Appropriate Coding and Documentation for the OB/Gyn Practice

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Coding Principles
- Correct coding implies the selection is:
  - Most accurate description of “what” and “why”
  - Supported by documentation
  - Consistent with coding guidelines

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

Code Sets
- Key code sets:
  - HCPCS (includes CPT-4)
  - ICD-9 CM
- HCPCS describe “what”
- ICD-9 CM describes “why”

Development of CPT-4 Codes
- Clinical vignette must accompany all requests
- Vignettes reflect typical patient and therefore the typical work associated with service
- Same vignette used during development of work values for the Medicare Fee Schedule (RBRVS)
### Medicare Fee Schedule

- **Resource Based Relative Value Scale (RBRVS)**
- Adopted in 1992 for Medicare payments to physicians (excluding clinical laboratory)
- **Purpose:**
  - Establish standardized physician payment
  - Enable payments to be based on resource costs

### Medicare Fee Schedule

- $ CF is determined using a formula called the Sustainable Growth Rate (SGR)
- By law, if fee schedule adjustments cause expenditures to change by >$20 million, adjustments are made to the $ CF and/or RVUs
  - CF for 2013: Proposed at $25.00
  - CF for 2013: Final $34.00
  - Same as 2012

### Medicare Fee Schedule

- **Product of 3 factors:**
  - Uniform relative value unit (RVU)
  - Geographic adjustment factor (GAF)
  - Uniform conversion factor (CF)

### Medicare Fee Schedule

- Calculating Payments:
  - Each component of the RVU is multiplied by the corresponding geographic adjustment (GPCI)
  - This product is multiplied by the $ CF to produce a payment amount
  - RVUs and other payment information are posted on the ACOG website

### Assignment of Values for Physician Services

- Specialty societies must survey members to identify resources typically included in new, revised, or reviewed codes.
- Surveys incorporate the vignette used in the CPT approval process

### Assignment of Values for Physician Services

- Specialty society members then present information to the RUC
- AMA/Specialty Society Relative Value System Update Committee (RUC)
  - 29 physicians/providers (ACOG member)
  - Supported by advisory committee (sub-specialties)
  - Chair of Committee is ACOG member
Assignment of Values for Physician Services

- RUC compares recommended values to services within and outside the specialty
- Specialty society defends its recommendations
- RUC makes recommendations to CMS on:
  - Work RVU’s and
  - Practice expense components for new/revised codes
- CMS makes final determination and incorporates into Fee Schedule

Provider Neutral Language

- Clinical staff member is a person who works under the supervision of a physician or other qualified healthcare 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

Provider Neutral Language

- Changes have been made throughout the CPT manual to clarify that certain services may be performed by physicians and other “qualified healthcare professionals” or have other provider neutral language
- In select instances, codes may define a service as limited to professionals or limited to other entities (eg, hospital or home health agency)

Provider Neutral Language

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

Provider Neutral Language

- 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 service within his/her scope of practice and independently reports that professional service
- This is distinct from clinical staff

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
Chemodenervation of the Bladder (52287)

- 52287- Cystourethroscopy, with injection(s) for chemodenervation of the bladder
- Chemodenervation agent reported separately (eg, botox)
- Only gyn specific code change for 2013

Revisions to ICD-9 CM

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

ICD-9 CM

- ICD stands for International Classification of Diseases
- 9 is for the 9th edition
- CM is for Clinical Modifications of the World Health Organization’s (WHO) ICD-9

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 valid code set

ICD-9 CM

- Indicates medical necessity by linkage to CPT codes
- Helps “justify” the services and improves claim processing
- Provides information used in tracking disease trends

Why The Change

- ICD-9-CM: Out of date- Out of space!
- ICD-9: 30 years old
- ICD-10: International standard for a number of years
- U.S. only country in WHO not using ICD-10!
Key Differences: ICD-9-CM to ICD-10-CM

- 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 part of main classifications

Key Changes 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 of 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 alpha or numeric
- O9A.311: Physical abuse complicating pregnancy, first trimester

Key Differences: ICD-9-CM to ICD-10-CM

- ICD-10: Reclassification of certain diseases to reflect current medical knowledge
- ICD-10: Postoperative complications in procedure specific system chapters (complications of GU surgery in GU chapter)

Structure and Format of 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 of 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 deliver
  - Trimester of both labor and delivery
  - Fetus affected

Coding for Specificity

- Each service must be supported by an ICD-9 code
- The most specific diagnosis code helps ensure proper reimbursement

ICD-9 vs. ICD-10

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obstructed labor due to face presentation</strong></td>
<td>2 codes 660.0X (obstructed labor) and 652.4X (unstable lie) X = episode of care</td>
</tr>
<tr>
<td><strong>Hemorrhage associated with procedures</strong></td>
<td>3 codes (injury Chapter 900) 988.11 Hemorrhage 988.12 Hematoma 988.13 Seroma (Complicating px.)</td>
</tr>
<tr>
<td></td>
<td>4 codes (GU chapter “N”) Intraoperative vs. postprocedural Complicating GU px. vs. Other px.</td>
</tr>
</tbody>
</table>

Coding for Specificity

- Use the maximum number of digits
  - If 5 digits available, must use 5
  - If only 4 digits available, use 4, if 3 digits…
- Do not add a “0” unless included in ICD-9
- Use the most appropriate descriptor
  - Code that most accurately and specifically describes the patient’s condition

Basic Guidelines for Diagnosis Coding

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

Linkage and Medical Necessity

- ICD-9 codes “justify” the services provided
- Important to “link” the ICD-9 code to the CPT-4 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
- Never code for condition being “ruled out”

### Solution 1  
**Code the Signs/Symptoms**
- Use categories 780-799 as provisional diagnoses
  - Urinary hesitancy: 788.64
  - Straining on urination: 788.65
  - Findings, abnormal, without diagnosis
  - Mammogram: 793.80
  - Papanicolaou (cervix): 795.0X

### Solution 2  
**Wait for Test Results**
- If test results available, code for the definitive diagnosis
- If findings non-specific, use codes from 780-799 categories

### Solution 3  
**Report “V” Code and Symptoms**
- “V” codes provide valuable additional information
  - V10.43 Personal history of malignant neoplasm of ovary
  - V84.02 Genetic susceptibility to malignant neoplasm of ovary

### Solution 1  
**Code the Signs/Symptoms**
- Look for provisional diagnoses in specific disease chapters
  - Lump in the breast: 611.72
  - Vaginal bleeding: 623.8

### Pap Smear Follow-up**
- V72.32- Encounter for Pap cervical smear to confirm findings of recent normal smear following initial abnormal smear
- Used to identify normal Pap smears during the surveillance period following an abnormal Pap
- Not used once the typical surveillance (f/up) is completed
Preventive Medicine Services

- E/M Services for adults, children, infants (99381-99387; 99391-99397)
  - Codes based on age of patient and whether new/established
  - Not gender specific
  - Well-woman exams (9938X and 9939X)

Comprehensive Exam

- Multi-system exam based on age, gender, and identified risk factors
  - E/M Documentation Guidelines do not apply

Content of the E/M Preventive Service

- Service includes:
  - Comprehensive History and PE
  - Risk factor reduction/counseling
  - Anticipatory Guidance
  - Ordering of lab/diagnostic procedures
  - Treatment of insignificant abnormalities

Comprehensive Exam

- Multi-system exam based on age, gender, and identified risk factors
  - E/M Documentation Guidelines do not apply

Counseling

- Age appropriate counseling included
  - Contraception in women of child-bearing age
  - Menopausal concerns with older women
  - Other examples:
    - Safety issues
    - Need for screening tests
    - Status of previously diagnosed stable conditions

Comprehensive History

- Not problem-oriented and does not require CC or HPI
- Does include comprehensive ROS, comprehensive or interval PFSH, and assessment of risk factors appropriate for the patient's age, gender, and identified risks
- E/M Documentation Guidelines do not apply

Content of the Service

- Services not included:
  - Performance of ancillary studies or immunizations
  - Significant additional work associated with abnormalities or pre-existing problems
Preventive Visits and Other Services

- Patient presents with:
  - Complaints or medical problems, OR
  - Problem found during exam
- Additional service reported if:
  - Problem/abnormality is significant enough to require additional work to perform key components of an E/M service

Preventive Visits and Other Services

- Documenting the encounter:
  - Distinguish the encounters in your note
  - Clearly document problem-oriented portion
  - Indicate portion of the visit that is Preventive Care
  - Remember you are billing for 2 services!

Preventive Visits and Other Services

- Level of service should be consistent with additional work for problem/abnormality
- Insignificant or trivial problems that do not require performance of key components should not be reported

Preventive Visits and Other Services: Principles

- You can only bill ONCE for the same service for the same patient on the same day
- Services must be medically necessary and clinically relevant
- Documentation should reflect the additional work performed

Medicare Preventive Coverage

- Comprehensive preventive exams never covered
- Covered screening services:
  - Pelvic/clinical breast exam
  - Screening Pap test
  - Screening hemoccult
  - Screening mammography
  - Bone mass measurement
Medicare Preventive Coverage

- Covered screening services (cont’):
  - Initial Preventive Physical Examination
  - Annual Wellness Visit
  - Diabetes screening
  - Cardiovascular screening
  - Depression and alcohol abuse screening
- CMS publishes number of documents outlining covered screening and preventive services

Women at High Risk

- Other women at high risk for cervical cancer with one of the following 5 criteria:
  - Onset of sexual activity under age 16
  - Five or more sexual partners in a lifetime
  - History of STI (including HIV)

Screening Pelvic/ Clinical Breast Exam

- Once every 2 years for all women
- Annually for high risk women
- Both deductible and co-pays are waived under the Affordable Care Act (ACA)

Women at High Risk

- Fewer than 3 negative Pap smears within previous 7 years
- Absence of any Pap smear within previous 7 years
- Women at high risk for vaginal cancer:
  - Prenatal exposure to DES

Women at High Risk

- Childbearing age and any of the following apply:
  - Cervical or vaginal cancer is/was present
  - Abnormalities found in preceding 3 years
  - Meets other Medicare high risk criteria

Screening Pelvic/ Clinical Breast Exam (G0101)

- 7 of the following 11 elements:
  - Inspection/palpation of breasts
  - Digital rectal
  - External genitalia
  - Urethral meatus
  - Urethra
  - Bladder
  - Vagina
  - Cervix
  - Uterus
  - Adnexa/parametria
  - Anus and perineum
Content of G0101

- Includes only defined exam elements
- Does not include other elements common to a well-woman exam
- Does not include a ROS or PFSH

Procedural Coding for Screening Services

- HCPCS codes:
  - Screening pelvic/clinical breast exam: G0101
  - Collection of screening pap smear: Q0091
  - Q0091, G0101, and/or problem-oriented E/M all may be reported as appropriate

Collection of Screening Pap Smear

- Screening- Absence of illness, disease, symptoms
- Reported with HCPCS code Q0091
- Criteria for coverage same as G0101
- No deductible but 20% co-pay for collection only
- Interpretation paid separately to lab/pathologist
- Patient has no deductible/co-pay per ACA

Diagnosis Coding for Screening Services

- ICD-9 CM codes:
  - V15.89 High risk
  - V72.31 Routine gyn exam (only if comprehensive preventive service performed)
  - V76.2 Cervix
  - V76.47 Vagina
  - V76.49 Other sites

Collection of Diagnostic Pap Smear

- Diagnostic- Presence of illness, disease, symptoms
- Separate payment not made for collection
- Collection part of exam
- Interpretation of Pap smear and E/M service will be paid when medically necessary

Medicare: Preventive Service With Other Services

- Comprehensive Preventive Medicine Service is never covered by Medicare
- Preventive Service with covered service
  - Non-covered “carved out” (preventive)
  - Medicare pays only for covered service
- May occur with:
  - G0101, Q0091
  - 99201-99215
Allowable Charges and Patient Billing

- Physician charges patient the difference between:
  - Established charge for non-covered preventive service, AND
  - Medicare’s allowable for the covered E/M service

Reporting Covered E/M with Non-Covered Preventive Service

- Care of abnormalities or pre-existing problems reported using E/M code
- Must require significant, separately identifiable E/M service
- Level of service consistent with evaluation of problem
- 25 modifier appended to covered E/M

Medicare Regulations

- Must code accurately for preventive and problem-oriented services
- Cannot accept payment for non-covered services from Medicare
- Cannot charge the patient for any covered services

Understanding E/M Services

- Developed in 1992 to accommodate RBRVS
- Describes outpatient and inpatient “visits”
- Divided into categories, subcategories, and levels of service

Covered Screening Service with Non-Covered Preventive Service

- Non-covered services “carved out”
- Patient responsible for non-covered Preventive Service
- Medicare responsible for covered screening services

How Do You Choose Levels of E/M Services?

- History
- Exam
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of Problem
- Time
New Patient

- Professional services defined as face-to-face services reported by a specific CPT code(s)
- Patients are:
  - Self-referred, referred by friend
  - Sent by a health care provider for treatment

New vs. Established

- Mary is seen in the emergency department by Dr. Phillips. Dr. Phillips asks her to come to his office for follow-up. In the office, Mary is seen by Dr. Phillip’s partner, Dr. Wickham. Mary is Dr. Wickham’s established patient.

New Patient

- A new patient is one who has not received professional services from the physician/QHP OR another physician/QHP of the exact same specialty and subspecialty in the same group practice within the past 3 years

New vs. Established

- Lydia has been seeing Dr. Bennett for years. Dr. Bennett leaves the Longbourne Medical Group and joins the Pemberley Medical Group. Lydia comes to the new practice to see Dr. Bennett within three years of her last visit. Lydia is Dr. Bennett’s established patient.
New vs. Established

- Kitty has been seeing Dr. Darcy for years. Dr. Darcy leaves the Longbourne Medical Group. Kitty then sees Dr. Gardiner, another general gyn at the Longbourne Medical Group. Kitty is Dr. Gardiner’s established patient.

E/M Guidelines: Transfer of Care

- Transfer of Care: Process by which a physician providing management for some or all of a patient’s care relinquishes responsibility to another physician.
- Receiving physician:
  - Explicitly agrees to accept responsibility for patient
  - Should not report consultation service for transfer

E/M Services: Consultation

- Consultation is type of E/M service provided by a physician at the request of another physician or other appropriate source:
  - To recommend care for a specific condition or problem, OR
  - To determine whether to accept responsibility for entire care or care of a specific condition or problem

Criteria For a Consultation

- Must be requested by a physician or other appropriate source
  - eg, physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech-language pathologist, psychologist, social worker, lawyer, or insurance company

Criteria For a Consultation

- Written or verbal request may be documented by either the consulting or requesting physician (or other appropriate source)
- Requires a written report of findings to the requesting party
  - Copy of consultant’s note
  - Separate letter
  - Entry in shared medical record

Reporting Transfer of Care Services

- Outpatient Services:
  - New or established patient codes (99201-99215)
- Inpatient Services:
  - Subsequent hospital care codes (99231-99233)
- If must evaluate before accepting patient, then may report consultation code
## Other Services With a Consultation
- At the same or subsequent visit you may:
  - Initiate diagnostic and/or therapeutic services
  - Report any specific CPT code performed
    - Modifier 25 appended to consultation code

## Time Factors
- Physician may perform PE, obtain history
  - BUT may spend most of the encounter providing counseling, OR
  - All of the visit involves counseling with patient/family

## Reporting Subsequent Services
- Inpatient setting:
  - Subsequent hospital codes (99231-99233)
- Office setting:
  - Established patient codes (99211-99215)

## Using Time To Determine Levels
- Time may be the key factor for the selection of the level of service when counseling and/or coordination of care dominates the encounter (more than 50%)

## Selecting Levels of E/M Services
- Visits requiring 3 of 3 key components
  - New Outpatient Consultations
  - Initial Inpatient Observation care
- Visits requiring 2 of 3 key components
  - Established Outpatient Subsequent inpatient and observation care

## Documentation
- Document description of the counseling/coordination activities
- Document total time and time spent counseling with the patient or indicate that counseling is >50% of total time
Measuring Time

- Outpatient: Time spent by the provider face-to-face with the patient and/or family
- Inpatient: Time spent both with the patient and on the patient’s unit or floor
- Report using the code with the closest actual time

Medically Necessary Services

- In accordance with generally accepted standards for medical practice;
- Clinically appropriate in terms of type, frequency, extent, site, and duration; and
- Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, physician, or other health care provider.”

Selecting E/M Services

- Based on "physician work"
  - History, Exam, MDM, or time
  - Includes services medically necessary to evaluate/treat the patient
  - Code selection must be supported by “work” and “medical necessity”

Medicare and E/M Services

- Medicare Carrier Manual:
  - Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code
  - The volume of documentation should not be the primary influence upon which a specific level of service is billed

Medically Necessary Services

- AMA’s Model Managed Care Contract definition:
  “Health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is:

Medical Necessity and E/M Services

- Influences:
  - Nature of the presenting problem
  - CC, HPI, PFSH
  - MDM
    - Number of diagnosis and management options
    - Volume and complexity of data
    - Risk to the patient
  - CPT Clinical Examples
1995 and 1997 Documentation Guidelines

- Documentation Guidelines (DG) developed by AMA and CMS
- In many instances, the DGs "quantify" the extent of the key components
- Both sets of guidelines still in effect

Selecting Levels of Service

- History
  - CC
  - HPI
  - ROS
  - PFSH
- Exam
  - 1995 vs. 1997

1995 and 1997 Documentation Guidelines

- **1995**
  - Exam based on number of organ systems/body areas examined
  - Criticized for not reflecting work of specialists

- **1997**
  - Created single-organ system exams to reflect work of specialists
  - Criticized for complexity of system

Selecting Levels of Service

- Medical Decision Making
  - Diagnoses
  - Data
  - Risk

Gynecologists and The DGs

- Comprehensive Exam
  - 1995 guidelines less restrictive
    - 8 organ systems vs. 9 systems in 1997 DGs
  - Less than comprehensive exams
    - 1997 DGs recognizes work of single organ system exam
    - Pelvic exam has 9 specific elements under 1997 vs. representing only 1 organ system in 1995 DGs

Types of Medical Decision Making

- Straightforward (SF)
- Low complexity (Low)
- Moderate complexity (Mod)
- High complexity (High)
Selecting the Level of MDM

- Does not involve “counting” of elements
- Supporting documentation can be anywhere in clinical note
- Appendix C of CPT contains clinical vignettes for various levels of service
- CPT code descriptors suggest the nature of the presenting problem

Documenting MDM

- Documentation should indicate (Con’t):
  - Type of tests
  - Review and findings of tests
  - Relevant findings from records
  - Discussion of test results
  - Direct visualization of specimen, images, etc.

Selecting the Level of MDM

<table>
<thead>
<tr>
<th>Level of Medical Decision Making</th>
<th>Number of diagnoses or management options</th>
<th>Amount and/or complexity of data to be reviewed</th>
<th>Risk of complications and/or morbidity or mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward (99241, 99242, 99201, 99202, 99212)</td>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low complexity (99243, 99203, 99213)</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate complexity (99244, 99204, 99214)</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High complexity (99245, 99205, 99215)</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

Documenting MDM

- Documentation should indicate (Con’t):
  - Co-morbidities/underlying conditions
  - Type of surgical or invasive procedure
  - Referral for or decision to perform procedure on an urgent basis

History

- Four Types:
  - Problem-focused
  - Expanded problem-focused
  - Detailed
  - Comprehensive
## Components of History
- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past, Family, and/or Social History (PFSH)

## History of Present Illness
- Eight elements:
  - Location
  - Quality
  - Severity
  - Duration
  - Timing
  - Context
  - Modifying factors
  - Associated signs/symptoms

## Key Documentation Guidelines
- CC required for all levels
- Extent dependent on clinical judgment
- No specific format requirements
- Describe circumstances which preclude obtaining history

## Documenting the HPI
- Brief
  - 1-3 elements
- Extended (99243+, 99203+, 99214+)
  - 4+ elements, OR
  - Comments on 3 or more chronic or inactive conditions

## Key Documentation Guidelines
- ROS/PFSH may be recorded by pt. or staff
  - Provider must supplement/confirm info
  - ROS/PFSH updated by:
    - New information or noting change
    - Noting date/location of previous information
  - Note all positive and pertinent negatives in ROS

## Review of Systems
- 14 systems:
  - Constitutional
  - Eyes
  - ENT, mouth
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Genitourinary
  - Musculoskeletal
  - Integumentary (skin and/or breasts)
  - Neurological
  - Psychiatric
  - Endocrine
  - Hematologic/Lymp.
  - Allergic/Immun.
Documenting the ROS

- Problem Pertinent (99242, 99202, 99213)
- System of complaint
- Extended (99243, 99203, 99214)
  - 2-9 systems
- Complete (99244, 99245, 99204, 99205, 99215)
  - 10 individual systems
  - *Pertinent pos/neg. plus “all other systems neg”
- Comment on hx. form

Choosing the Level of History

<table>
<thead>
<tr>
<th>Type</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>PF</td>
<td>Brief (1-3)</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>EPF</td>
<td>Brief (1-3)</td>
<td>Problem Pertinent</td>
<td>None</td>
</tr>
<tr>
<td>Detailed</td>
<td>Extended (4+)</td>
<td>Extended (2-9)</td>
<td>Pertinent (1 of 3)</td>
</tr>
<tr>
<td>Comp.</td>
<td>Extended (4+)</td>
<td>Complete (10+)</td>
<td>Complete (2 of 3 or 3 of 3)</td>
</tr>
</tbody>
</table>

Chief complaint required for all types. Requirements for all components must be met for a given type.

Past, Family, Social History

- PFSH consists of 3 areas
  - Past History- Patient’s past
  - Family History- Family medical events
  - Social History- Age appropriate review of activities

Choosing the Level of Exam

<table>
<thead>
<tr>
<th>TYPE OF EXAM</th>
<th>1995 REQUIREMENTS</th>
<th>1997 REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>1 body area or organ system</td>
<td>1-5 elements</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>2-4 organ systems including affected area</td>
<td>6-11 elements</td>
</tr>
<tr>
<td>Detailed</td>
<td>4 elements examined in 4 body areas or 4 organ systems</td>
<td>12 or more elements</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>8 or more organ systems</td>
<td>Not defined</td>
</tr>
<tr>
<td>Multi-System</td>
<td>Not defined</td>
<td>2 elements from at least 3 areas/systems</td>
</tr>
<tr>
<td>Single Organ System</td>
<td>Not defined</td>
<td>All elements in shaded boxes f element in all unshaded boxes</td>
</tr>
</tbody>
</table>

Examination

- Four Types
  - Problem-focused
  - Expanded problem-focused
  - Detailed
  - Comprehensive

Documenting the PFSH

- Pertinent (99243, 99203, 99214)
  - 1 of 3 areas
- Complete (99244, 99245, 99204, 99205, 99215)
  - 3 of 3 for new and comprehensive assessments
  - 2 of 3 for established outpatient and ED
### 1995 Guidelines
- Describe all abnormal and unexpected findings
- Describe specific abnormal/relevant neg. findings
- "Neg" or "nl" sufficient for unaffected areas
- Deferred elements explained

### 1997 Guidelines
- Tables identify included systems/areas
- Content or “elements” detailed
- All numeric requirements must be met
- Exams not “specialty specific”
- Type and content dependent on clinical judgment and needs of patient

### 1995 Examination

<table>
<thead>
<tr>
<th>Type of Exam</th>
<th>1995 Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>1 body area or organ system</td>
</tr>
<tr>
<td>(99241, 99201, 99212)</td>
<td></td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>2-4 organ systems including affected area</td>
</tr>
<tr>
<td>(99242, 99202, 99213)</td>
<td></td>
</tr>
<tr>
<td>Detailed</td>
<td>4 elements examined in 4 body areas or 4 organ systems</td>
</tr>
<tr>
<td>(99243, 99203, 99214)</td>
<td></td>
</tr>
<tr>
<td>Comprehensive</td>
<td>8 or more organ systems</td>
</tr>
<tr>
<td>(99244, 99245, 99204, 99205, 99215)</td>
<td></td>
</tr>
</tbody>
</table>

### Female Genitourinary Exam
- Constitutional (shaded)
- Neck
- Respiratory
- Cardiovascular
- Chest (breast)
- Lymphatic
- Skin
- Neurological/Psych
- **GI (shaded)**
- **GU (shaded: 7 of 11 elements)**

### 1997 Defined Exams
- General multi-system
- Skin
- Eyes
- ENT, mouth
- Cardiovascular
- Respiratory
- Genitourinary
- Musculoskeletal
- Heme/Lymph/Immun.
- Neurologic
- Psychiatric

### Female Genitourinary Exam
- Shaded boxes only important when documenting comprehensive exam
- All other levels of exam dependent on the number of exam elements documented.
### 1997 Examination

<table>
<thead>
<tr>
<th>Type of Exam</th>
<th>1997 Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>1-5 elements</td>
</tr>
<tr>
<td>(99241, 99201, 99212)</td>
<td></td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>6-11 elements</td>
</tr>
<tr>
<td>(99242, 99202, 99213)</td>
<td></td>
</tr>
<tr>
<td>Detailed</td>
<td>12 or more elements</td>
</tr>
<tr>
<td>(99243, 99203, 99214)</td>
<td></td>
</tr>
<tr>
<td>Comprehensive</td>
<td>2 elements from at least 9 areas/systems</td>
</tr>
<tr>
<td>(99244, 99245, 99204, 99205, 99215)</td>
<td></td>
</tr>
<tr>
<td>Multi-System</td>
<td></td>
</tr>
<tr>
<td>Single Organ System</td>
<td>All elements in shaded boxes</td>
</tr>
<tr>
<td></td>
<td>1 element in all unshaded boxes</td>
</tr>
</tbody>
</table>

### CPT Global Package

- Includes:
  - Operation per se
  - Local infiltration, metacarpal/digital block, topical anesthesia
  - One related E/M encounter on the date immediately prior to or on the date of the procedure if decision for surgery previously made (includes H&P)

### CPT Global Package

- Does not include:
  - Administration of regional anesthesia or conscious sedation (unless specifically noted)
  - Care provided for complications, exacerbations, recurrence, or other diseases or injuries

### Medicare Global Package

- Includes:
  - Pre-operative Services
  - Intra-operative Services
  - Post-operative Services
  - Also includes supplies and certain miscellaneous services such as removal of sutures, insertion of lines, wires, tubes, etc.
Medicare Global Package

- Pre-operative Work
  - Hospital admission paperwork
  - Interval H&P
  - Review records
  - Obtain consent
  - Check instruments, position patient etc.
  - Scrub, gown, glove

Medicare and Global Periods

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>General Description</th>
<th>Global Periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>57420-57460</td>
<td>Colposcopy, vagina and cervix</td>
<td>000</td>
</tr>
<tr>
<td>57461</td>
<td>Colposcopy with loop electrode conization of the cervix</td>
<td>000</td>
</tr>
<tr>
<td>57520-57522</td>
<td>Conization of cervix; cold knife, laser/loop electrode excision</td>
<td>090</td>
</tr>
<tr>
<td>58120</td>
<td>Dilation and curettage</td>
<td>010</td>
</tr>
</tbody>
</table>

Medicare Global Package

- Intra-operative Work
  - “Skin-to-skin time”
  - Varies according to surgery
- Post-operative Work
  - Other services in OR, recovery, hospital
  - Post-op visits in hospital, discharge management
  - Related office visits during global period
  - Number and level of visits varies

Medicare and Global Periods

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>General Description</th>
<th>Global Periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>58555-58563</td>
<td>Hysteroscopy, diagnostic and surgical (including w/ D&amp;C)</td>
<td>000</td>
</tr>
<tr>
<td>58565</td>
<td>Hysteroscopy, sterilization</td>
<td>090</td>
</tr>
<tr>
<td>58660-58673 (Except 58661)</td>
<td>Laparoscopy, surgical</td>
<td>090</td>
</tr>
<tr>
<td>58661</td>
<td>Laparoscopy with removal of adnexal structures</td>
<td>010</td>
</tr>
</tbody>
</table>

Medicare Global Package

- Minor procedures
  - 0 or 10 day global period
- Major procedures
  - 90 day global period

Medicare and Global Periods

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>General Description</th>
<th>Global Periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>58720</td>
<td>Salpingo-oophorectomy, complete or partial (open)</td>
<td>090</td>
</tr>
<tr>
<td>49320</td>
<td>Laparoscopy, diagnostic</td>
<td>010</td>
</tr>
<tr>
<td>49321-49322</td>
<td>Laparoscopy, with biopsy/aspiration of cyst</td>
<td>010</td>
</tr>
</tbody>
</table>
### Medicare and Global Periods

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>General Description</th>
<th>Global Periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>58100</td>
<td>Endometrial sampling</td>
<td>000</td>
</tr>
<tr>
<td>+58110</td>
<td>Endometrial sampling with colposcopy</td>
<td>ZZZ</td>
</tr>
</tbody>
</table>

### Minor Surgical Procedures

- **Include:**
  - Postoperative:
    - 0 day global: Related visits on same day
    - 10 day global: Follow-up visits for 10 days that are related to recovery from surgery

- **Do not include:**
  - Preoperative: Significant, separately identifiable E/M services
  - Intra-operative: Unrelated procedures

### Payer's Response

- Most payers follow Medicare’s global period
- Many do not pay separately for E/M services for management of “expected complications”
- In most instances, patient will have a co-pay for all E/M billed in addition to the global package (related or unrelated to surgery)

### Minor Surgical Procedures

- **Include:**
  - Preoperative: Same day visits
  - Intra-operative: All integral procedures
    - Supplies usually used

- **Do not include:**
  - Preoperative: Significant, separately identifiable E/M services
  - Intra-operative: Unrelated procedures
  - Postoperative:
    - 0 day: Visits after day of procedure
    - 10 day: Unrelated visits/visits after 10 day global period
    - All 10 day global codes include at least 1 post-operative visit
Major Surgical Procedures

- Include:
  - Preoperative: EM services beginning one day prior
  - Intra-operative:
    - All usual intra-operative procedures
    - Anesthesia administered by surgeon

Major Surgical Procedures

- Do not include:
  - Preoperative:
    - E/M services at which decision for surgery made
    - Diagnostic tests and procedures
    - Treatment required to stabilize seriously ill patient (burns, trauma)

Surgical Modifiers

- Definition:
  - Two digit numeric codes that indicate a basic service has been altered by particular circumstance

- Purpose:
  - Identify “excluded” services for Medicare
  - Provide additional information about services provided

- Intra-operative: Unrelated procedures
- Postoperative:
  - Visits unrelated to the diagnosis for surgery
  - Treatment of underlying condition

- Intra-operative: Unrelated procedures
- Postoperative:
  - Visits unrelated to the diagnosis for surgery
  - Treatment of complications in the OR or procedure room

- Do not include:
  - Postoperative:
    - Complications treated outside the operating or procedure room
    - Related visits for 90 days
    - Post-surgical pain management by surgeon
### Surgical Modifiers

- **Usage:**
  - Medicare accepts most
  - Third-party payers vary
  - Use consistently for all payers and monitor EOB’s
  - Complete listing with definition in Appendix A of CPT

### E/M Services and Same Day Procedures

- **Usage:**
  - You generally report both services if:
    - Physician must address signs, symptoms, conditions before deciding to perform px., OR
    - Work was above and beyond normal pre/post procedure work, OR
    - Diagnosis for E/M and procedure are different, AND
    - E/M service is supported by documentation in the medical record
  - Medicare:
    - Both services payable
    - Same or different diagnoses
    - Must attach 25 modifier to E/M service
    - Modifier required when service has a global period of 0 or 10

- **25- Significant, Separately Identifiable E/M**
  - Appended to E/M Service when procedure performed on the same day by same physician
  - Visit must be above and beyond the usual pre- and post-operative care associated with the procedure
  - Different diagnoses not required

- **Documentation**
  - Clear documentation of distinct E/M Service
    - Significant- Requiring Hx, PE, MDM, counseling time
    - Separately Identifiable- Beyond that typically provided in conjunction with procedure
  - Must support level of service reported
  - Distinct notes for E/M service and procedure

- **Payer’s Response**
  - Medicare:
    - Both services payable
    - Same or different diagnoses
    - Must attach 25 modifier to E/M service
    - Modifier required when service has a global period of 0 or 10
<table>
<thead>
<tr>
<th>Payer's Response</th>
<th>57- Decision for Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Medicare Payers:</strong></td>
<td><strong>E/M reported separately from global package</strong></td>
</tr>
<tr>
<td>- May pay for both based on payment policy</td>
<td>- Only required when visit within pre-operative global period</td>
</tr>
<tr>
<td>- May require different diagnoses</td>
<td>- Medicare and CPT definition: 1 day prior to surgery</td>
</tr>
<tr>
<td>- May require documentation prior to payment</td>
<td>- Not for routine pre-op H&amp;P</td>
</tr>
<tr>
<td>- May never pay for both services on same day</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>57- Decision for Surgery</th>
<th>Payer’s Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Both Medicare and CPT global definitions include visits beginning day prior to “major” surgery when:</strong></td>
<td><strong>Medicare:</strong></td>
</tr>
<tr>
<td>- Decision for surgery previously made</td>
<td>- 57 Major procedures (90 day)</td>
</tr>
<tr>
<td>- Work performed is related to the surgical procedure (including H&amp;P)</td>
<td>- 25 Minor procedures (0, 10 day)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>57- Decision for Surgery</th>
<th>Medicare and CPT Global Surgical Package</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Visits “one day prior to” or “day of” surgery can be reported when:</strong></td>
<td><strong>Key Questions</strong></td>
</tr>
<tr>
<td>- E/M service resulted in initial decision to perform “major” surgery</td>
<td>- What intra-operative procedures or services are integral to the primary procedure?</td>
</tr>
<tr>
<td>- Modifier 57 is added to E/M service</td>
<td>- What intra-operative services are unrelated?</td>
</tr>
</tbody>
</table>

**Medicare and Other third party payers:**
- Dependent on payment policy
Intraoperative Bundling and Unbundling

- Bundling: Lesser procedures usually performed in conjunction with other procedures are considered “bundled” into primary procedure
- Only services not typically performed during the primary procedure should be billed separately

Bundling Guidelines

- CPT
  - CPT descriptors
  - (Separate procedure) designations
- Medicare
  - Correct Coding Initiative (CCI)
- Other Payers
  - Internal policies

Intraoperative Bundling and Unbundling

- Unbundling means: Reporting more than one code when:
  - One code includes the description of the other code(s)
  - Codes are bundled according to CPT and/or Medicare rules
  - One code includes various sub-services

ACOG and Bundling Issues

- Components of Correct Procedural Coding
- OB/Gyn Coding Manual
- Reflects knowledge of Committee
- May differ from CCI or other payer guidelines

Intraoperative Bundling and Unbundling

- Services included in description:
  - 58267- MMK and vaginal hysterectomy
- CPT bundles codes:
  - 58263- Vaginal hysterectomy… with enterocle repair, AND
  - 57283- Colpopexy, vaginal; intraperitoneal…
- Services included in payment:
  - EUA (57410) at time of surgical procedure

Medicare’s Correct Coding Initiative

- CCI intended to ensure consistent application of bundling rules
- Guiding Principle:
  - All services integral to accomplishing a procedure are bundled into the primary service
  - Only comprehensive procedure reported
Correct Coding Initiative
- Service considered bundled when:
  - Represents standard of care in performing procedure
  - Necessary to successfully accomplish procedure
  - Not separate and unrelated from primary procedure

51- Multiple Procedures
- More than one procedure performed at the same session
- Procedures identified by different CPT codes
- Only services not typically performed during primary procedure are reported
- Modifier 51 distinguishes the primary procedure from other procedures

Correct Coding Initiative
- CCI presents “code pairs” that are not separately payable if performed at the same setting
- Updated quarterly with input from medical community ACOG publishes on website (www.acog.org)

Payer’s Response
- 100% of allowable for highest valued procedure
- Reduced payment for all others
  - Medicare: 50% of allowable for 2nd-5th procedures
  - Other payers: frequently same
- List highest valued or most significant procedure first
  - Highest valued procedure has greatest RVUs

CCI Guidelines
- Diagnostic laparoscopy is component of surgical laparoscopy
- Exploratory laparotomy is component of open surgical procedure
- EUA is component of gyn procedures
- Only the successful procedure (method) paid (vaginal hysterectomy to TAH)

Payer’s Response
- Attach modifier to lesser valued procedures
- Report full fee for all procedures and let payer make reduction
  - Charge: $1,000 if:
    - Physician reduces by 50%, and
    - Payer reduces by 50%, then
  - Reimbursement: $250
59- Distinct Procedural Services

- May be circumstances when appropriate to report code combinations that are usually "bundled"
- Modifier 59 indicates that a service is distinct from another service reported on same day
- Indicates an “exception” - not typical situation
- Use only if no other appropriate modifier

Payer’s Response

- Medicare
  - Modifier appropriate if procedures performed on different anatomical sites or at different patient sessions
  - Represents an unusual circumstance
- Other payers
  - Monitor use closely for appropriateness
  - Multiple procedure discount still applies

59- Distinct Procedural Services

- Applied to services that are usually bundled
- Indicates that both services should be reimbursed
- Attach 59 only if procedure distinct from primary procedure (not integral)

Payer’s Response

- 59- Indicates a clinical exception to bundling guidelines
- 51- Distinguishes “lesser” services from primary procedure for multiple service reduction
- Not generally necessary to apply both 59 and 51 unless instructed by payer

59- Distinct Procedural Services

- Services may be distinct because they represent:
  - Different session
  - Different procedure or surgery
  - Different site or organ system
  - Separate incision/excision
  - Separate lesion or injury

80- Assistant Surgeon

- Actively “assists” in the performance of a surgical procedure
- Does not dictate op report
- Does not admit or follow patient
- Does not perform distinct part of surgery
- Both surgeons report same CPT code
- Only assistant reports modifier
- Usually report 30-50% of established charge
62- Two Surgeons

- Surgeons working together to perform distinct parts of a single procedure
- Each surgeon has key role in the performance of the procedure
- Both surgeons report same CPT code and same modifier

Medicare’s Rules

- CPT procedures divided into 3 groups:
  - Co-surgeons not permitted
  - May be permitted if medical necessity documented
  - Permitted without additional documentation if of different board-certified specialties

62- Two Surgeons

- If a single code is available that describes all the elements, then it must be used
- It is considered unbundling for the surgeons to report separate codes for the individual portions of the procedure

Independent Surgical Procedures

- Not a single CPT code available to describe the services of both surgeons
- Each physician reports own CPT code
- No modifier required
- Full allowable paid to each surgeon
- Payer guidelines determine if additional reimbursement made for assistant services, if performed

62- Two Surgeons

- 58200- TAH, partial vaginectomy, para-aortic and pelvic lymph node sampling with/without removal of tubes/ovaries
- General Gynecologist: Hysterectomy
- Gynecologist/Oncologist: Lymph nodes
- Each reports same code, same modifier and own established fee

22- Increased Procedural Services

- CPT codes based on typical patient and typical work
- Modifier added only if work of the procedure is substantially greater than typically required
- Documentation important and must:
  - Support the substantial additional work
  - Indicate the reason for the additional work
22- Increased Procedural Services

- Criteria for increased work:
  - Increased intensity
  - Increased time
  - Technical difficulty of procedure
  - Severity of patient’s condition
  - Physical and mental effort required

Post Op Modifiers 24 and 79

- Both Medicare and CPT global packages exclude post-op services unrelated to the problem resulting in the surgery
  - 24- Unrelated E/M services
  - 79- Unrelated procedures

22- Increased Procedural Services

- Examples:
  - Extensive lysis of adhesions
  - Morbid obesity
  - Increased time or intensity to complete procedure
    - Time alone not sufficient-need to reflect additional work

24- Unrelated E/M Service During Post-op Period

- E/M service unrelated to the problem associated with the original surgery
- Modifier not used for treatment of complications
- Distinct diagnosis important
- Level of reimbursement not affected

79- Unrelated Procedure During Post-op Period

- Distinct procedure performed by same physician during another global period
- Unrelated to original procedure
- Own global period established
- Reimbursed at full allowable amount

Payer’s Response

- Documentation required
- Careful operative report dictation critical for payment
- Cover letter helpful
- Expect to appeal
### Global Obstetric Package

- "Global" obstetric package includes those services normally provided in uncomplicated cases.

### 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 provided
- Late enrollment
  - Report global if care matches or surpasses given to typical OB patient

### CPT Global Package

- Antepartum services
- Delivery services
- Postpartum services

### 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
<table>
<thead>
<tr>
<th>Services Excluded From the Antepartum Package</th>
<th>Services Unrelated to Pregnancy</th>
</tr>
</thead>
</table>
| ■ Initial E/M service 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 | ■ Diagnosis unrelated to pregnancy  
  ■ URI, flu, etc.  
  ■ Report labs, visits, etc. separately  
  ■ Services reported at time of encounter |
<table>
<thead>
<tr>
<th>Services Excluded From the Antepartum Package</th>
<th>Services Unrelated to Pregnancy</th>
</tr>
</thead>
</table>
| ■ Additional E/M service for related or unrelated conditions  
  ■ Inpatient admission, observation care, and subsequent visits for complications  
  ■ Only those occurring more than one calendar date before delivery | ■ Clearly document treatment of the presenting problem  
  ■ Preferable to document outside of antepartum flow chart  
  ■ Level of service for unrelated problem must be supported |
<table>
<thead>
<tr>
<th>Services Excluded From the Antepartum Package</th>
<th>Services Unrelated to Pregnancy</th>
</tr>
</thead>
</table>
| ■ Diagnostic services:  
  ■ Ultrasounds  
  ■ NST  
  ■ External cephalic version  
  ■ Certain other procedural services | ■ The visit does not count in the total number of antepartum visits  
  ■ ICD-9 indicates V22.2 should be listed as secondary diagnosis  
  ■ 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
  - Current complication
  - Need for diagnostic tests

Services Related to Pregnancy

- Additional E/M services reported at the time of delivery
- Diagnostic tests, etc 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

Services Related to Pregnancy

- High risk is not the same as current “complications of pregnancy”
- Additional visits are not reported if active problems do not develop
- Medically necessary diagnostic tests may be reported

Services Related to Pregnancy

- Do not report visits in addition to package if:
  - Total number of visits is <13, OR
  - Visits are not for complications in current pregnancy
- The level of E/M visit is determined by CPT-4 definitions and guidelines

Services Related to Pregnancy

- Additional visits for current complications of pregnancy may be reported
  - Pregnancy complicated by hypertension
  - Vaginal bleeding

Delivery Services

- Admission to the hospital
- Admission history and physical exam
- Management of uncomplicated labor including induction using IV medications
### Delivery Services
- Vaginal or cesarean delivery
  - Episiotomy
  - Use of forceps
  - 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

### Examples of Excluded Services
- External cephalic version
- Insertion of cervical dilator on a day prior to delivery
- E/M services for medical problems or complications provided >24 hours prior to delivery
  - Observation services
  - Inpatient services
  - Critical care

### 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

### 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
- 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

Selecting the Type of E/M Services

- First obstetrical visit
  - New to the practice (99201-99205), OR
  - Established within practice (99211-99215)
- Second, third visits
  - Established patient visit codes (99211-99215)

Reporting Non-Global Services

- Antepartum care only (59425, 59426)
- Delivery only (59409, 59514, 59612, 59620)
- Delivery plus postpartum care (59410, 59515, 59514, 59622)
- Postpartum care only (59430)

Selecting the Type of E/M Services

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

Antepartum Care Only

- Two methods depending on total number of visits:
  - E/M codes (1-3 visits)
  - Antepartum care codes (4 or more visits)

Antepartum Care Codes

- CPT 59425 (4-6 total visits)
- CPT 59426 (7 or more total visits)
- Watch for payer variation
- Not reported if global package billed
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

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

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

Postpartum Care Only

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

Ultrasounds-Component Services

- Certain diagnostic tests including, ultrasound and fetal stress tests, include 2 components:
  - Professional component
  - Technical component
- Together they comprise the total service
Ultrasound Components

- Professional Component (26)
  - Supervision of test (if any)
  - Interpretation
  - Written report
- Technical Component (TC)
  - Technician salary/benefits (if any)
  - Equipment
  - Necessary supplies

Components of Ultrasound Codes

- All codes include:
  - Supervision of sonographer performing examination (if any)
  - Image documentation
  - Preparation of written report

Reporting Ultrasound Services

- Performed at hospital or other facility:
  - Physician who performs or interprets the test bills the Professional Component (26)
  - Facility bills the Technical Component (TC)
- Performed at physician’s office or physician owned facility:
  - Physician reports total service without a modifier

Fetal and Maternal Evaluation

1st Trimester

- 76801 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation
- +76802 each additional gestation (List separately in addition to code for primary procedure performed)

Reporting Ultrasound Services

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

Fetal and Maternal Evaluation

1st Trimester

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

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

Fetal and Maternal Evaluation

2nd & 3rd Trimester
- Assessment of the umbilical cord insertion site
- Survey of placenta location
- Amniotic fluid assessment
- Examination of maternal adnexa, when visible

Fetal and Maternal Evaluation

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

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 (List separately in addition to code for primary procedure performed)

Fetal and Maternal Evaluation

2nd & 3rd Trimester
- Determination of the number of fetuses and amniotic/chorionic sacs
- Measurements appropriate for gestational age
- Survey of intracranial, spinal, and abdominal anatomy
- Evaluation of the four chambered heart

Detailed Fetal Anatomic Exam
- Performed during 2nd & 3rd 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
<table>
<thead>
<tr>
<th>Detailed Fetal Anatomic Exam</th>
<th>Fetal Nuchal Translucency Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Brain/ventricles and face</td>
<td>- Performed first trimester to assess risk of chromosomal abnormalities</td>
</tr>
<tr>
<td>- Heart/outflow tracts and chest anatomy</td>
<td></td>
</tr>
<tr>
<td>- Abdominal organ specific anatomy</td>
<td></td>
</tr>
<tr>
<td>- Number/length/architecture of limbs</td>
<td>- Transabdominal or transvaginal approach</td>
</tr>
<tr>
<td></td>
<td>- Should not be billed routinely in combination with codes 76801-76802 (first trimester ultrasound)</td>
</tr>
<tr>
<td></td>
<td>- Documentation should support need for both services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Detailed Fetal Anatomic Exam</th>
<th>Fetal Nuchal Translucency Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Detailed evaluation of:</td>
<td>- The code includes:</td>
</tr>
<tr>
<td></td>
<td>- At least three separate measurements of the shortest distance between the inner edges of the nuchal translucency</td>
</tr>
<tr>
<td></td>
<td>- A comparison of the largest measurement to crown-rump length and gestational age specific medians</td>
</tr>
<tr>
<td></td>
<td>- Calculation of the risk of Down syndrome</td>
</tr>
<tr>
<td>- Umbilical cord</td>
<td></td>
</tr>
<tr>
<td>- Placenta</td>
<td></td>
</tr>
<tr>
<td>- Other fetal anatomy as clinically indicated</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fetal Nuchal Translucency Measurement</th>
<th>Limited Ultrasound</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 76813  Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation</td>
<td>- 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</td>
</tr>
<tr>
<td>- +76814  each additional gestation (List separately in addition to code for primary procedure)</td>
<td></td>
</tr>
<tr>
<td>Limited Ultrasound</td>
<td>Follow-Up Ultrasound</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Used for one or more fetuses</td>
<td>Used for either of the following:</td>
</tr>
<tr>
<td>No trimester designation</td>
<td>Reassessment of fetal size and interval growth, OR</td>
</tr>
<tr>
<td>Quick look of one or more of the following:</td>
<td>Re-evaluation of one or more anatomic abnormalities of a fetus previously demonstrated on ultrasound</td>
</tr>
<tr>
<td>Fetal position</td>
<td></td>
</tr>
<tr>
<td>Fetal heart beat</td>
<td></td>
</tr>
<tr>
<td>Placental location</td>
<td></td>
</tr>
<tr>
<td>Qualitative amniotic fluid volume</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Follow-Up Ultrasound</th>
<th>Transvaginal Ultrasound</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>76817 Ultrasound, pregnant uterus, real time with image documentation, transvaginal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Follow-Up Ultrasound</th>
<th>Transvaginal Ultrasound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code reported once per fetus</td>
<td>May include:</td>
</tr>
<tr>
<td>CPT states that modifier 59 should be attached to each fetus beyond the first</td>
<td>Evaluation of the embryo and gestational sac(s)</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the maternal uterus, adnexa, and/or cervix</td>
</tr>
<tr>
<td></td>
<td>No multiple gestation designation</td>
</tr>
<tr>
<td></td>
<td>May be reported in addition to transabdominal as clinically indicated</td>
</tr>
</tbody>
</table>
**Biophysical Profile**

- A complete BPP (76818) measures physiologic activity in the fetus
- Includes:
  - NST
  - Fetal breathing movements
  - Fetal movement
  - Fetal tone
  - Amniotic fluid volume

**Other Services with BPP**

- Complete BPP (76818) and additional NST (59025) during Separate Sessions on same day
  - Report 76818 AND 59025-59
  - Need for 2nd NST demonstrated
  - Modifier 59 (Distinct procedure)

---

**Biophysical Profile**

- CPT 76819 describes an incomplete BPP without NST
- Obstetrician performs NST (reports 59025)
- Radiologist performs other elements (reports 76819)

**Other Services with BPP**

- Complete BPP (76818) and Ultrasounds on Same Day
  - Both BPP and ultrasound reported
  - Ultrasound: Anatomic examination
  - BPP: Physiologic examination
  - Medical necessity must be supported

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**Other Services with BPP**

- 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

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**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, then Ob reports procedure code only
## Ultrasound Imaging

<table>
<thead>
<tr>
<th>Description</th>
<th>Procedure Code</th>
<th>Radiological Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrauterine fetal transfusion</td>
<td>36460</td>
<td>76941</td>
</tr>
<tr>
<td>Intrauterine cordocentesis</td>
<td>59012</td>
<td>76941</td>
</tr>
<tr>
<td>Chorionic villus sampling</td>
<td>59015</td>
<td>76945</td>
</tr>
<tr>
<td>Amniocentesis</td>
<td>59000</td>
<td>76946</td>
</tr>
<tr>
<td>Aspiration of ova</td>
<td>58970</td>
<td>76948</td>
</tr>
<tr>
<td>Sonohysterography</td>
<td>58340</td>
<td>76831</td>
</tr>
<tr>
<td>Hysterosalpingography</td>
<td>58340</td>
<td>74740</td>
</tr>
<tr>
<td>Transcervical catheterization of fallopian tube</td>
<td>58345</td>
<td>74742</td>
</tr>
</tbody>
</table>

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### THANK YOU!

- Thank you for inviting me
- Make plans to attend an ACOG Coding Workshop in 2014 in preparation for ICD-10!