Obstetrics and Gynecology

Presented by:
Peggy Stilley, CPC, CPC-I, CPMA, CPB, COBGC

Objectives

• Procedures
• Pregnancy
• Payments
• Patient Relationships
Female Genital Anatomy

Terminology and Abbreviations

- Endometriosis
- Neoplasm
- BUS
- TAH/BSO
- G₃P₂
Procedures

- Hysterectomy
- Prolapse repairs
- IUDs
- Colposcopy

Hysterectomy

- Approach
  - Open
  - Vaginal
  - Total Laparoscopic
  - Laparoscopic assisted

- Extent
  - Total
  - Subtotal
  - Supracervical

- Diagnosis
CPT Codes

- **Abdominal**
  - 58150 – 58240
  - With or without removal tubes/ovaries
  - Some additional services

- **Vaginal**
  - 58260-58270
  - Size of uterus < 250 grams, > 250 grams
  - 58275-58294
  - Additional services

- **LAVH**
  - 58541-58544
  - Detach uterus, cervix, and structures through the scope
  - Uterus removed thru the vagina

- **TLH**
  - 58548-58554
  - Detach structures laparoscopically entire uterus, cervix, bodies
  - Removed thru the vagina or abdomen

- **LSH**
  - 58570 – 58573
  - Detaching structures through the scope, leaving the cervix
  - Morcellating – removing abdominally
  - 58541 – 58544
Hysterectomy

Additional procedures performed

- Tubes & Ovaries removed
- Enterocele repair
- Repairs for incontinence
  - Marshall-Marchetti-Krantz
  - Colporrhaphy
  - Colpo-urethropexy
  - Urethral Sling
    - TVT, TOT
Procedures

- 57288 Sling
- 57240 Anterior Repair
- 57250 Posterior Repair
  - +57267 Add on code for mesh/graft
- 57260 Combo of A&P
- 57425 Laparoscopic Colpopexy
- 57280 Colpopexy, Abdominal approach
- 57282 Colpopexy, vaginal approach

Example 1

PREOPERATIVE DIAGNOSES:
1. Menorrhagia unresponsive to medical treatment with resulting chronic blood loss anemia

POSTOPERATIVE DIAGNOSES:
1. Menorrhagia
2. Blood loss anemia

TITLE OF SURGERY:
Total abdominal hysterectomy

ANESTHESIA: GENERAL ENDOTRACHEAL ANESTHESIA.

INDICATIONS: The patient is a lovely 52-year-old female who presented with menorrhagia that is non-responsive to medical treatment. Also has chronic blood loss anemia. She was taken to the operating room for definitive surgery.

DESCRIPTION OF PROCEDURE: The patient was placed under general anesthesia in the dorsal lithotomy position. Examination revealed a large, boggy uterus. The vagina was prepped and a Foley catheter inserted. The patient was placed in the supine position and her abdomen was prepped and draped.
A low midline incision was made from the symphysis to the umbilicus and was carried down to the anterior and posterior sheaths until the peritoneal cavity was entered. Exploration of the upper abdomen revealed two normal kidneys and a smooth right lobe of the liver from the lateral margin to the ligamentum teres. Both diaphragmatic surfaces were smooth. The large and small bowel were grossly normal. Retroperitoneally, there were no enlarged or suspicious periaortic nodes from the level of the renal vessels to the bifurcation of the iliaca.

Within the pelvis, there seemed to be an enlarged uterus with a normal right and left ovaries and fallopian tubes. The surgical plan was to perform hysterectomy and retain bilateral ovaries and fallopian tubes. We then went to the lateral pelvic side walls and were eventually able to find the round ligaments; these were identified and singly clamped and ligated with 0-Vicryl. We then developed a plane of the pubovesical cervical fascia, thereby freeing the bladder from the underlying cervix and vagina. We were able to doubly clamp the uterine arteries. We then continued with single clamping of the cardinals, and then opened up the rectovaginal septum so we could cross-clamp the uterosacral ligaments. In this manner, we were eventually able to complete hysterectomy. Angled sutures were placed in the vagina with 0-Vicryl and reinforced. The cuff itself was then closed with continuous running 0-Vicryl suture. There were a number of bleeders in the pelvis which we then controlled with clips and hot cautery. The pelvis was then copiously irrigated. When hemostasis was seen to be excellent. generous portions of Gelfoam were placed over all raw peritoneal surface areas.

Following correct lap pad, sponge, instrument, and needle counts, attention was turned to closure of the abdomen. Then 0-Prolene was used to place a row of interrupted horizontal mattress sutures through the anterior sheath. The anterior sheath itself was closed with two continuous running #1 PDS sutures starting inferiorly and superiorly and meeting in the lower 1/3 of the incision. The Prolene sutures were then tied. The subcutaneous tissue was then copiously irrigated with Ringer's, and the subcutaneous tissue approximated with interrupted 2-0 Monocryl sutures. The skin edges were approximated with 4-0 Monocryl subcuticular suture reinforced with 1/2" Steri-Strips and benzoin.

Estimated blood loss was 700 cc. Fluid replaced was 3400 cc crystalloid. Drains included a Foley catheter draining blue urine, and a cul-de-sac J-Vac. There were no complications The patient was sent to the recovery room in satisfactory condition.

CPT and ICD-10-CM
Example 1

CPT Code(s):

ICD-10-CM Code(s):
Example 2

PREOPERATIVE DIAGNOSES:
1. LEFT OVARIAN MASS.
2. ELEVATED CA-125 LEVEL.

POSTOPERATIVE DIAGNOSES:
1. BILATERAL OVARIAN ENDOMETRIOMAS.
2. PELVIC ENDOMETRIOSIS.
3. MYOMATA UTERI.

TITLE OF SURGERY:
1. EXAMINATION UNDER ANESTHESIA.
2. EXPLORATORY LAPAROTOMY.
3. LYSIS OF ADHESIONS.
4. EXTRA-FASCIAL HYSTERECTOMY.
5. BILATERAL SALPINGO-OOPHORECTOMY.

ANESTHESIA: GENERAL ENDOTRACHEAL ANESTHESIA.

INDICATIONS: The patient is a lovely 57-year-old female who presented with bilateral ovarian masses and an elevated CA-125 level. She was taken to the operating room for definitive surgery.

DESCRIPTION OF PROCEDURE: The patient was placed under general anesthesia in the dorsal lithotomy position. Examination revealed a large left 15-cm ovarian mass which appeared fixed, and fullness in the right adnexa. Fortunately, neither nodularity nor thickness was appreciated. The vagina was prepped and a Foley catheter inserted. The patient was placed in the supine position and her abdomen was prepped and draped.

A right paramedian incision was made from the symphysis to the umbilicus and was carried down to the anterior and posterior sheaths until the peritoneum was reached. Peritoneal washings were then taken. Exploration of the upper abdomen revealed two normal kidneys and a smooth right lobe of the liver from the lateral margin to the ligamentum teres. Both diaphragmatic surfaces were smooth. The large and small bowel were grossly normal.

Retroperitoneally, there were no enlarged or suspicious paraaortic nodes from the level of the renal vessels to the bifurcation of the iliacs. Within the pelvis, there seemed to be an enlarged uterus with a right ovarian endometrioma about 5 cm in diameter. The uterus, the surgical plan was to perform hysterectomy and bilateral salpingo-oophorectomy. Therefore, we began the surgery by freeing up the anterior attachments of the large left adnexal mass to the sigmoid colon.

We then went to the lateral pelvic side walls and were eventually able to find the round ligaments; these were identified and singly clamped and ligated with o-Vicryl. We then developed a plane of the pubovesical cervical fascia, thereby freeing the bladder from the underlying cervix and vagina. Indigo carmine was given intravenously and was eventually seen to exit in the Foley catheter with no intraperitoneal or retroperitoneal spillage.

Dissection of the large left ovarian mass, allowed us to find the infundibulopelvic pedicle from the left mass, and to doubly clamp and ligate this with o-Vicryl. We continued to free up the large left pelvic mass and came to the uterine arteries on both sides. We were able to doubly clamp the uterine arteries. We then continued with single clamping of the cardinals, and then opened up the rectovaginal septum so we could cross-clamp the uterosacral ligaments. In this manner, we were eventually able to completely perform extramural hysterectomy, and the uterus, large left adnexal mass, right ovarian endometrioma, and tubes were removed as a single specimen. The endometrioma was then opened. As expected, it was completely filled with dark chocolate fluid.

Angled sutures were placed in the vagina with o-Vicryl and reinforced. The cuff itself was then closed with continuous running o-Vicryl suture. There were a number of bleeders in the pelvis which we then controlled with clips and hot cautery. On account of the patient's weight, the difficulty of the surgery, and the persistent small bleeds, it was elected to placed a 19-mm J-Vac drain deep in the cul-de-sac and to bring this out through the right lower quadrant. The pelvis was then copiously irrigated. When hemostasis was seen to be excellent. Generous portions of Gelfoam were placed over all raw peritoneal surface areas.

Following correct lap pad, sponge, instrument, and needle counts, attention was turned to closure of the abdomen. Then o-Prolene was used to place a row of interrupted horizontal mattress sutures through the anterior sheath. The anterior sheath itself was closed with two continuous running #1 PDS sutures starting inferiorly and superiorly and meeting in the lower 1/3 of the incision. The Prolene sutures were then tied. The subcutaneous tissue was then copiously irrigated with Ringer's, and the subcutaneous tissue approximated with interrupted 2-0 Monocryl sutures. The skin edges were approximated with 4-0 Monocryl subcuticular suture reinforced with 1/2" Steri-Strips and benzoin.

Estimated blood loss was 600 cc. Fluid replaced was 3400 cc crystalloid. Drains included a Foley catheter draining blue urine, and a cul-de-sac J-Vac. There were no complications. The patient was sent to the recovery room in satisfactory condition.
CPT and ICD-10-CM
Example 2

CPT Code(s):

ICD-10-CM Code(s):

Prolapse Example

PREOPERATIVE DIAGNOSIS: Vaginal vault prolapse with enterocele

POSTOPERATIVE DIAGNOSIS: Vaginal vault prolapse with enterocele.

PROCEDURES:
1. Abdominal sacrocolpopexy and cystoscopy.
2. Lysis of adhesions.

ANESTHESIA: General.

ESTIMATED BLOOD LOSS: 100 mL.

SPECIMENS TO PATHOLOGY: None.

COMPLICATIONS: None.

DRAINS: Urethral catheter.

INDICATIONS: The patient is a 75-year-old with recurrent pelvic organ prolapse, who desires surgical repair. She would like to maintain sexual activity, and therefore, we opted for abdominal sacrocolpopexy rather than colpocleisis given that previous vaginal surgeries were not successful. She had a TVT placed previously, and therefore, no urethropexy was entertained.

FINDINGS: Examination under anesthesia revealed complete vaginal vault prolapse with the vaginal apex 7 cm beyond the hymenal ring. There were dense intraabdominal adhesions between the bowel, epiploica, and the pelvis, and this necessitated approximately 30 extra minutes to lyse adhesions which was done both with cautery and with suture ties. Cystoscopy at the end of the case revealed quick efflux of indigo carmine-stained urine from each ureteral orifice. No lesions in the bladder and no sutures in the bladder.
DESCRIPTION OF PROCEDURE: The patient was taken to the operating room, given intravenous antibiotics, and sequential compression devices were placed on her legs. She was placed under general anesthesia without incident. She was placed in Allen stirrups, and her legs were carefully padded. She was prepped and draped in the usual fashion. She had a previous transverse abdominoplasty incision as well as a second small suprapubic incision. We elected to go through part of the abdominoplasty incision to avoid potential necrosis of the wound by placing another incision below that. Therefore, we did a Pfannenstiel incision which was approximately 8 cm in length. The tissue was quite scarred, but otherwise, the abdomen was entered without incident. At this point, there were dense adhesions between the epiploica of the sigmoid, the omentum, the bladder, and the pelvis. These were taken down with a combination of cautery and suture ties. Once the adhesions were lysed, we then packed the bowel and placed the self-retaining retractor using the short blades and with care to avoid excessive pressure. The sigmoid was retracted to the left, and the ureter on the right was identified. The peritoneum overlying the promontory was opened until the anterior longitudinal ligament was reached. The bladder was dissected off of the anterior vagina for approximately 5 cm. Six sutures of Gore-Tex were placed through the anterior vagina, and these were then placed through a cut strip of Mersilene mesh. The posterior peritoneum was opened to the level of the rectal reflection. Five sutures of Gore-Tex were placed through the outer vagina, and these were then placed through a second cut strip of Mersilene mesh. The anterior mesh was then attached to the posterior mesh at the sites incorporating a stitch through the vagina at the sides to prevent egress of small bowel down to sidewalls. Using differential tension and with care to avoid excessive tension on the anterior mesh, the previously placed sutures through the anterior longitudinal ligament were then placed through the mesh, and these were then tied such that the mesh was directly approximated to the sacrum. The peritoneum overlying the posterior vaginal mesh was then closed using 3-0 Vicryl. Cystourethroscopy was done and showed quick efflux of indigo carmine-stained urine from each ureteral orifice and no sutures in the bladder. The Foley catheter was replaced. The sponges removed. The sponge count was correct. The fascia was closed using a running suture of 0 PDS. Three sutures were placed through the subcutaneous tissue to decrease tension. The skin was then closed with staples. The patient tolerated the procedure well and was taken to the recovery room in stable condition.

CPT and ICD-10-CM

CPT Code(s):

ICD-10-CM Code(s):
IUD

- 58300 IUD Insertion
- J7297 Liletta® (52 mg)
- J7298 Mirena ® (52 mg)
- J7300 ParaGuard
- J7301 Skyla® (13.5 mg)

Always verify coverage:
- Prior authorization
- RX plan
- Co-pay/Out of pocket

Colposcopy

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Colposcopy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>56820</td>
<td>Colposcopy of vulva</td>
</tr>
<tr>
<td>57421</td>
<td>with biopsy(s)</td>
</tr>
<tr>
<td>57420</td>
<td>Colposcopy of entire vagina, with cervix, if present</td>
</tr>
<tr>
<td>57421</td>
<td>with biopsy(s) of vagina/cervix</td>
</tr>
<tr>
<td>57452</td>
<td>Colposcopy of the cervix including upper/adjacent vagina;</td>
</tr>
<tr>
<td>57454</td>
<td>with biopsy(s) of the cervix and endocervical curettage</td>
</tr>
<tr>
<td>57455</td>
<td>with biopsy of the cervix</td>
</tr>
<tr>
<td>57456</td>
<td>with endocervical curettage</td>
</tr>
<tr>
<td>57460</td>
<td>with loop electrode biopsy(s) of the cervix</td>
</tr>
<tr>
<td>57461</td>
<td>with loop electrode conization of the cervix</td>
</tr>
</tbody>
</table>

10 GLOBAL DAYS

Colposcopy Example

Description of Procedure: Colposcopy with biopsy, ECC

Indication for Procedure: Atypical squamous cell changes undetermined sign favor dysplasia

Consent obtained, procedure and risks explained in detail. All questions were answered about the procedure. Patient was given ibuprofen peroperatively.

A bivalve speculum was placed in the vagina. Under colposcopic exam the transformation zone was seen in its entirety. The endocervix was curetted with a Kevorkian curette. Performed punch biopsy at 7 o'clock and 10 o'clock. Specimen was sent to pathology. Monsel's solution was applied.

Impression: Low grade dysplasia

Patient tolerated the procedure and left the clinic in good condition. We will call with pathology results. Discharge instructions provided.

CPT Code(s):

ICD-10-CM code(s):
Pregnancy

• Global care
• Interrupted pregnancy
• Prenatal services

Obstetrical Global Package

• CPT describes all services that are provided in a *non-complicated* case; including the ante-partum care, delivery, and post-partum care.
• Carriers do not always follow CPT or ACOG guidelines – it is vital for you to check with your provider representatives to verify what services are covered and included.
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 (4)
- Weekly visits from 36 weeks to delivery (4)

Global Package Codes

- **59400**
  - Routine OB
  - Vaginal delivery
  - RVU 60.31

- **59510**
  - Routine OB
  - Cesarean delivery
  - RVU 66.97

- **59610**
  - Routine OB
  - Vaginal delivery after previous cesarean
  - RVU 63.50

- **59618**
  - Routine OB
  - Cesarean delivery after attempted vaginal; previous cesarean
  - RVU 67.87
Interruption of Pregnancy

- CPT codes are dependent on several variables
  - Gestational age
  - How completed
  - Reason for procedure
- Missed AB
  - No bleeding, no expulsion
  - Generally discover lack of growth or heart tones
- Spontaneous AB
  - Miscarriage
  - Cramping, bleeding, expulsion of tissue

Abortion Coding

- Defined as the premature expulsion or extraction of products of conception.
- Three types
  - Spontaneous (miscarriage)
  - Therapeutic
  - Voluntary
- Further defined by
  - Complete
  - Incomplete
Abortion Coding

• Surgical treatment:
  • 59812 Incomplete spontaneous abortion
  • 59820 Missed abortion, First trimester
  • 59821 Missed abortion, Second trimester

If a physician inserts prostaglandin to augment an incomplete abortion after the membranes have spontaneously ruptured, code 59200 may be reported.

Induced Abortions

Defined by type of treatment:
• 59840 Dilation and curettage
• 59841 Dilation and evacuation
• 59850 Intra-amniotic injection
• 59851 With dilation and curettage and/or evacuation
• 59852 With hysterotomy (failed intra-amniotic injection).
• 59855 Vaginal suppositories
• 59856 With dilation and curettage and/or evacuation
• 59857 With hysterotomy
Vacutage

In vacutage, doctor gently vacuums cavity of the uterus to remove products of conception, either in an incomplete miscarriage or for an early abortion.

Pregnancy with Abortive Outcomes

<table>
<thead>
<tr>
<th>Missed Abortion</th>
<th>Intrauterine Fetal Death</th>
<th>Hydatidiform Mole</th>
<th>Blighted ovum and nonhydatidiform mole</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 20 weeks gestation</td>
<td>&gt; 20 weeks gestation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>O02.1 Z3A.- week of gestation</td>
<td>O36.4 Z3A.- week gestation</td>
<td>O01.0 classical O01.1 Incomplete O01.9 Unspecified Z3A.- week gestation</td>
<td>O02.0 blighted ovum Z3A.- week gestation</td>
</tr>
<tr>
<td>Requires a 7th character fetal extension</td>
<td>Use additional code from O08 to identify any associated complication</td>
<td>Use additional code from O08 to identify any associated complication</td>
<td></td>
</tr>
</tbody>
</table>
Example

Pre-op Dx: 10 week Missed AB
Procedure: Suction D&C

Patient has an anteverted 10-week-sized uterus with no adnexal masses. Weighted speculum is placed in the posterior aspect of the vagina and the cervix was visualized and grasped with single-toothed tenaculum. Cervix was sequentially dilated with Hanks dilators and 10 mm suction curette was introduced into the endometrial cavity and a general suction curettage was then performed retrieving what appeared to be products of conception. The uterine cavity was smooth and normal in contour. Polyp forceps were then introduced without further retrieval of tissue. All vaginal instruments were then removed with sponge, needle, and instrument count correct. The patient tolerated the procedure well, was awakened, and taken to recovery room in stable condition. POC were sent for pathologic evaluation.

CPT Code:

ICD-10-CM Code:

Split OB Care

• When less than Global care is provided
  • Patient that miscarries
  • Patient that delivers elsewhere
  • Patient that changed insurance
  • Patient transferring into the practice

• Capture prenatal care provided
• Capture delivery, post partum care
Examples

• Patient presents to the practice at 18 weeks gestation, having moved from New Mexico where she had prenatal care. 5 visits – cesarean delivery with post-partum care

• Patient has had care from 7 weeks thru 22 weeks and is moving out of state, documented 7 prenatal visits

• Patient has PNC with Dr. A for 14 visits. Dr. Z delivers the patient via vaginal delivery at 39 weeks. She will return to Dr. A for PP care. Dr. A and Dr. Z are in the same practice.

ICD-10-CM
Supervision of Pregnancy

- Codes are based on
  - First or Subsequent pregnancy
  - Trimester

<table>
<thead>
<tr>
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<th>Description</th>
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<tbody>
<tr>
<td>Z34.00</td>
<td>Encounter for supervision of normal first pregnancy, unspecified trimester</td>
</tr>
<tr>
<td>Z34.01</td>
<td>Encounter for supervision of normal first pregnancy, first trimester</td>
</tr>
<tr>
<td>Z34.02</td>
<td>Encounter for supervision of normal first pregnancy, second trimester</td>
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<tr>
<td>Z34.03</td>
<td>Encounter for supervision of normal first pregnancy, third trimester</td>
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<tr>
<td>Z34.80</td>
<td>Encounter for supervision other pregnancy, unspecified trimester</td>
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<tr>
<td>Z34.81</td>
<td>Encounter for supervision other pregnancy, first trimester</td>
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<tr>
<td>Z34.82</td>
<td>Encounter for supervision other pregnancy, second trimester</td>
</tr>
<tr>
<td>Z34.83</td>
<td>Encounter for supervision other pregnancy, third trimester</td>
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</tbody>
</table>

ICD-10-CM Coding for Pregnancy

- O00-O9A
- Codes from chapter 15 take sequencing priority over all other chapters and are only reported on the maternal chart
- Concepts for code selection
  - Trimesters
  - Weeks of Gestation (Z3A)
  - Use of 7th character to identify the fetus affected by a condition
Trimesters

- Trimester identified as follows:
  - 1st Trimester - less than 14 weeks, 0 days
  - 2nd Trimester – 14 weeks 0 days to less than 28 weeks 0 days
  - 3rd 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.

Weeks of Gestation

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>Z3A.00</td>
<td>Weeks of gestation not specified</td>
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<td>Z3A.01</td>
<td>Less than 8 weeks gestation</td>
<td>Z3A.36</td>
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<td>Z3A.08</td>
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<td>Z3A.09</td>
<td>9 weeks gestation</td>
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<td>Z3A.42</td>
<td>42 weeks gestation</td>
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<tr>
<td></td>
<td></td>
<td>Z3A.49</td>
<td>&gt; Than 42 weeks gestation</td>
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</table>

This category is used for ANY 0 code Ooo-O9A.
7th Character Fetal Extension

<table>
<thead>
<tr>
<th>Character</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>Unspecified, singleton</td>
</tr>
<tr>
<td>1</td>
<td>Fetus 1</td>
</tr>
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<td>Fetus 2</td>
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<td>4</td>
<td>Fetus 4</td>
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<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

Preop Diagnosis:
1. IUP at 41 weeks 6 days
2. Previous cesarean
3. Mal presentation
4. Agreed to repeat cesarean

Post op Diagnosis:
1. Occiput posterior
2. Thick meconium

Procedure:
Repeat low transverse cesarean
Lysis of intraperitoneal adhesions
31 year-old, gravida 2, para 1-0-0-1 at 41 weeks-6 days. She did not want elective repeat, she wanted trial of labor and VBAS. She was admitted and subjected to Pitocin, but failed to progress past 1 cm and baby’s heartbeat was baseline and after extensive counseling patient agreed to repeat cesarean.

A low transverse incisions was made and extensive adhesions were found on the anterior surface of the uterus to the anterior abdominal wall. Adhesions were dissected and when the uterine peritoneum was reached it was separated from the uterus and pushed down. The fetal head was found to be in direct occiput posterior presentation. Fetal head delivered, baby was suctioned, there was a lot of thick particulate meconium in the uterine cavity. Umbilical cord was clamped and baby was handed off to RN. Placenta removed manually from the uterine cavity. (assume complete for sake of space) Baby with Apgar of 9-9 at 1 and 5, weighing 7-13.

Preop Diagnosis:
1. IUP at 41 weeks 6 days
2. Previous cesarean
3. Mal presentation
4. Agreed to repeat cesarean

Post op Diagnosis:
1. Occiput posterior
2. Thick meconium

Procedure:
Repeat low transverse cesarean
Lysis of intraperitoneal adhesions
31 year-old, gravida 2, para 1-0-0-1 at 41 weeks-6 day that I have seen since 7 weeks gestation. She did not want elective repeat, she wanted trial of labor and VBAC. She was admitted and subjected to Pitocin, but failed to progress past 1 cm and baby’s heartbeat was baseline and after extensive counseling patient agreed to repeat cesarean.

A low transverse incisions was made and extensive adhesions were found on the anterior surface of the uterus to the anterior abdominal wall. Adhesions were dissected and when the uterine peritoneum was reached it was separated from the uterus and pushed down. The fetal head was found to be in direct occiput posterior presentation. Fetal head delivered, baby was suctioned, there was a lot of thick particulate meconium in the uterine cavity. Umbilical cord was clamped and baby was handed off to RN. Placenta removed manually from the uterine cavity. (assume complete for sake of space) Baby with Apgar of 9-9 at 1 and 5, weighing 7-13.

Answer

59618  TOB with cesarean after trial of labor, after previous VBAC

O32.8XXo  Maternal care for malpresentation of fetus, unspecified
O77.0  Labor and delivery, complicated by meconium in amniotic fluid
O34.21  Maternal care for scar from previous cesarean delivery
O99.89  Other specified diseases and conditions complicating pregnancy, childbirth, and the puerperium
N73.6  Female pelvic peritoneal adhesions (postinfective)
O66.41  Failed attempted vaginal birth after previous cesarean
O48.0  Post-term pregnancy
Z37.0  Single live birth
Z3A.41  41 weeks gestation of pregnancy
Business Office

Payments

• Co-pays, Deductible
• Contracts
Patient Relationships

- Appointments
- Time Management
- Expectations
  - Collections
  - HIPAA

Staffing

- Interviewing Process
- Policies, Procedures
- Training & Expectations
Difficult people come in every conceivable variety.

- Some talk constantly and never listen
- Others must always have the last word
- Some cannot tolerate change
- Others criticize anything that they did not create or do not understand
- Difficult coworkers compete for power, privilege and the boss’s positive approval – to your detriment

Food for Thought

It really is better to hire no one than to hire the wrong one!!!

More damage is done by discontent & gossip than a sharp blade!
Remember:

Those who talk to you about others will also talk about you to others."
Training

- Billing Software
- EMR, Chart Organization
- Office Flow
- Credentialing, Contracts
- Physician, Provider Preferences
- Office policies

Policies and Procedures

- Policy
  - Tells the employee what you want to accomplish (Expectations)
    - Attendance policy
    - Dress code
    - Overtime

- Procedures (Step-by-Step)
  - Tells the employee how to accomplish the policy
    - Who to call and when
    - Scrubs, Standard uniform
    - Who approves, What are the guidelines
Hospital Charges

- Date stamp on the day received
- They should be processed within 5-7 days of being received. (The exception would be if waiting on Medical Records)
- All demographics should be entered into Misys accurately.
- Coding should be documented on the ticket (ICD-10, CPT, modifiers, charges)
- All information is to be added to an Excel sheet for CBO to post.
- This should be sent to CBO no more than 7 days from the date received.
- Include all op notes, tubal consents, hsyt consents required to file a claim.
- Complete the batch header form supplied by CBO
- Make copies of all documents and send to CBO in locked bag.
- Scan entire batch to email folder, save until verification of posting.
- Use the Desktop of the surgery scheduler as the master for monitoring billed procedures. After the procedure is posted, mark the referral completed and remove from the desktop.

Surgery Scheduling

- Surgery requests will be sent to Referrals Desktops from EMR
- Surgery is coordinated with hospital, resident, attending.
- Any difficulty or scheduling problem should be discussed with the medical director.
- Verify insurance eligibility and benefits, need for pre-cert or authorization.
- Calculate patient financial responsibility and counsel patient, make payment arrangements
- Document prepays or arrangements in Tiger and on the appointment schedule, if applicable.
- Notification should be sent to the ordering provider about date and time of surgery.
- Surgery is put on the resident surgery calendar, attending calendar, and letters are sent to the patient.
- Use your personal desktop as the master for monitoring billed procedures. After a surgery is scheduled, send a flag as a reminder until the billing sheet is received and sent to CBO.
Office Charges

- All office charges are to be verified for accuracy and completeness before being sent for posting
- If the patient applied for discounted care, attach copy of paperwork
- All charge tickets should document payments, receipt #, check number
- Charges should be sent daily with receipt copies, batch header form, and any adjustments to be posted
- When the charge ticket is completed and being sent to CBO, mark the referral that is “in process” in EMR as “complete”
- Scan all documents before sending to CBO
- All documents are sent to CBO in a locked bag

Check-Out

- Charge tickets will be returned by the patient to the check out area.
- Check out staff is responsible to verify presence of procedure code, diagnosis code, signature of resident and faculty.
- Responsible for collecting any applicable co-pay, deductible, Ob or surgery pre-pay.
- Issue a receipt giving one copy to the patient and retaining one for CBO.
- Make return appointments according to information on the charge ticket.
- Issue an appointment card to the patient with accurate date and time.
- Responsible to insure that small bills are available to make change and verify cash box amount is accurate each day.
- Balance receipt copies with money, checks and credit cards at the end of the day.
- Complete portion of batch header form each day for the deposit.
- Assists in accounting for all tickets by matching to appointment schedule.
Practice Manual

- Job descriptions
- Physician names, Practice name
- Appointment Schedules
- Credentialing information
- List of pagers, Contact numbers
- Vendors, Purchasing information
- Step-by-step of each employees duties

Example Protocol

- **DRUG:** Depo-Provera
- **CLASS:** Hormone (Contraceptive)
- **USUAL DOSAGE:** 150 mg, or 1 ml
- **ROUTE:** IM, (intramuscularly) in the hip or buttock
- **RECONSTITUTION:** None. Must be rolled in palms or gently shaken or 2 minutes
- **STORAGE:** Depo-Provera is stored in the locked cabinet.
- **DISCARD:** Label medication after drawing up per injection protocol. Discard the syringe immediately after giving the injection

**SPECIAL PRECAUTIONS:**
- The patient must be on their period or within 7 days after their period started to receive their first injection.
- Regardless of whether the patient is on their period, a pregnancy test must be performed prior to giving the first injection.
- This negative pregnancy test must be documented in the chart.
- The patient must understand that they should make an appointment in 12 weeks to receive their next injection.
- There is a 7 day window before and after the 12 weeks, but ideally, the patient should return to the clinic at 12 weeks. If it is greater than 7 days before or after the injection is due, you must check with the chief resident to see if the injection can be given.
QUESTIONS

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