AAGL 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

PG-26068

Excellence in GYN Coding: Empowering Surgical Practice

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Nash S. Moawad, MD

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PG-26068: Excellence in GYN Coding: Empowering Surgical Practice

Chair: Nichole Mahnert
Co-Chair: Jacob Lauer
Faculty: Jon K. Hathaway, Stephanie Henderson, Jacob Lauer, Nichole Mahnert

Course Description

This course provides a comprehensive overview of gynecological surgical and procedural coding, with special attention to coding in office and hospital settings. Participants will stay up to date with the latest coding guidelines and updates, while honing practical skills essential for accurate and efficient documentation. The course features interactive small group question-and-answer sessions, enabling participants to connect with peers, clarify complex coding topics, and apply their knowledge to real-world scenarios. Join us to elevate your coding expertise, advance your practice, and empower your impact on patient care.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Enhance proficiency in surgical coding and the correct use of modifiers to ensure accuracy and compliance in gynecological procedures and strengthen understanding of coding for consults; 2) Develop expertise in in-office procedural coding, stay current with the latest updates in Evaluation and Management (E/M) coding; and 3) Apply documentation strategies to decrease denials and improve reimbursement in a Complex Benign Gynecology Practice through practical application and interactive discussion.

Course Outline

2:00 pm	Welcome, Introduction and Course Overview	N. Mahnert
2:05 pm	Surgical Coding	N. Mahnert
2:30 pm	Efficient Documentation for Improved Reimbursement	J. Lauer
2:55 pm	Office and Procedural Coding	S. Henderson
3:20 pm	Updates and Advocacy in GYN Coding	J. Hathaway
3:45 pm	Discussion Questions & Answers	All faculty
4:00 pm	Adjourn	

ADA Statement: In accordance with the Americans with Disabilities Act (ADA), please contact CMEsupport@aagl.org should you require any special assistance.

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Asterisk (*) denotes no financial relationships with ACCME-defined ineligible companies to disclose.

PLANNER DISCLOSURES

The following members of AAGL have been involved in the educational planning and/or review of this course (listed in alphabetical order by last name).

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COURSE CHAIR DISCLOSURE

Nichole Mahnert, MD*

COURSE CO-CHAIR DISCLOSURE

Jacob Lauer, MD, MBA*

FACULTY DISCLOSURES

The following faculty have agreed to support their presentations and clinical recommendations with the best available evidence from the medical literature (in alphabetical order by last name).

Jon K. Hathaway, MD, PhD*
Stephanie Henderson, MD – Consultant: Intuitive Surgical
Jacob Lauer, MD, MBA*
Nichole Mahnert, MD*

MITIGATION OF RELEVANT FINANCIAL RELATIONSHIPS

All relevant financial relationships have been mitigated.

Drs. Lee, Lemos, Mikhail, and Chaudhari's planning decisions, as part of the Scientific Program Committee (SPC), were peer reviewed by other planners on the SPC who had disclosed no financial relationships with ineligible companies, and found to be fair, balanced, and free of commercial bias. Dr. Moawad's financial relationships ended 12/2024, thus mitigating them. For most of his AAGL Professional Education Committee service, Dr. Mourad had no financial relationships to disclose. He recently disclosed a new relationship as a Proctor for Intuitive Surgical. Since then, he has not participated in activities involving control or influence over accredited educational content; therefore, no additional mitigation was necessary.

The products and services provided by Intuitive Surgical, with which Dr. Henderson has a financial relationship, do not relate to the content of this presentation; therefore, the relationship is not considered a relevant financial relationship. No further mitigation action was deemed necessary.



Excellence in GYN Coding

Empowering Surgical Practice

1

Disclosures

We have no formal disclosures to report

We are not certified medical billing professionals. You should always adhere to CMS guidelines and regulations and consult your institutional coder where necessary

2

Objectives

1. Select and document appropriate E/M service levels in outpatient gynecology care
2. Apply correct coding principles for office-based gynecologic procedures
3. Accurately code gynecologic surgical procedures, including appropriate modifier use and intraoperative consultation coding
4. Use documentation strategies that reduce denials, support medical necessity, and improve compliant reimbursement

3

Agenda

2:10-2:35
- E/M office coding

2:35-3:00
- Office Procedures

3:00-3:25
- Surgical billing and coding

3:25-3:50
- Documentation strategies

3:50-4:00
- Questions

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Updates

2027 Final Rule

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2027 Proposed Final Rule

- Reimbursement for Physician Fee Schedule expected to decrease due to expiration of 2.5% increase to conversion factor approved by Congress in 2026
- Maternity codes
  - The global package is OVER
  - Sub-total or Total Hysterectomy after cesarean: 59XX9, 15.56 RVU

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2027 Proposed Final Rule

- Proposal to decrease payment for procedure on same day as E/M. Most expensive service (E/M or procedure) 100% and the 2nd at 50%
- Delete G2211 and use MOD1 instead with same descriptor, billed at 16% of E/M

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E/M Outpatient Coding

Dr. Jon Hathaway

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Office Procedural Coding

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Nichole Mahnert, MD
Clinical Associate Professor
University of Michigan

9

Common Office Procedures

- Endometrial biopsy
- Hysteroscopy
- SIS
- Ultrasound
- IUD insertion/removal
- Colposcopy
- LEEP

10

Preparation for office procedures

May need prior authorization for procedures

CPT code and E/M billing on the same day

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AUB office visit

- Patient is a 47yo G3P3 who presents to clinic complaining of abnormal bleeding.
  - Menses are irregular. Sometimes goes 6-8 weeks without bleeding and then will bleed for 3 weeks straight.
  - She has never been seen for this before. It started 6 months ago
  - BMI of 31
  - Pregnancy test negative and you do an ultrasound that shows a normal uterus and normal ovaries. You also order a send out for CBC and TSH.

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Codes	MDM Level	Patient Complexity	Data Amount & Complexity	Risk
99211	Established patient that did not require physician or QHP care			
99202 99212	Straightforward	Minimal	Minimal	Minimal
99203 99213	Low	Low	Limited	Low
99204 99214	Moderate	Moderate	Moderate	Moderate
99205 99215	High	High	Extensive	High

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AUB and EMB

- **99214**
- **CPT 58100**
  - Endometrial sampling (biopsy) with or without endocervical sampling, without cervical dilation
- **Modifier -25**
  - Significant, separately identifiable E/M service performed by the same physician on the same day as a procedure or other service

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What if she returned another day for EMB?

- **CPT 58100**
  - Endometrial sampling (biopsy) with or without endocervical sampling, without cervical dilation

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What if the procedure was difficult due to BMI and patient habitus?

- **Modifier 22**: increased procedural services when the work required for a medical procedure is substantially greater than typically expected

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Modifier 22-

CPT codes based on typical patient and typical work

Work is substantially greater

- Intensity: lysis of adhesions
- Time: cannot be only measure
- Technical difficulty: morbid obesity
- Severity of patient condition
- Physical and mental effort required

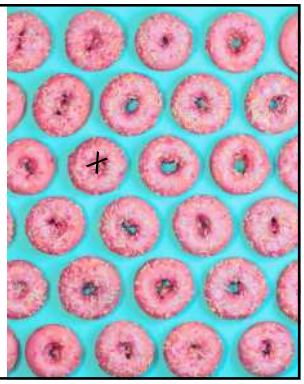
Documentation



17

I had to unexpectedly perform a cruciate incision for cervical stenosis?

- **CPT 58120**, Dilation and Curettage, diagnostic and/or therapeutic (nonOB)
  - 10-day global



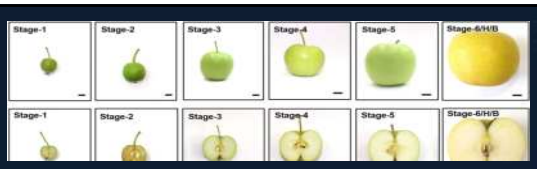
18

Global Period



Description	Global Period
Colposcopy	0
LEEP	0
Conization	90
Bartholin I/D or marsupialization	10
Dilation and curettage	10
Hysteroscopy	0

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I had to sequentially dilate the cervix to allow passage of the pipelle?

- **CPT 58120**, Dilation and Curettage, diagnostic and/or therapeutic (nonOB)
  - 10-day global

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What if the patient wanted a Mirena IUD placed after the EMB?

- **CPT 58100,** Endometrial sampling (biopsy) with or without endocervical sampling, without cervical dilation
  - Primary procedure because higher wRVU value
- **58300,** IUD insertion
- **Modifier 51**, Multiple Procedures, multiple services provided on same date by same physician. The highest valued code is reported without the modifier, with subsequent procedures reported with modifier
  - Append to secondary procedure



21

I started the procedure and could not complete?



- **Modifier 53-** Discontinued Procedure: procedure terminated after anesthesia induction or surgical prep
  - 50% of usual
  - N95.0 (PMB) and N88.2 (stenotic cervix)
- Versus **Modifier 52-** Reduced services, all components of CPT not performed

22

Office hysteroscopy

Procedure	CPT	wRVU
Hysteroscopy, diagnostic	58555	2.65
Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D&C	58558	4.17
Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)	58559	5.2
Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)	58560	5.75
Hysteroscopy, surgical, with removal of leiomyomata	58561	6.6
Hysteroscopy, surgical; with removal of impacted foreign body	58562	4

23

Patient SM

- Patient is a 56yo perimenopausal patient who saw you 2 weeks ago for AUB. She had not had a period for 12 months then had a period followed by subsequent irregular spotting intermittently for several months. She has sleep apnea with CPAP, HTN, DM2, BMI 50.
- The pelvic ultrasound showed thickened endometrium. You scheduled her for a hysteroscopy with possible EMB.
- You perform an office flexible hysteroscopy and see an overall normal endometrial cavity without a polyp. You remove the hysteroscope and perform an endometrial sampling.

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Postmenopausal bleeding

N95.0 Postmenopausal bleeding

58558 Hysteroscopy with endometrial sampling

25

You see her follow 2 weeks later to check on bleeding and review results

- Her bleeding has stopped so she is happy about that
- You discuss findings from the hysteroscopy and review the EMB results that shows hyperplasia without atypia
- You recommend provera and have he schedule to return for a repeat EMB in 3-6 months



26

Follow up hysteroscopy

N85.07 endometrial hyperplasia without atypia

99214, new moderate problem, limited data, moderate risk

Hysteroscopy does not have a global period

27

Global Period



Description	Global Period
Colposcopy	0
LEEP	0
Conization	90
Bartholin I/D or marsupialization	10
Dilation and curettage	10
Hysteroscopy	0

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What if the patient had an endometrial polyp?

- You see a large endometrial polyp and patient did not want this removed in office due to discomfort so you stop the hysteroscopy and discuss a hysteroscopic polypectomy at the surgery center.
- **N95.0** Postmenopausal bleeding
- **58555** Hysteroscopy, diagnostic
- **Modifier 25**
- **99214** New moderate problem, limited data, moderate risk

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Patient NL

- Patient is a 46yo woman who presents for irregular heavy vaginal bleeding and possible submucous fibroids on pelvic ultrasound. She has tried OCPs and is currently using norethindrone with persistent bleeding. She is referred by a colleague in your practice for saline sonogram.
- You perform an office saline sonogram and note a 1.5cm anterior type 1 fibroid.



30

Saline Sonogram

D25.0 Submucous fibroid

58340 Catherization and introduction of saline or contrast material for SIS or HSG

76831 Saline infusion sonohysterography (SIS), including color flow Doppler when performed

31

Patient HK

- Patient is a 43yo who presents for colposcopy with EMB. She also happens to have a vulvar lesion that you examine and offer a biopsy at the same time. You place topical lidocaine at the vulvar site then perform the hysteroscopy and EMB then perform a punch biopsy

32

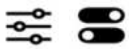
Colposcopy with an EMB

- **57454**, Colposcopy with cervical biopsies and ECC
- **58110**, Endometrial sampling (biopsy) performed in conjunction with colposcopy
  - EMB add on code for colposcopy
- **Modifier 59**, Distinct services, procedures are separate and distinct; performed on different sites or organ systems, used separate incision or excisions

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Patient JK

- Patient is a 36yo with who presents for Mirena IUD insertion for dysmenorrhea and contraception
- You review the menu of option for pain control, and she decides on IM Toradol
- You place the paracervical block and easily place the Mirena IUD to 7cm and cut the strings to 3cm



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IUD insertion

Z30.430, Encounter for insertion of intrauterine contraceptive device

58300, Insertion of IUD

J7298, Mirena IUD

35

You started the IUD insertion and had to stop due to pain

Z30.430, Encounter for insertion of intrauterine contraceptive device

58300, Insertion of IUD

Modifier 53, Discontinued procedure

J7298, Mirena IUD

36

What if she decided on topical lidocaine and a paracervical block?



- **Z30.430**, Encounter for insertion of intrauterine contraceptive device
- **58300**, Insertion of IUD
- **J7298**, Mirena IUD
- **64435**, Paracervical block

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IUD and Paracervical Block: bill separately or included in procedure

- Medicare National Correct Coding Initiative (NCCI), paracervical blocks (64435) are bundled into nearly all vaginal/cervical procedures
- Unbundle with **Modifier 59** only when it is performed unrelated to the primary procedure
- IUD insertion and paracervical block is not addressed in the NCCI edits because contraception not covered by Medicare
- *Payor dependent*

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Documentation

- Indication for procedure
- Associated diagnosis
- Specific procedure performed
- Modifier support
- Signed consent form
- Pathology
- Findings
- Complications

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Surgical Billing and Coding

Stephanie Henderson, MD

40

DOCUMENTATION THAT PAYS OFF

Practical Strategies to Improving Coding and Workflows

Jacob Lauer, MD, MPH, MBA, FACOG | Assistant Professor
Columbia University Department of Obstetrics & Gynecology
Division of Gynecologic Specialty Surgery

COLUMBIA

1

Disclosures and Disclaimers

I have no financial conflicts of interest

I am not a certified medical coding or billing professional. The information neither replaces information in Medicare regulations, the CPT-4 code book, or the ICD-10 CM code book; nor does it constitute legal advice. Questions regarding medical billing/coding practices should be directed to your professional billing/coding team.

COLUMBIA 2

2

Knowledge vs Application

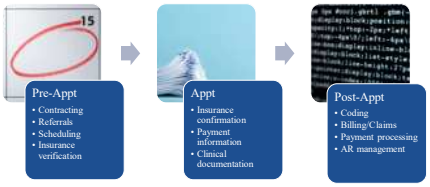




COLUMBIA 3

3

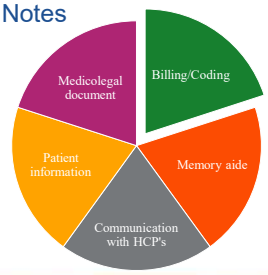
The Revenue Cycle



COLUMBIA 4

4

Multi-purpose Notes

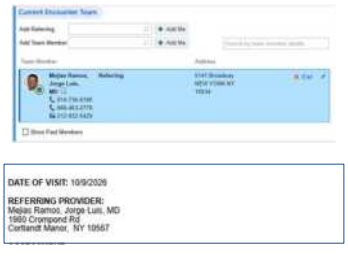


COLUMBIA 5

5

Capturing Referrals

- Billing consults
- Maintaining referral base
- Data on referral patterns



COLUMBIA 6

6

Comprehensive Documentation

- Diagnoses
- Treatment options discussed
- Risk factors for surgical complications
- Independent review of imaging
- Plans including medication management and surgical planning

COLUMBIA 7

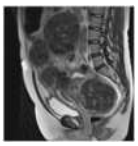
7

Level	Problems Addressed	Amount and/or Complexity	Risk
2	• 1 Self-limited or minor problem	**Minimal or None**	**Minimal**
3	• 2 or more self-limited or minor problems • 1 stable chronic illness • 1 acute, uncomplicated illness or injury	**Limited — any combination of 2:** • Review of prior external notes from unique source (1, 2, 3+) • Review of the results from each unique test (1, 2, 3+) • Ordered of each unique test (1, 2, 3+) or • Assessment requiring an independent historian that is not the patient	**Low** • OTC drugs • Minor surgery with no identified risk factors
4	• 1 or more chronic illness with exacerbation, progression, or side effects of treatment • 2 or more stable chronic illnesses • 1 undiagnosed new problem with uncertain prognosis • 1 acute illness with systemic symptoms • 1 acute complicated injury	**Moderate — one from below:** • Tests, documents, or independent historians • Independent interpretation of tests completed by another healthcare professional • Discussion of management or test interpretation with another healthcare professional	**Moderate** • Prescription drug management • Minor surgery with identified risk factors • Elective major surgery with no identified risk factors • Diagnosis or treatment significantly limited by social determinants of health
5	• 1 or more chronic illness with severe exacerbation, progression, or side effects of treatment • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive — two from below:** • Tests, documents, or independent historians • Independent interpretation of tests completed by another healthcare professional • Discussion of management or test interpretation with another healthcare professional	**High** • Elective major surgery with identified risk factors • Emergency major surgery • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis • Decision regarding hospitalization

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Comprehensive Documentation





COLUMBIA 9

9



COLUMBIA 10

10



COLUMBIA 11

11

Coding/Billing as Clinical Operations & Revenue Cycle

- Good surgical coding/billing starts at the first visit
- Accurate documentation of patient's medical history
  - Medical comorbidities
  - Prior surgery
  - Necessary testing (paps, ultrasounds)
- Billing for your work
- Use your documentation as a checklist (decrease inquiries)



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Revenue Cycle Considerations

- Select the right CPT code(s) for prior-authorization
  - Avoid non-allowed code combinations
  - Easier to "downgrade" a code than to "upgrade" a code
- Learn from prior-authorization and reimbursement denials
- Standardize codes used in booking and prior-authorization
- Improve reimbursement lag
  - Don't delay your documentation
  - Weight of uterus in operative report
  - Collaborate with coding team for diagnosis and procedure description language



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Modifier 22

- Modifier 22 is used to reflect "increased procedural services" – substantial additional work
- It can be used when the surgery involves
  - Increased technical difficulty
  - Longer time
  - A more severe patient condition

Example Uses of Modifier 22
Significant adhesions requiring adhesiolysis
Obesity requiring increased technical difficulty for abdominal access/closure
Extensive endometriosis excision
Large uteri requiring extraction/morcellation
Ureterolysis when performing endometriosis excision

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22 Modifier – Key Points

- Rarely reimbursed by Medicare/Medicaid (Childers et al, JAMA Surg, 2024)
- Commercial payers reimbursement varies (10-40%) (Smith et al, JSES Reviews Reports, and Techniques 2025)
- Describe in detail the justification for the increased charge
- Consider average time of the procedure
- Possible consequences to frequent use





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22 Modifier – Key Points

CPT Code/Procedure	Minutes of Intraservice Time
58571 TLH w/ adnexa < 250g	90 minutes
58573 TLH w/ adnexa > 250g	130 minutes
58546 LSC Myomectomy 5+ fibroids	180 minutes
58662 LSC with fulguration/excision of lesions	80 minutes

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22 Modifier – Example Language

A 22 modifier is requested because of the patient's obesity and adhesions.

vs

This procedure required an additional 90 minutes of intraoperative time compared to the typical procedure – representing a 50% increase in the surgical time. 30 minutes of this time additional time was due to the patient's obesity (BMI 47) which required increased time for placing the laparoscopic trocars and for closing the abdominal fascia after extraction. 60 minutes of the time was required for extensive adhesiolysis of small and large bowel owing to the patient's multiple prior abdominal surgeries.

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Assistant Surgeon Modifiers

- An assistant surgeon is a provider who actively assists the surgeon in performing the procedure
- Multiple modifiers exist depending on the role of the assistant surgeon
- Variable reimbursement policies, typically a percentage of the established fee (15-30%)
- Can only be used with allowable procedures

Modifier	Description
80	Assistant surgeon
81	Minimum assistant surgeon
82	Assistant when qualified resident is not available
AS	Assistant is a PA, NP, or RN

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Assistant Surgeon Modifier – Key Points

- Describe the role/need for the assistant surgeon
- Section 1842(b)(7)(D) of the Social Security Act has to be considered
  - No assistant surgeon when a qualified resident is available
  - Allowable for most laparoscopic/robotic procedures
- Not-allowable for most hysteroscopic procedures



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Assistant Surgeon Modifier – Example Language

Assistant Surgeon Attestation

I understand that section 1842(b)(7)(D) of the Social Security Act generally prohibits Medicare physician fee schedule payment for the services of assistants-at-surgery in teaching hospitals when qualified residents are available to furnish such services.

At the time of the surgery no residents were available to assist and another attending provider was requested to serve as assistant surgeon.

I certify that the services for which payment is claimed were medically necessary. I further understand that these services are subject to post-payment review by the Medicare administrative contractor.

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Workflows for Sanity

Tips/Tricks to make your life better

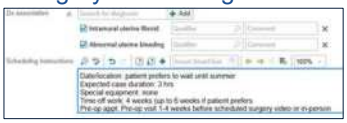


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Workflows for Sanity – Surgery Scheduling

- Scheduling workflows and staff can make or break your practice
- Ask your staff "what can I do to make your work easier"
- Standardize and use lists for all the details



SCHEDULING INSTRUCTIONS

Date/location: patient prefers to wait until summer
Expected case duration: 3 hrs
Special equipment: none
Time off work: 4 weeks (up to 6 weeks if patient prefers
Pre-op appt: Pre-op visit 1-4 weeks before scheduled surgery video or in-person
Post-op appt: in-person or video visit 2 weeks post-op
Clearance needed: Clearance needed from primary care
Labs: Patient will need to come in for labs 3-10 days before the surgery. Labs ordered

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Workflows for Sanity – Patient AVS Instructions



Patient Instructions

- Pick up your medications from the pharmacy before your surgery day
  - Oxycodone (prescription)
  - Extra strength Acetaminophen (prescription)
  - Extra strength Ibuprofen (prescription)
  - Senakot 'Stool softener (prescription or over the counter)
  - Miralax Laxative (over the counter)
- The hospital will call you the day before your surgery to confirm time of arrival and further instructions
- Please carefully read all of the pre-op and post-op information that was provided to you.

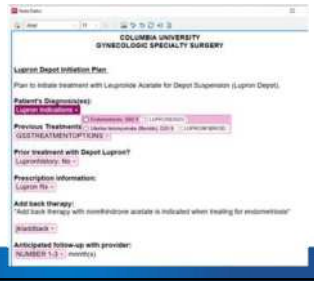
To have your pre-op EKG done, you can go to the NYP-Westchester (formerly Lawrence Hospital) Hospital at 55 Palmer Ave, Bronxville, NY 10708. No appointment is necessary. You can go between 8:00 am and 2:00 pm. You will need to register on the 1st floor at patient registration and then go to the 5th floor for the EKG.

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Workflows for Sanity – Prior Authorization for Meds

- For common medications/imaging that requires prior authorization, create templates of necessary information for the submission



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GYNECOLOGIC SPECIALTY SURGERY

Lupron Depot Initiation Plan:

Plan to initiate treatment with Leuprolide Acetate for Depot Suspension (Lupron Depot).

Patient's Diagnosis(es):

Previous Treatments:

Prior treatment with Depot Lupron?

Prescription information:

Add back therapy:

Anticipated follow-up with provider:

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24

Workflows for Sanity – Patient Instructions

- Patient instructions in plain language standardized for the surgery procedure
- Make sure the hospital and practice instructions are consistent



POSTOPERATIVE SURGERY INSTRUCTIONS: LAPAROSCOPIC/ROBOTIC HYSTERECTOMY (FORM 81)

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25



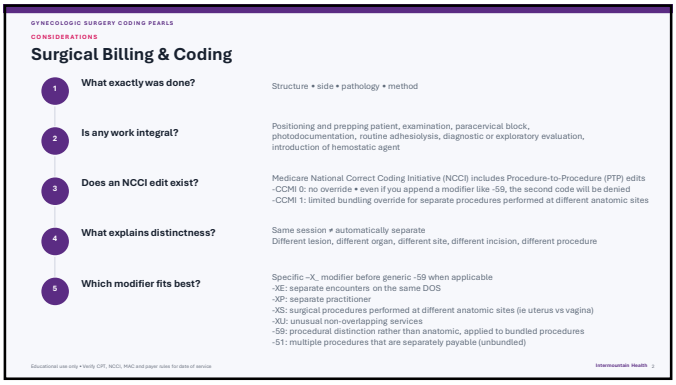
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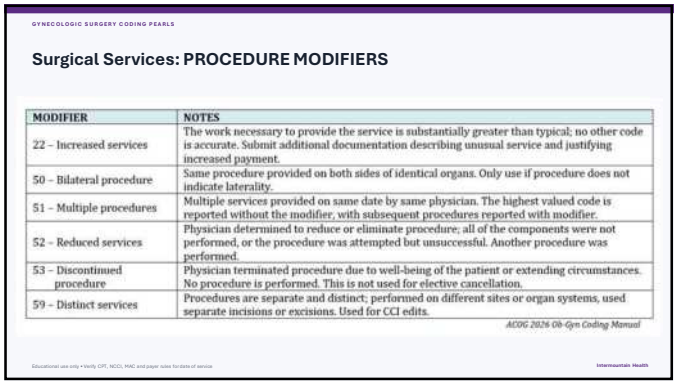
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AAGL26
Gynecologic Surgery Coding Pearls
Optimizing pay for the work we do
even with bundling, modifiers and global periods
Stephanie Henderson, MD · Intermountain Health
NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

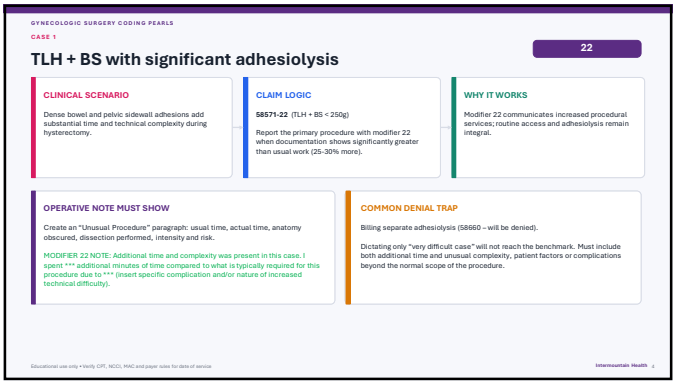
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GYNECOLOGIC SURGERY CODING PEARLS
CONSIDERATIONS
Surgical Billing & Coding
1 What exactly was done?
Structure • side • pathology • method
2 Is any work integral?
Positioning and prepping patient, examination, paracervical block, photodocumentation, routine adhesiolysis, diagnostic or exploratory evaluation, introduction of hemostatic agent
3 Does an NCCI edit exist?
Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits
-CCMI 0: no override • even if you append a modifier like -59, the second code will be denied
-CCMI 1: limited bundling override for separate procedures performed at different anatomic sites
4 What explains distinctness?
Same session ≠ automatically separate
Different lesion, different organ, different site, different incision, different procedure
5 Which modifier fits best?
Specific –X_ modifier before generic -59 when applicable
-XE: separate encounters on the same DOS
-XP: separate practitioner
-XS: surgical procedures performed at different anatomic sites (ie uterus vs vagina)
-XU: unusual non-overlapping services
-59: procedural distinction rather than anatomic, applied to bundled procedures
-51: multiple procedures that are separately payable (unbundled)
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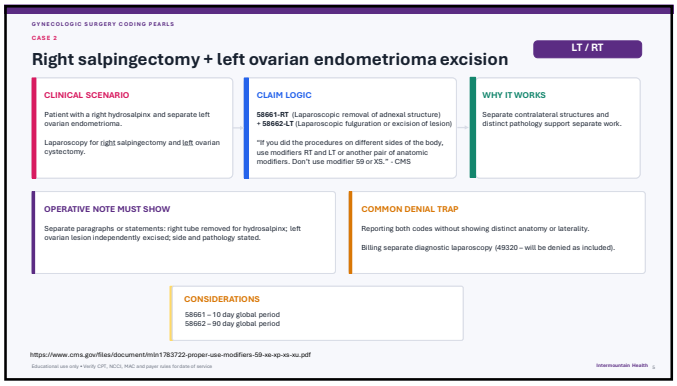
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GYNECOLOGIC SURGERY CODING PEARLS
Surgical Services: PROCEDURE MODIFIERS
MODIFIER
NOTES
22 – Increased services
The work necessary to provide the service is substantially greater than typical; no other code is accurate. Submit additional documentation describing unusual service and justifying increased payment.
50 – Bilateral procedure
Same procedure provided on both sides of identical organs. Only use if procedure does not indicate laterality.
51 – Multiple procedures
Multiple services provided on same date by same physician. The highest valued code is reported without the modifier, with subsequent procedures reported with modifier.
52 – Reduced services
Physician determined to reduce or eliminate procedure; all of the components were not performed, or the procedure was attempted but unsuccessful. Another procedure was performed.
53 – Discontinued procedure
Physician terminated procedure due to well-being of the patient or extending circumstances. No procedure is performed. This is not used for elective cancellation.
59 – Distinct services
Procedures are separate and distinct; performed on different sites or organ systems, used separate incisions or excisions. Used for CCI edits.
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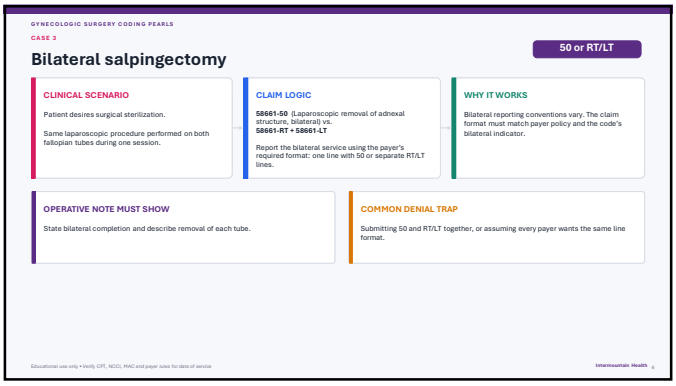
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GYNECOLOGIC SURGERY CODING PEARLS
CASE 1
TLH + BS with significant adhesiolysis
22
CLINICAL SCENARIO
Dense bowel and pelvic sidewall adhesions add substantial time and technical complexity during hysterectomy.
CLAIM LOGIC
58571-22 (TLH + BS < 250g)
Report the primary procedure with modifier 22 when documentation shows significantly greater than usual work (25-30% more).
WHY IT WORKS
Modifier 22 communicates increased procedural services; routine access and adhesiolysis remain integral.
OPERATIVE NOTE MUST SHOW
Create an "Unusual Procedure" paragraph; usual time, actual time, anatomy obscured, dissection performed, intensity and risk.
MODIFIER 22 NOTE: Additional time and complexity was present in this case. I spent *** additional minutes of time compared to what is typically required for this procedure due to *** (insert specific complication and/or nature of increased technical difficulty).
COMMON DENIAL TRAP
Billing separate adhesiolysis (58660 – will be denied).
Dictating only "very difficult case" will not reach the benchmark. Must include both additional time and unusual complexity, patient factors or complications beyond the normal scope of the procedure.
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GYNECOLOGIC SURGERY CODING PEARLS
CASE 2
Right salpingectomy + left ovarian endometrioma excision
LT / RT
CLINICAL SCENARIO
Patient with a right hydrosalpinx and separate left ovarian endometrioma.
Laparoscopy for right salpingectomy and left ovarian cystectomy.
CLAIM LOGIC
58661-RT (Laparoscopic removal of adnexal structure) + 58662-LT (Laparoscopic fulguration or excision of lesion)
"If you did the procedures on different sides of the body, use modifiers RT and LT or another pair of anatomic modifiers. Don't use modifier 59 or XS." - CMS
WHY IT WORKS
Separate contralateral structures and distinct pathology support separate work.
OPERATIVE NOTE MUST SHOW
Separate paragraphs or statements: right tube removed for hydrosalpinx; left ovarian lesion independently excised; side and pathology stated.
COMMON DENIAL TRAP
Reporting both codes without showing distinct anatomy or laterality.
Billing separate diagnostic laparoscopy (49320 – will be denied as included).
CONSIDERATIONS
58661 – 10 day global period
58662 – 90 day global period
https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xe-xp-xs-xu.pdf
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GYNECOLOGIC SURGERY CODING PEARLS
CASE 3
Bilateral salpingectomy
50 or RT/LT
CLINICAL SCENARIO
Patient desires surgical sterilization.
Same laparoscopic procedure performed on both fallopian tubes during one session.
CLAIM LOGIC
58661-50 (Laparoscopic removal of adnexal structure, bilateral) vs.
58661-RT + 58661-LT
Report the bilateral service using the payer's required format: one line with 50 or separate RT/LT lines.
WHY IT WORKS
Bilateral reporting conventions vary. The claim format must match payer policy and the code's bilateral indicator.
OPERATIVE NOTE MUST SHOW
State bilateral completion and describe removal of each tube.
COMMON DENIAL TRAP
Submitting 50 and RT/LT together, or assuming every payer wants the same line format.
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GYNECOLOGIC SURGERY CODING PEARLS

Modifier 51 vs 59: Decision Rule

Does an NCCI Procedure-to-Procedure (PTP) edit exist?

ex: bundled procedures

YES — bundled procedures

NO

YES — Non-bundled procedures

Modifier 59

Overrides NCCI bundling edits when services were truly distinct, allowing payment for both procedures

- CCMI 0: no override, even if you append a modifier like -59, the second code will be denied
- CCMI 1: limited bundling override for separate procedures performed at different anatomic sites

Modifier 51

Reduced payment for secondary procedures but allows them to be billed; highest-valued procedure paid in full and subsequent ones reduced under MPPR rule

Proceed without modifier

Reduced payment for secondary procedures; highest-valued procedure paid in full and subsequent ones reduced under MPPR rule

NCCI Procedure-to-Procedure Lookup

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GYNECOLOGIC SURGERY CODING PEARLS

CASE 4

Vaginal hysterectomy + true apical suspension

59

CLINICAL SCENARIO

Vaginal hysterectomy plus a separately performed high uterosacral ligament suspension to address prolapse.

CLAIM LOGIC

58260 (vaginal hysterectomy) + **57283-59** (colpopexy, intraperitoneal = USLS)

WHY IT WORKS

The apical procedure is additional reconstructive work beyond routine cuff support.

OPERATIVE NOTE MUST SHOW

Separate paragraphs: apical defect; ligament exposure; suture placement; suspension steps; restored apical support.

Specific diagnosis to justify the additional procedure and define the different anatomical sites

COMMON DENIAL TRAP

Only routine distal ligament incorporation into the cuff was performed (prophylaxis) as this is considered a component part of hysterectomy. Must document "high" suspension and have operative description support billing code.

Reporting both codes without showing distinct anatomy, or using 59 solely because two procedures occurred.

CONSIDERATIONS

59 modifier requires a procedural distinction

- Two (or more) procedures are performed during the same surgical encounter that are usually considered bundled or integral to each other → overrides bundling
- The documentation is critical and should always include medical necessity for the procedures.
- The operative report should clearly describe the reason for performing the additional procedure and include a separate paragraph describing the additional procedure in detail.

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GYNECOLOGIC SURGERY CODING PEARLS

CASE 5

Vaginal hysterectomy + midurethral sling

51

CLINICAL SCENARIO

The same surgeon performs two distinct procedures that are not bundled and both are independently reportable and payable in the same session.

Vaginal hysterectomy plus midurethral sling.

CLAIM LOGIC

List the primary service first: **58260** (vaginal hysterectomy)
List secondary procedure with modifier: **57288-51** (sling)

WHY IT WORKS

Modifier 51 signals multiple procedures; it is not an NCCI override of bundled procedures and is not appended to add-on codes (something that can never be billed on its own).

OPERATIVE NOTE MUST SHOW

Each procedure's indication and work.
Confirm neither is integral and no edit prevents separate reporting.

COMMON DENIAL TRAP

Applying 59 to an unedited pair, appending 51 to an add-on code, or assuming 51 guarantees payment.

CONSIDERATIONS

51 modifier requires a procedural distinction

- It signals that multiple-procedure payment sequencing should apply — the highest-valued procedure is paid in full, and subsequent ones are reduced under Medicare's Multiple Procedure Payment Reduction (MPPR) rules

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GYNECOLOGIC SURGERY CODING PEARLS

CASE 6

TLH with therapeutic adnexal removal

Do not unbundle

CLINICAL SCENARIO

37 yo patient with AUB and a right ovarian endometrioma.

Total laparoscopic hysterectomy with bilateral salpingectomy plus right oophorectomy

CLAIM LOGIC

First determine whether the adnexal work is included in the hysterectomy code family selected.

Allowed: **58571** (TLH + removal of tube and/or ovary)
Not: 58570 (TLH) + 58661-RT-59 (removal of adnexa)

WHY IT WORKS

A more comprehensive code already describes the surgical package. Code selection comes before modifier selection.

OPERATIVE NOTE MUST SHOW

Indication, specimen, laterality and whether adnexal removal was therapeutic versus inherent to the selected hysterectomy service.

COMMON DENIAL TRAP

Adding a laparoscopic adnexal code without reviewing the hysterectomy descriptor and NCCI edit.

CONSIDERATIONS

If ovarian cystectomy was performed instead of oophorectomy, it would be appropriate to bill as separate and distinct procedures as these are note bunded codes:
58571 (TLH + BS)
+58662-RT-51 (right ovarian cystectomy for distinct and separate procedure and problem; ovarian cystectomy is not inclusive of hysterectomy)

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GYNECOLOGIC SURGERY CODING PEARLS

CASE 7

Procedure discontinued for patient safety

53

CLINICAL SCENARIO

After the physician begins the procedure, a clinical event requires termination to protect the patient.

Planned hysteroscopy, D&C with cervical stenosis and inability to visualize the endometrial cavity

CLAIM LOGIC

58555-53 (diagnostic hysteroscopy; discontinued)

WHY IT WORKS

Modifier 53 describes a discontinued physician procedure due to extenuating circumstances or threat to patient well-being.

Modifier 52 communicates a partially reduced or eliminated service at physician discretion.

OPERATIVE NOTE MUST SHOW

What was initiated, point of discontinuation, reason, patient risk and services completed.

COMMON DENIAL TRAP

Using 52 for an unplanned safety stop (use -52 instead for a *planned* reduction of a procedure).

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GYNECOLOGIC SURGERY CODING PEARLS

Surgical Services: MULTIPLE SURGEONS

MODIFIER	NOTES
62 – Two surgeons (co-surgeons)	Two surgeons perform distinct part(s) of the surgical procedure; documentation is separate for their procedure.
80 – Assistant surgeon	Primary surgeon reports procedure without modifier and assistant reports with modifier. Assistant does not have separate operative report.
82 – Assistant surgeon (resident unavailable)	For services provided at a teaching facility. Medicare does not reimburse for assistant surgeons at teaching facilities.
AS – Physician assistant, nurse practitioner, or clinical nurse specialist for assistance at surgery	Medicare will reimburse if the assistant surgical services are covered if provided by a physician.

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GYNECOLOGIC SURGERY CODING PEARLS

CASE 8

Physician vs APP: first assistant

AS / 80

CLINICAL SCENARIO

1. An NP, PA or clinical nurse specialist performs covered first-assist work.

2. A second physician provides medically necessary first-assist work beyond that of operating-room staff.

CLAIM LOGIC

1. *APP* → reports the eligible surgical service with **modifier AS**, subject to scope, payer and assistant eligibility.
2. Physician → reports the eligible procedure with **modifier 80**; primary surgeon reports without an assistant modifier.

WHY IT WORKS

Modifier AS identifies nonphysician practitioner assistance at surgery.

Modifier 80 identifies a physician assistant surgeon when the procedure and payer permit assistant payment.

OPERATIVE NOTE MUST SHOW

Medical necessity and tasks demonstrating expertise beyond a scrub technician; name the assistant and critical portions, specific skilled tasks and why assistance was medically necessary.

"_____(Enter Name Here)_____ was present for all critical parts of this surgery and provided essential skills and expertise over and above that of a scrub technician as they assisted this surgery, including _____(add specifics here)_____."

COMMON DENIAL TRAP

Assuming presence supports billing or failing to document work beyond routine OR assistance.

Modifier 82 communicates qualified-resident unavailability in the teaching setting.

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GYNECOLOGIC SURGERY CODING PEARLS

CASE 9

Two surgeons as co-surgeons

62

CLINICAL SCENARIO

Two surgeons of different specialties each perform a distinct, necessary part of a single reportable procedure.

CLAIM LOGIC

Each surgeon reports the same procedure with modifier 62 when co-surgery is allowed and documented.

WHY IT WORKS

Co-surgery is not assistant surgery. Each surgeon performs a distinct portion requiring their expertise.

OPERATIVE NOTE MUST SHOW

Separate operative responsibilities, distinct work, shared procedure, and medical necessity for both surgeons.

COMMON DENIAL TRAP

One surgeon documenting only assistance, or reporting 62 when the code is not eligible.

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GYNECOLOGIC SURGERY CODING PEARLS

Surgical Services: POSTOPERATIVE PERIOD

MODIFIER	NOTES
58 – Stage or related procedure or service by the same physician or other qualified health professional during postoperative period	The additional service is related to but not a complication of the original surgery. Medicare rules are this service begins a *new* global surgical package.
76 – Repeat procedure or service by same physician or other qualified health care professional	Modifiers 76 and 77 are used to clarify the claim is not a duplicate
77 – Repeat procedure by another physician or other qualified health care professional	
78 – Unplanned return to the operating/procedure room by the same physician or other qualified health care professional after initial procedure for a related procedure during the postoperative period	Indicates that the procedure required a return to the operating/procedure room and is therefore payable. Medicare reimburses only for the intraoperative portion of the related service. This service does *not* begin a new global surgical package.
79 – Unrelated procedure or service by the same physician or other qualified health care professional during the post-operative period	Treatment may or may not require a return to the operating/procedure room. This service begins a *new* global surgical package.

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GYNECOLOGIC SURGERY CODING PEARLS

CASE 10

Repeat procedure by the same surgeon

76

CLINICAL SCENARIO

A repeat service is medically necessary on the same day or later by the same physician.

Pelvic ultrasound performed to evaluate abnormal bleeding. The initial u/s is inconclusive and the provider performs a repeat ultrasound later that day.

CLAIM LOGIC

Append modifier 76 to the repeated procedure when the code and payer rules permit.

DOS 2/21/26: **76700** (Abdominal u/s, complete)
DOS 2/21/26: **76700-76** (Repeat abd u/s)

WHY IT WORKS

Modifier 76 distinguishes a repeat procedure from an accidental duplicate claim. It signals that the repeat was intentionally and medically necessary and not due to an error or equipment failure.

OPERATIVE NOTE MUST SHOW

Why repetition was medically necessary, findings before each service and the separate performance.

COMMON DENIAL TRAP

Using 76 when the second service is actually a different procedure.

Using 76 when the second service is provided by a different provider (use -77).

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GYNECOLOGIC SURGERY CODING PEARLS

CASE 11

Return to OR for postoperative hemorrhage

78

CLINICAL SCENARIO

Same surgeon returns the patient to the operating room during the global period to control bleeding related to the original surgery.

CLAIM LOGIC

Report the related procedure with modifier 78.

This does NOT start a new global period.

WHY IT WORKS

Modifier 78 identifies an unplanned return to an operating/procedure room for a related service during the postoperative period.

OPERATIVE NOTE MUST SHOW

Clinical complication, urgency, return-to-room setting and treatment performed.

COMMON DENIAL TRAP

Using 58, which is for staged, planned or more extensive related work, not treatment of a complication.

Medicare reimburses only the intraoperative portion of the related service.

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GYNECOLOGIC SURGERY CODING PEARLS

CASE 12

Unrelated surgery during global

79

CLINICAL SCENARIO

During the global period of one operation, the same surgeon performs surgery for a separate diagnosis.

CLAIM LOGIC

Report the unrelated procedure with modifier 79.

This service DOES start a new global period.

WHY IT WORKS

Modifier 79 distinguishes a new, unrelated operation by the same physician during the postoperative period.

OPERATIVE NOTE MUST SHOW

Independent diagnosis, indication and lack of relationship to the first surgery.

COMMON DENIAL TRAP

Using 79 for a complication or staged treatment of the original condition.

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GYNECOLOGIC SURGERY CODING PEARLS

Surgical Services: DIVISION OF GLOBAL SURGICAL PACKAGE

MODIFIER	NOTES
64 – Surgical care only	Medicare recognizes modifiers when there is documentation of: -a formal transfer of care -surgeons are in the same practice but different specialties, or -surgeons are in different practices and do not have a covering relationship
55 – Postoperative management only	
56 – Preoperative management only	Submit documentation with the claim to private payers to explain extenuating circumstances

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GYNECOLOGIC SURGERY CODING PEARLS

CASE 13

Split global surgical care

54 / 55 / 56

CLINICAL SCENARIO

One physician performs surgery and another eligible clinician assumes postoperative management under a formal transfer.

CLAIM LOGIC

Surgical care only: -54.

Postoperative management only: -55.

Preoperative management only: -56, when applicable.

WHY IT WORKS

These modifiers allocate portions of the global package when care is formally transferred.

OPERATIVE NOTE MUST SHOW

Written transfer, dates of responsibility, providers involved and components furnished.

COMMON DENIAL TRAP

Using transfer-of-care modifiers for casual cross-coverage or isolated visits.

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GYNECOLOGIC SURGERY CODING PEARLS



Global Periods

Typical 0, 10 or 90 days.

Know your global for each common procedure – follow up or routine postop visits are either 99024 (no charge) OR billable E/M based on global period and date of visit.

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GYNECOLOGIC SURGERY CODING PEARLS

TAKE-HOME

Modifier quick reference

22	More work than usual	24	Unrelated E/M in global	25	Separate E/M + minor procedure
50	Bilateral procedure	51	Multiple procedures	52	Reduced service
53	Discontinued physician procedure	57	Decision for major surgery	58	Staged/related procedure
59 / X	Distinct service under edit	62 / 66	Co-surgery / team surgery	76 / 77	Repeat procedure
78 / 79	Related return / unrelated surgery	80 / 82 / AS	Assistant at surgery	54 / 55 / 56	Split global care

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Review

Enhance proficiency in surgical coding to ensure accuracy and compliance including:

- Components of correct coding
- Use of procedure modifiers
- Global surgical periods

References

CMS 2026 NCCI Policy Manual: https://www.cms.gov/files/document/2026-ncci-medicare-policy-manual-all-chapters.pdf
CMS MLN: Proper Use of Modifiers 59, XE, XP, XS & XU: https://www.cms.gov/files/document/mln1783727-proper-use-modifiers-59-xe-xp-xs-xu.pdf
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Outpatient Coding and Billing

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1

Objectives

- What are CPT and ICD codes?
- How do I determine what level to bill in the office?
- What do I need to document?

2

Purpose of Coding

- To $tandardize the de$cription of the patient'$ $ymptom or di$ea$e proce$$.
- To allow for retro$pective re$earch to evaluate outcome$, intervention$, etc.
- To evaluate quality and complexity of care.
- To evaluate what procedure$ are being performed for which diagno$e$.

3

Types of Codes

- ICD-10: Identifies diseases or symptoms. International Classification of Disease.
- CPT-4: Identifies procedures performed. Current Procedural Terminology.

4

ICD

- ICD does not allow you to code for "rule out", "suspected" or "Probable" conditions—indicate a symptom if you don't have a specific diagnosis.
- Use only current conditions that are the reason for the visit (if you don't treat or address the HTN or hypothyroidism, then don't code it).
- Use "O" codes for obstetric patients.
  - R11: Nausea and Vomiting
  - O21: Excessive Vomiting in Pregnancy
  - Hypertension vs Hypertensive Disease in Pregnancy
- Use mostly "N" codes for GYN patients.
  - N92: Excessive, Frequent and Irregular Menstruation
- "Z" codes are identifiers, not pathologic conditions
  - Z01.419-'Annual Exam' or 'Breast and Pelvic Exam'

5

Elements of a Visit

- History
  - Chief Complaint
  - History of Present Illness (HPI)
  - Past Medical, Family and Social Hx (PSFH)
  - Review of Systems (ROS)
- Examination
  - 1995 & 1997 guidelines
- Medical Decision Making
  - Number of Diagnoses
  - Amount/Complexity of Data or Mortality
  - Risk of Complications or Morbidity

6

Elements of a Visit

- History
- Exam
- Assessment
- Plan

} Medical Decision Making

7

What about documentation?

- ~~History?~~
- ~~Examination?~~
- Medical Decision Making?

8

Here Comes the Hard Part

- Medical Decision Making
  - Straightforward
  - Low Complexity
  - Moderate Complexity
  - High Complexity
  - Number and Complexity of Problems Addressed
  - Amount and/or Complexity of Data to Review/Analyze
  - Risk of Complications or Morbidity/Mortality

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Medical Decision Making

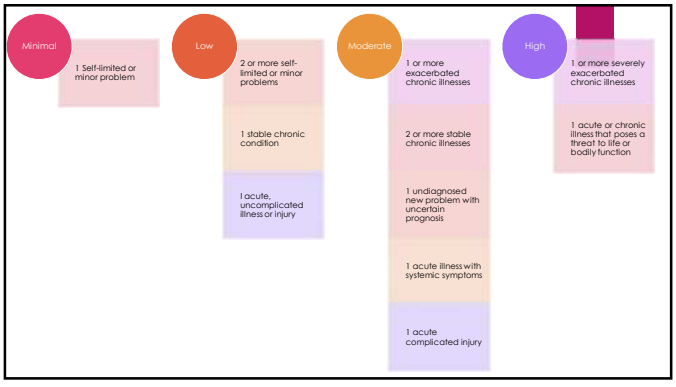
Diagnoses	Minimal	Low	Moderate	High
Data	Minimal	Limited	Moderate	Extensive
Risk	Minimal	Low	Moderate	High
	Straight Forward	Low Complexity	Moderate Complexity	High Complexity

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Documenting MDM

- Number of diagnoses or management options
  - How many conditions?
  - Condition category (acute, chronic, stable, exacerbated, complicated, uncomplicated)

11



12

Documenting MDM

- Amount and/or complexity of data to be reviewed
  - How many external notes reviewed?
  - How many unique test results reviewed?
  - How many unique tests ordered?
  - Was an independent historian required?
  - Was there independent interpretation of test(s)?
  - Was there discussion or management of test(s) with outside physician/provider?

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Amount and Complexity of Data

14

Minimal

- None
- Less than "Limited"
  - One external note
  - Review of one test
  - Ordering of one test

Limited

- Two of the following:
  - Order/Review unique test
  - Review prior external notes

OR

- Assessment requiring an independent historian

14

Number and Complexity of Data

15

Moderate

- **One out of the three options below:**
- Three of the following:
  - Order/Review unique test
  - Review prior external notes
  - Assessment requiring an independent historian

OR

- Perform independent interpretation of test (not one you were already paid for!)

OR

- Discuss care with external physician

Extensive

- **Two out of the three options below:**
- Three of the following:
  - Order/Review unique test
  - Review prior external notes
  - Assessment requiring an independent historian

OR

- Perform independent interpretation of test (not one you were already paid for!)

OR

- Discuss care with external physician

15

Documenting MDM

- Risk of complications and/or morbidity or mortality
  - Level of risk
  - Type of risk
    - Prescription drug management w/ or w/o intensive monitoring
    - Minor surgery w/ or w/o risk factors
    - Elective major surgery w/ or w/o risk factors
    - Social determinants of health?
    - Emergency major surgery
    - Hospitalization?
    - DNR or poor prognosis?

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Level of Risk

- Minimal: Minimal risk of morbidity from additional diagnostic testing or treatment.
- Low: Low risk of morbidity from additional diagnostic testing or treatment.
  - OTC medications
  - Arterial blood tests, Imaging studies with contrast (SIS)
  - Minor surgery with no identified risk factors, IV fluids
- Moderate: Moderate risk of morbidity from additional diagnostic testing or treatment.
  - Fetal STRESS test, CV imaging, Deep needle or incisional bx (including culdocentesis or amniocentesis)
  - Minor surgery with risk factors,
  - Elective major surgery w/o risk factors,
  - Management of prescription drugs, IV fluids with additives
  - Diagnosis or treatment significantly limited by social determinants of health
- High: High risk of morbidity from additional diagnostic testing or treatment
  - 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 care
  - Decision not to resuscitate or to de-escalate care because of poor prognosis
  - Decision regarding parental controlled substances

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Level of Risk

- Moderate: One or more chronic illnesses w/ mild exacerbation, progression or side effects/diagnostic endoscopies w/ no identified risk factors.
  - New problem with uncertain prognosis (breast lump)
  - Irregular bleeding
  - Diagnostic endoscopies w/ no identified risk factors
  - Minor surgery with risk factors
  - Elective major surgery w/o risk factors
  - Management of prescription drugs
  - IV fluids with additives
- High: Acute or Chronic illnesses or injuries that pose a threat to life or bodily function/diagnostic endoscopies w/ identified risk factors/Emergency major surgery.
  - Dx endoscopies with risk factors
  - Pelvic Pain
  - Multiple complaints
  - Elective or emergency major surgery with risk factors
  - Drug therapy requiring intensive monitoring for toxicity.

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Medical Decision Making

- Number of Diagnoses or Management Options
- Amount or Complexity of Data to Review
- Risk of Complications or Morbidity/Mortality

Only need 2 out of 3!!

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Putting it all together

	History	Exam	Medical Decision Making
Level 1			
Level 2			Straight Forward
Level 3			Low Complexity
Level 4			Moderate Complexity
Level 5			High Complexity

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Medical Decision Making

Diagnoses	Minimal	Low	Moderate	High
Data	Minimal	Limited	Moderate	Extensive
Risk	Minimal	Low	Moderate	High
MDM	Straight Forward	Low Complexity	Moderate Complexity	High Complexity
Code	99202 99212	99203 99213	99204 99214	99205 99215

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Total Time Documented

New Patients		Established Patients	
15-29	99202	99212	10-19
30-44	99203	99213	20-29
45-59	99204	99214	30-39
60-74	99205	99215	40-54

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GYN Case #1

- A 27 yo P3 presents to clinic complaining of abnormal bleeding. Menses are irregular. Sometimes goes 6-8 weeks without bleeding and then will bleed for 3 weeks straight. She has never been seen for this before. It started 6 months ago. She is not trying to get pregnant. She is a non-smoker and does not get migraines.
- She delivered her last child 2.5 years ago.
- Her exam is normal except BMI of 31.
- In the clinic, you order a pregnancy test that comes back negative and you do an ultrasound that shows a normal uterus and normal ovaries. You also order a send out for CBC and TSH.

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Diagnosis and Treatment

- AUB:O (anovulatory bleeding)
- Obesity

- Prescription for OCPs as cycle control medications.
- Exercise regimen for health

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Categories for Determining MDM

Codes	MDM Level	Diagnoses	Data Amount & Complexity	Risk
99211	Established patient that did not require physician or QHP care			
99202 99212	Straightforward	Minimal	Minimal	Minimal
99203 99213	Low	Low	Limited	Low
99204 99214	Moderate	Moderate	Moderate	Moderate
99205 99215	High	High	Extensive	High

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What do you bill?

- 99214 and the US code.
  - Need to document US report separately to bill for it separately.
- Medical Decision Making:
  - New diagnosis of uncertain prognosis (moderate)
  - Ordered 3 tests so Moderate Data
  - Prescribed a prescription medication so moderate risk.
- Cannot count independent interpretation of US result if you are the one doing the US reporting. If you view the CT images or someone else does the report and you review the images, then you can count that as independent.
- If you review the CT or US images with the radiologist, that counts as talking with another physician.

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Work RVU values

	New Patient	Established Patient
Level 2	0.93	0.70
Level 3	1.60	1.30
Level 4	2.60	1.92
Level 5	3.50	2.80

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Time to complete the billing

- Level 2: Should have asked their mother
- Level 3: Should have asked their PCP/FP
- Level 4: Right in my wheelhouse! I've got this!
- Level 5: Well this is going to throw off the schedule for today. Wish they had seen someone else. In fact, I'm going to send them to see someone else—GYN Onc, Urogyn, etc.

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Seven modifiers to remember

- 22: Unusual and increased services.
- 24: Unrelated E&M service. E&M service provided by the surgeon during a global surgical period. (Dx code must be unrelated to original code.)
- 25: Procedure and E&M on the same day.
- 57: Decision to perform surgery.
- 95: Synchronous telemedicine service rendered via a real-time interactive audio and video communications system.
- GE: Billing a level 2 or 3 (new or established) problem visit in the primary care setting and the attending did not see the patient.
- GC: Billing an outpatient problem visit in the primary care setting and the attending DID see the patient.

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Inpatient Coding

- Initial Inpatient Care (Admission)
- Subsequent Inpatient Care
- Discharge Inpatient Care
- Inpatient Consults
- Observation (Admit and Discharge same date)

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What about inpatient documentation?

- History?
- Examination?
- Medical Decision Making?

- As of Jan 2023, just need to document medically appropriate Hx and Exam. Billing based on MDM.

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CULTURAL AND LINGUISTIC COMPETENCY & IMPLICIT BIAS

The California Medical Association (CMA) outlines standards for Cultural Linguistic Competency and Implicit Bias in CME. The goal of the standards is to support the role of accredited CME in advancing diversity, health equity, and inclusion in healthcare. These standards are relevant to ACCME-accredited, CMA-accredited, and jointly accredited providers located in California. AAGL is ACCME-accredited and headquartered in California.

CMA developed the standards in response to California legislation (Business and Professions (B&P) Code Section 2190.1), which directs CMA to draft a set of standards for the inclusion of cultural and linguistic competency (CLC) and implicit bias (IB) in accredited CME.

The standards are intended to support CME providers in meeting the expectations of the legislation. CME provider organizations physically located in California and accredited by CMA CME or ACCME, as well as jointly accredited providers whose target audience includes physicians, are expected to meet these expectations which began on January 1, 2022. AAGL has been proactively adopting processes that meet and often exceed the required expectations of the legislation.

CMA CME offers a variety of resources and tools to help providers meet the standards and successfully incorporate CLC & IB into their CME activities, including FAQ, definitions, a planning worksheet, and best practices. These resources are available on the CLC and IB standards page on the CMA website.

Important Definitions:

Cultural and Linguistic Competency (CLC) – The ability and readiness of health care providers and organizations to humbly and respectfully demonstrate, effectively communicate, and tailor delivery of care to patients with diverse values, beliefs, identities and behaviors, in order to meet social, cultural and linguistic needs as they relate to patient health.

Implicit Bias (IB) – The attitudes, stereotypes and feelings, either positive or negative, that affect our understanding, actions and decisions without conscious knowledge or control. Implicit bias is a universal phenomenon. When negative, implicit bias often contributes to unequal treatment and disparities in diagnosis, treatment decisions, levels of care and health care outcomes of people based on race, ethnicity, gender identity, sexual orientation, age, disability and other characteristics.

Diversity – Having many different forms, types or ideas; showing variety. Demographic diversity can mean a group composed of people of different genders, races/ethnicities, cultures, religions, physical abilities, sexual orientations or preferences, ages, etc.

Direct links to AB1195 (CLC), AB241 (IB), and the B&P Code 2190.1:

Bill Text – AB-1195 Continuing education: cultural and linguistic competency.
Bill Text – AB-241 Implicit bias: continuing education: requirements.
Business and Professions (B&P) Code Section 2190.1

CLC & IB Online Resources:

Diversity-Wheel-as-used-at-Johns-Hopkins-University-12.png (850×839) (researchgate.net)
Implicit Bias, Microaggressions, and Stereotypes Resources | NEA
Act, Communicating, Implicit Bias (racialequitytools.org)
https://www.contemporaryobgyn.net/view/overcoming-racism-and-unconscious-bias-in-ob-gyn
https://pubmed.ncbi.nlm.nih.gov/34016820/
https://hr.ucdavis.edu/departments/learning/certificate/implicit-bias
https://pmc.ncbi.nlm.nih.gov/articles/PMC7011228/