REVIEWS IN UROLOGY

Coding Corner: *Current Procedural Terminology* Code 99459, Female Pelvic Examination

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Introduction

Coding and reimbursement issues are front and center for urology practices. With the relaunch of *Reviews in Urology,* we've put together a new group of editors to inform and educate our readers about the appropriate use of *Current Procedural Terminology (CPT)*/Healthcare Common Procedure Coding System and *International Classification of Diseases, Ninth Revision/International Statistical Classification of Diseases, Tenth Revision* codes. Our team includes 3 people:

- **Jonathan Rubenstein**, MD, urologist and chief compliance officer, United Urology Group
- **Mark Painter**, managing partner of PRS Consulting, LLC; chief executive officer of PRS Urology Service Corporation; vice president of Coding and Reimbursement Information for Physician Reimbursement Systems, Inc; and chief executive officer of Relative Value Studies, Inc
- **Celeste Kirschner**, former secretary of the CPT Editorial Panel and current LUGPA chief executive officer

Each quarter, we will comment on key urology-specific coding issues, bringing you up-to-date on the latest coding changes, interpretations, and payment policy issues that affect your everyday practice. In this issue of *Reviews in Urology,* we tackle the new 2024 *CPT* code 99459, female pelvic examination (used in addition to the code for the primary procedure).

Applying *CPT* code 99459 for female pelvic examinations may appear straightforward, but its use requires a nuanced understanding. Since the code's introduction on January 1, 2024, it has been used as an add-on to female pelvic examination codes related to outpatient evaluation and management visits. It is crucial to understand the intricacies of *CPT* code 99459 to apply it properly, report it accurately, and adhere to best practices.

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Applying *CPT* Code 99459

An add-on code intended to accompany outpatient or well-patient office visits, the application of *CPT* code 99459 is broad, facilitating its use in various contexts, including screening and annual wellness visits, provided that these visits are conducted for patients in need of such examinations. The code's designation as an add-on implies that it cannot be independently billed; rather, it must be reported with other, specific service codes on the same date of service.

The code can be added to a specific list of services, including new or established patient, consultation, and wellness examination office visits, as is common with *CPT* codes. Medicare and private insurance payers typically conform to this defined list, though Medicare may expand it to include additional G codes for annual visits or "Welcome to Medicare" examinations. The list of applicable services is subject to change, so health care professionals are advised to keep abreast of any updates to ensure compliance and accurate billing.

In urology, the code is predominantly applied within the context of evaluation and management services for new, established, and consulting patients (Table 1) primarily because urologists, unlike physicians and clinicians in other specialties, typically do not conduct well-patient or screening visits. To date, only a limited number of urology groups have integrated a primary care component into their practices, often facilitating annual Medicare and wellness visits through advanced practice clinicians. Still, a segment of urology practices does engage in these types of patient visits.

Recording *CPT* Code 99459

The examination required to report this add-on code must meet certain criteria to be considered valid for billing purposes. These criteria serve as safeguards against the submission of claims for superficial or perfunctory pelvic examinations.

Initially, the boundaries for these requirements may not seem straightforward, yet a close analysis of how *CPT* and Medicare valued this code reveals implicit standards. Notably, the code is classified as a practice expense only, lacking a physician work component, which means that no work value is attributed to the clinician's efforts during the examination itself and interpretation of findings because these are seen to be within the evaluation and management service. The reimbursable elements pertain solely to practice expenses associated with this type of examination.

These practice expenses, determined through direct input files, include 2 main components: (1) 4 minutes of staff time and (2) a pelvic examination kit (typically containing a speculum, drapes, and other required items). With the value set at approximately $2.00 for staff time and about $20.00 for the kit (based

Table 1. Nonfacility Codes Relevant to Add-On *Current Procedural Terminology* Code 99459

Report only on the same date of service with 1 of the following services:		
Evaluation and management services office or other outpatient	New patient 99202-99205	Established patient 99212-99215
Evaluation and management services consultation[a]	Office or other outpatient 99242-99245	–
Preventive medicine services	New patient 99383-99387	Established patient 99393-99397

[a] More commonly used by urology practices.

on 2024 metrics), the implication is clear: To justify the reporting of code 99459, documentation must verify that a comprehensive pelvic examination was performed, necessitating the specified equipment and staff involvement. This examination entails more than a cursory assessment of the external genitalia, suggesting a thorough examination likely conducted with the patient in stirrups and appropriately draped.

Thus, the primary intent behind *CPT* code 99459 is to compensate health care practices for the additional, otherwise-nonreimbursable expenses incurred during this examination. Perhaps, therefore, referring to the code as involving a female speculum examination may offer a clearer understanding, potentially minimizing confusion or misinterpretation.

Because the *CPT* system is intended to catalog medical, surgical, and diagnostic services—not specifically for reimbursement purposes—the detailed descriptions of services often lack explicit guidelines. This lack of detail leaves room for interpretation by payers, such as Medicare, in their application and reimbursement protocols.

The distinction between the general categorization of a pelvic examination and the specific activities reimbursable under *CPT* code 99459 underscores the importance of precise documentation. Medicare may eventually provide further clarification on appropriately applying the code. Based on the current understanding and interpretation, however, documentation that substantiates a comprehensive female pelvic examination, including inspection of the vagina and cervix, should justify reporting code 99459 with an evaluation and management code.

Labor Reimbursement in *CPT* Code 99459

The absence of a work component within the code signifies that physicians do not receive direct reimbursement for the labor involved in conducting the examination through code 99459. Instead, the code is designed to cover the overhead costs associated with the examination, specifically accounting for additional staff time and use of equipment. It would be difficult to justify billing for equipment that was not actually used.

Some have interpreted that the requirement to have a chaperone in the room, which some states and practices mandate, can be applied to the staff time provided within the code. Others argue that staff time is intended to cover assistance provided to the patient, such as undressing, mounting the examination table, and positioning in the stirrups, activities that typically require at least 4 minutes.

Despite Medicare's final rules mentioning "chaperone," there is a perspective that this term is merely illustrative of the kinds of activities contributing to the valuation of extra staff time rather than mandating a chaperone's presence during the examination. Considerable staff involvement is indeed associated with these examinations, encompassing tasks ranging from assisting the patient in preparation and positioning for the examination to postexamination processes such as cleaning up, helping the patient dress, and processing specimens. Clarification about this staff time is lacking. Notably, the value assigned to these 4 minutes of staff time is relatively minor compared with the costs of equipment and supplies at which this code is valued.

Discussions of billing, reimbursement, and the associated coding often overlook other facets of health care. In jurisdictions mandating the presence of a chaperone during certain medical examinations, adherence to state regulations is imperative. From both medical and legal standpoints, especially considering current trends, it is crucial to document whether a chaperone was offered and either accepted or present, aligning with medical-legal standards. There is no indication, nor is it expected, that specifying the involvement of a chaperone will become a requisite for using *CPT* code 99459.

Reporting *CPT* Code 99459 With Modifier 25

A common question is whether an evaluation and management visit appended by modifier 25 would qualify for use of *CPT* code 99459. For instance, if

a patient undergoes both an office evaluation and management visit and a cystoscopy on the same day, the feasibility of reporting code 99459 concurrently with modifier 25 (assuming medical necessity and actual performance of the procedures) is unclear. Currently, there do not seem to be any explicit restrictions against such reporting. That said, medical necessity is paramount. If a patient's pelvic examination is postponed to coincide with a cystoscopy and a justified medical need for an evaluation and management service exists during the procedure, it is considered reasonable to include it in the claim.

Summary: Applying *CPT* Code 99459

Within urology, *CPT* code 99459 is best used alongside an evaluation and management service conducted in an office setting rather than in hospital or operating room environments. The code applies when a comprehensive pelvic examination is performed, aimed at compensating for the overhead costs standard reimbursement does not cover. These costs include use of a speculum and drapes and extra staff time. It is important to note that the requirement for staff time does not necessarily dictate the presence of a staff member in the room during the examination; rather, it encompasses the additional time spent assisting the patient in preparation for and following the examination. This assistance goes beyond the typical scope and expenses associated with the primary evaluation and management services.

Code 99459 emerges as a crucial tool for urology practices, designed to ensure appropriate reimbursement for the additional, nonreimbursable expenses incurred during comprehensive female pelvic examinations. Through meticulous application and reporting, practices can navigate the complexities of health care billing, enhancing patient care while ensuring practice financial sustainability.

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