



CONFIDENT CODING FOR OB/GYN

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CONFIDENT CODING FOR OB/GYN

- ✓ So when exactly does the global period start?
 - ✓ *Unraveling the confusion in antepartum care coding*
- ✓ Correct coding for multiple gestations!
 - ✓ *Vaginal deliveries vs. c-sections*
- ✓ Ultrasounds and non-stress tests
 - ✓ *How to code for multiple ultrasounds and other tests*
- ✓ What's new for 2009?
 - ✓ *New ICD-9 CM codes in OB and Gyn!*
 - ✓ *New codes and changes for OB and Gyn in CPT!*

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CONFIDENT CODING FOR OB/GYN

- ✓ So when exactly does the global period start?
 - ✓ CPT and ACOG descriptions of global ob care.
 - ✓ What is not included in the global package?
 - ✓ Global package CPT and ICD-9 coding.
 - ✓ Billing for services without the global period.

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- ✓ CPT Description of Global OB care includes:
 - ✓ Antepartum services included in the global package are: the initial and subsequent history; physical examinations; recording of weight, blood pressure, and fetal heart tones; routine urine dipstick analysis; monthly visits up to 28 weeks of gestation; biweekly visit up to 36 weeks of gestation; and weekly visit until delivery.
 - ✓ Delivery services include admission to the hospital; labor management, including fetal monitoring and induction of labor; and delivery, including delivery of the placenta.
 - ✓ Postpartum services include an inpatient hospital visit post delivery and outpatient post partum care up to 6 weeks after delivery.

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- ✓ Also included according to ACOG (American College of Obstetricians and Gynecologists):
 - ✓ Induction of labor (unless the obstetrician personally starts the IV and sits with the patient during the infusion).
 - ✓ Insertion of cervical dilator on day of delivery (code 59200).
 - ✓ Simple removal of cerclage (eg, local anesthesia only)

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- ✓ What is not included in the global package?
 - ✓ Treatment of conditions unrelated to Pregnancy:
 - ✓ Use E/M codes to report services for treatment of conditions unrelated to pregnancy.
 - ✓ Be sure provider has documented that condition is unrelated or not complicating the pregnancy.
 - ✓ Treatment of complications of Pregnancy:
 - ✓ Additional visits (over the usual 13 antepartum visits) to treat complications of the pregnancy may be reported after the patient has delivered.
 - ✓ Services for patients admitted for observation or inpatient care who deliver with 24 hours of admission are not reported separately.
 - ✓ Monitoring of high risk patients:
 - ✓ If a patient is seen for additional visits (more than 13) to monitor for a possible problem that does not materialize, then only the global package code should be reported.

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- ✓ What is not included in the global package? (cont.)
 - ✓ Additional delivery services:
 - ✓ Examples of delivery care not included in the global package are:
 - ✓ External cephalic version
 - ✓ Insertion of cervical dilators more than 24 hours before delivery
 - ✓ E/M services (eg, observation, inpatient services, critical care) if provided **more than 24 hours before delivery**.
 - ✓ Additional postpartum services:
 - ✓ Examples of postpartum care not included in the global package are:
 - ✓ Treatment of postpartum complications
 - ✓ Treatment of conditions not related to routine postpartum care

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- ✓ Global package CPT and ICD-9 coding:
 - ✓ CPT codes for global OB care are:
 - ✓ 59400 Total OB care with routine vaginal delivery
 - ✓ 59510 Total OB care with routine cesarean delivery
 - ✓ 59610 Total OB care with routine VBAC delivery
 - ✓ 59618 Total OB care with routine repeat cesarean delivery after attempted VBAC delivery
 - ✓ ICD-9 codes for routine global OB care are:
 - ✓ 650 Routine vaginal delivery, and the appropriate V27.x code for the outcome of the delivery.
 - ✓ 654.21 Prior cesarean section delivery used for repeat c-section and for VBAC delivery, and the appropriate V27.x code for the outcome of the delivery.
 - ✓ Primary cesarean section delivery ICD-9 codes should be the diagnosis code for the condition requiring c-section delivery (eg, obstructed labor 660.xx, or abnormality forces of labor 661.xx), and the appropriate V27.x code for the outcome of the delivery.

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- ✓ Billing for services without the global package:
 - ✓ Antepartum care only:
 - ✓ 1-3 antepartum visits are billed using the appropriate E/M codes
 - ✓ 4-6 antepartum visits are billed using CPT code 59425
 - ✓ 7+ antepartum visits are billed using CPT code 59426
 - ✓ Delivery only or delivery with postpartum care only:
 - ✓ 59409 and 59410 vaginal delivery only or delivery w/pp care.
 - ✓ 59514 and 59515 cesarean delivery only or delivery w/pp care.
 - ✓ 59612 and 59614 VBAC delivery only or delivery w/pp care.
 - ✓ 59620 and 59622 Repeat c-section delivery after attempted VBAC delivery or delivery w/pp care only.
 - ✓ Postpartum care only:
 - ✓ 59430 is used when the physician only provides outpatient postpartum care for the patient, the antepartum, delivery and inpatient postpartum care has been provided by another physician.

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- ✓ Billing for service without the global package:
 - ✓ When the patient transfers care mid-pregnancy:
 - ✓ Each provider will report the care they provided with the appropriate antepartum care and/or delivery codes.
 - ✓ When the patient changes insurance mid-pregnancy:
 - ✓ Check with insurance carrier to determine how they want care reported. Some will want the global fee reported while others may require that the care be reported using the antepartum care and delivery codes separated.
 - ✓ Delivery prior to term:
 - ✓ If patient has been seen for less than 10 regular ob visits and delivers prior to 37 weeks gestation, you can append a modifier -52 to the global fee and send documentation to the insurer. Most insurers will allow the global fee for this situation.
 - ✓ Miscarriage and pregnancy loss:
 - ✓ Prior to 20 weeks gestation, report the appropriate antepartum care code for the number of visits and then the appropriate care codes for treatment of the miscarriage along with the appropriate ICD-9 code(s). If the fetus is born alive it is allowed to bill the global code with a 52 modifier.
 - ✓ After 20 weeks gestation the global care code may be utilized with a 52 modifier and the appropriate ICD-9 code(s).

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- ✓ Correct coding for multiple gestations!
 - ✓ Vaginal delivery
 - ✓ Twin or more gestation delivery reporting uses the standard 59400 for global antepartum and postpartum care including delivery of the first fetus. For each additional fetus delivered report 59409, delivery only.
 - ✓ Be sure to use the appropriate ICD-9 code for the multiple gestation and the V27.x code for the outcome of the delivery.
 - ✓ Some insurance carriers may prefer having the global 59400 reported with a modifier -22 and the fee increased to account for the additional work provided in the antepartum care and delivery.
 - ✓ Cesarean section delivery
 - ✓ In most cases, the global c-section code 59510 is reported only once, but a modifier -22 may be appended, and the fee increased, to report the additional work for delivery of the second and subsequent fetuses.
 - ✓ Since there is only one incision, you cannot report an additional c-section delivery with 59514 code by the same physician.
 - ✓ An assistant surgeon may report 59514 with modifiers -80 and -22.

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- ✓ Ultrasounds and non-stress tests:
 - ✓ 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)
 - ✓ 1st trimester maternal and fetal evaluations include:
 - ✓ Supervision of sonographer performing the exam
 - ✓ Determination of the number of gestations sacs and fetuses
 - ✓ Gestational sac/fetal measurements appropriate for gestation
 - ✓ Survey of visible fetal and placental anatomic structure
 - ✓ Qualitative assessment of amniotic fluid volume/gestational sac shape
 - ✓ Examination of maternal uterus and adnexa

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CONFIDENT CODING FOR OB/GYN

- ✓ **Ultrasound and non-stress tests**
 - ✓ 76805 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation (+76810 each additional gestation)
 - ✓ 2nd and 3rd trimester maternal and fetal evaluations include:
 - ✓ Supervision of sonographer performing the examination
 - ✓ Determination of the number of fetuses and amniotic/chorionic sacs
 - ✓ Measurements appropriate for gestational age
 - ✓ Survey of intracranial/spinal/abdominal anatomy
 - ✓ Evaluation of the four-chambered heart
 - ✓ Assessment of the umbilical cord insertion site
 - ✓ Survey of placenta location and amniotic fluid assessment
 - ✓ When visible, examination of maternal adnexa

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CONFIDENT CODING FOR OB/GYN

- ✓ **Ultrasound and non-stress tests:**
 - ✓ 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 maternal and fetal examinations include:
 - ✓ Supervision of sonographer performing this examination
 - ✓ **All the components of 76805 and 76810, plus**
 - ✓ **Detailed anatomic evaluation of:**
 - ✓ The fetal brain/ventricles and face
 - ✓ Heart/outflow tracts and chest anatomy
 - ✓ Abdominal organ specific anatomy
 - ✓ Number/length/architecture of limbs
 - ✓ **Detailed evaluation of:**
 - ✓ Umbilical cord
 - ✓ Placenta
 - ✓ Other fetal anatomy as clinically indicated

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- ✓ **Ultrasound and non-stress tests**
 - ✓ 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 includes:
 - ✓ Supervision of sonographer performing the exam
 - ✓ Interpretation of the exam limited to a “quick-look” assessment of once or more of the elements listed in the description
 - ✓ 76816 Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by standard measuring 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

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- ✓ **Ultrasound and non-stress tests:**
 - ✓ 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) includes:
 - ✓ Orientation of transducer to mid-sagittal view of the embryo
 - ✓ Crown-rump measurement
 - ✓ Observation of embryo at high magnification until the embryonic neck is in a neutral position and spontaneous embryonic movement allows for differentiation between the outer edge of nuchal skin and the amnion
 - ✓ At least three separate measurements for the shortest distance between the inner edges of nuchal translucency
 - ✓ Comparison of the largest measurement from an acceptable image to crown-rump length and gestational age specific median.

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- ✓ **Ultrasound and non-stress tests**
 - ✓ 76817 Ultrasound, pregnant uterus, real time with image documentation, transvaginal approach
 - ✓ Evaluation of the embryo(s) and gestational sac(s)
 - ✓ Evaluation of the maternal uterus, adnexa and/or the cervix
 - ✓ Supervision of the sonographer performing the exam

 - ✓ Some payers may not reimburse for both a transvaginal and transabdominal ultrasound performed at the same encounter. Some payers may require a modifier -59 (distinct procedural service) or a modifier -51 (multiple procedures) attached to the transvaginal code.

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- ✓ **Ultrasound and non-stress tests**
 - ✓ 76818 Complete Biophysical profile consists of:
 - ✓ Fetal non-stress test (NST)
 - ✓ Fetal breathing movements (1 or more episodes of rhythmic fetal breathing movements of 30 seconds or more within 30 minutes)
 - ✓ Fetal movement (3 or more discrete body or limb movements with 30 minutes)
 - ✓ Fetal tone (1 or more episodes of extension of a fetal extremity with return to flexion)
 - ✓ Quantification of amniotic fluid volume
 - ✓ 76819 Limited Biophysical profile
 - ✓ Includes all of the above with the exception of the non-stress test (NST)
 - ✓ 59025 Non-stress test (NST)
 - ✓ Evaluates fetal heart rate response to it's own activity. Patient reports fetal movements as an external monitor records fetal heart rate changes. Non-invasive 20- 40 minutes to perform, fetus can be stimulated with an acoustic device in necessary to induce activity.

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- ✓ Ultrasound and non-stress tests:
 - ✓ Ultrasound guidance may be reported in addition to an ultrasound procedure code if both are performed at the same encounter, as long as the physician was in attendance and supervised or performed one or both procedures.

 - ✓ Some procedures have specific ultrasound guidance codes such as 76946 (ultrasound guidance for amniocentesis). For other procedures the ultrasound guidance is included in the procedure and cannot be reported separately. For example, all fetal surgery codes include ultrasound guidance.

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- ✓ Ultrasound and non-stress tests:
 - ✓ Ultrasound documentation - CPT includes the following definition of results, tests, interpretations and reports:

“Results are the technical component of a service. Testing leads to results; results lead to interpretation. Reports are the work product of the interpretation of numerous test results.”

 - ✓ In order to report an ultrasound code, there must be a separate, final written report with interpretation of the findings of the radiological procedure. The report and interpretation should be stored in the medical record. These instruction also mean that a brief summary within the documentation of an E/M service is insufficient to justify reporting an ultrasound code.

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- ✓ Ultrasound and non-stress tests
 - ✓ Modifiers and ultrasound procedures
 - ✓ If an ultrasound procedure is performed in the physician's office, either by the physician or an employee, the appropriate code is reported without a modifier.
 - ✓ If an ultrasound procedure is performed in a hospital or other facility setting, it may be appropriate to use a modifier:
 - ✓ Professional Component – Modifier 26 is used when the physician component is reported separately.
 - ✓ Technical Component – Modifier TC is used when the technical component is reported separately.

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- ✓ What's new for 2009?
- ✓ CPT
 - ✓ Be sure to review all codes specific to your practice for changes, additions and deletions!
 - ✓ Only a few changes specific to OB/Gyn in CPT
 - ✓ 57400, 57410, 57415 the phrase "other than local" has been added to each of these codes to clarify that the procedures are performed under general anesthesia or conscious sedation which carries a greater risk for the patient and more work for the physician.
 - ✓ 90650 HPV vaccine for Cevarix new from GlaxoSmithKline. Different dosing schedule from the Gardasil vaccine so they each have their own code.

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- ✓ What's new for 2009?
 - ✓ CPT Category III codes
 - ✓ Be sure to review the Category III codes for any "emerging technology" codes that might be pertinent to your particular practice. Use Category III rather than "unspecified" CPT codes whenever appropriate.
 - ✓ HCPCS Level II codes
 - ✓ New G0406, G0407, G0408 Telehealth consultation codes. Not generally reimbursed by insurance, but part of the emerging technology in health care in general.
 - ✓ Many of the "J" codes have the term "injection" added to clarify the route of administration.

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- ✓ What's new for 2009?
 - ✓ ICD-9 CM new codes for 2009
 - ✓ 078.19 Other viral warts
 - ✓ 249.xx Secondary Diabetes
 - ✓ 339.xx Other Headache syndromes
 - ✓ 346.xx Migraine
 - ✓ 599.7x Hematuria
 - ✓ 611.8x Other disorders of the breast
 - ✓ 612.x Deformity and disproportion of reconstructed breast
 - ✓ 625.7x Vulvodynia
 - ✓ 649.7x Cervical shortening
 - ✓ 678.xx Other fetal conditions
 - ✓ 679.xx Complications of in utero procedures

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- ✓ What's new for 2009?
 - ✓ ICD-9 CM new codes for 2009
 - ✓ 780.6x Fever and other physiologic disturbances of temperature
 - ✓ 788.91 Functional urinary incontinence
 - ✓ 795.07 Satisfactory cervical smear but lacking transformation zone
 - ✓ 795.1x Pap smear of vagina
 - ✓ 796.7x Pap smear of anus
 - ✓ V07.5x Prophylactic use of agents affecting estrogen receptors and estrogen levels
 - ✓ V15.2x Personal history of undergoing in utero procedure (while pregnant or while fetus)

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- ✓ What's new for 2009?
 - ✓ ICD-9 CM new codes for 2009
 - ✓ V23.8x Pregnancy resulting from assisted reproductive technology
 - ✓ V28.81 Encounter for fetal anatomic survey
 - ✓ V28.82 Encounter for screening for risk of pre-term labor
 - ✓ V28.89 Other specified antenatal screening
 - ✓ V88.01 Acquired absence of both cervix and uterus
 - ✓ V88.02 Acquired absence of uterus with remaining cervical stump
 - ✓ V88.03 Acquired absence of cervix with remaining uterus

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- ✓ What's new for 2009?
 - ✓ ICD-9 CM new codes for 2009
 - ✓ V89.01 Suspected problem with amniotic cavity and membranes not found
 - ✓ *Suspected oligohydramnios not found*
 - ✓ *Suspected polyhydramnios not found*
 - ✓ V89.02 Suspected placental problem not found
 - ✓ V89.03 Suspected fetal anomaly not found
 - ✓ V89.04 Suspected problem with fetal growth not found
 - ✓ V89.05 Suspected cervical shortening not found
 - ✓ V89.09 Other suspected maternal and fetal condition not found

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- ✓ Tips to remember when coding OB/Gyn
 - ✓ Per the guidelines in ICD-9 CM any condition a pregnant patient is seen for is considered to be complicating the pregnancy, and coded as such, unless the physician documents specifically that the problem is not complicating the pregnancy.
 - ✓ If a pregnant patient transfers care to your physician, remember that you will need to code out antepartum care and delivery separately.
 - ✓ If a Biophysical profile and an NST are performed on the same day, you must use code 76818 (not 76819 and 59025).
 - ✓ If a transabdominal and a transvaginal ultrasound are performed at the same encounter, you will probably need separate diagnosis codes for the insurer to consider reimbursement on both procedures.

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Thank you for listening!

Questions?

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