



Ob-Gyn Coding Alert

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

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3 FAQs Banish Your Coding Vaginal Cuff Repair Frustrations

Find out what colporrhaphy code you'll use for an injury repair.

If you're stuck trying to figure out what code to use for a vaginal cuff repair, you should ask yourself one main question: Why did the ob-gyn need to perform the repair?

The answer is the best way to decide what code (and possibly modifiers) to choose. Follow these three expert steps, and you'll find the solution to one of the most frequently asked questions in an ob-gyn office: "Which CPT® code should I use for repair of vaginal cuff?"

Q1: How Do I Decide What Repair Code to Use?

The first thing you should do when the ob-gyn performs a vaginal cuff repair is examine the operative report to determine why the patient required the repair, says **Cindy Foley**, billing manager for three separate gynecology practices in Syracuse, N.Y.

Rationale: "Your code might depend on whether the patient had an injury versus a surgical wound in that area," Foley explains. For example, was it due to loosening or disruption of sutures from a previous surgery, or was it a repair of an injury to the vagina?

Answering these questions will pinpoint the correct code to use. Follow the next two FAQ for code examples.

Q2: If Repair Dealt With Loose Sutures, What Should I Do?

You read your op notes and discovered the vaginal cuff repair dealt with loose sutures. Suppose the patient, who underwent a total abdominal hysterectomy (58150, *Total abdominal hysterectomy [corpus and cervix], with or without removal of tube[s], with or without removal of ovary[s]*), needs to return to the operating room for a vaginal cuff repair because the original sutures became loose and a simple re-closure is documented.

In this case, you should report 58999 (*Unlisted procedure, female genital system [nonobstetrical]*). You would also need to submit your op report along with a cover letter that explains in simple, straightforward language exactly what your ob-gyn did, says **Melanie Witt, RN, COBGC, MA**, an ob-gyn coding expert based in Guadalupita, N.M.

Remember to explicitly reference the nearest equivalent listed procedure in your explanatory note. For example, you might consider comparing the work to 12020 (*Treatment of superficial wound dehiscence; simple closure*), which has 4.74 RVUs.

Alternatively, if your physician has documented the repair's size, use 12011-12018 (*Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes ...*), which range in RVUs from 2.70 to 8.41, as a comparison.

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Be sure to append modifier 78 (*Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period*) if the surgeon performs the repair during the previous surgery's global period. Your diagnosis code for this repair will be 998.32 (*Disruption of external operation [surgical] wound*), Witt says. Note that while you may also find a code for the disruption of an internal surgical wound (998.31), this code would be incorrect to report since the disruption is taking place outside of the peritoneal cavity.

ICD-10: When your diagnosis coding system changes in 2013, 998.32 will become T81.31XA (*Disruption of external operation [surgical] wound, not elsewhere classified, initial encounter*). The ICD-10 code for 998.31 would be T81.32XA (*Disruption of internal operation (surgical) wound, not elsewhere classified, initial encounter*).

Q3: What Code Should I Report For a Repair Due to Injury?

On the other hand, if the surgeon performs the repair because of an injury, you would use 57200 (*Colporrhaphy, suture of injury of vagina [nonobstetrical]*).

Let's say a patient slips and catches herself in the shower a week after a total abdominal hysterectomy (58150) and ruptures the sutures at the vaginal cuff and part of the vaginal wall. The ob-gyn returns her to the operating room to repair the cuff and vaginal wall laceration.

In this case, you would report 57200-78. You can report this code because now your diagnosis code (878.6, *Open wound of vagina, without mention of complication*) matches the CPT® code's description.

ICD-10: When your diagnosis system changes in 2013, 878.6 will become S31.40XA (*Unspecified open wound of vagina and vulva, initial encounter*). □

Coding Quiz Part 2

Find Out When to Bill Visits Inside or Outside Global Ob Package

Tip: Global code means ob-gyn did the delivery and provided all antepartum care.

Last month, you took a four-part situational challenge asking, should this visit be inside or outside the global ob package? Look at four more scenarios, and see how you fare.

Monitoring the Pregnancy is Key

Situation 5: A new patient transfers into your practice and comes to see your ob-gyn for the first time. She is pregnant and has received care elsewhere. Is this visit inside or outside the global ob package?

Answer 5: You should count this visit as **inside** the global ob care.

Rule of thumb: The patient is presenting for obstetric care, and the global code choices for this situation all include an initial new patient visit. You can report an unmodified

ICD-10

646.83 Explodes Into a Litany of Pregnancy Complication Options

Tip: The majority of your new options specify trimester.

No longer should you look to 646.83 (*Other specified complications of pregnancy; antepartum condition or complication*) as a catch-all code to use when a patient comes in with a symptom complicating her pregnancy.

When October 1, 2013 rolls around, you'll have a variety of more specific options from which to choose:

- » O26.11 (*Low weight gain in pregnancy, first trimester*)
- » O26.12 (... *second trimester*)
- » O26.13 (... *third trimester*)
- » O26.41 (*Herpes gestationis, first trimester*)
- » O26.42 (... *second trimester*)
- » O26.43 (... *third trimester*)
- » O26.811 (*Pregnancy related exhaustion and fatigue, first trimester*)
- » O26.812 (... *second trimester*)
- » O26.813 (... *third trimester*)

- » O26.891 (*Other specified pregnancy related conditions, first trimester*)
- » O26.892 (... *second trimester*)
- » O26.893 (... *third trimester*)

Documentation tips: Notice how these conditions range from low weight to herpes to exhaustion and fatigue. Check your physician's notes for the specific complication and trimester (which is usually already stated).

Coding tips: Don't be confused by O99.89 (*Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium*). This code is one of 648.93 (*Other current conditions classifiable elsewhere of mother antepartum*)'s equivalents. You would use this code (ICD-10: O99.89, ICD-9: 648.93) for conditions she has developed while pregnancy or had before her pregnancy that don't have a specific code. The codes listed above pertain to conditions related to pregnancy. In other words, she would not have them were she not pregnant. □

global code only if your ob-gyn also does the delivery and provides all of the antepartum care. When the patient transfers into your practice from elsewhere, you can either bill the global package code with modifier 52 (*Reduced services*) if your payer allows, or your payer may ask you to itemize by billing antepartum care (59425 or 59426) and delivery with postpartum care separately (59410, 59515, 59614 or 59622).

Situation 6: A patient presents for the first time with complaints of spotting and a missed period. Is this visit inside or outside the global ob package?

Answer 6: You should count this visit as **outside** the global ob package. Again, the ob-gyn is not monitoring the patient's pregnancy during this visit.

Because you do not know if she is pregnant, you may submit 626.8 (*Other disorders of menstruation and other abnormal bleeding from female genital tract*) for the missed period, but you have no clear diagnosis code for the spotting other than 626.8 — unless your ob-gyn confirms the patient's pregnancy during this visit. In that case, the diagnosis code changes to 649.53 (*Spotting complicating pregnancy; antepartum condition or complication*). Another option might be threatened abortion (640.03) if your physician's documentation denotes evidence of cervical dilation or contractions.

ICD-10: When your diagnosis coding system changes in 2013, code 626.8 will expand to two options: N92.5 (*Other specified*

irregular menstruation) or N93.8 (*Other specified abnormal uterine and vaginal bleeding*). But keep in mind that this may not be your only option. If you check the ICD-10 Index, you will note that looking up the term, "menstruation, suppression," you are directed to code N94.89 (*Other specified conditions associated with female genital organs and menstrual cycle*). In other words, always check the ICD-10 Index before deciding which code best describes the situation.

Code 649.53 will expand into three options, based on trimester: O26.851 (*Spotting complicating pregnancy, first trimester*), O26.852 (... *second trimester*), or O26.853 (... *third trimester*).

Code 640.03 will become O20.0 (*Threatened abortion*).

Watch Out For Complications

Situation 7: A pregnant patient presents for her second ob visit complaining of spotting and abdominal pain. Is this visit inside or outside the global ob package?

Answer 7: You should report this visit as **outside** the global ob package, but the payer may deny it as inclusive.

Under CPT® guidelines you should code any complaints a pregnant patient has, such as malaise, general fatigue, spotting,

(Continued on next page)

nausea, vomiting and pelvic pain. These could be complications of the pregnancy.

Think of it this way: The global ob package is for uncomplicated pregnancy with delivery and uncomplicated postpartum care. You should bill any complications that require extra care separately. However, if the payer disagrees and will not consider payment until the patient has delivered, you will have filed the claim within a possible timely filing period that will permit you to appeal the decision after delivery. Remember, many payers consider the antepartum period to consist of 13 visit, and the reason for the visit after the physician initiates ob care does not affect their decision to include them (unless totally unrelated to the pregnancy).

The diagnosis for the spotting will be 649.53. For the abdominal pain, you should report 646.83 (*Other specified complications of pregnancy; antepartum condition or complication*) and 789.0x (*Abdominal pain*) if your ob-gyn does not confirm a threatened abortion.

Situation 8: A pregnant patient presents for her third ob visit for lactation or nutritional counseling. Is this visit inside or outside the global ob package?

Answer 8: You should count this visit as **inside** the global ob package (59400-59622). *Rationale:* This isn't a complication of her pregnancy. You should consider this type of counseling as part of routine ob care. ☐

E/M Coding

Stop Forfeiting Level Four and Five E/Ms With 3 PFSH Tips

Make your physician's job easier by letting the patient or nurse document the history.

If your ob-gyn glosses over a patient's past, family, and social history (PFSH), you may be missing out on up to \$69 per E/M.

Accurately counting the number of PFSH items could result in more money for an encounter, because the top-level E/M codes require PFSH elements in addition to an extended history of present illness, and more than 1 system reviewed. Learn these three quick tips to ensure your physician is capturing, and you're recognizing, every history component the patient mentions.

Determine the Level of PFSH

For coding purposes, the history portion of an E/M service requires all three elements — history of present illness (HPI), review of systems (ROS), and a past, family and social history (PFSH).

Therefore, the PFSH helps determine patient history level, which has a great effect on the E/M level you can report. If you do not know the PFSH level, you may have to select a lower level of E/M service than might otherwise be warranted.

There are three levels of PFSH: none, pertinent, and complete, says **Leah Gross, CPC**, coding lead at Metro Urology in St. Paul, Minn.

Pertinent: To reach a detailed level of history for the encounter (in addition to an extended HPI and the review of 2-9 systems), you need a pertinent PFSH. According to Medicare's Documentation Guidelines for E/M Services, you need at least one specific item from any of the three PFSH areas to achieve the pertinent level. When the physician asks only about one history area related to the main problem, this is a pertinent PFSH.

Complete: To reach a comprehensive level of history for the encounter (in addition to an extended HPI and the review of 10 or more systems), you need a complete PFSH which includes, per Medicare's Documentation Guidelines, at least one specific item from two of the three areas for the following categories of E/M services:

- » Established patient office/outpatient services
- » Emergency department services
- » Established patient domiciliary care
- » Established patient home care.

For all other E/M services, a complete PFSH includes at least one specific item from each of the three areas.

Pointer: You need only one element of PFSH to receive some credit for the history component of the encounter. Best bet: "Document it all. You never know what may be pertinent to the patient's current situation!" Gross advises.

Choose a Code Based on PFSH Element Requirement

Once you determine the level of PFSH your physician's documentation contains, you can see which codes that history element supports.

Beware: If your physician does not document any PFSH elements, you can only reach a problem focused or an extended problem-focused level of history, warns **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPCH, CPC-P, CPC-I, CHCC**, president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. That means the highest codes you'll be able to report are a level-two

new patient code (99202) or a level-three established patient code (99213). Reporting 99202 pays \$71.01 (the national unadjusted rate based on the Medicare Physician Fee Schedule assignment of 2.09 RVUs times the 2011 conversion factor of 33.9764) and 99213 pays \$68.97 (2.03 RVUs).

A pertinent PFSH can support a detailed history level. With detailed history you can report a level-three new patient code (99203) and a level-four established patient code (99214). You'll earn \$102.95 for 99203 (3.03 RVUs) and \$102.27 (3.01 RVUs) for 99214.

To get to level-four and five new patient visits and level-five established patient visits, you need to have a comprehensive level of history, Cobuzzi says. To do that, you must find a complete PFSH in your physician's documentation. If you can achieve 99204 or 99205, you'll earn \$158.33 (4.66 RVUs) and \$197.06 (5.8 RVUs), respectively. You can expect \$137.60 (4.05 RVUs) for 99215 — nearly \$69 more than if you're forced to report 99213 because you didn't have enough PFSH to match other supporting history elements.

Note: Since established patient office visits require two of three key components, a higher level service is still possible based on the service's examination and medical decision making (MDM) types. "For an established patient, you may decide to leave history off and count only the exam and MDM and then just have the low history," Cobuzzi says. "So, if you have a weak history, you might still reach the higher level E/M."

Count Unchanged PFSH in Current Encounter

Based on E/M guidelines, if a patient's PFSH has not changed since a prior visit your physician doesn't have to document the information again. He does, however, need to document that he reviewed the previous information to be sure it's up to date and also note in the present encounter's documentation the date and location of the initial earlier acquisition of the PFSH. Some payers will give no PFSH credit if you overlook one of these criterion.

In writing: Both the 1995 and 1997 E/M documentation guidelines include the following: A ROS and/or a PFSH

obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:

- » describing any new ROS and/or PFSH information or noting there has been no change in the information; and
- » noting the date and location of the earlier ROS and/or PFSH.

For example: Your physician may note, "PFSH: Same as documented in my note of January 7, 2011." If there's been a change, he should record it, such as: "PFSH: Same as documented in my note of January 7, 2011, except the patient no longer drinks alcohol."

Good news: As with the review of systems (ROS), Medicare states that either the patient or nurse can fill out a history form for PFSH. "The patient usually will get a questionnaire to fill out with these questions, and often the nurse or assistant will expand on the answers." Gross says. "However, the physician must document that he or she reviewed these answers to receive credit." As long as the physician signs the form or nurse's notes and documents that he reviewed them, you can meet the requirements for PFSH with that information. □

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You Be the Coder

Confront Early Glucose Testing Diagnoses

Question:

At the initial ob visit, my ob-gyn does a hemoglobin A1C on all of our patients. If the test results come back elevated, what diagnosis code should I use for the early glucose testing?

California Subscriber

Answer: See page 47. □

Reader Questions

“Extended Visit” Does Not Always Mean 99215

Question:

Can I use 99215 for an extended office visit?

Kansas Subscriber

Answer:

You would report 99215 (*Office or other outpatient visit for the evaluation and management of an established patient ...*) when your ob-gyn documentation supports high complexity of medical decision making (along with a comprehensive history and/or exam). You can also report 99215 when, due to the presenting problem, extensive counseling and/or coordination of care dominates the visit. Your ob-gyn has to document this with details and the need for it.

An “extended” office visit does not mean anything without details about the context of why it is extended and that those circumstances follow E/M documentation guidelines. □

Count Excision As Part of 58150 Under These Circumstances

Question:

My ob-gyn performed a total abdominal hysterectomy (TAH) with excision of retroperitoneal mass and excision of bladder mass, lysis of adhesions, and cystotomy repair. Should I count the excision of the retroperitoneal and bladder masses as bundled with TAH?

Montana Subscriber

Answer:

No, you should not count them as bundled with the TAH (58150, *Total abdominal hysterectomy [corpus and cervix], with or without removal of tube[s], with or without removal of ovary[s]*) — unless your ob-gyn documents these circumstances:

- » these masses were somehow attached to the uterus or part of the connections that the ob-gyn removed along with the uterus, or
- » it was part of radical debulking for cancer (for which you would use a different code than 58150).

If not part of debulking, you should be looking at 49203-49205 (*Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors ...*). □

Make the LEEP Conization, Biopsy Distinction

Question:

My ob-gyn performed a LEEP of cervix as an outpatient procedure. Should I code this as 57522, or should I request the notes to see if the ob-gyn did something more extensive?

Washington Subscriber

Answer:

You need to look at your ob-gyn’s notes. A LEEP of the cervix can be a LEEP biopsy or a LEEP conization.

You should have documentation showing that the ob-gyn removed all of the exocervix, all of the transformation zone, and all or part of the endocervix to call it a conization. For a LEEP conization, you should report 57522 (*Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision*). The procedure includes an ECC and D&C if performed so nothing more would be billed.

Code 57500 (*Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration [separate procedure]*) is simply a biopsy of the cervix by any method. You would report this code if the physician performed a LEEP biopsy without colposcopy. □

Don’t Count Out Consults Entirely

Question:

If our ob-gyn only reviews patient records but doesn’t actually examine the non-Medicare patient, can we bill a consult?

Oregon Subscriber

Answer:

A consult is not a consult unless you meet the requirements. These requirements include:

- » written request from a physician or other appropriate source
- » medically necessary reason for the consultation
- » face-to-face history, exam and medical decision-making rendered by the ob-gyn for the patient’s problem
- » written report sent to the requesting physician with recommendations regarding the patient’s care.

If your ob-gyn does not see the patient, you have no face-to-face encounter to bill and therefore cannot report a consultation or any E/M service.

If the ob-gyn sees the patient and simply does not perform an examination but the visit qualifies otherwise as a consultation, the physician would have to document face-to-face counseling and/or coordination-of-care activities that dominated the visit to be able to meet the criteria for reporting these codes in the absence of all three key components of history, exam and medical decision-making. Your ob-gyn’s documentation would then need to specifically outline the counseling’s content. He should also clearly document the total time with the patient and the percent of time he spent counseling (which must be more than 50 percent of the entire visit to report an E/M service based on time).

Pick your level: After that, the ob-gyn should pick the code level based on the typical time included for each E/M code. You may not go to a higher code level until the physician equals or exceeds the total time for that code, according to CPT®. □

No Void Leaves a Void in Your Urodynamics Coding

Question:

If a patient cannot urinate at the end of the biofeedback, can we charge 51741, 51728, or 51797? I know we cannot charge if the patient cannot void during the study, but what if you have performed the testing, and the patient then can't void?

New York Subscriber

Answer:

If you are doing urodynamic studies and the patient cannot void either during or after the study, you cannot bill the following codes:

- » 51741 — *Complex uroflowmetry (eg, calibrated electronic equipment)*
- » 51728 — *Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique*
- » 51729 — *... with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique*
- » +51797 — *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure).*

Remember, the purpose of these tests is to measure the patient's response to voiding situations; if she cannot void, the test cannot be performed. □

Here's How to Handle Pregnant Patient Insurance Changes

Question:

One of my ob-gyn's patients changed her insurance during her pregnancy. I was told to split antepartum care and bill appropriate number of visits to each insurance, but what if this patient had four visits with Anthem and 10 antepartum visits, delivery, and postpartum with Aetna? Should I just bill global to Aetna?

Texas Subscriber

Answer:

Most payers will let you know if they expect you to bill globally, even if she had a previous insurance during her pregnancy. But they don't want to pay more than they were responsible for. So you could bill 59425 (*Antepartum care only; 4-6 visits*) to Anthem and then 59400-52 (*Routine obstetric care including antepartum care, vaginal delivery [with or without episiotomy, and/or forceps] and postpartum*

care; Reduced services) to Aetna, and let them know the circumstance. Aetna would then decide whether to pay you their full allowable or reduce it. □

— *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.*

You Be the Coder

Confront Early Glucose Testing Diagnoses

(Question on page 45)

Answer:

First of all, you are doing a screening test, and per ICD-9 guidelines, your primary diagnosis is screening:

- » V28.89 (*Other specified antenatal screening*) because this test is part of your antenatal screening tests
- » V77.1 (*Screening for diabetes mellitus*) because your ob-gyn is testing for DM

ICD-10: When your diagnosis system changes in 2013, V28.89 will become Z36 (*Encounter for antenatal screening of mother*) and V77.1 will become Z13.1 (*Encounter for screening for diabetes mellitus*).

If the results come back elevated (which you won't know until a few days after the patient underwent the actual test), you code the result.

For instance, if the A1C is less than 6.5% and a fasting glucose is between 96-126, you can then call this gestational diabetes (which may be the case if the patient's previous pregnancy involved gestational diabetes). On the other hand, the ob-gyn might simply consider her high risk for developing diabetes. In that case, you would assign a V23 code (*Supervision of high risk pregnancy*) with 790.29 (*Other abnormal glucose*).

ICD-10: When your diagnosis system changes in 2013, V23 will become the O09 (*Supervision of high risk pregnancy*) category, and 790.29 will become R73.09 (*Other abnormal glucose*).

But if the test results specify elevations greater than 6.5%, the ob-gyn would say she has overt diabetes. For this condition, you would assign code 648.03 (*Antepartum diabetes mellitus*).

ICD-10: Code 648.03 will expand into three options, based on trimester: O24.911 (*Unspecified diabetes mellitus in pregnancy, first trimester*), O24.912 (*... second trimester*), and O24.913 (*... third trimester*).

Bottom line: You will need to work with your provider on this issue. □

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* and reimbursement to the Editor indicated below.

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