Gambling with High Risk Pregnancy Coding

Presented by:
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I am currently the Revenue Integrity Auditor for Oklahoma Sports and Orthopedic Institute in Norman, Oklahoma. I am a member of the Oklahoma City AAPC local chapter and have served as chapter officer for the Pro-Tulsa chapter.

I was previously employed by AAPC, a member of the ICD-10 Training and Education team, and formerly Director of Audit Services. With more than 30 years of experience in the healthcare industry I have seen many changes. I started as a medical assistant, then expanded to billing and coding, and progressed to clinic manager in a teaching facility. My experience extends to specialties including OB-Gyn, Maternal Fetal Medicine, General Practice, General Surgery, Neurology, and currently Orthopedics.
Obstetrics

• CPT and AMA do not specifically address the issue of high-risk pregnancy

• CPT defines global care of any uncomplicated pregnancy
Challenges

• Complicated patients

• Patients require more time, more clinical resources

• Requires communication about additional charges
Obstetrical Global Package

- CPT describes all services that are provided to a full-term non-complicated case; including the antepartum care, delivery, and routine postpartum care.

- Carriers may not follow CPT or ACOG guidelines
What is included in OB package?

Prenatal visits
- Exams, UA, BP, FHT, Wt
- 13-15 average

Delivery
- Vaginal
- Cesarean

Post-partum care
- Inpatient
- Outpatient
Antepartum Care

- Initial and/or subsequent history and physical exams
- Blood pressure, weight, fetal heart tones, routine urine dips

- Monthly visits up to 28 weeks (5-6)
- Bi-weekly visits from 28–36 weeks (5)
- Weekly visits from 36 weeks to delivery (4)

Average of 13-15 prenatal visits
## Delivery

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>59400</td>
<td>TOB vaginal</td>
<td>60.28</td>
</tr>
<tr>
<td>59510</td>
<td>TOB cesarean</td>
<td>66.91</td>
</tr>
<tr>
<td>59610</td>
<td>TOB VBAC</td>
<td>63.45</td>
</tr>
<tr>
<td>59618</td>
<td>TOB cesarean after VBAC</td>
<td>67.81</td>
</tr>
</tbody>
</table>
Twin delivery

Routine OB with vaginal delivery of both
• 59400
• 59409-51

Routine OB care with cesarean delivery of both
• 59510-22

Routine OB care with vaginal delivery of one, cesarean of one
• 59510
• 59409-51
High-risk Indications

- Presence of medical conditions in the mother
- Presence of risk factors or potential risk
- Abnormality of the fetus
- Hospitalizations that occur outside admission for delivery
- Need for consultation or intervention by physicians with additional training

Every problem/issue does NOT make the pregnancy high risk.
Concurrent Care /Co-Management

• General OB seeing the patient for regular visits, documented on the prenatal flow sheet; documentation should indicate who is co-managing the patient and for what condition

• Specialist sees the patient periodically for monitoring, ultrasound, lab, etc. separately documented services

• Services are outside global package
Consults - E/M visits

Consult

• Must meet requirements (request from provider, render your opinion, report your findings)

• Can establish course of treatment

E/M visits

• New

• Established

• Coding Tips:

  • Can be billed by time (> 50% counseling)

  • Counseling, education, answering questions, etc. are a billable service

  • Modifier not required if done with US
Ultrasounds

- Do not include pre and post op elements
- Do not include discussion of results with patient
- Multiple scans do not require Modifier 51
- Documentation requirements - ACOG, SMFM, AIUM
Ultrasounds

76801, +76802

• Trans-abdominal approach
• Less than 14 weeks gestation
• Determine number of sacs
• Survey fetal structures, amniotic fluid, maternal structures including adnexa and uterus

76813, +76814

• First trimester screening
• Focus on the fetal neck
• Non-invasive means of looking for chromosomal abnormalities/heart defects
• Calculate fetal length / depth of tissue
• Blood testing at the same session
Ultrasounds

**76805, +76810**

- Greater than or equal to 14 weeks gestation
- Number of fetuses and amniotic/chorionic sacs
- Survey of intracranial/spinal/abdominal anatomy, 4 chambered heart, umbilical cord insertion site, placental location, and amniotic fluid assessment, examination maternal adnexa; if visible

**76811, +76812**

- 76805 plus
- Detailed fetal anatomy including Brain/ventricles, face, heart/ outflow tracts, chest anatomy, abdominal organs, limbs (number, length, structure), umbilical cord and placenta evaluation, other fetal anatomy as indicated
Nuchal Translucency
Fetal brain
Twin
Umbilical vein
Spine
Placenta
Stomach
Nuchal Translucency
## Ultrasounds

<table>
<thead>
<tr>
<th>76815</th>
<th>76816</th>
</tr>
</thead>
</table>
| • Represents a “quick look”  
• Evaluates one or more elements: position, size, activity, placental location, AFI  
• **Reported only once per exam**  
• Not used with other US codes | • Limited follow-up  
• Re-evaluate or reassess a confirmed or suspected abnormality on initial ultrasound  
• Use code once for each fetus examined with Modifier 59 for the additional fetus |
Ultrasounds

76817

- Transvaginal ultrasound of a pregnant uterus
- Evaluation of fetus and placenta
- Evaluation of maternal adnexa and uterus
- Evaluation of characteristics of cervix; including length and structure
- Can be billed with US performed by abdominal approach
Biophysical Profile

Physiologic test

- Measures well-being of the fetus
  - fetal breathing movements
  - fetal movements
  - fetal tone
  - quantification of amniotic fluid volume

- Maternal HTN, Diabetes, Coagulations defects, multiple gestations

- Fetal – Small/Large for dates, congenital abnormalities, multiple gestations
Amniocentesis

59000
• Diagnostic
• Genetic
• FLM (fetal lung maturity)

• Add 76946 US guidance
Therapeutic Amniocentesis

59001

- Amnio reduction
- Polyhydramnios
- Indications: HTN, maternal DM, fetal anomalies like cleft palate, hydrocephalus, pyloric stenosis, multiples

59070

- Amnio Infusion
- Allows for visualization of fetal anatomy
- Oligohydramnios
- Indications: HTN, fetal anomalies (fetal urinary obstruction or absence of kidneys), poor placental function, leakage of fluid, multiples

Ultrasound guidance is included in these procedures
Therapeutic Amniocentesis

• 59074
  • Fetal fluid drainage
  • Bladder tap, pleural effusion

• 59076
  • Fetal shunt placement
  • Fetal urethral blockage, pleural effusions

Ultrasound guidance is included in these procedures
Fetal Invasive Procedures

59012
- Percutaneous umbilical blood sampling
- Report also 76941 for guidance
- Cordocentesis is a diagnostic procedure

36460
- Fetal blood transfusion
- Report also 76941 for guidance
- Causes: Rh incompatibility, Parvo virus in mother affecting fetus
Coding Tips

• Transvaginal US can be billed with transabdominal US

• Professional component can be billed for services at the hospital

• Use Modifier 59 for BPP on multiple gestations

• Use Modifier 59 for NST on multiple gestations

(US with add-on code is do not require Modifier 51, 59)
ICD-10-CM Coding

• Chapter 15 codes take priority over codes from other chapters

• It is the physicians responsibility to state that the condition being reported is **NOT** complicating the pregnancy.

• Codes from other chapters can be used in conjunction to specify a condition

• Read ALL of the ICD-10-CM instructional notes, Excludes1 and Excludes2
High Risk Supervision

- Category O09 first listed
- Other Chapter 15 codes secondary
Trimesters

- Trimester identified as follows:
  - 1\textsuperscript{st} Trimester - less than 14 weeks, 0 days
  - 2\textsuperscript{nd} Trimester – 14 weeks 0 days to less than 28 weeks 0 days
  - 3\textsuperscript{rd} Trimester – 28 weeks, 0 days to delivery

- Trimester will not be a component in conditions that occur in specific trimesters.

- Patient admitted for a complication with an extended stay that crosses trimesters, report the trimester in which the complication developed.
# 7th Character Fetal Extension

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>0</td>
<td><strong>Unspecified, singleton</strong></td>
</tr>
<tr>
<td>1</td>
<td>Fetus 1</td>
</tr>
<tr>
<td>2</td>
<td>Fetus 2</td>
</tr>
<tr>
<td>3</td>
<td>Fetus 3</td>
</tr>
<tr>
<td>4</td>
<td>Fetus 4</td>
</tr>
<tr>
<td>5</td>
<td>Fetus 5</td>
</tr>
<tr>
<td>9</td>
<td>Other fetus</td>
</tr>
</tbody>
</table>

For use with Category O31, O33.3 – O33.7, O35, O36, O40, O41, O60.1 – O60.2, O64, and O69
<table>
<thead>
<tr>
<th>Z3A.00</th>
<th>Weeks of gestation not specified</th>
<th>Z3A.36</th>
<th>36 weeks gestation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z3A.01</td>
<td>Less than 8 weeks gestation</td>
<td>Z3A.37</td>
<td>37 weeks gestation</td>
</tr>
<tr>
<td>Z3A.08</td>
<td>8 weeks gestation</td>
<td>Z3A.38</td>
<td>38 weeks gestation</td>
</tr>
<tr>
<td>Z3A.09</td>
<td>9 weeks gestation</td>
<td>Z3A.39</td>
<td>39 weeks gestation</td>
</tr>
<tr>
<td>Z3A.10</td>
<td>10 weeks gestation</td>
<td>Z3A.40</td>
<td>40 weeks gestation</td>
</tr>
<tr>
<td>Z3A.11</td>
<td>11 weeks gestation</td>
<td>Z3A.41</td>
<td>41 weeks gestation</td>
</tr>
<tr>
<td>Z3A.12</td>
<td>12 weeks gestation</td>
<td>Z3A.42</td>
<td>42 weeks gestation</td>
</tr>
<tr>
<td>Z3A.13</td>
<td>13 weeks gestation</td>
<td>Z3A.49</td>
<td>&gt; Than 42 weeks gestation</td>
</tr>
</tbody>
</table>
Primary Diagnosis for Delivery

• Complication is first listed

• If complication during antepartum period resolves, the delivery is reported as uncomplicated

• Indications: malposition, cord issues, delayed delivery, fetal complication, maternal condition
Delivery Diagnosis

Example: Patient delivers a full-term, single, liveborn male at 39.5 weeks
HIV in pregnancy

- **O98.7** HIV related conditions
- Follow Chapter 2 guidelines
- Medication management
- Viral load used to determine delivery method
- Monitoring to determine fetal exposure
- Testing of newborn mandated in some states
Diabetes in pregnancy

- O24 Type I, Type 2, gestational
- Follow Chapter 4 guidelines
- Potential for maternal kidney disease, fetal cardiac problems, increased fetal size, more prone to pre-eclampsia, eclampsia
- Frequent lab work
- Monitoring during pregnancy for uncontrolled sugars, insulin adjustments
- Frequent fetal monitoring to watch for fetal size, fetal well-being and congenital abnormalities
Hypertension in pregnancy

- May result in additional prenatal visits to monitor maternal BP
- May require
  - anti-hypertensive's or a change in medications
  - antenatal testing to verify well-being of the fetus (NST,BPP,fetal echo)
- Monitoring for decreased fetal movement, oligohydramnios, pre-eclampsia
- Elevated BP in mother puts additional stress on placenta
Pre-eclampsia

- Albuminuria and unresponsive edema between 20 weeks gestation and first week post partum
- Excess weight gain of 2+ pounds in one week
- Excessive swelling of hands, feet, and face
- BP of greater than 140/90
- Albuminuria and elevated creatinine on 24 hour urine
- Timing of delivery is critical
• **Eclampsia** – Similar to pre-eclampsia/toxemia but can be accompanied by convulsions, coma, and edema

• **HELLP** – severe pre-eclampsia with severe hypertension, elevated liver function tests, low platelet count.

The treatment is delivery.
### Hypertensive Disorder

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>O10</td>
<td>Pre-existing HTN</td>
</tr>
<tr>
<td>O11</td>
<td>Pre-existing HTN with pre-eclampsia</td>
</tr>
<tr>
<td>O12</td>
<td>Gestational edema, proteinuria, edema with proteinuria</td>
</tr>
<tr>
<td>O13</td>
<td>Gestational HTN w/o significant proteinuria</td>
</tr>
<tr>
<td>O14</td>
<td>Pre-eclampsia</td>
</tr>
<tr>
<td></td>
<td>• O14.0 Mild to moderate</td>
</tr>
<tr>
<td></td>
<td>• O14.1 Severe</td>
</tr>
<tr>
<td></td>
<td>• O14.2 HELLP</td>
</tr>
<tr>
<td>O15</td>
<td>Eclampsia</td>
</tr>
</tbody>
</table>
Maternal Conditions Related to Pregnancy

- Hemorrhage
- Hyperemesis
- Venous complications
- Infections
- Recurrent loss
- Weight disorders
- Herpes
- Cervical shortening
- Liver disorders
Other Maternal Conditions

099

• Anemia
• Alcohol use
• Drug use
Coagulation Defects

O99.1

• Abnormal coagulation in mother with risk to both fetus and mother

• Risks of fetal growth restriction, fetal death, spina bifida, genetic risks, complications for mother include miscarriage, hemorrhage, DVT, other vascular episodes, post partum hemorrhage

• Requires antenatal testing and close monitoring

• May require daily aspirin or heparin therapy

• Use additional code to identify specific defect
Obesity in Pregnancy

O99.21

• Risk for cesarean, GDM, HTN, PET,

• Fetal complications, shoulder dystocia, childhood obesity

• Use additional code for type of diabetes
Alcohol Use in Pregnancy

O99.31

• Risks for premature birth, birth defects and fetal alcohol spectrum disorders.

• Alcohol passes through placenta, can affect brain and other vital fetal organs

• Use additional code
Tobacco Use in Pregnancy

O99.33

• At greater risk for miscarriage, preterm birth, low-birth weight babies, placental abruption

• Fetus at risk for SIDS, upper respiratory and ear infections

• Use additional code for nicotine dependence
Epilepsy in Pregnancy

O99.35

- Conditions classifiable to G00-G99
- Use additional code to identify specific type of epilepsy G40
- Drugs are major factor
- Increased risk for fetal problems
Multiple Gestations

- Very time consuming pregnancies
- Require multiple ultrasounds, fetal monitoring
- Possible bed rest for mother after specified gestational age
- Usually require additional prenatal visits, but often deliver early in gestation
- Remember the outcome code (Z37)
- Malposition is first listed (O36)
# Twins

<table>
<thead>
<tr>
<th>Di-Di</th>
<th>Mono-Di</th>
<th>Mono-Mono</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2 placentae&lt;br&gt;• 2 sacs</td>
<td>• Shared placenta&lt;br&gt;• 2 sacs&lt;br&gt;• Anomalies, abnormal growth, TTT possible</td>
<td>• Single placentae&lt;br&gt;• Single sac&lt;br&gt;• Risk of cord entanglement&lt;br&gt;• IP 24 weeks, early delivery</td>
</tr>
</tbody>
</table>
Monochorionic placentas imply monozygotic (identical) twins. Dichorionic placentation may occur with either monozygotic or dizygotic twins.
**Twin-to-Twin Transfusion**

**O43.02-**
One twin “guzzles” the nutrients

- Donor twin
  - Exhibits anemia
  - Decreased growth
  - Oligohydramnios

- Recipient twin
  - Increased growth
  - Cardiac hypertrophy
  - Polyhydramnios
  - Polycythemia

- Demise of one threatens the survivor
- Risk of cerebral palsy, mental retardation, premature labor
- Personal or family history of congenital cardiac defects requires close monitoring, especially if defects appear in other offspring
- Codes based on trimester, number of placentae and amniotic sacs
Patient is a 31 yrs. old G5 P4004 female with intra-uterine pregnancy of 15.4 duration here for consultation regarding pregnancy complications of monochorionic diamniotic twin gestation.

Discussed with patient, fetal growth is appropriate and no new anatomic abnormalities noted for either twin at this early gestational age. The membrane is thin and can only be seen on endovaginal scan today. The fluid for twin 1 is low, but the fluid for twin 2 is normal thus far. Urine is not seen in the bladder for twin 1 by the sonographer nor myself today. Umbilical artery Doppler resistance indices are normal for gestational age for both twins. MCA PSV normal for gestational age and not suspicious for fetal anemia either twin. Her cervical length is reassuring.
Example

Triplet IUP at 29.2 weeks
Previous cesarean section
Morbid Obesity
Pre-eclampsia without severe features
Non-reassuring fetal heart tracing of triplet C
Transverse lie of presenting triplet A
Transverse back up triplet C
Triplets, all liveborn
Weeks of gestation

Procedure: Stat repeat low segment transverse cesarean delivery

Findings: Live newborn in transverse back down presentation (A), Apgars, birth weight and sex not available at time of this dictation. Live newborn cephalic presentation for triplet B; again, Apgars and birth weight, sex not available at time of this dictation, and triplet C was transverse back up presentation, birth weight, sex and Apgars not available at time of this dictation. Normal appearing uterus, tubes and ovaries. Placenta to pathology.
Example

Triplet IUP at 29.2 weeks O30.103
Previous cesarean section O34.211
Morbid Obesity O99.214
Pre-eclampsia without severe features O14.04
Non-reassuring fetal heart tracing of triplet C O76
Transverse lie of presenting triplet A O32.2XX1
Transverse back up triplet C O32.2XX3
Triplets, all liveborn Z37.51
Weeks of gestation Z3A.29

Procedure: Stat repeat low segment transverse cesarean delivery

Findings: Live newborn in transverse back down presentation (A), Apgars, birth weight and sex not available at time of this dictation. Live newborn cephalic presentation for triplet B; again, Apgars and birth weight, sex not available at time of this dictation, and triplet C was transverse back up presentation, birth weight, sex and Apgars not available at time of this dictation. Normal appearing uterus, tubes and ovaries. Placenta to pathology.
Cord Conditions Complicating Delivery

O69

- Prolapse
- Cord around neck
  - With compression
  - Without compression
- Short cord
- Vasa previa
- Vascular lesion
Maternal Care for Fetal Abnormality or Damage

O35

• Description is “known or suspected”

• Use an additional code for associated maternal condition

• Indications: chromosome, central nervous, alcohol, drugs, IUD

• Requires 7\textsuperscript{th} character

•
Other Fetal Problems

O36

• Confirmed conditions

• Require 7th character

• Require prenatal monitoring for fetal well-being

• Maternal condition: isoimmunization (rH, Anti-A, Anti-B) hydrops

• Fetal condition: Large for dates, small for dates, DFM, fetal anemia
Capturing all the Charges

- Unscheduled visits
- Non-stress tests
- Ultrasounds
- Biophysical profile
- Fetal echocardiography
- Doppler velocimetry
- Cervical length

- Amniocentesis
- Paracentesis
- Amniotic fluid reduction
- Hospital admission for prenatal condition, trauma, condition not directly associated with the pregnancy
Charges Outside Global

- These charges should be billed as they occur.
- The patient needs to be aware of the possibility these are not covered and they are responsible.
- Define global, high-risk, medical necessity.
Questions ???