.4, uterovaginal prolapse, unspecified	N81.4, uterovaginal prolapse, unspecified

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# Other Prolapse

ICD-9-CM	ICD-10-CM
618.1, Uterine prolapse only	No ICD10 equivalent
618.5, Vaginal vault prolapse after hysterectomy	N99.3, Prolapse of vaginal vault after hysterectomy
618.6, Vaginal enterocele	N81.5, Vaginal enterocele Excludes enterocele with uterine prolapse (N81.2-N81.4)
618.7, Old laceration of pelvic floor muscles	N81.85, Other female genital prolapse Includes deficient perineum

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# Other...

ICD-9-CM	ICD-10-CM
618.81, Incompetence or weakening of pubocervical tissue	N81.82, Incompetence or weakening of pubocervical tissue
618.82, Incompetence or weakening of rectovaginal tissue	N81.83, Incompetence or weakening of rectovaginal tissue
618.83, Pelvic muscle wasting	N81.84, Pelvic muscle wasting
618.84, Cervical stump prolapse	N81.85, Cervical stump prolapse
618.89, Other specified genital prolapse	N81.89, Other female genital prolapse
618.9, Unspecified genital prolapse	N81.9, Female genital prolapse, unspecified

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# Resources



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- ▶ American Medical Association, Current Procedural Terminology, Professional Edition, 2011
- ▶ International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), 10/01/11
- ▶ ICD-9-CM Official Guidelines for Coding and Reporting, 10/01/11
- ▶ Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative, Version 16.0
- ▶ Urogynecology and Reconstructive Pelvic Surgery, Third Edition, Mark D. Walters, Mickey M. Karram

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## ▶ Boston Scientific

- [www.bostonscientific.com](http://www.bostonscientific.com)
- [www.bostonscientific.com/reimbursement](http://www.bostonscientific.com/reimbursement)
- [www.pelvic-floor-institute.com](http://www.pelvic-floor-institute.com)

## ▶ American Medical Systems

- [www.americanmedicalsistemas.com/womens\\_health.html](http://www.americanmedicalsistemas.com/womens_health.html)

## ▶ Gynecare

- [www.clinicalexpertise.com/clinical-focus/pelvic-organ-prolapse](http://www.clinicalexpertise.com/clinical-focus/pelvic-organ-prolapse)

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# Questions & Answers



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