Coding for laparoscopic colpopexy

By Emily H. Hill, PA

As physicians' laparoscopic surgical skills have increased, laparoscopic approaches to procedures that traditionally involved open incisions have emerged. CPT 2004 includes a new code for laparoscopic colpopexy (Table 1). Before it was introduced, this procedure was reported using an unlisted CPT code, which meant the physician had to submit documentation for the procedure and manually process the claim. The new code provides a more precise way to report this service and eliminates the delays in reimbursement that often result with unlisted codes. Consider Dr. Montague's approach to coding for Juliet's care.

TABLE 1: Procedural coding for vaginal prolapse

Colposcopy of the vulva	
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy
57260	Combined anteroposterior colporrhaphy
57265	with enterocele repair
57280	Colpopexy, abdominal approach
57282	Sacrospinous ligament fixation for prolapse of vagina
57284	Paravaginal defect repair (including repair of cystocele, stress urinary incontinence, and/or incomplete vaginal prolapse)
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)

A visit to Dr. Montague

Juliet, an established patient of Dr. Montague, comes to the office on January 15 for evaluation of vaginal discomfort. She describes the discomfort as a pressure-like sensation and indicates she has tissue protruding through her vagina. Juliet's history is significant for an abdominal hysterectomy 25 years ago and an anterior and posterior repair 5 years ago for symptoms associated with a cystocele and rectocele. During a pelvic examination, Dr. Montague notes that Juliet's vaginal vault is prolapsed but the anterior and posterior support is good. He discusses the need for surgery and possible surgical approaches with her. She prefers laparoscopic surgery but wants to talk with her husband before setting a date for the procedure. A week later, Juliet calls the office to schedule her surgery for February 9.

Preparing for the surgery

Juliet comes to the office 5 days before surgery for a preoperative history and physical. At the same time, Dr. Montague reviews the consent form with Juliet and her husband and completes the remaining paperwork for her hospital admission.

On the day of surgery, Dr. Montague reviews Juliet's records and meets with her briefly to answer any remaining questions.

Performing the procedure

Dr. Montague positions the patient and prepares the equipment. He makes a "Y" graft by suturing two pieces of mesh and enters and explores Juliet's abdominal cavity laparoscopically. Dr. Montague then lyses adhesions to gain access to the patient's vaginal apex and incises her peritoneum. He develops the vesicovaginal and rectovaginal spaces and mobilizes the bladder and rectum. Next, Dr. Montague performs a culdoplasty to obliterate the cul-de-sac and prevent bowel entrapment and secures the graft anteriorly and posteriorly to the pubocervical and rectovaginal fascia. Then he opens and extends the peritoneum down to the superior margin of the culdoplasty. To expose the anterior longitudinal ligament of the sacrum, he performs presacral dissection. The graft is then secured, and the peritoneum closed over it. After Dr. Montague closes the trocar and skin incisions, Juliet is taken to the recovery room in stable condition.

Surgical follow-up

Dr. Montague speaks with Juliet's husband, completes postoperative orders, and dictates the operative report. He sees Juliet in the hospital later that day and for follow-up on postop days 1 and 2. On the third postoperative day, Dr. Montague sees Juliet and discharges her from the hospital with instructions and completes the necessary paperwork, including the discharge summary. Before releasing Juliet from care, Dr. Montague sees Juliet for two additional office visits.

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

Understanding the codes

The initial visit. Dr. Montague reports an Evaluation and Management Code (E/M) from the category of Office or Other Outpatient Services because Juliet came to the office to have her problem evaluated (Figure 1). The code Dr. Montague selected indicates that Juliet is an established patient and it corresponds with the extent of the history, examination, and/or medical decision-making (key components) required to evaluate the problem and determine a course of treatment. Levels of service for E/M services provided to established patients are determined by two of the three key components. This sub-category of E/M codes is used when a patient is seen again by the physician or another physician in the same specialty and in the same group practice within a 3-year period.

Figure 1. Initial visit – January 15

21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 618.5 **Prolapse of vaginal vault after hysterectomy** 2. 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		9921X		1		1	

The diagnosis reported is specifically for hysterectomized patients who have vaginal prolapse. There are other codes in the 618 series that describe prolapse of the vaginal wall without mention of uterine prolapse. In Juliet's case, *ICD-9 code 618.5* is the most specific code and therefore the best choice. Additional codes could have been reported if Juliet had been experiencing urinary incontinence.

Additional preoperative visits. The office visit 5 days before surgery and the hospital admission are not reported separately. CPT states that the global surgical package begins 1 day before surgery and includes the preoperative history and physical. Although Dr. Montague saw Juliet several days before that, the services he provided are part of standard surgical care. The Medicare payment system (RBRVS) includes the work associated with obtaining consents, completing hospital paperwork, and performing a preoperative history and exam in the relative value units (RVUs) assigned to the surgery. Most payers that use this payment methodology also consider these activities part of the global surgical package.

The surgical procedure. The concept of global surgical care extends to the intraoperative setting (Figure 2). Generally speaking, all services integral or necessary to complete the procedure are included in payment for the surgical procedure code. Standard of care dictates that inspection and exploration of the abdominal or pelvic anatomy be performed at the time of associated definitive surgical procedures. Likewise, simple adhesiolysis might be required to gain access to anatomic sites.

In these instances, lysis of adhesions is not reported separately. In the case of colpopexy, a graft is used to suspend the vaginal apex. Its preparation and placement are integral parts of the surgical procedure and therefore are implied components of the CPT code.

Figure 2. Surgical Procedure – February 9

21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)										22. MEDICAID RESUBMISSION CODE	
1. 618.5 Prolapse of vaginal vault after hysterectomy 2. 3. 4.										23. PRIOR AUTHORIZATION NUMBER	
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From MM	DD	YY	To MM	DD	YY			CPT-4/HCPCS	MODIFIER			
						21		57425		1	24.15	1

Postoperative care. The global surgical package also includes routine inpatient and outpatient postoperative care. The intensity and number of patient encounters varies with the procedure, the patient, and sometimes the physician's standard of care. All services typically provided during the postoperative period are included in the procedure and are not reported separately. Third-party payers, not CPT, define the duration of the global package. Medicare has set a 90-day postoperative global period for the new laparoscopic colpopexy code. Most other payers follow Medicare's global periods.

The bottom line for Dr. Montague

Medicare assigned 24.15 RVUs to CPT code 57425 (laparoscopic colpopexy). 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.

It sometimes takes a few months for payers to incorporate new codes and payment levels into their computer systems. Dr. Montague's staff may have to refile this claim if it is initially rejected as an invalid code number. If Juliet is a Medicare beneficiary, however, there will be no delay, since Medicare was prepared to accept the new codes as of January 1.

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.

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