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Ob-Gyn Coding Alert

Your practical adviser for ethically optimizing coding, payment, and efficiency in ob-gyn offices and clinics

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Obstetrics

Safeguard Your Split Antepartum Care Reimbursement With Expert Tips

You may have more options than you think.

When dividing ob-gyns' roles with split antepartum care, the key is counting the visits, coding experts say.

When your obstetrician shares maternity care with a physician outside a group practice, you will have to abandon the global codes (59400, *Routine obstetric care including antepartum care, vaginal delivery [with or without episiotomy, and/or forceps] and postpartum care*; 59510, *Routine obstetric care including antepartum care, cesarean delivery, and postpartum care*; 59610, *Routine obstetric care including antepartum care, vaginal delivery [with or without episiotomy, and/or forceps] and postpartum care, after previous cesarean delivery*; and 59618, *Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery*).

CPT® states that antepartum care includes monthly visits up to 28 weeks gestation, biweekly visits up to 36 weeks gestation, and weekly visits until delivery. Ob services include obtaining the patient's history, performing a physical exam, recording vital statistics, and doing other examinations necessary to provide safe and appropriate care for the mother and fetus.

When patients change providers during the course of their pregnancies, the question for ob coders becomes: What options do we have in accurately coding and reporting the services provided?

Tip 1: 3 Choices for Coding Antepartum Care

If your ob-gyn only provides antepartum care, you have three potential ways to report his services.

Option 1: "If the patient had a total of one to three antepartum visits, report the appropriate level of E/M service for each visit with the date of service that the visit occurred and the diagnosis for why the patient was seen," states the American Congress of Obstetricians and Gynecologists (ACOG). For example, if the doctor sees an ob patient twice before she moves to a different area, you would report the appropriate E/M code (99201-99215) for each visit with V22.0 (*Supervision of normal first pregnancy*) or V22.1 (*Supervision of other normal pregnancy*).

ICD-10: When your diagnosis coding system changes, code V22.0 expands into four options: Z34.00 (*Encounter for supervision of normal first pregnancy, unspecified trimester*), Z34.01 (*… first trimester*), Z34.02 (*… second trimester*), Z34.03 (*… third trimester*).

Code V22.1 will include one of the following four codes: Z34.80 (*Encounter for supervision of other normal pregnancy, unspecified trimester*), Z34.81 (… *first trimester*), Z34.82 (… *second trimester*), and Z34.83 (… *third trimester*).

Option 2: On the other hand, if the ob-gyn sees the patient four to six times before she leaves his care, you will report 59425 (*Antepartum care only; 4-6 visits*), ACOG states. Because 59425 represents the total work involved with all of the visits, you should submit it only once with a "1" in the units box of the CMS-1500 claim form. Also, be sure to include the "to" and "from" dates during which the services occurred.

Enter the first prenatal visit in box 15 and only enter the last visit the patient was seen for prenatal care in box 25a. Many coders were receiving rejections due to file limit if they entered a duration of dates. The claim software was looking at the first date in box 25a and not the "from" date.

Option 3: If your physician provides seven or more antepartum visits, you should report 59426 (... *7 or more visits*), according to ACOG. As with 59425, you should report 59426 only once and place a "1" in the units box. You should also record the "to" and "from" dates for the services your ob-gyn provided.

To avoid reimbursement hassles, be sure to ask your carriers how they want multiple antepartum visits coded. Each carrier may have different requirements for reporting services — especially those services that vary from the usual — and physicians must know how to correctly report the services they provide to be in compliance, as well as receive appropriate reimbursement for the services provided.

Some payers may allow you to bill an E/M service instead of the antepartum visit package codes. And reporting individual visits allows you to get paid at the time of service rather than waiting until you complete the required number of visits and billing the corresponding code.

Tip 2: Patient Transfer May Mean Reporting the Global

When a patient transfers to your ob-gyn practice late in her pregnancy, your first task is to determine if she has received any antepartum care elsewhere, ACOG recommends. If she has received antepartum care from another physician, you will not be able to report the global ob code (59400, 59510, 59610 or 59618). Instead, you will have to report the antepartum care (59425-59426), delivery (59409-59410, 59514-59515, 59612-59614) and possibly postpartum care (59430) separately. If the ob-gyn performs the delivery and postpartum care, CPT® includes 59430 with the code for delivery with postpartum care.

The physician who provided the initial antepartum care will bill separately for his services. Consequently, if you bill the global in this case, you would be reporting some antepartum care that you did not perform.

On the other hand, if the patient did not receive any antepartum care before coming to your practice, you may be able to report the global code. The physician may perform all the global ob package components in a short time because CPT® doesn't require

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a minimum number of antepartum visits to report this service. But some carriers do require an established number — usually 12-15 — of antepartum visits before you can submit the global ob code(s). If your ob-gyn performs substantially fewer visits than the payer normally requires for the global package, you may report the global ob code appended with modifier 52 (*Reduced services*).

Experts contend that you should check with the carrier concerning their policy on global maternity when the patient changes insurance or transfers to your practice during her pregnancy. Some carriers can request that you send the claim when the patient delivers as a global fee and enter the first prenatal visit in box 15. They will then prorate the global depending on the duration of care with your ob-gyn. ❑

2013 AMA Symposium Update

Get the Scoop on Transition Codes, Medicare Rates

Caution: Missing primary care designation could wreck your Medicare pay.

2013 will bring more inclusive language in CPT® codes and new codes for transitional care.

So said speakers at the American Medical Association's (AMA) annual CPT® and RBRVS Symposium, held Nov. 14-16 in Chicago, with presenters sharing the latest news on fee schedules, new codes for 2013, and more.

Don't Fret Over Far-Reaching Terminology Change

The most widespread changes throughout CPT® 2013 — the switch to more inclusive or provider-neutral language — shouldn't be difficult for physician practices to put into place.

"The concepts are pretty straightforward," said **Richard Duszak, Jr., M.D.,** an AMA CPT® Editorial Panel member and practicing radiologist. "There's been an evolution in CPT® for how codes report services by non-physicians."

Result: Hundreds of codes were revised for 2013 to include "provider neutral language." Codes throughout the book have replaced designations of "physician" with "individual" or "qualified health care provider."

Exception: A few codes retained the "physician" language, such as those related to skilled nursing facility admissions, because regulations require that a physician admit the patient.

"CPT® is not the turf police," Duszak said. "We're focusing on the services provided and recognize that sometimes professionals other than physicians are qualified to provide some services. As a nationally recognized reporting system, it's important for CPT® to maintain provider neutrality."

Prepare Now for New Transitional Care Codes

CPT® 2013 introduces two new codes for transitional care management (TCM) services:

» 99495 — *Transitional care management services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; medical decision making of at least moderate complexity during the service period; face-to-face visit, within 14 calendar days of discharge*

» 99496 — *... medical decision making of high complexity during the service period; face-to-face visit, within 7 calendar days of discharge*.

(Continued on next page)

The codes are meant to represent situations when a physician oversees an established patient whose medical/psychosocial issues require moderate to high complexity medical decision making (MDM) during the shift from a healthcare facility setting back to the patient's community (home) setting. Another key to determining whether to report 99495 or 99496 hinges on timely follow-up — how many days pass between the patient's discharge and when the physician is able to see the patient.

Hold On for More Payment News

Medicare rates are scheduled to take a 26.5 percent hit in 2013 unless Congress takes action to avert the cut.

"The President's budget calls for an aversion of the cut and a permanent fix," Bryant told Symposium attendees. "They seem to be working on it, but we haven't heard yet where it's going." ❑

E/M Coding

Implement These 5 Simple Steps to Boost Your E/M Bottom Line

Heads up: Dig past 'follow-up' for acceptable chief complaint.

E/M coding might be part of your everyday routine, but that doesn't mean you have to fall into a coding rut. An education expert with Palmetto GBA, a Part B MAC in seven states, offers five simple ways to keep your claims clean and sailing through the reimbursement process.

Step 1: Change the Documentation Wording

Although you might think of "cloned documentation" as only existing when using electronic health records (EHRs), the truth is that even paper records can be considered "cloned," if they are all worded exactly alike. The answer? Help providers remember to document things differently, so they don't look like carbon copies.

"Whether the cloned documentation is handwritten, the result of a pre-printed template, or use electronic health records, cloning of documentation will be considered misrepresentation of the medical necessity requirement for coverage of services," says **Carrie Weiss**, senior provider education consultant with Palmetto.

Even if the physician sees seven patients with the flu on the same date of service, they won't all have the same history, symptoms, treatment recommendation, or prognosis, so copying documentation from one patient to the next is inappropriate. The notes should be tailored to each patient's individual case.

Step 2: Verify That Provider Signatures Are Legible

Practitioners who are signing documentation by hand should ensure that they include both their first and last names, and that the signature is legible. In addition, Weiss said, Palmetto recommends that practitioners include their credentials (such as MD, DO, PA, etc.) after their signature.

If a signature is illegible, auditors will use a signature log or attestation statement to determine who authored a medical record entry. If a signature is missing from an order for other services, the order will be disregarded as if it didn't exist.

Step 3: Grab the Billing Provider's Signature for Ancillary Services

If ancillary staff members perform a service and write documentation, the record must be signed by the practitioner who is billing for the service.

Example: "If an injection for B12 was provided in the office, whoever was covering for the incident-to or providing that supervision would need to sign that documentation," Weiss says.

Step 4: Choose Between 1995 and 1997 Guidelines for a Single Visit

Most coders are familiar with both sets of Medicare guidelines when selecting an E/M code, but what some practices don't know is that you can't choose from both sets of guidelines a la carte during the same patient encounter.

"You cannot interchange the two guidelines," Weiss warns. "So once you start out using a set of guidelines for an encounter, you must continue using that set of guidelines. That doesn't mean that at the next visit you can't use the other set of guidelines, but per encounter, you must stick to one."

Step 5: Avoid 'Follow-Up' as a Catch-All Complaint

All E/M documentation must include a chief complaint, but what your physician lists as the chief complaint may not fit your MAC's requirements.

"The chief complaint is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the E/M encounter," Weiss says. "It is typically stated in the patient's own words. An example would be a sore throat, or chest pain. Just stating 'follow-up' is not appropriate."

Find it: Although some coders were trained to only look for a chief complaint in one particular section of the documentation, that is inaccurate. "The chief complaint may be listed as a separate element of the history, or it may be included in the history of present illness (HPI) — and that's very important," Weiss said. ❑

ICD-10

Learn This "Late Effects" Change Sooner Rather Than Later

Here's how to sequence this diagnosis code.

When a patient develops a breast abscess three months after her delivery due to an inverted nipple that was problematic during her pregnancy, you'll have to assign a late effect code.

Currently, you would report 677 (*Late effect of complication of pregnancy, childbirth, and the puerperium*).

ICD-10-CM: When your diagnosis coding system changes, you will report O94 (*Sequelae of complication of pregnancy, childbirth, and the puerperium*). That's the letter "O" and not the number "0." According to the ICD-10 Guidelines, you should report O94 when an initial complication of a pregnancy develops a sequelae requiring care or treatment at a future date.

Heads up: You have a one-to-one correlation between 677 and O94. However, note how "late effect" is retermed as "Sequelae."

Documentation: Here is how you will find this code in the Alphabetic Index:

Sequelae (of) - see also condition

- childbirth O94

- obstetrical condition O94

- pregnancy O94

- puerperium O94

Coder Tips: You can use this code at any time after the initial postpartum period. Also, you should sequence this code, like all late effects code, **second** after the code describing the sequelae of the complication. ❑

Reader Questions

Fluoroscopy? Don't Bill for Ultrasound Guidance Too

Question:
My ob-gyn's notes state, "The patient's Nexplanon was unable to be palpated for removal. Ultrasound did not help in locating it, so I had to use fluoroscopy. After several attempts in the OR, it was able to be removed. Procedure took 2 hours, certainly more than a normal removal." Can we bill for the fluoroscopy? How do we code that?

Arkansas Subscriber

Answer:
Code 76000 (*Fluoroscopy [separate procedure], up to 1 hour physician time, other than 71023 or 71034 [e.g., cardiac fluoroscopy]*) is the fluoroscopy code to use — BUT the ob-gyn must have documented that there was a permanent image and also describe what he saw during the use of the fluoroscope.

Warning: You can't bill in addition for ultrasound guidance since that failed and you moved on to a more "extensive" method.

The only way you are going to qualify for a modifier 22 (*Increased procedural services*) on the removal code 11982 (*Removal, non-biodegradable drug delivery implant*) is if he documented more than time (see CPT® guideline for use of 22). If the time was only related to finding the device and not significant work in removing it, your request for additional reimbursement will probably get shot down (especially as you are already billing the 76000). ❑

(Reader Question continued on next page)

You Be the Coder

Straighten Out These Laboratory Issues

Question:
When we are billing for a colposcopy with biopsy, we are billing 56820 and 88305. For the tray, we are using A4550. We send the specimen for pathology out to be processed. Should append modifier 90 to that lab code?

California Subscriber

Answer: See page 6. ❑

Look Into This Laceration Repair Scenario

Question:
Patient has a normal spontaneous vaginal delivery (NSVD) with bilateral sulcus tear. My ob-gyn's documentation says it took about an hour to complete the repair, but I can't say that it was a third degree. Is there a code for a long repair? Or is that bundled into the global fee?

New York Subscriber

Answer:
The diagnosis code for this would be 665.41 (*High vaginal laceration with delivery*). In ICD-10, this code will become O71.4 (*Obstetric high vaginal laceration alone*).

You won't find any appropriate CPT® code for repair of a vaginal laceration (as opposed to a perineal laceration) since the vaginal canal is not "external genitalia" as referred to in the integumentary repair codes. Your option here is to add a modifier 22 (*Increased procedural service*) to the delivery code or report the repair as a multiple procedure using the unlisted code 59899 (*Unlisted procedure, maternity care and delivery*) and comparing the work to 57200 (*Colporrhaphy, suture of injury of vagina [nonobstetrical]*) (which you can't report since this is a non-ob code). ❑

Strike Modifier 24 From This Episiotomy Pain Visit

Question:
Patient is about 4 weeks postpartum and comes in complaining of pain at episiotomy site. Exam shows a very slight separation of episiotomy. The ob-gyn recommends sitz baths. Can we bill an office visit or is this considered global?

Florida Subscriber

Answer:
Most experts suggest you should consider this global, as this is not a significant complication. However, if your physician disagrees and wants you to code the visit, you can bill an E/M code (99201-99215, *Office or other outpatient visit …*). Link it to 674.24 (*Disruption of obstetrical perineal wound postpartum*) and see what happens. In ICD-10, this diagnosis will be O90.1 (*Disruption of perineal obstetric wound*).

You can't append modifier 24 (*Unrelated evaluation and management service by the same physician during a postoperative period*) to this E/M service, however, because the problem is 1) related to recovery from delivery, and 2) not a significant unexpected complication (CPT®'s clarification about when to use 24 for a related problem). ❑

Check Out These STD Tests

Question:
A patient came in for her annual routine exam. While she was in the exam room, she requested a STD screening as well. Doctor did annual exam with Pap and took cultures for the STD screening. What would be the best way to code this visit? The ob-gyn used V72.31 and V73.88. Is this correct?

Massachusetts Subscriber

Answer:
The STD tests the ob-gyn ordered determines the code. For gonorrhea and syphilis, the code is V74.5 (*Special screening examination for bacterial and spirochetal diseases; venereal disease*); for chlamydia the code is V73.88 (*Other specified chlamydial diseases*); for HPV, it is V73.81 (*Special screening examination, human papillomavirus [hpv]*); and hepatitis is V73.89 (*Other specified viral diseases*).

ICD-10: When your diagnosis system changes:

» Code V74.5 will become will become Z11.3 (*Encounter for screening for infections with a predominantly sexual mode of transmission*)

You Be the Coder

Straighten Out These Laboratory Issues

(Question on page 5)

Answer:
First of all, if your ob-gyn is performing a biopsy with the colposcope, the correct code is 56821 (*Colposcopy of the vulva; with biopsy[s]*), not 56820 (*Colposcopy of the vulva*). You should consider the taking of the biopsy as included in 56821. Therefore, you should not be billing 88305 (*Level IV - Surgical pathology, gross and microscopic examination*) — *unless* your physician is personally doing the biopsy interpretation.

You should include A4550 (*Surgical trays*) in all procedures that you do in your office as part of an increased site of service payment (assuming the payer is recognizing relative value units [RVUs] in making payments).

You should not use modifier 90 (*Reference [outside] laboratory*) unless you are billing on behalf of the laboratory for biopsy interpretation. But remember you must use the CLIA number of the lab for which you are billing, and most insurances will not allow you to mark up the cost beyond what the lab is charging you. ❑

- » Code V73.88 will become Z11.8 (*Encounter for screening of other infectious and parasitic diseases*).
- » Code V73.81 will become Z11.51 (*Encounter for screening for human papillomavirus [HPV]*).
- » Code V73.89 will become Z11.59 (*Encounter for screening for other viral diseases*).

Remember: Your ob-gyn is not doing the culture; he is ordering the tests. Therefore, you should supply the lab with the screening diagnoses for the tests ordered.

If you are billing on behalf of the lab, then you must add modifier 90 (*Reference [outside] laboratory*) to each lab code. Every lab procedure must be supported with a diagnosis for ordering it or performing it. So in this case, V72.31 (*Routine gynecological examination*) is linked only to the routine exam code, and the other screening diagnoses are each linked to their respective lab tests. ❑

Match Injection Code to the Amount

Question:
I need help coding an injection of testosterone. The patient received a 100mg injection. I know the codes for the injections are J1070 for 100mg and J1080 for 200mg. However, the problem we seem to be having is the dosage on the bottle is 200mg. How would I charge for a 100mg injection from a 200mg dosage bottle?

New Mexico Subscriber

Answer:
This drug comes in two different dosage bottles; 100mg/ml and 200mg/ml. If you give 0.5 ML from the 200mg vial, then you are giving 100mg of the drug. Therefore, you should bill code J1070 (*Injection, testosterone cypionate, up to 100mg*) for this. ❑

Make These Modifier 52, 53 IUD Distinctions

Question:
A patient came in for an intrauterine device (IUD) removal. The ob-gyn made multiple attempts to remove the IUD but to no avail. She is going to have to have it removed hysteroscopically. So my question is do I add modifier 53 to the 58301?

Virginia Subscriber

Answer:
No. Modifier 53 (*Discontinued procedure*) means there was a problem with the patient that stopped the procedure. You should use modifier 52 (*Reduced services*) since the ob-gyn did work to remove it. Append it to 58301 (*Removal of intrauterine device [IUD]*). ❑

A Suspected Problem Means You Should Report V28.82

Question:
We have an ob patient that is 21 weeks pregnant that had a transvaginal ultrasound (76817). The patient has a history of LEEPs. Do we need to use threatened code for cervical length? If so, what is the diagnosis code?

South Dakota Subscriber

Answer:
If you mean 649.7x (*Cervical shortening complicating pregnancy childbirth or the puerperium*), the answer would be no — unless she has a short cervix as a result of the scan. The ob-gyn suspects a problem, so you should go with V28.82 (*Encounter for screening for risk of pre-term labor*) because he is doing it to screen for pre-term labor (to see if she has a short cervix which is a risk factor for it).

ICD-10: When your diagnosis coding system changes, the 649.7x will become the O26.87- (*Cervical shortening*) series. Code V28.82 will become Z36 (*Encounter for antenatal screening of mother*). ❑

Headache Doesn't Always Point to 346.x

Question:
A co-worker says we can submit "headache" and "migraine" on the same claim, but I think that if the physician has established a migraine diagnosis, you can't code a headache. Who is correct?

Michigan Subscriber

Answer:
A migraine is a type of headache. Coding separately will depend on whether the provider uses the term "headache" as a sign/symptom of the migraine or if the patient has both a migraine and a separate, distinct headache.

ICD-9 guidelines direct us as to whether we report things separately: "Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification." Further instructions state, "Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present."

Tip: Remember that having a previous diagnosis of migraine doesn't mean you automatically report a migraine for future complaints. Every headache doesn't meet the migraine level, so a diagnosis such as tension headache (339.1x) or cluster headache (339.0x) could sometimes be more appropriate. ❑

— *The answers for* You Be the Coder *and* Reader Questions *provided by* ***Melanie Witt, RN, CPC, COBGC, MA,*** *an ob-gyn coding expert based in Guadalupita, N.M.*

Ob-Gyn CODING ALERT

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to *Ob-Gyn Coding Alert* to the Editor indicated below.

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