Coding for colposcopy

By Emily H. Hill, PA

CPT 2003 introduced a number of changes in the codes used to report pelvic colposcopy (Table 1). The codes describing colposcopy of the cervix were revised and three new codes were added to more clearly represent the services provided by gynecologists. New codes also were added to describe colposcopy of the vulva and the entire vagina. The new series of codes are listed in three subsections of CPT: vulva (56820-56821), vagina (57420-57421), and cervix uteri (57452, 57454, 57455, 57456, 57460, 57461). It is important to understand how to use these codes to ensure appropriate reimbursement. Let's look at the case of Cordelia and her colposcopy.

Table 1: Colposcopy codes

Colposcopy of the vulva	
56820	Colposcopy of the vulva
56821	with biopsy (s)
Colposcopy of the vagina	
57420	Colposcopy of the entire vagina, with cervix if present
57421	with biopsy(s)
Colposcopy of the cervix	
57452	Colposcopy of the cervix including upper/adjacent vagina
57454	with biopsy(s) of the cervix and endocervical curettage
57455	with biopsy(s) of the cervix
57456	with endocervical curettage
57460	with loop electrode biopsy(s) of the cervix
57461	with loop electrode conization of the cervix

Cordelia's referral

Dr. Lear, Cordelia's family physician, sends her to gynecologist Dr. King because of an abnormal Pap smear favoring dysplasia. In his letter to Dr. King, Dr. Lear notes that Cordelia also has a 1-year history of vulvar irritation and itching that has been unresponsive to antifungal therapy and antibiotic creams.

A visit to Dr. King

Dr. King takes an appropriate history, performs a relevant physical examination, and discusses the management options with Cordelia. She agrees with the recommendation for a colposcopic examination. In preparation for the colposcopy, Dr. King cleans Cordelia's vulva several times with 5% acetic acid. Once the acetic acid has taken effect, he directs the colposcope to the vulva under appropriate magnification and visualizes the entire vulva at several magnifications. Dr. King sees no suspicious lesions, so no biopsy is performed and he proceeds with a colposcopic exam of Cordelia's cervix. During the exam, he views both the entire transformation zone and the upper/adjacent vagina and notes a discrete lesion on the cervix. Dr. King then cleans Cordelia's cervix with povidone iodine, locally infiltrates it with lidocaine, and performs a loop electrode excision biopsy.

The findings are in

Cordelia's biopsy indicates CIN III. Dr. King recommends a loop electrode conization and Cordelia returns for the procedure the next week.

How would you have coded this case? Read below for the report of services and an explanation of the codes.

Unraveling the codes

The E/M code. Dr. King reports an Evaluation and Management Service (E/M) code because he obtained additional history and performed a physical examination prior to determining the need for the colposcopic procedures. CPT guidelines indicate that if a significant and separately identifiable E/M service is necessary, it can be reported by appending the –25 modifier (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) to the appropriate level of care. Because Dr. Lear asked Dr. King to assess Cordelia's condition, Dr. King selects a consultation code. The level reflects the history, examination, and medical decision-making provided by Dr. King. Another physician who sees a similar patient might select a different level of care.

Caveat: Despite CPT guidelines, some payers have internal payment policies that prevent reimbursement for an E/M service when it is provided on the same day as a procedure. Medicare, however, will reimburse for both services if the –25 modifier is appended to the E/M code.

Why choose 57460? All of the cervical colposcopy codes (57452-57461) include examination of the entire transformation zone and may also include an examination of the upper/adjacent portion of the vagina. The primary focus of the colposcopy is on the cervix. Code 57460 includes the colposcopy and a loop electrode biopsy of the cervix, a procedure done to remove a large tissue specimen(s) from the exocervix. Code 57460 is reported only once regardless of the number of specimens obtained. It does not, however, include removal of a portion of the endocervix or removal of the transformation zone, so the loop excision described by this code is not a conization. Code 57461 is the proper code to report when a loop electrode conization and a colposcopic exam are performed at the same time.

Code 56820 and RVUs. Code 56820 describes colposcopy of the vulva and is reported in addition to cervical colposcopy because it represents a distinct anatomic site. The –51 modifier signifies that multiple procedures were performed by the same physician on the same day. On the mock claim form in Figure 1, column F indicates the relative value units (RVUs) assigned to each code. RVUs reflect the degree of physician work and the relative costs associated with providing the service. Third-party payers multiply the units by a set dollar amount, called a conversion factor, to determine the payment for the service. If this were an actual claim, the physician practice would list its established dollar fee rather than RVUs.

Figure 1. Dr. King's report of Cordelia's colposcopy

21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 795.02 ASCUS, favor dysplasia 2. 624.8 Specified non-inflammatory disorder of vulva and perineum 3. 4.											22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER	
24. A						B	C	D		E	F	G
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	RVUs	DAYS OR UNITS
From MM	DD	YY	To MM	DD	YY			CPT-4/HCPCS	MODIFIER			
						11		99242	- 25	1, 2	2.40	
						11		57460		1	8.12	1
						11		56820	- 51	2	3.24	1

Don't forget the -51. Most payers reduce payment, usually by 50%, for all procedures beyond the first. It is important to append the –51 modifier to the lesser-valued service to ensure the most appropriate reimbursement. It's best to list the full fee for each service and let the payer make the multiple procedure reduction. Some payers' computer systems are pre-programmed to reduce fees for procedures done beyond the first one. If you make the reduction yourself, and then the payer discounts it again, you won't get the proper reimbursement.

Coding for the conization. Dr. King reports code 57522 (conization of cervix without colposcopy). Code 57461 (colposcopy with conization) is not reported since a repeat colposcopy probably is not required.

ICD-9 coding. The ICD-9 coding is also important in this case. The ICD-9 codes in the 795.0 series describe nonspecific, abnormal findings on a Papanicolaou smear of the cervix. The codes in this section have a fourth digit, indicating the type of cellular change. Because an abnormal Pap smear is what triggered the cervical colposcopy, this code is linked on the claim form to CPT 57460. The biopsy results indicate CIN III, so Dr. King reports ICD-9 code 233.1 (CIN III) when Cordelia returns for the conization. There is no specific code to describe vulvar irritation and itching. Code 624.8 is for identification of a noninflammatory disorder for which there is no specific ICD-9 code. Dr. King links this code to the vulvar colposcopy code to support the clinical need for the additional procedure.

The bottom line for Dr. King

Let's assume that the payer allows $450 for the cervical colposcopy and $200 for the vulvar colposcopy. Dr. King can expect to receive $450 for the first procedure and $100 for the other service, or a total of $550. For the purposes of illustration, assume that Dr. King's fees are the same as the payer's allowable amounts. If Dr. King had reduced his fee for the vulvar colposcopy to $100 and the payer reduced it again by 50%, he would receive only $500 for the two procedures ($450 for the first and only $50 for the second). Billing the full fee for all services prevents multiple payment reductions. The multiple procedure reduction does not apply to E/M services. The consultation should be paid at the full allowable amount if the payer follows CPT guidelines.

Ms. Hill is President of Hill & Associates, Inc., a consulting firm specializing in coding and compliance. She teaches coding seminars for the American College of Obstetricians and Gynecologists and serves as a representative on the American Medical Association's Correct Coding Policy Committee and the Health Care Professionals Advisory Committee Review Board for the Relative Value Update Committee (RUC) and the National Uniform Claim Committee. She has also served on the AMA's CPT-5 Project and on a Clinical Practice Expert Panel for the Centers for Medicare and Medicaid Services (formerly HCFA) Practice Expense Study.

Emily Hill. Coding for colposcopy. *Contemporary Ob/Gyn* Jan. 1, 2004; 49:86-91.