

OB/GYN

A comprehensive illustrated guide
to coding and reimbursement

2020



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Getting Started with Coding Companion

Coding Companion for OB/GYN is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

For ease of use, *Coding Companion* lists the CPT codes in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, medicine, and evaluation and management (E/M) codes pertinent to the specialty. Each CPT code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum360 *Coding Companion* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the page following the sample.

Appendix Codes and Descriptions

Some CPT codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

The codes in the appendix are presented in the following order:

- HCPCS
- Pathology and Laboratory
- Surgery
- Medicine Services
- Radiology
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edit Updates

The *Coding Companion* series includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 23.3, the most current version available at press time. The CCI edits are located in a section at the back of the book. Optum360 maintains a website to accompany the Coding Companions series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is <http://www.optum360coding.com/ProductUpdates/>. The 2018 edition password is: **SPECIALTY18**. Please note that you should log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

Evaluation and Management

This resource provides documentation guidelines and tables showing evaluation and management (E/M) codes for different levels of care. The components that should be considered when selecting an E/M code are also indicated.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

69501 Transmastoid antrotomy (simple mastoidectomy)
could be found in the index under the following main terms:

Antrotomy

Transmastoid, 69501

Excision

Mastoid

Simple, 69501

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xii of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

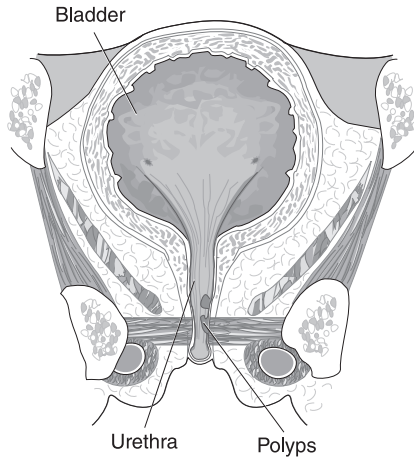
Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

53260-53275

- 53260** Excision or fulguration; urethral polyp(s), distal urethra
- 53265** urethral caruncle
- 53270** Skene's glands
- 53275** urethral prolapse



Physician fulgurates or excises polyp(s) in the distal urethra (53260), urethral caruncle (53265), Skene's gland (53270), and/or urethral prolapse (53275)

Explanation

The physician removes urethral polyps, caruncles, Skene's glands or treats urethral prolapse. The physician separates the urethra from the vaginal wall. The urethra is incised. A circular excision is made around the lesion and the targeted tissue is resected. The urethra and vaginal mucosa are reattached in layers. Report 53260 if removing distal urethral polyps; 53265 if removing a urethral caruncle; 53270 if removing the Skene's glands; or 53275 if treating urethral prolapse.

Coding Tips

Report 52285 if fulguration of urethral polyps is part of the treatment for female urethral syndrome. For drainage of an abscess or a cyst of the Skene's gland, see 53060.

ICD-10-CM Diagnostic Codes

- C68.1 Malignant neoplasm of paraurethral glands
- C79.19 Secondary malignant neoplasm of other urinary organs
- D09.19 Carcinoma in situ of other urinary organs
- D30.8 Benign neoplasm of other specified urinary organs
- D41.8 Neoplasm of uncertain behavior of other specified urinary organs
- D49.59 Neoplasm of unspecified behavior of other genitourinary organ
- N34.0 Urethral abscess
- N36.2 Urethral caruncle
- N36.8 Other specified disorders of urethra
- Q64.71 Congenital prolapse of urethra

AMA:

53260 2014,Jan,11 53265 2014,Jan,11 53270 2014,Jan,11 53275 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
53260	3.03	2.43	0.35	5.81
53265	3.17	2.78	0.35	6.3
53270	3.14	2.48	0.34	5.96
53275	4.57	2.53	0.51	7.61
Facility RVU	Work	PE	MP	Total
53260	3.03	1.82	0.35	5.2
53265	3.17	1.86	0.35	5.38
53270	3.14	1.84	0.34	5.32
53275	4.57	2.53	0.51	7.61

	FUD	Status	MUE	Modifiers			IOM Reference	
53260	10	A	1(2)	51	N/A	N/A	N/A	None
53265	10	A	1(3)	51	N/A	N/A	N/A	
53270	10	A	1(2)	51	N/A	N/A	N/A	
53275	10	A	1(2)	51	N/A	N/A	N/A	

* with documentation

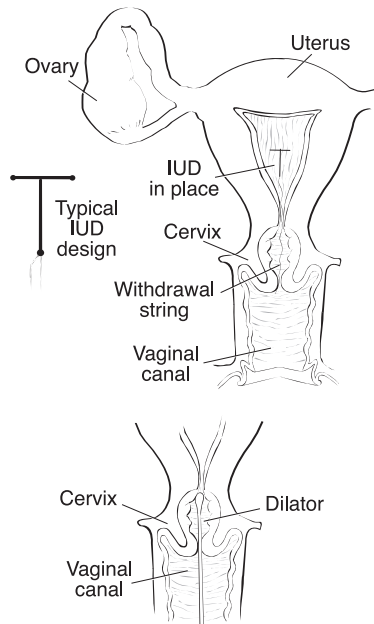
Terms To Know

- anomaly.** Irregularity in the structure or position of an organ or tissue.
- congenital.** Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.
- fulguration.** Destruction of living tissue by using sparks from a high-frequency electric current.
- polyp.** Small growth on a stalk-like attachment projecting from a mucous membrane.
- prolapse.** Falling, sliding, or sinking of an organ from its normal location in the body.
- resect.** Cutting out or removing a portion or all of a bone, organ, or other structure.
- simple polyp.** Mucosal outgrowth of tissue that is hanging from a stalk and can easily be removed.
- Skene's gland.** Paraurethral ducts that drain a group of the female urethral glands into the vestibule.
- urethral caruncle.** Small, polyp-like growth of a deep red color found in women on the mucous membrane of the urethral opening.

58300-58301

58300 Insertion of intrauterine device (IUD)

58301 Removal of intrauterine device (IUD)



An intrauterine device (IUD) is inserted. Report 58301 to report removal of an IUD

Explanation

The physician inserts a speculum into the vagina to visualize the cervix. A tool is used to gently pull down the cervix; it is dilated. In 58300, an intrauterine device (IUD), any of a variety of shapes (coil, loop, T, 7), is guided into the uterus through an insertion tube placed in the cervical os. In 58301, to remove a previously placed IUD from the uterus, a device is inserted through the cervical os and used to grasp and remove the IUD.

Coding Tips

These procedures may be performed by a registered nurse, physician assistant, nurse practitioner, or other trained paramedical person under a physician's supervision. For IUD removal and insertion of a new device during the same visit, report both the IUD removal (58301) and insertion (58300) codes separately. The cost of the IUD is not included in these codes and should be reported separately using the appropriate HCPCS Level II code (J7300). These procedures are usually not done out of medical necessity; therefore, the patient may be responsible for charges. Verify with the insurance carrier for coverage. Local anesthesia is included in these services. Report the HCPCS Level II code for Levonorgestrel-releasing intrauterine contraception system (Mirena), 52 mg, 3 year duration (J7297) or 5 year duration (J7298). Surgical trays (A4550) are not separately reimbursed by Medicare; however, other third-party payers may cover them.

ICD-10-CM Diagnostic Codes

- T83.69XA Infection and inflammatory reaction due to other prosthetic device, implant and graft in genital tract, initial encounter
- T83.81XA Embolism due to genitourinary prosthetic devices, implants and grafts, initial encounter

- T83.82XA Fibrosis due to genitourinary prosthetic devices, implants and grafts, initial encounter
- T83.83XA Hemorrhage due to genitourinary prosthetic devices, implants and grafts, initial encounter
- T83.84XA Pain due to genitourinary prosthetic devices, implants and grafts, initial encounter
- T83.85XA Stenosis due to genitourinary prosthetic devices, implants and grafts, initial encounter
- T83.86XA Thrombosis due to genitourinary prosthetic devices, implants and grafts, initial encounter
- T83.89XA Other specified complication of genitourinary prosthetic devices, implants and grafts, initial encounter
- Z30.014 Encounter for initial prescription of intrauterine contraceptive device
- Z30.430 Encounter for insertion of intrauterine contraceptive device
- Z30.431 Encounter for routine checking of intrauterine contraceptive device
- Z30.432 Encounter for removal of intrauterine contraceptive device
- Z30.433 Encounter for removal and reinsertion of intrauterine contraceptive device

AMA: 58300 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11; 2012,Jan,15-42; 2011,Jan,11 58301 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11; 2012,Jan,15-42; 2011,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
58300	1.01	0.94	0.14	2.09
58301	1.27	1.28	0.15	2.7
Facility RVU	Work	PE	MP	Total
58300	1.01	0.39	0.14	1.54
58301	1.27	0.5	0.15	1.92

	FUD	Status	MUE	Modifiers			IOM Reference
58300	N/A	N	-	N/A	N/A	N/A	None
58301	0	A	1(3)	51	N/A	N/A	80*

* with documentation

Terms To Know

dilation. Artificial increase in the diameter of an opening or lumen made by medication or by instrumentation.

insertion. Placement or implantation into a body part.

IUD. Intrauterine device.

medical necessity. Medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and national medical practice guidelines regarding type, frequency, and duration of treatment; rendered in a cost-effective manner.

removal. Process of moving out of or away from, or the fact of being removed.

speculum. Tool used to enlarge the opening of any canal or cavity.