

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Obstetrics and Gynecology Services

Presenter:

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Objectives

- Preventive Services
- Non-OB services
- Screenings
- NCCI
- CPT 2015
- Obstetrics Package/Antepartum Care
- Delivery Services
- Ultrasounds and other obstetric services
- ICD-10 coding and documentation

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Preventive services

Typical well-woman exam includes three components:

- General preventive examination that includes an age and gender appropriate exam
 - Gynecological issues including breast and pelvic exam
 - Pap smear
- Should not be billed for a current complaint or problem



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Preventive services

- ACOG recommendations for 99385 or 99395:
 - Age 19-39
 - History (Complete or Interval HPI, ROS and PFSH)
 - Exam (Height/Weight/BP, Neck and Thyroid, Breasts, Abdomen, Pelvic Exam, Skin)
 - Counseling & Risk factor Reductions (STDs, pregnancy, birth control, exercise and diet, psychosocial eval, CV risk factors, smoking, skin exposure, injury prevention and general mental health)



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Preventive services

- ACOG recommendations for 99386 or 99396:
 - Age 40-64
 - History (Complete or Interval HPI, ROS and PFSH)
 - Exam (Height/Weight/BP, Neck and Thyroid, Breasts, Abdomen, Pelvic Exam, Skin plus Oral Cavity)
 - Counseling & Risk factor Reductions (STDs, pregnancy, birth control, exercise and diet, psychosocial eval, CV risk factors, smoking, skin exposure, injury prevention, general mental health and self breast exam)



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Preventive services

- ACOG recommendations for 99387 or 99397:
 - Age 65+
 - History (Complete or Interval HPI, ROS and PFSH)
 - Exam (Height/Weight/BP, Neck and Thyroid, Breasts, Abdomen, Pelvic Exam, Skin plus Oral Cavity)
 - Counseling & Risk factor Reductions (STDs, pregnancy, birth control, exercise and diet, psychosocial eval, CV risk factors, smoking, skin exposure, injury prevention, general mental health, self breast exam and HRT)
- Medicare does not cover 99385-99387 or 99395-99397; They do cover pelvic/breast exam (G0101) and pap smear (Q0091) every 2 years for eligible patients



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Screenings

- Screening per ICD-9
 - Testing to rule out or confirm a suspected diagnosis because of a sign or symptom is a diagnostic exam, not a screening
 - Screening codes should be first listed when the reason for visit is for the screening exam
 - If done during an office visit for other health problems it maybe the second listed code
 - Screening test showing abnormal or positive result:
 - Screening code listed first
 - Secondary code for finding
 - Example: V76.2 (special screening for malignant neoplasm of cervix) followed by 795.01 (Papanicolaou smear of cervix with atypical squamous cells of undetermined significance)

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Non-obstetric D&C

- CPT 58120
 - Lining of uterus or endometrium
 - Treatment for thickened uterine lining or retained menstrual blood and tissue
- CPT 58558
 - Includes hysteroscopy, biopsy of endometrium and/or polypectomy
- CPT 57558
 - Cervical stump
 - Uterus has been previously removed
 - Look for precancerous cells in the remaining portion of the cervical canal

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Procedures

- Biopsies of the Cervix
 - 57460 – LEEP biopsy of the cervix
 - 57461 – LEEP conization of the cervix
 - includes Endocervical curettage
 - Removal of portion of the endocervix and transformation zone
- Repairs of Paravaginal defects
 - Anterior Repairs – Cystocele
 - CPT 57420 – Anterior Colporrhaphy, repair of cystocele with or without urethrocele
 - CPT 57423, 57284 & 57285 – Paravaginal defect repair (various approaches)

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Procedures

- Repairs of Paravaginal defects
 - Posterior Repairs – Rectocele & Enterocele
 - CPT 57250 - Posterior Colporrhaphy, repair of rectocele with or without perineorrhaphy
 - CPT 45560 – Repair of rectocele (separate procedure)
 - CPT 57260 – Combined anteroposterior colporrhaphy
 - CPT 57265 – Combined anteroposterior colporrhaphy with enterocele repair
 - CPT 57268 & CPT 57270 – Repair of enterocele, various approaches
 - Separate Procedure Designations
 - CPT +57267 – Mesh insertion, **each site** (anterior/posterior)

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Procedures

- Colpopexy:
 - 57280 – Abdominal approach
 - 57282 – Vaginal Colpopexy; extra-peritoneal approach
 - 57283 – Vaginal colpopexy; intra-peritoneal approach
 - 57425 – Laparoscopic colpopexy
 - Includes Mesh
- Myomectomy:
 - 58140 – Open, abdominal (1-4 tumors <250 grams)
 - 58146 – Open, abdominal (5+ tumors and/or >250grams)
 - 58145 – Vaginal approach (1-4 tumors <250 grams)
 - 58545 – Lap approach (1-4 tumors <250 grams)
 - 58546 – Lap approach (5+ tumors and/or >250 grams)

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Procedures

- Endometrial biopsy
 - 58100 – any method (separate procedure)
 - +58110 – performed in conjunction with colposcopy
 - 57420/57421 endoscopic colposcopy
 - 57452-57461 endoscopic cervical colposcopy
 - 58561 – Hysteroscopy with removal of leiomyomata
 - 58563 – Hysteroscopy with endometrial ablation

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NCCI Edits

- Pelvic exams with gynecologic procedures
- Pelvic exam under anesthesia (57410) is included in major and most minor gynecological procedures and not separately reportable
- Laparoscopic/hysteroscopic or peritoneoscopic procedures include diagnostic procedures
- Vaginal or cervical dilation not separately reportable when done with vaginal approach procedures unless the CPT descriptor says "without cervical dilation"

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NCCI Edits

Colposcopy

- Scout procedure is not separately billable
- Diagnostic performed resulting in non-colposcopic procedure report with -58 modifier
- Diagnostic colposcopy not reportable with other colposcopic procedures
- Scope procedure is not separately coded if:
 - The physician knows prior the scope what therapeutic open procedure will be performed or
 - Has already performed a diagnostic scope procedure or
 - Goes on to perform a therapeutic scope procedure

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NCCI Edits

- Laparoscopic procedures converted to open, only the open procedure is reported
- Laparoscopic Lysis of Adhesions (44180 or 58660)
 - Not separately reportable with other lap procedures unless the lysis is extensive.
- Pelvic Exenteration (CPT 45126, 51597 & 58240) includes removal of structures from the pelvis
 - Providers should not report separately for removal of these structures (colon, ovaries, lymph nodes, etc.)

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CPT 2015

Maternity Care and Delivery

- Editorial changes
 - Clarification on Pregnancy Confirmation Visit – Bill E/M
 - Antepartum includes initial prenatal history and physical
 - Postpartum guidelines were moved to reflect the chronological sequence of events

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Obstetric package

- Global obstetric package includes those services normally provided in uncomplicated cases
 - Antepartum services, delivery services and postpartum services
 - Usually involving approximately 13 weeks
 - Includes – UA for glucose and protein
 - Used when one physician or group provides all obstetric care
 - Cannot be reported if a physician in a different practice provides any of the routine antepartum care and no physician covering relationship exists with that provider



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Obstetric package

- Less than the 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 patients
- When obstetricians from different groups are covering
 - Primary bills the global service
 - Covering physician does not bill any portion of the package
 - Physician providing services outside the package bills for service(s)

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Antepartum Care

- Typical Antepartum care consists of:
 - Initial and subsequent history
 - Weight, BP, FHT, U/A
 - Visits (13)
 - Monthly to 28 weeks
 - Bimonthly to 36 weeks
 - Weekly to delivery
 - Other services normally provided



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Antepartum Care

- Excluded Antepartum services:
 - 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 is not separately reported
 - Additional E/M services for related or unrelated conditions
 - Inpatient Admissions, observation care and subsequent visits for complications
 - Only those services occurring more than one calendar date before delivery
 - Diagnostic Services
 - Ultrasound
 - NST
 - Amniocentesis
 - External cephalic version
 - Certain other procedural services

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Unrelated services

- Diagnosis unrelated to pregnancy
 - URI, flu, etc.
- Report labs and other visits separately
- Clearly document treatment of the presenting problem
 - Preferable to document outside of the antepartum flow chart
- Does not count in the total number of antepartum visits
- ICD-9 primary code should be the reason for the encounter
 - V22.2 should be listed as secondary
 - May be necessary to omit V22.2 as payer's software may bundle the visit into the global payment

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Pregnancy related services

- Patient may be seen more frequently than 13 antepartum visits due to:
 - High risk status
 - Not the same as current complications 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
 - Reported at the time of service
 - Reported with the diagnosis that prompted the visit
 - Date the service was provided should be reported on the claim

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Delivery services

- Admission to the hospital
- Admission H&P
- Management of uncomplicated labor including use of IV medications
- Vaginal or cesarean delivery
 - Episiotomy
 - Use of Forceps
 - Fetal monitoring during labor
- Delivery of placenta
- Routine follow-up inpatient care
- According to ACOG, the following are also included:
 - Insertion of cervical dilator on the same day as delivery (59200)
 - Simple removal of cerclage
 - Repair of first and second degree lacerations



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ACOG – laceration repairs

1st and 2nd degree lacerations shouldn't be reported
 3rd and 4th degree lacerations that extend beyond the perineum into other areas (rectum, anus) are reportable because these repairs require significant additional physician work.

For 3rd and 4th degree lacerations:

- Append modifier 22 to the delivery or global package code.
 - Documentation describing the extent of the injury should be submitted with the claim.

*NCCI does not permit CPT code (12001-13153) to be reported to describe closure for codes with a global period of MMM (59400, 59612, etc.)

- If the physician who performs the repair is not the physician who delivered the baby report 59300 instead.

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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:
 - External cephalic version
 - Insertion of cervical dilator on day prior to delivery
 - E/M for medical problems less than 24 hrs prior to delivery



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Postpartum care

- Includes both inpatient and outpatient services
- Typical inpatient stay
 - Vaginal delivery – 2 days
 - Cesarean delivery – 3+ days
- Excluded services:
 - Treatment of postpartum complications
 - Conditions not related to postpartum care

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Postpartum care

- Routine outpatient visit(s) normally at 6 weeks
 - Office visit
 - Discussion of:
 - Complications encountered during labor, delivery and pregnancy
 - Maternal sleep issues, postpartum anxiety/depression
 - Contraception
 - Sexual activity
 - Infant behavior and health
 - Preventive medicine concerns, pap smears, mammograms and breast exams

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Non-global services

- Antepartum care only (59425, 59526)
 - Two methods depending on the number of visits
 - E/M codes (1-3 visits only)
 - Antepartum care codes
 - 59425 (4-6 visits)
 - 59426 (7+ visits)
- Delivery only (59409, 59514, 59612, 59620)
- Delivery & postpartum care (59410, 59515, 59514, 59622)
- Postpartum care only (59430)

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Ultrasounds

- Professional Component (Modifier – 26)
 - Supervision of test
 - Interpretation and report
- Technical Component (Modifier –TC)
 - Technician salary/benefits
 - Equipment
 - Necessary supplies
- If performed at the hospital or an outpatient department of the hospital, 2 codes are reported (professional and technical)
- Fetal and maternal evaluation 1st trimester
 - 76801 – ultrasound (less than 14 wks, 0 days), transabdominal
 - +76802 – each additional gestation
- Fetal and maternal evaluation 2nd & 3rd trimester
 - 76805 – ultrasound (greater than 14 wks), transabdominal
 - +76810 – each additional gestation



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Ultrasounds

- 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
 - Performed during 2nd or 3rd trimester
 - Intended for the evaluation of a known or suspected fetal or genetic abnormality



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Ultrasounds

- Fetal Nuchal Translucency Measurement
 - CPT 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 in 1st trimester
 - Should not be reported routinely with 1st trimester ultrasound
 - Documentation must support the need for both services



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Ultrasounds

- Limited Ultrasound
 - CPT 76815 Ultrasound, pregnant uterus, real time with image documentation, limited (i.e. fetal heart beat, placental location, fetal position, and/or qualitative amniotic fluid volume), one or more fetuses
 - No trimester designation
- Follow-up Ultrasound
 - CPT 76816 Ultrasound, pregnant uterus, real time with image documentation, follow-up (i.e. re-eval of fetal size by measuring standard growth parameters and amniotic fluid volume, re-eval of organ system(s) suspected or confirmed to be abnormal on previous scan) transabdominal approach per fetus
- Transvaginal ultrasound
 - CPT 76817 Ultrasound, pregnant uterus, real time with image documentation transvaginal

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Ectopic Pregnancy

- CPT 59120-59140, Surgical treatment of ectopic pregnancy
- Code selection based on type and if ovaries/tubes are removed
 - Tubal
 - Ovarian
 - Abdominal
 - Interstitial
- Laparoscopic 59150-59151

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Abortions

- Incomplete abortion
 - CPT 59812
 - Any trimester
 - Completed Surgically
- Missed abortion
 - CPT 59820 (prior to 14 weeks 0 days)
 - CPT 59821 (14 weeks 1 day to 20 weeks 0 days)
 - CPT 59821-22 (20 weeks 1 day+)
- Septic abortion
 - CPT 59830
- Induced abortion (without admission and labor)
 - CPT 59840 (prior to 14 weeks 0 days)
 - CPT 59841 (14 weeks 1 day to 20 weeks 0 days)
 - CPT 59841-22 (20 weeks 1 day+)

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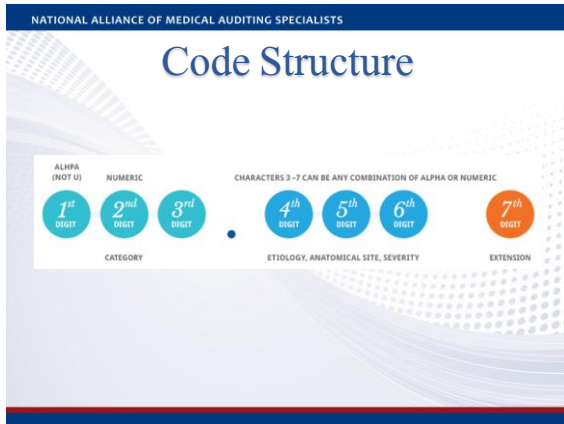
Abortions

Induced abortion (with admission, visits and labor)

- Intra-amniotic injections
 - Before 20 weeks 0 days
 - CPT 59850
 - CPT 59851 w/D&C
 - CPT 59852 w/hysterotomy
 - After 20 weeks 0 days
 - Maternity care and delivery codes
- Vaginal suppositories/cervical dilation
 - Before 20 weeks 0 days
 - CPT 59855
 - CPT 59856 w/D&C
 - CPT 59857 W/hysterotomy
 - After 20 weeks 0 days
 - Maternity care and delivery codes

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ICD-10 Pregnancy, Childbirth & Puerperium (O00-O99)



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Codes OB/GYN

- Routine Gynecological Exams:
 - Z01.411 Encounter for gynecological exam with abnormal findings
 - Use additional code to identify the abnormal findings
 - Z01.419 Encounter for gynecological exam without abnormal findings
 - Z11.51 HPV Screening
 - Z12.72 Screening vaginal Pap Smear
 - Z12.4 Encounter for screening for malignant neoplasm of cervix
- Supervision of Normal Pregnancy
 - Z34.80 Supervision, unspecified trimester
 - Z34.81 Supervision, first trimester
 - Z34.82 Supervision, second trimester
 - Z34.83 Supervision, third trimester

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Codes OB/GYN

- Contraception Management, NEC
 - Z30.09 Encounter for general counseling and advice on contraception
 - Z30.8 Encounter for other contraceptive management
 - Z30.430 Encounter for insertion of intrauterine contraceptive device
- Urinary Tract Infection
 - 18 possible codes
 - With an additional code to identify the infectious agent
- Irregular Menstruation
 - 6 possible codes
- Cystitis
 - 14 possible codes
 - With an additional code to identify the infectious agent

Pregnancy, Childbirth & Puerperium

- Codes take sequencing priority over codes from other chapters
 - Additional codes from other chapters used in addition to Obstetrics codes to further specify conditions
- Key Changes:
 - Time frame changed from 22 to 20 weeks
 - Differentiating the abortion & fetal death codes
 - Subcategory O36.4-
 - Differentiating early & late vomiting in pregnancy
 - Category O60-



Documentation

- Laterality
 - Right, left or bilateral
- Trimester of Pregnancy or Number of Weeks
 - 1st Trimester (Up to 13 weeks, 6 days)
 - 2nd Trimester (14 weeks, 0 days to 27 weeks, 6 days)
 - 3rd Trimester (28 weeks, 0 days to delivery)
- Episode of Care (delivered, antepartum, postpartum)
 - No longer the secondary axis of classification
- Inpatient care for multiple trimesters
 - Coding based on the trimester when the condition developed
- Not all conditions include codes for all three trimesters
- Trimester is not a component of some obstetric codes

Documentation

- Identification of the Fetus
 - Requires 7th character
 - One of the following 7th characters is to be assigned to each code under category O32
 - 0, not applicable or unspecified
 - 1, fetus 1
 - 2, fetus 2
 - 3, fetus 3
 - 4, fetus 4
 - 5, fetus 5
 - 9, other fetus
 - Multiple gestations, will need a code from category O30.-

Fetus Identification & Outcome of Delivery

- Fetus Identification
 - Fetus complication codes
 - Seventh Character "0"
 - Single gestations
 - Documentation is insufficient to determine which fetus is affected
 - Not possible to clinically determine which fetus is affected
- Outcome of Delivery
 - Z37-
 - Included on every maternal record when a delivery has occurred

Delivery, Peripartum & Postpartum

- Full term uncomplicated delivery of single, healthy newborn
 - Code O80 is principal
 - Z37.0 (Single live birth) only outcome appropriate
- Postpartum period
 - Immediately after delivery to six weeks following delivery
- Peripartum period
 - Last month of pregnancy to five months postpartum



Z-Codes

- Z32, Encounter for pregnancy test & childbirth & childcare instruction
- Z33, Pregnant state
- Z34, Encounter for supervision of normal pregnancy
- Z36, Encounter for antenatal screening of mother
- Z37, Outcome of delivery
- Z39, Encounter for maternal postpartum care & examination


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References

- CPT Manual, Published by AMA 2014
- NCCI Manual, Female Reproductive System Section
- Understanding Medicare's NCCI: Logic and Interpretation of the Edits, Published by AMA
- NAMAS – Coding for OB/GYN practice

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