Coding for the OB/GYN Practice

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Coding Principals

- Correct coding implies the selection is
  - What are we doing? Procedures
  - Why are we doing it? Diagnosis
  - Supported by documentation
  - Consistent with coding guidelines
Coding Principals

- Reporting Services
  - Is there physician work or practice expense?
  - Can it be supported by an ICD-9 code?
  - Is it independent of other procedures/services?
  - Is there documentation of the service?

Billing “Rule”

- “Not documented” means “Not done”
  - “Not documented” “Not billable”
- Documentation must support type and level of extent of service reported

Code Sets

- Key Code sets
  - HCPCS (includes CPT-4)
  - ICD-9-CM/ICD-10-CM
- HCPCS describes “what”
- ICD-9 CM describes “why”
Who can bill as a Provider?

• Change have been made throughout the CPT manual to clarify who may provide certain services with the addition of the phrase “other qualified healthcare professionals”.
• Some codes define that a service is limited to professionals or limited to other entities such as hospitals or home health agencies.

Providers

• CPT defines a “Physician or other qualified health care professional” as an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable), who performs a professional services within his/her scope of practice and independently reports that professional service.
• This is distinct from clinical staff
Providers

- Clinical staff members are people who work under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.

Example

- 2012
  - 59300—Episiotomy or vaginal repair, by other than attending physician
- 2013
  - 59300—Episiotomy or vaginal repair, by other than attending

New vs. Established Patient Definition Update

- Advanced practice nurses (APN) and physician assistants (PA) working with physicians are considered as working in the exact same specialty and subspecialty as the physician
- Applies to determination of new vs. established codes and covering situations.
Obstetric Definitions and General Rules

• Amenorrhea—a lack of menstruation
• Primary— a lack of menstruation in a woman at least 16 years old.
• Secondary—when established menstruation has ceased for 3 months in a women with a history of a regular cycles or for 6 months for a women with irregular periods.
• A missed period or two with confirmed pregnancy is NOT amenorrhea.

• Periods of Gestation—the number of completed weeks of pregnancy, between the 1st day of the LMP and the date in question.
• If ICD-9 specifies “Before 22 completed weeks of gestation” (up to 21 weeks 6 days)
• If ICD-9 specifies “Before 37 completed weeks of gestation” (applies up to 36 weeks, 6 days)
• Anything outside that realm would not meet the definition

• Gravida—A women who has been pregnant
  — Includes abortions, ectopic, or molar pregnancies
  — Prima gravida—1st pregnancy
• Parity—the state of having given birth to an infant or infants weighing 500 gm or more, alive or dead.
  — If you do not know the weight, may apply for any pregnancy that is 20 weeks 0 days or later.
• Abortion
  – Missed—early fetal death before completion of 22 weeks gestation
    • Retention of dead fetus or retained products of conception, not following spontaneous or induced abortion or delivery.
  – Incomplete—not all of the products of conception are expelled at the time of the encounter
  – Complete—all of the products of conception are expelled at the time of the encounter
    • Can include elective or therapeutic legal abortions

ICD-9-CM
• International Classification of Diseases, 9th Edition, Clinical Modification
• Indicates medical necessity by linking to the CPT codes
• Helps “justify” the services and improves claims processing
• Provides information used in tracking disease trends
Revisions to ICD-9-CM

• ICD-9-CM Coordination and Maintenance Committee
• Representatives from Centers of Medicare and Medicaid Services (CMS and National Center for Health Statistics (NCHS))
• Changes effective October 1st each year
  – AGOG Coding Committee provides input

Revisions to ICD-9-CM

• Codes must be compatible with the World Health Organization’s (WHO) ICD-9
• Changes/additions are made only if
  – Codes are outdated
  – New diseases are identified
  – Current code is too general

Revisions to ICD-9-CM

• October 1, 2011
  – Last regular update to ICD-9-CM
• October 1, 2012
  – Limited code updates to both ICD-9-CM and ICD-10-CM
    • New technology, new diseases only
• October 1, 2014
  – ICD-9-CM no longer a valid code set
Why Change?

- ICD-9-CM
  - Out of date
  - Out of space
  - 30 years old
- ICD-10-CM
  - International standard for a number of years
  - U.S. is the only country in WHO not using ICD-10

Key Differences:

- ICD-10-CM: 21 Chapters
  - ICD-9-CM: 17 Chapters
- Increased specificity resulting in increased number of codes and added documentation requirements
- ICD-10 chapters divided into “blocks” of codes with additional subcategories
- V and E code supplemental classifications are part of the main classifications
Key Differences

• ICD-10: Reclassification of certain diseases to reflect current medical knowledge
• ICD-10: Postoperative complications in procedure specific system chapters
  – Complications of GU surgery is in GU chapters
• ICD-10: Alphanumeric codes with up to 7 characters
  – ICD-9-CM: numeric 3 to 5 characters in length except V and E codes

Key Differences

• ICD-10: Full code titles vs. references to common 4th-5th digits
  – Additional 6th characters for some
  – Additional of code extensions (7th digit)
  – Addition of dummy placeholders (X)

Key Differences for OB/GYN

• Inclusion of trimesters in obstetric codes
• Elimination of episodes of care for obstetric codes
• Changes in timeframes
  – Abortion vs. Fetal death (20 weeks)
  – Early vs. Late pregnancy (20 weeks)
• Extensions to denote specific fetus
• New GU codes and notes including category title changes
Structure and Format

ICD-10-CM

• First character is always alphabetic letter
  — Chapter 14 Diseases of the GU system (N00-N99)
  — Chapter 15 Pregnancy, Childbirth and Puerperium (O00-O9A)
• Second character is always a number
• Characters 3-7 can be alpha or numeric
  — 09A.311—Physical abuse complicating pregnancy, first trimester

Structure and Format

ICD-10-CM

• Code Format: XXX.XXX.X
  — XXX = Category
  — XXX = Etiology, anatomic site, severity
  — X = Extension
• Placeholder Character (X)
  — Used with certain codes for potential future expansion
  — When placeholder exists, must use X in that location for valid code

Structure and Format

ICD-10-CM

• Preterm labor, third trimester with preterm delivery
  third trimester, single gestation =O60.140
  — O60 =Preterm labor
  — 14 = Preterm labor, third trimester with preterm delivery,
    third trimester
  — 0 = Single fetus
• Must document
  — With or without delivery
  — Preterm or term delivery
  — Trimester of both labor and delivery
  — Fetus affected
ICD-9 vs. ICD-10

<table>
<thead>
<tr>
<th></th>
<th>ICD-9</th>
<th>ICD-10</th>
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<tbody>
<tr>
<td>Obstructed labor due to face presentation</td>
<td>2 codes&lt;br&gt;660.0X(obstructed labor)&lt;br&gt;652.4X(unsuitable lie)&lt;br&gt;X represents the episode of care</td>
<td>1 code&lt;br&gt;064.2XXX&lt;br&gt;5th, 6th X represents placeholder&lt;br&gt;7th X represents specific fetus</td>
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<tr>
<td>Hemorrhage associated with procedures</td>
<td>3 codes (Injury Chapter 900)&lt;br&gt;998.11 (Hemorrhage)&lt;br&gt;998.12 (Hematoma)&lt;br&gt;998.12 (Complicating procedure)</td>
<td>4 codes (GU chapter &quot;N&quot;)&lt;br&gt;Intraoperative vs. postprocedural&lt;br&gt;Complication GU procedure vs. Other procedure</td>
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Basic Guidelines for Coding Diagnosis

- Code to the highest level of specificity
- Link the ICD-9/ICD-10 to the correct CPT-4
- Code to the highest degree of certainty
- Sequence the diagnoses
- Code only relevant diagnoses

Coding for Specificity

- Each service must be supported by an ICD-9 code
- The most specific diagnosis code helps ensure proper reimbursement
- Use the maximum number of digits
  - If 5 digits, must have 5 digits
  - If only 3 digits needed, then only use 3 digits
  - Do not add a "0" unless directed to do so
- Use the most appropriate descriptor
  - Use the code that most accurately and specifically describes the patient’s condition
Medical Necessity

- ICD-9 codes “justify” the services provided
- It is important to “link” the ICD-9 code to the CPT code on the claim form
- Failure to appropriately link may result in denials
- Physicians should provide the linkage.

Code to the Highest Degree of Certainty

- Code only what you know to be fact
- Code only what is documented
- Never code for conditions being “ruled out”, “Questionable”, “Suspected”, etc.
  - Code signs and symptoms if no definitive diagnosis

Code for Signs/Symptoms

- Use categories 780-799 as provisional diagnoses
  - Urinary frequency 788.64
  - Straining on urination 788.65
  - Findings, abnormal, without diagnosis
    - Mammogram 793.80
    - Papanicolaou (Cervix) 795.0X
- Look for provisional diagnoses in specific disease chapters
  - Lump in breast 611.72
  - Vaginal bleeding 623.8
Wait for Test Results

- If test results are available; code for the definitive diagnosis if documented by physician
- If findings are non-specific, use codes from 780-799 categories

Example 1

- Patient presents with complaint of missed period and nausea. She is confirmed pregnant at this visit, which is the cause of the symptoms.
- In this case, you would report V72.42, Pregnancy examination or test, positive results, not 626.8, Other disorders of menstruation and other abnormal bleeding from genital tract, and not 787.02, Nausea

Example 2

- Patient presents with complaint of an irregular period and nausea. Last menstrual period was 45 days ago. A serum pregnancy test is ordered.
- Because pregnancy is not confirmed at the conclusion of the encounter, you would report 626.4, Irregular menstrual cycle; 787.02, nausea; V72.40, Pregnancy examination or test, pregnancy not confirmed.
Report “V” code and Symptoms

- V codes provide valuable additional information
  - V71.1 Observation for suspected malignant neoplasm
  - V10.43 Personal History of malignant neoplasm of the ovary
  - V84.02 Genetic susceptibility to malignant neoplasm of ovary

Counseling

- V-codes are used when a patient or family member receives assistance in the aftermath of an illness or injury, or when support is required in coping with family or social problems.

Example

- Patient’s Pap test comes back as high risk HPV. She presents to discuss the implications of this test result and is counseled on safe sex.
- Report 795.05 Cervical high risk human papilloma (HPV) DNA test positive with V65.45, counseling on other sexually transmitted diseases.
Some “counseling” codes

- V25.0X—General counseling and advice for contraceptive management
- V26.3X—Genetic counseling
- V26.4X—General counseling and advice for procreative management
- V61.XX—Other family circumstances
- V65.1X—Person consulted on behalf of another person

The difference between counseling codes for contraception management and procreative management
- IS the patient trying to prevent pregnancy (Contraception management) OR
- IS the patient trying to get pregnant (Procreative management)

Follow-up Care

- Categories V24 (postpartum care and evaluation) and V67 (Follow-up examination)
- Used to explain continuing surveillance following completed treatment of a disease, condition, or injury.
- Imply that the condition has been fully treated and no longer exists.
- Follow-up codes are always sequenced first when used with history or other explanatory codes
- But, if a condition is found at the time of the visit, use the diagnosis for the condition instead.
Example 1

- Patient presents for postpartum check and non-purulent mastitis is diagnosed
- 675.24 Postpartum nonpurulent mastitis (because the condition was found at this visit)
- V24.2 Routine postpartum follow-up

Example 2

- Patient is seen for follow-up to a conization of the cervix for cervical dysplasia, performed at a different practice
- V67.09—Follow up exam following other surgery
- V13.22—Personal history of cervical dysplasia.

Example 3

- Patient presents for a vaginal Pap smear after a hysterectomy 2 years ago for endometrial cancer.
- V67.01—Follow up vaginal pap smear
- V10.42—Personal history of malignant neoplasm, other parts of uterus
- V88.01—Acquired absence of both cervix and uterus
Screenings

- ICD-9-CM’s definition of a screening is “Testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease.”
- Example:
  - Amniocentesis to rule out fetal anomaly for pregnant women over 35 of age
  - Screening for incidence of Down’s syndrome in older mothers

- Testing to rule out or confirm a suspected diagnosis because of a sign or symptom is a diagnostic exam not a screening.
- Screening codes are the first listed code if the reason for the visit is specifically for the screening exam.
  - It may also be a secondary code if done during the office visit for other health problems

- A screening code is not necessary if the screening is inherent to a routine exam.
  - Example: the physician performs a GYN exam with Pap smear
  - V72.31 (Routine gynecological exam) is reported
  - V76.2 (Special screening for malignant neoplasm, cervix) would not be needed as it is included in the V72.31.
• When screening test shows an abnormal or positive finding for the condition being tested
• List the screening code first, followed by the code for the finding
  – Patient presents for routine screening Pap smear, which returns ASC-US.
  – Report V76.2 (Screening) and 795.01 (Papanicolaou smear of cervix with atypical squamous cells of undetermined significance (ASC-US) for the findings.

Preventive Services

• A typical well-woman exam includes three components
  – General preventive examination that includes an age- and gender-appropriate examination
  – Gynecological issues including a breast and pelvic exam
  – Pap smear
• Not for a current complaint or problem
AMA’s CPT Assistant, July 1998, specifies
“The comprehensive history obtained as part of the preventive medicine evaluation and management service is not problem oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, social history as well as a comprehensive assessment/history of pertinent risk factors.”

ACOG Recommendations a general preventive exam
• 99385 or 99395 Age—19-39
  – History
    • Complete or Interval
    • ROS & PFSH
  – Exam
    • HT, WT, BP
    • Neck and Thyroid
    • Breasts
    • Abdomen
    • Pelvic Exam
    • Skin
  – Counseling & Risk Factor Reductions
    • STD’s, pregnancy, Birth control, Exercise and Diet, Psychosocial eval, CV risk factors, Smoking, skin exposure, injury prevention, general mental health

• 99386 or 99396 Ages 40-64
  – History
    • Complete or Interval
    • ROS & PFSH
  – Exam
    • HT, WT, BP; Neck and Thyroid; Breasts; Abdomen;
    • Pelvic Exam; Skin; plus Oral cavity
  – Counseling and Risk Factor Reductions
    • STD’s, pregnancy, Birth control, Exercise and Diet, Psychosocial eval, CV risk factors, Smoking, skin exposure, injury prevention, general mental health; Plus self breast exam
• 99387 or 99397  Ages 65+
  - History
    • Complete or Interval
    • ROS & PFSH
  - Exam
    • HT, WT, BP; Neck and Thyroid; Breasts; Abdomen;
    • Pelvic Exam; Skin; plus Oral cavity
  - Counseling and Risk Factor Reduction
    • STD,s, pregnancy, Birth control, Exercise and Diet,
      Psychosocial eval, CV risk factors, Smoking, skin exposure,
      injury prevention, general mental health; self breast exam;
      Plus HRT

• Medicare will not cover a general preventive exam (99385-99387 or 99395-99397)
• They will pay for pelvic/breast exam (G0101) and collection of Pap smear (Q0091) every 2 years for eligible patients.

Hysterectomy

• TLH—Total Laparoscopic Hysterectomy
  – 58570-58573
    • All attachments are severed via the scope and the vaginal cuff is sewn via the scope
    • Uterus may be taken out via the scope or pulled out from the vaginal canal
• LAVH—Lap Vaginal Assisted Hysterectomy
  – 58550-58554
    • Only top attachments are severed via the scope
    • Vaginal cuff sewn via the vaginal canala
      – Incision made into vaginal wall
      – Uterus always removed via the vagina
Global Obstetric Package

- Global obstetric package includes those services normally provided in uncomplicated cases
- CPT Global Package
  - Antepartum Services
  - Delivery Services
  - Postpartum Services

Routine OB Care

- Generally considered “start to finish” care
- Usually involving approximately 13 weeks
- Includes
  - UA for glucose and protein
  - Always included in the OB visits even when billing an E/M service rather than global or split billing
Global Obstetrical Package

- Global codes used when one physician or group provides all obstetric care
- Global codes cannot be reported if a physician in a different practice provides any of the routine antepartum care (no covering relationship exists)

Less than full Package

- Services provided by more than one group
  - Report non-global codes
- Premature delivery
  - Report global if all antepartum and postpartum care is provided
- Late enrollment
  - Report global if care matches or surpasses given to typical OB patient

Covering Situations

- Obstetricians from different groups
  - Primary bills global
  - Covering physician does not bill any portion of the package
  - Physician providing services outside the package bills for service(s)
Typical Antepartum Care

- Initial and subsequent history
- All physical examinations
- WT, BP, FHT, U/A
- Visits (13)
  - Monthly to 28 weeks
  - Biweekly to 36 weeks
  - Weekly to delivery
- Other services normally provided

Excluded Services (Antepartum)

- Initial E/M visit to diagnose pregnancy
  - Patient presents with symptoms
  - Minimal counseling, order labs, prescribe prenatal vitamins
- If activities included in antepartum record are initiated, the encounter in not separately reported
- Additional E/M services for related or unrelated conditions

Excluded Services

- Inpatient admissions, observation care, and subsequent visits for complications
  - Only those services occurring more than one calendar date before delivery
- Diagnostic services
  - Ultrasounds
  - NST
- External cephalic version
- Certain other procedural services
Services Unrelated to Pregnancy

- Diagnosis unrelated to pregnancy
  - URI, flu, etc
- Report labs, visits, etc, separately
- Services reported at time of encounter
- Clearly document treatment of the presenting problem
  - Preferable to document outside of antepartum flow chart

Unrelated

- Level of service for unrelated problem must be supported
- The visit does not count in the total number of antepartum visits
- ICD-9 code Primary code should be the reason for the encounter.
  - V22.2 should be listed as secondary diagnosis, not the first listed.
  - May be necessary to omit V22.2 as payer’s software may bundle visit into global payment

Services Related to Pregnancy

- Patient may be seen more frequently than the typical 13 antepartum visits due to
  - High risk status
    - High risk is not the same as current complication of pregnancy
    - Additional visits are not reported if active problems do not develop
  - Current complications
    - Pregnancy complicated by hypertension
    - Vaginal bleeding
  - Need for diagnostic tests
    - Diagnostic tests must be medically necessary
Related ....
• Diagnostic tests, etc, are reported at the time of the service
• Report the diagnosis that prompted the additional visits
• The date the service was provided should be reported on the claim form

Related...
• Do not report visits in addition to package if
  – Total number of visits is less than 13
  – Visits are not for complications of current pregnancy
• The level of E/M visit is determined by CPT-4 definitions and guidelines

Delivery Services
• Admission to the hospital
• Admission history and physical exam
• Management of uncomplicated labor including induction using IV medications
• Vaginal or cesarean delivery
  – Episiotomy
  – Use of Forceps
• Delivery of Placenta
• Routine follow-up inpatient care
Delivery Services

• According to ACOG, the following are also included
  – Insertion of cervical dilator on the same day as delivery (59200)
  – Simple removal of cerclage

Excluded Delivery Services

• Global maternity package includes only services for uncomplicated deliveries
• Management of medical problems requiring additional services may be reported separately
  – ICD-9 Code must support the clinical need for additional services

Examples of Excluded Services

• External cephalic version
• Insertion of cervical dilator on day prior to delivery
• E/M services for medical problems or complications provided less than 24 hours prior to delivery
  – Observation services
  – Inpatient services
  – Critical Care
Postpartum Care

- Includes both inpatient and outpatient services
- Typical inpatient stay
  - Vaginal delivery = 2 days
  - Cesarean delivery + 3 days
- Routine outpatient visit(s) normally at 6 weeks

Postpartum Care

- Excluded services:
  - Treatment of postpartum complications
  - Conditions not related to postpartum care
- Examples
  - Delayed postpartum hemorrhage (666.2X)
  - Infection, perineal wound (674.3x)
  - Puerperal thrombophlebitis (670.3X)

Non-Global Obstetric Services

- Sometimes global services may not be provided because:
  - Patient transfers in or out of practice
  - Patient referred to another physician
  - Patient delivered by another physician not covering or within the practice
  - Pregnancy is terminated
  - Patient changes insurers
Reporting Non-Global Services

- Antepartum care only (59425, 59526)
- Delivery Only (59409, 59514, 59612, 59620)
- Delivery plus postpartum care (59410, 59515, 59514, 59622)
- Postpartum care only (59430)

Antepartum Care Only

- Two methods depending on total number of visits
  - E/M codes
    - 1 to 3 visits only
  - Antepartum care codes
    - 4 or more visits
      - 59425 4-6 visits
      - 59426 7 or more visits
- Watch for payer variation.
  - Check with your payers for their policies
- Not reported if billing for global package

Selecting the Type of E/M Services

- First obstetrical visit
  - New to practice (99201-99205) or
  - Established with practice (99211-99215)
- Second, third visits
  - Established Patient (99211-99215)
Selecting Type...

- Levels based on CPT definitions and guidelines
  - Initial visit typically level 99204 or 99215 per ACOG
  - Subsequent visits generally consistent with 99213
- Levels may vary based on complexity of patient and physician work
- CMS guidelines not developed for routine obstetrical care

Delivery Care Only

- Sometimes a physician performs the delivery but provides none or limited antepartum care
  - Patient moves or changes insurer
  - One provider manages prenatal care but Ob delivers due to complications.
- Delivery only codes also used for multiple gestations

Delivery Care Only

- 59409 Vaginal delivery only
- 59410 including postpartum care
- 59514 Cesarean delivery only
- 59515 including postpartum care
- 59612 VBAC delivery Only
- 59614 including postpartum care
- 59620 Repeat cesarean delivery only
- 59622 including postpartum care
Delivery Care Only

- Delivery care only codes include
  - Admission to the hospital
    - Including H & P
  - Inpatient care provided one calendar date prior to delivery
  - Vaginal or cesarean delivery, including placenta

Delivery Care Only

- Delivery only codes do not include
  - Inpatient postpartum visits
  - Outpatient care following discharge
- Delivery with postpartum care includes
  - Inpatient and outpatient postpartum care

Postpartum Care Only

- Code 59430 is reported when
  - A physician or group provided only the postpartum care
  - A physician or group provided antepartum and postpartum care, but did not perform the delivery
    - Report both the antepartum only and postpartum only codes
Ultrasounds

• Certain diagnostic tests, including ultrasounds and fetal stress tests, include 2 components
  – Professional Component (Modifier 26)
    • Supervision of test (if any)
    • Interpretation
    • Report
  – Technical Component (Modifier TC)
    • Technician salary/benefits (if any)
    • Equipment
    • Necessary supplies
• Together they comprise the total service

Reporting Ultrasound Services

• Performed at hospital or other facility
  – 2 Codes used
  – Physician bills for the Professional Component
  – Facility bills for the Technical Component
• Performed at physician’s office or physician owned facility
  – Physician reports the total service without a modifier
Reporting U/S...

• Payers have various rules for reimbursing ultrasound procedures
  – Limited number per pregnancy
  – Routine considered part of the package with variations on “diagnostic” ultrasounds
• Most payers will only reimburse for one interpretation of the same ultrasound

Components

• All codes include
  – Supervision of sonographer performing the examination (if any)
  – Image documentation
  – Preparation of written report

Fetal and Maternal Evaluation
1st Trimester

• 76801 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (less than 14 weeks 0 days), transabdominal
• +76801 each additional gestation (List separately in addition to code for primary procedure performed)
1st Trimester...

- Determination of the number of gestational sacs and fetuses
- Gestational sac/fetal measurements appropriate for gestation.

1st Trimester

- Survey of visible fetal and placental anatomic structure
- Qualitative assessment of amniotic fluid volume/gestational sac shape
- Examination of maternal uterus and adnexa
- Service generally performed for a specific indication

2nd & 3rd Trimesters

- 76805 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (greater than 14 weeks 0 days), transabdominal approach; single or first gestation
- +76810 each additional gestation (List separately in addition to code for primary procedure)
2nd & 3rd Trimester

• Determination of the number of fetuses and amniotic/chorionic sac
• Measurements appropriate for gestational age
• Survey of intracranial, spinal, and abdominal anatomy
• Evaluation of the four chambered heart

2nd & 3rd Trimester

• Assessment of the umbilical cord insertion site
• Survey of placenta location
• Amniotic fluid assessment
• Examination of maternal adnexa, when visible

Detailed Fetal Anatomic Exam

• 76811 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
• 76812 each additional gestation
Detailed Fetal Anatomic Exam

• Performed during 2\textsuperscript{nd} and 3\textsuperscript{rd} trimesters
• All components of fetal and maternal evaluation, Plus
• Complete evaluation of fetal anatomy
• It is NOT used to report a routine screening ultrasound
• Intended to be reported for the evaluation of a known or suspected fetal anatomic or genetic abnormality

Brain/ventricles and face
Heart/outflow tracts and chest anatomy
Abdominal organ specific anatomy
Number/length/architecture of limbs
Detailed evaluation
– Umbilical cord
– Placenta
– Other fetal anatomy as clinically indicated

Fetal Nuchal Translucency Measurement

• 76813 Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach, single or first gestation
• +76814 each additional gestation
• Performed first trimester to assess risk of chromosomal abnormalities
• Transabdominal or transvaginal approach
• Should not be billed routinely in combination with codes 76801-76802 (1st trimester U/S)
• Documentation should support the need for both services

• This code includes
  – At least three separate measurements of the shortest distance between the inner edges of the nuchal translucency
  – A comparison of the largest measurement to crown-rump length and gestational age specific medians
  – Calculation of the risk of Down’s syndrome

**Limited Ultrasound**

**76815** Ultrasound, pregnant uterus, real time with image documentation, limited (eg fetal heart beat, placental location, fetal position, and/or qualitative amniotic fluid volume), one or more fetuses
• Used for one or more fetuses
• No trimester designation
• Quick look of one or more of the following
  – Fetal position
  – Fetal heart beat
  – Placental location
  – Qualitative amniotic fluid volume

Follow-up Ultrasound
• 76816 Ultrasound, pregnant, uterus, real time with image documentation, follow-up (EG re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach per fetus

• Code reported once per fetus
• CPT states that modifier -59 should be attached to each fetus beyond the first
• Used for either of the following
  – Reassessment of fetal size and interval growth
  • OR
  – Re-evaluation of one or more anatomic abnormalities of a fetus previously demonstrated on ultrasound
Transvaginal Ultrasound

- 76817  Ultrasound, pregnant uterus, real time with image documentation, transvaginal

- May include
  - Evaluation of the embryo and gestational sac(s)
  - Evaluation of the maternal uterus, adnexa, and/or cervix
- No multiple gestation designation
- May be reported in addition to transabdominal as clinically indicated

Biophysical Profile

- A complete BPP (76818) measures physiologic activity in the fetus
- Includes
  - NST
  - Fetal breathing movements
  - Fetal movement
  - Fetal tone
  - Amniotic fluid volume
- CPT 76819 describes an Incomplete BPP without NST
- Obstetricians perform NST (59025)
- Radiologists perform other elements (76819)
- **Complete BPP** (76818) and NST (59025) at **same session**—Report only 76818
- **Incomplete BPP** (76819) and NST (59025) at separate sessions on same day—Report 76818

- **Complete BPP** (76816) and additional NST (59025) during **Separate sessions on same day**
  - Report 76818 and 59025-59
  - A really good reason for doing the 2nd NST must be documented to support medical necessity
- **Complete BPP** (76818) and Ultrasounds on **Same day**
  - Both BPP and ultrasound is reported
  - Ultrasound: Anatomic examination
  - BPP: Physiologic examination
- Medical necessity must be supported

**Ultrasound Imaging and Interpretation**

- Some services are reported using both an ultrasound procedure code and an ultrasound guidance code
- Physician must perform the procedure and perform or supervise the guidance to report both services
- If radiologist provided guidance, the OB reports procedure code only
**Ectopic Pregnancy**

- 59120-59140
- Surgical treatment of an ectopic pregnancy
- Selected by type of ectopic pregnancy and if ovaries and tubes are also removed
  - Tubal
  - Ovarian
  - Abdominal
  - interstitial
- Laparoscopic codes—59150-59151

**Termination of Pregnancy**

- What was the cause or reason for termination?
- When was pregnancy terminated?
- What services were rendered (CPT)?
- Was patient in labor before termination?
- Was labor enhanced?
- Was labor induced?
- Were products of conception already expelled? Completely?

**Incomplete Abortion**

- CPT 59812—Treatment of incomplete abortion, any trimester, completed surgically
- D&C or D&E—surgical management of incomplete abortion
- Defined by ACOG as the expulsion of some products of conception with the remainder evacuated surgically.
**Missed Abortion**

- D&C or D&E—surgical management of missed abortion
- Defined by ACOG as a pregnancy containing an empty gestational sac, a blighted ovum, or a fetus or fetal pole without a heartbeat;
- CPT 59820—Prior to 14 weeks 0 days
- CPT 58921—Prior to 14 weeks 0 days gestation prior to 20 weeks 0 days gestation
- CPT 59821-22—After 20 weeks 0 days

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**Induced abortion**

- Without hospital admission and labor
- Via D&C or D&E
- CPT 59840—Prior to 14 weeks 0 days
- CPT 58941—14 weeks to prior to 20 weeks 0 days
- CPT 58941-22—20 weeks 0 days or more by D&E

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**Induced abortion**

- Via intra-amniotic injections,
- With hospital admission, visits, and labor
- Prior to 20 weeks 0 days gestation
  - 59850
  - 59851 with D&C or D&E
  - 59852 with hysterotomy
- After 20 weeks 0 days
  - Report maternity care and delivery codes (59400-59515) as appropriate
Induced abortion

- Via vaginal suppositories/cervical dilation
- With hospital admission, visits, and delivery
- Prior to 20 weeks 0 days gestation
  - 59855
  - 59856—with D&C or D&E
  - 59857—with hysterosomy
- After 20 weeks 0 days
  - Report maternity care and delivery codes 59400-59510, as appropriate
- Septic abortions
  - 59830

Non-Obstetrical D&C

- 58120
  - D&C for the lining of the uterus or endometrium
  - Performed to provide treatment for thickened uterine lining or for retained menstrual blook and tissue
  - To diagnosis for abnormal cells such as cancer

- 57558
  - D&C for a cervical stump
  - The uterus has been removed and the cervical stump is what remains of the cervix
  - Performed to see if there is precancerous cells located in the portion of the cervical canal that is still there.
Resources

- ACOG  http://www.acog.org/
- AAPC  http://www.aapc.com/

QUESTIONS?
THANK YOU

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