Can you report ultrasounds separately from the global package? Here’s the official word from both the AMA and the American Congress of Obstetricians and Gynecologists (ACOG).

**Highlight This Antepartum Care Inclusion Reference**

Although many insurance providers include ultrasounds (76801-76802 or 76805-76810) as a standard part of the ob global package (for example, 59400, *Routine obstetric care including antepartum care, vaginal delivery [with or with episiotomy, and/or forceps] and postpartum care*), CPT® maintains otherwise. "Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery," CPT® states. "Any other visits or services within this time period should be coded separately."

In addition, the AMA states that the ob global package does not include diagnostic ultrasound.

**Get it Right with Your Payer’s Policy**

The American Congress of Obstetricians and Gynecologists (ACOG) also upholds this advice. Some payers, however, include one or more ultrasounds in the global care.

So the best bet is to check your payer’s policy. It may or may not follow ACOG and the AMA’s advice.

**Get Up to Snuff with Swine Flu Diagnosis, Admin Codes**

Pregnant women are among those at the highest risk of hospitalization and death from the H1N1 swine flu – even the healthy ones, according to the Centers for Disease Control (CDC). That means your ob-gyn practice could see an influx of patients with swine flu or seeking swine flu vaccinations, and it’s up to you to know how to report these encounters.

**Fact 1: Use New Code 488.1x**

Provided you’re up to date with the latest ICD-9 coding expert recommendations, your coding for confirmed cases should be on track. ICD-9 has expanded the 488.1 to 5th digit specifications now to report the swine flu with associated respiratory conditions.

The old avian flu code 488.1 was not enough to report the condition. Swine flu almost always presents itself with other respiratory complications and the old code was not meant to cover the complete conditions. With the new codes that has become easier:

- 488.11 – *Influenza due to identified novel H1N1 influenza virus with pneumonia*
- 488.12 – *...with other respiratory manifestations*
- 488.19 – *...with other manifestations*
Fact 2: Report Medicare G Codes for Vaccine, Admin

If you’re dealing with a Medicare patient, you should know the H1N1 vaccine administration codes. The two codes that were introduced in 2010 to report the H1N1 vaccine are as follows:

• For the vaccine, you’ll use G9142 (Influenza A [H1N1] vaccine, any route of administration)
• The code for the vaccine administration is G9141 (Influenza A [H1N1] immunization administration [includes the physician counseling the patient/family]).

**Remember:** Because the H1N1 vaccine is generally available to providers free of charge, you should not bill Medicare for the vaccine itself – only for the administration.

Providers should report one unit of HCPCS code G9141 for each administration of the H1N1 vaccine.

**Payment:** CMS intends to pay you the same amount for G9141 as it reimburses for other vaccine administration codes G0008 (Administration of influenza virus vaccine) and G0009 (Administration of pneumococcal vaccine).

**Bonus:** Although Medicare normally pays for just one vaccination per year, it will pay for both a seasonal flu vaccine and an H1N1 vaccine if both are medically necessary.

Fact 3: Use vaccines for pandemic (H1N1) for Non-Medicare Patients

You should choose and submit a code from general pandemic vaccine codes 90664, 90666, 90667, or 90668 (influenza virus vaccine, pandemic formulation ...) based on the route of administration for a non-Medicare patient receiving the H1N1 vaccine. You would also report an appropriate immunization administration code 90460/90461 in conjunction with any of those influenza virus vaccines codes for the administration of the vaccine...

90460 – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

90461 – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)

Proper Reporting Recoups more for Your Multiple Ob Ultrasounds

If an obstetric patient undergoes multiple ultrasounds, even during a single visit, and you’re not reporting these services separately from the global ob package, you could be seriously undercutting your practice’s bottom line.

**Check this out:** In the United States, almost 70 percent of pregnant women undergo a routine ultrasound evaluation, usually at 18-20 weeks’ gestation. In fact, the American Congress of Obstetricians and Gynecologists (ACOG) maintains that one complete ultrasound should be included as a part of routine obstetric care. Patients and pregnancies can vary. You can have a normal pregnancy where the ob-gyn performs only the anatomical survey and that’s all – but then you could have another pregnant patient who requires serial ultrasounds to access growth.

Distinguish Regular versus Detailed U/S

Generally, physicians use obstetric ultrasounds (for example, 76801, Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester [<14 weeks 0 days], transabdominal approach; single or first gestation) to show viability, the number of fetuses, fetal position, amniotic fluid volume, fetal measurements, placental location, and fetal weight estimation and to allow a basic anatomical review.
For regular types of ultrasounds, you’ll use 76801-76802 for less than 14 weeks gestation and apply routine screening code V28.3 *(Encounter for routine screening for malformation using ultrasonics)*. Use 76805-76810 for greater than 14 weeks gestation and apply V28.3.

Doctors often use these ultrasounds as more precise dating tools to better determine delivery dates. Or the ob-gyn can use them to check viability when the patient has a threatened miscarriage or has a history of habitual miscarriages.

For a more detailed fetal view using ultrasound, you would report 76811 *(Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation)*. These ultrasounds allow the ob-gyn to take more detailed measurements and assess any malformations.

**Important:** You should reserve this level of ultrasound for cases where the ob-gyn suspects fetal anomalies either due to a finding on a previous ultrasound or due to family or personal history concerns. In other words, you’ll use 76811-76812 when the ob-gyn does complete anatomy exams due to abnormal results from a previous exam, an abnormal lab result, or some other abnormal finding.

**Multiple Ultrasounds Mean Multiple Codes**

Apart from 76801 and 76805 *(... after first trimester \( \geq 14 \text{ weeks 0 days} \) ...)*, you generally will use the other pregnancy-related ultrasounds (76810-76828) for high-risk or problem pregnancies. If a patient presents with problems that indicate she may be high-risk or if a routine ultrasound indicates a problem that may need to be followed, the ob-gyn may decide to schedule more than one ultrasound during the pregnancy, perform one or more amniocenteses, or even do multiple ultrasonic procedures during the same visit.

**Example:** A 35-year-old patient presents at 18 weeks of gestation for a routine ultrasound (76805), but the ultrasound indicates a possible fetal anomaly. Consequently, the ob-gyn decides to perform an amniocentesis (59000, *Amniocentesis; diagnostic*) with ultrasonic guidance (76946, *Ultrasonic guidance for amniocentesis, imaging supervision and interpretation*) during the same visit. The physician uses the ultrasound to visualize needle placement as he extracts the amniotic fluid sample from the pregnant uterus while avoiding needle contact with the fetus.

When the ob-gyn performs the regular ultrasound, amniocentesis, and ultrasonic guidance in his office and the amniocentesis directly follows the ultrasound, you should code this as:

- 76805
- 59000
- 76946-51.

If your ob-gyn found an anomaly and documented the additional elements, you could bill 76811 as well.

Even though the ultrasonic guidance is a different procedure from the regular ultrasound, you should append modifier 51 *(Multiple procedures)* to 76946 because it is the same “type” of procedure and many carriers consider it a multiple. If the doctor performs the regular ultrasound on a different day than the amniocentesis with ultrasonic guidance, then you would not need to use modifier 51 because the two procedures are of different types.

Remember, however, that if you’re reporting ultrasonic guidance, the ob-gyn should include a report in the medical record documenting the procedure, which includes supervision and interpretation. If the physician also performs a regular ultrasound on the same date of service, that requires its own separate report. Question the necessity of multiple ultrasounds. You need to justify the medical necessity with the diagnosis and correct documentation.
High-Risk Pregnancies Require Multiple Ultrasounds

High-risk pregnancies frequently require multiple ultrasounds to assess the fetus's development. The high-risk status may be caused by the patient’s age, pre-existing medical condition(s), multiple gestation, or other diagnoses.

To avoid carrier rejections for claims that are above and beyond the normal range for global ob care, you should include a clause in your carrier contracts for high-risk ob care that specifies payment for additional services.

In addition, denials may be a problem for multiple ultrasounds when the patient has a history of complications with previous pregnancies (for example, 646.33, Recurrent pregnancy loss; antepartum condition or complication) but is now having an uncomplicated pregnancy. To avoid this problem, be sure to include the patient’s history on the claim form by also reporting a V23.x (Supervision of high-risk pregnancy) in most cases. Otherwise, such cases will look like multiple ultrasounds for a noncomplicated pregnancy.

Know your Rules for Pregnant Patient Transfer

Think you can handle situations where a pregnant patient moves out-of-state mid-pregnancy?

Prepare for coding your ob-gyns services up to the date of the patient’s move depending on how many antepartum visits the physician provides — either one to three, four to six, or seven or more.

1-3 Visits Mean Office E/M Codes

Scenario: Your ob-gyn sees a pregnant patient for only one to three antepartum visits. How should you report this?

Solution: You need to report the appropriate E/M codes for payment.

First visit: For the first ob visit, don’t automatically look at a level-four established patient visit (99214, Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision-making of moderate complexity…).

You won’t have a set E/M code for the patient’s first visit. Your patient could be new to the practice, or the first visit may meet the criteria for a level-five established visit. Therefore you should look to the entire code series (99201-99205 for new patients, 99211-99215 for established patients) as possible options.

Second and third visits: Your coding options are more limited for visits two or three. Medicare values the follow-up visit as 99213 (Office or other outpatient visit for the evaluation and management of an established patient …), so this code is your best bet for each of these visits in the absence of documented problems.

Heads up: In some rare circumstances, such as when the patient has absolutely no problems during the visit, however, the documentation might support reporting only 99212 (Office or other outpatient visit for the evaluation and management of an established patient … Typically 10 minutes are spent face-to-face with the patient and/or family) for each visit.

If the patient’s pregnancy is without complication, your diagnosis would be either V22.0 (Supervision of normal first pregnancy) or V22.1 (Supervision of other normal pregnancy).

Watch out: Because you do not have a specific antepartum code for one to three visits and have to report E/M codes, payers sometimes will deny these claims and tell you to “include in the global.” You are forced to appeal these decisions. Explain to the payer that you cannot report a global code because you are no longer the patient’s OB care provider.

4-6 Visits Mean Antepartum Code

Scenario: Your ob-gyn sees a pregnant patient for four to six antepartum visits. How should you report this?
Solution: Four to six visits means you’ll be flipping through your book to the maternity care and delivery section — particularly the antepartum codes.

You should report 59425 (Antepartum care only; 4-6 visits), which represents the total services rendered by your ob-gyn. This means that you’ll report only one unit of this code.

Rare case: Sometimes, you’ll encounter a payer that instructs providers to report a separate E/M service for the first ob encounter. You would need to have this in writing from your payer, and then you would need to meet the criteria of at least four additional visits to report 59425.

Note: Your diagnosis will be the same (V22.0 or V22.1) unless the patient has any problem or complication.

7+ Visits May Mean Variation

Scenario: Your ob-gyn sees a pregnant patient for more than seven or more visits. The patient then leaves your practice. How should you report this?

Solution: You’ll find more variation in your coding choices for this scenario — but one thing is certain: you should avoid reporting global codes at all costs. You can report a global code only if your ob-gyn provides all of a patient’s maternity care. Because you’re talking about a patient who leaves the practice before delivery, codes 59400-59622 do not apply.

Option 1: For seven or more visits, CPT® has a specific code: 59426 (7 or more visits). You would include diagnosis codes V22.X-V23.84, as appropriate.

Option 2: Some payers may ask you to report each visit separately. Good idea: Ask the insurer what “separate” means.

“Separate” may mean reporting 59426 along with a list of the dates. This is why you should definitely keep track of a patient’s prenatal visits by noting the date the ob-gyn sees the patient.

The payer may also want you to report the appropriate E/M code for each visit, but that isn’t likely.

Prevent your Delivery Coding From Claim Mishaps

Coding deliveries isn’t as easy as simply reporting a global code. Sometimes extenuating circumstances require you to choose from itemized delivery codes — and use modifiers like 51, 59 and 22.

Read the following four scenarios and see if your answers match up with our experts’ guidance.

1. Your Ob-Gyn Deliveres for Unaffiliated Ob-Gyn

Scenario: A pregnant patient’s regular ob-gyn is out of town when the patient goes into labor. Your ob-gyn, who is not affiliated with the regular ob-gyn, performs a normal delivery. How should you report this?

Answer: You should report the delivery according to how your ob-gyn performed it - either vaginal (59409, Vaginal delivery only [with or without episiotomy and/or forceps]) or cesarean (59514, Cesarean delivery only).

As for diagnoses, you should use 650 (Normal delivery) and V27.0 (Mother with Single liveborn).

Keep in mind: You should allow the patient’s regular ob-gyn to bill for the antepartum visits. The delivery CPT® code will include postpartum visits in the hospital if there are no complications, as well as discharge.

But if your ob-gyn provides all postpartum care services both in and out of the hospital, you should look to 59410 (including postpartum care). Use V24.2 (Routine postpartum follow-up) for your supporting diagnosis.
2. What to Do When Nurse Delivers Instead

**Scenario:** The nurse delivers the baby because the ob-gyn is in the next room doing a procedure on another patient. How should you report this?

**Answer:** You can use a global code (such as 59400). You should probably add modifier 52 (Reduced services) to account for the fact that the ob-gyn wasn’t present. Be sure to include information about which part of the process he did participate in, so you’ll lessen the impact of any fee reduction the payer might apply.

3. Master Multiple-Gestation Deliveries

**Scenario A:** One of your ob-gyn’s regular patients is having twins, and your ob-gyn delivers them both vaginally. How should you report this?

**Answer A:** You should report 59400 (Routine obstetric care including antepartum care, vaginal delivery [with or without episiotomy, and/or forceps] and postpartum care) for the first baby and 59409-51 (Vaginal delivery only [with or without episiotomy and/or forceps]; multiple procedures) for the second. Modifier 51 on the second code is key for reimbursement.

**Caution:** Some carriers require you to bill vaginal deliveries broken up into two separate codes with modifier 59 (Distinct procedural service) or other appropriate modifier attached. Other payers will not pay anything additional for twin B when the delivery is vaginal.

Nevertheless, your diagnoses will be 651.01 (Twin pregnancy delivered) and V27.2 (Mother with twins, both liveborn).

**Scenario B:** The ob-gyn delivers the first baby vaginally but the second by cesarean. How should you report this?

**Answer B:** You should report 59510 (Routine obstetric care including antepartum care, cesarean delivery, and postpartum care) for the second baby and 59409-51 for the first. Why: You should bill the cesarean first because 59510 has higher RVUs (relative value units).

The diagnoses for the vaginal birth will include 651.01 and V27.2.

For the second twin born by cesarean, use additional ICD-9 codes to explain why the ob-gyn had to perform the c-section — for example, malpresentation (652.6x, Multiple gestation with malpresentation of one fetus or more) — and the outcome (such as V27.2).

**Scenario C:** The ob-gyn delivers both babies by c-section. How should you report this?

**Answer C:** When the doctor delivers all of the babies — whether twins, triplets or more — by cesarean, you should submit 59510-22. The reason you report only one code is that the ob-gyn is only making one incision.

**Focus on this:** Report 59510 with modifier 22 (Increased procedural services) appended. The ob-gyn performed only one cesarean, but the modifier shows that the ob-gyn performed a significantly more difficult delivery due to the presence of multiple babies. Always include a letter of explanation for modifier 22 and the reason why you are asking for higher reimbursement along with a copy of the operative report.

Finally, for the diagnoses, include the reason for the cesarean, 651.01, and V27.2.

4. Check Your Complications Coding

**Scenario:** During a vaginal and/or cesarean delivery, the patient has a complication. How should you report this?
**Answer:** For complications of pregnancy, the old rule some are easy, some are hard comes to mind.

If the complication required extra work (such as a third- or fourth-degree repair, or uterine atony after cesarean), you should report the main procedure code (such as 59510) with modifier 22 appended. You should be able to explain the need for this modifier.

Also, when the patient requires additional services such as extra visits, ultrasounds, and testing that are not included in the routine global ob package, you should definitely bill those out.

**Heads up:** When billing for complications of the delivery, you want to make sure you are using diagnosis codes in the 641-677 series. For example, you should report 648.91 (Other current maternal conditions classifiable elsewhere of mother with delivery) with a secondary code describing the complication.

ICD-9 codes and documentation are critical to maximize ethical reimbursement for these services.

**See How 3 Coverage Agreements Affect Global Ob Care Coding**

Within and between groups, providers make specific arrangements ahead of time called coverage agreements. And before you apply a global code (such as 59400, Routine obstetric care including antepartum care, vaginal delivery [with or without episiotomy, and/or forceps] and postpartum care) to your claim, you need to understand what kind of agreement your practice has in place.

**Scenario:** Two ob-gyns cover for each other and for other groups. For example, the ob-gyn at your practice provides all of the antepartum care, and the covering MD performs the delivery. How should you report this?

**Confront These Types of Agreements**

You may encounter three types of agreements — and how these agreements work will affect how you code the global ob care.

You may have an informal agreement. In this situation, you code the global service under the ID of the ob-gyn on the patient’s record — even though a covering MD performed the delivery. In other words, this is an “I’ll cover for you if you cover for me” arrangement. No money changes hands, because both providers agree things will even out in time.

**Warning:** You need to check your state’s statutes or regulations to see if this arrangement works.

Another agreement is locum tenens. In this case, the ob-gyn on record reimburses the covering MD, a temporary employee of the ob-gyns practice. You’ll still report the ob global care under the ob-gyn’s ID.

Yet another agreement is that the physician, not part of the practice, performs the delivery. In this case, the covering MD codes for the delivery, while you report the antepartum and postpartum care under your ob-gyn’s ID. Note: you’ll need a letter of explanation to alert your payers the ob-gyn has this arrangement.

**Smart:** If the coverage agreement is in writing and agreed upon before the actual services are performed, there are less chances of problems occurring later. Once the practice alerted their insurance carriers to the coverage situation, and they agreed to it, it is easier billing-wise to handle these situations in the manner the practice outlined. Some of the carriers actually reduce the allowed amounts when the services are carved out.

**Prepare for Snags Now**

Sometimes you may have a dispute over who deserves the delivery compensation fee. When this happens, you have two choices:

**Option 1:** You can separately report each component of the global ob care. In other words, you’ll report the antepartum care (either 59425, Antepartum care only; 4-6 visits; or 59426, ... 7 or more visits), the delivery of the placenta (59414, Delivery of placenta [separate procedure]), episiotomy repair (59300, Episiotomy or vaginal repair, by other than attending ) and postpartum care (59430, Postpartum care only [separate procedure]).
Option 2: Or you can report the ob global service with modifier 52 (*Reduced services*) appended to 59400.

When Medicare assigned a value under the Resource-Based Relative Value Scale (RBRVS) for global ob package code 59400, they valued the components of the package as a percentage of the total work needed to provide complete ob care. In other words, they broke this code down as follows:

- Antepartum care is 41 percent of the work
- Admission H & P and labor management is 36 percent of the work
- Vaginal delivery is 15 percent of the work
- Postpartum care (includes inpatient and outpatient visits) is 8 percent of the work.

You can guesstimate your reduced services reimbursement accordingly, because your payer will likely deduct the percentage that your ob-gyn did not perform.

Bottom line: Before you apply the global code to your claim, you need to understand whether the covering provider will charge for his portion of the service.

5 ICD-9 Tips to Rein In Your Global Ob Coding

Saddle up your claims with the correct ICD-9 code for ob global packages and leave denials in the dust. The following tips will ensure your global ob package success every time.

**Tip #1:** Make sure that all your ICD-9 selections for ob billing are chosen from the 640-678 range of ICD-9 diagnoses.

**Tip #2:** Always code to the highest specificity when you need to add a fifth digit to denote the episode of care (such as for complications mainly related to pregnancy, 651-659):

- Unspecified as to episode of care or not applicable = 0
- Delivered, with or without mention of antepartum condition = 1
- Delivered, with mention of postpartum complication = 2
- Antepartum condition or complication = 3
- Postpartum condition or complication = 4.

**Tip #3:** Remember that ICD-9 selection in the 646.x (*Other complications of pregnancy, not elsewhere classified*) or 648.x (*Other current conditions in the mother …*) diagnosis categories requires additional codes to further specify the complication. For example, you’ll need to further specify 648.0x (*Diabetes mellitus complicating pregnancy childbirth or the puerperium*) using a code selected from the 250.xx series (*Diabetes mellitus*).

**Tip #4:** If possible, use the outcome codes for the delivery (V27.0-V27.9).

**Tip #5:** If the provider repairs a third- or fourth-degree laceration, don’t be afraid to attach modifier 22 (*Increased procedural services*). In that situation, ask for extra reimbursement for the extra work.

3 FAQs Obliterate Ob Global Package, Hospital, and Accident Coding Obstacles

Review the following three frequently asked ob coding questions and discover solid advice on what an ob package includes, what hospital services you can report, and what to do if an ob patient is in a car accident.

**FAQ 1: What’s Included in the Ob Package?**

**Question:** What services are considered part of the global maternity package (for example, routine dip urinalysis, blood draw, etc.)?

CPT® includes a definition of services that are part of the global package in the “Maternity Care and Delivery” section immediately before 59000 (*Amniocentesis; diagnostic*). The guidelines explain what is included in
Glitch: Some payers may try to include some of the tests performed as screening during pregnancy in the global package.

Example: The CPT® definition states that you should include a routine chemical urinalysis to check for glucose and protein. The package, however, does not specify a dipstick. Plus, it does not specify under microscopy or another method. The definition simply directs you to include a routine urinalysis, which is a chemical test. If that is what your ob-gyn is doing, regardless of the method used, you should include the urinalysis 81000-81003 (Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents ...) in the obstetric global package.

Don’t miss: Any other test that the ob-gyn performs on a patient during her pregnancy is probably excluded from the global package under CPT® guidelines. But you may run into complications.

Example: A physician was getting very nervous because he had been sued previously, so he decided to do an alpha-fetoprotein test (82105, Alpha-fetoprotein [AFP]; serum) on all pregnant patients. The insurance carriers saw that this ob-gyn billed the AFP regularly for all patients and notified him that they were no longer going to reimburse for that service. They stated that the AFP was now recognized as part of his routine obstetric package care, and they were rolling it in. Unfortunately, this is the view of many payers.

Watch out: If your practice consistently bills for things without good medical indication for the particular patient, the insurer will tend to view the service as part of your global package and refuse to pay for it. In other words, you are not performing the service because the patient needed it — you are doing it on all patients, regardless of need.

Good idea: Ensure that the tests you do outside of the routine urinalysis are medically indicated for the specific patient. For instance, if the patient needed to have some lab work done and the ob-gyn draws blood (36415, Collection of venous blood by venipuncture) to send a sample to the laboratory, you should not include it as part of the global service; the insurer should reimburse it.

Best advice: When you are dealing with any payer regarding obstetric services, you should spend some time in advance reading your contract or agreement with that payer. You’ll waste time if you bill for services that your contract or agreement clearly states you should include in the global ob package. Plus, you can take this information to your physicians who may have signed off on the contract to suggest they renegotiate the next contract to exclude specific services from the global because you do not perform them on every patient.

FAQ 2: What about Hospital Services?

Question: What hospital charges can the physicians report for obstetric patients?

You can sometimes bill hospital services outside of the global package. For instance, you could report the admission history and physical (99221-99223, Initial hospital care, per day, for the E/M of a patient ...) and any subsequent care (99231-99233, Subsequent hospital care, per day, for the E/M of a patient ...) if the ob-gyn admits the patient for a complication of pregnancy. But payers will usually not reimburse you for a service that takes place within 24 hours of the delivery.

Gray area: The 24-hour period is open to debate because payers tend to go by calendar dates and not hours in a day or number of hours prior to delivery. Generally, if you admit a patient on day one because of premature labor contractions that you were trying to stop and you deliver on day three, the carrier should pay for day one and two outside the package. The payer would not reimburse separately for day three because that was the date of the delivery.

Also, you can bill separately for procedures (other than labor management) the physician performs while the patient is in the hospital. For instance, most carriers consider induction of labor part of labor management, and hospital staff, not the physician, usually starts the IV. You can use the IV infusion codes if the physician personally starts the IV, sits with the patient the entire time, and documents that time.
If the ob-gyn admits the patient to the hospital for a condition and then discharges her without delivery, you can bill for the admission, the subsequent care and the discharge day management (99238-99239, Hospital discharge day management ...).

FAQ 3: What Happens if She’s in an Accident?

Question: When an obstetric patient is in a car accident, what diagnosis code should we use with an ultrasound or fetal non-stress test (NST)?

Action: Find out what’s wrong.

For instance, your ob-gyn may admit a pregnant patient involved in an automobile accident for observation, even if she has no complaints or signs of injury. In this case, you would use V71.4 (Observation following other accident), V22.2 (Pregnant state, incidental) and an E code for the automobile accident. These three codes will explain the situation.

Switch: If a patient comes in following an automobile accident and has an injury, this probably will affect the pregnancy. You would call it a complication affecting the management of the pregnancy. Report 648.93 (Other current conditions classifiable elsewhere of mother antepartum) in this case because she has not delivered. List all of the non-ob chapter codes that represent the injuries the obstetrician is treating.

Note: If the patient is seen in the emergency department (ED) and the ED staff takes care of that part, you would not report those services. You would indicate that there is a potential here for conditions elsewhere, etc., but you are not taking care of that part. You may still use the E code (such as E813.x, Motor-vehicle traffic accident involving collision with other vehicle).

Caution: If the accident affects the fetus in any way, such as decreased fetal movement or a change in the fetal heart rate, use a code in the ob chapter. Do not use the E code (E813.x).

Why? You cannot use E813.x with the fetal category codes or any other code outside the ob chapter because the cause code assigns the problem to the mother, and that is not the situation. You are saying something is wrong with the fetus.

If the physician thinks that the injuries are not impacting the pregnancy at all, but he is taking care of those injuries, you are going to bill the injury codes, V22.2 and the E code (E813.x).

Reporting for Post-Delivery Laceration and Hemorrhage

Avoid denials and accidentally reducing the allowable fee on multiple services by testing your modifier 51 versus modifier 78 savvy with this complicated ob op note.

First, Read the Op Note

Preoperative/Postoperative diagnosis: Postpartum hemorrhage with uterine atony, hematoma of vaginal sidewall.

Procedure Performed: Evacuation of hematomas and repair of vaginal laceration.

Operation: The patient was taken to the operating room after working with the patient for 30-45 minutes back in the delivery room with the anesthesia and nurses. She had significant uterine atony after a vaginal delivery and lost at least 1,000 cc of blood after the 400 cc of blood loss that occurred during the delivery. Upon arrival, she was sitting in a large pool of blood, estimated at least 1,000 cc.

Her uterus was atonic. Vigorous uterine massage was carried out with Pitocin infusion, stepped up to 60 international units per liter, rushing it in as fast as we could. A second IV was started. She was given Methergine with Cytotec rectally and Hemabate IM.

Vigorous uterine massage was carried out throughout that time. Her uterus clamped down after I evacuated the blood clots which were part of the 1000 cc. After she was stabilized, however, vaginal bleeding continued. She was placed in stirrups and exploration of the vagina was carried out and a hematoma was noted in the right upper
vaginal sidewall which could not be reached from the delivery room. She was taken back to the operating room after risks, benefits, and alternatives were discussed. She was placed in the dorsal lithotomy position and examined carefully. A large hematoma approximately 2.5 x 2.5 sq. cm. was noted in the upper right vaginal sidewall and, by this time, there was some bleeding through a laceration in the mucosa. Evacuation of blood clot was carried out and deep sutures of 2-0 Vicryl were placed in an interrupted fashion, approximately 5 sutures. The laceration continued down and slightly lower into the vaginal canal. Several interrupted 2-0 Vicryl sutures were placed. Eventually all the bleeding stopped.

Vigorous uterine massage was carried out when she was asleep and her uterus had clamped down nicely. Total estimated blood loss is approximately 1,500 cc with the delivery as well as uterine atony. The patient was transported to the recovery room in stable condition. Transfusing blood 2 units.

**Turn to Your Ob for Repair, Return Clarifications**

In this note, you have a delivery and you know you will either bill a global or delivery ob code – but that doesn’t mean your coding is cut and dry. Ask yourself the following questions:

• **Did the ob-gyn perform and document postpartum curettage?** No. The ob-gyn did not discuss the curettage, only the removal of clots and uterine massage.

• **Can you code the repair of the laceration?** Not with the available information. You should include the repair of a first or second degree laceration with the delivery. From the documentation, you can discern she has a large hematoma that the ob-gyn removed from the vaginal canal. After this, the ob-gyn placed sutures. What you don’t know is the extent of the vaginal laceration he mentions (its total length). Nor is it clear whether the physician did a simple or intermediate repair of the extended laceration. In other words, you will have to go back to your ob-gyn for more information.

• **What modifier should you append on the vaginal hematoma evacuation?** This documentation does not explain whether the ob-gyn returned the patient to the operating room (OR) for the hematoma procedure, or if this was simply a continuation of the delivery. Given the information you have, that is unknown. Again, you should ask your ob-gyn for clarification.

Answering these questions will lead to the best coding solution. You have two options:

**Option 1: Append Modifier 22 to a Global Code**

You can submit the global code 59400 (*Routine obstetric care including antepartum care, vaginal delivery [with or without episiotomy and/or forceps] and postpartum care*) with modifier 22 (*Increased procedural services*) appended.

Your diagnosis codes will be 666.12 (*Other immediate postpartum hemorrhage, with delivery*) and 665.71 (*Pelvic hematoma, with delivery*).

**Action:** Include the operative report and a letter explaining why the procedure was more complicated than a normal delivery.

**Option 2: Itemize Each Service**

You can cross out the need for modifier 22 by itemizing each of the ob-gyn’s services in addition to the global delivery. For the removal of the clots and uterine massage, you would report 59899 (*Unlisted procedure, maternity care and delivery*) with modifier 51 (*Multiple procedures*). Keep in mind many payers no longer require modifier 51. Processing claims electronically allows the payer to recognize when your physician performs multiple procedures and automatically makes the necessary reduction in payment. Check with your payer to see if you need to use modifier 51 when your ob-gyn performs more than one procedure in a session.

**Tip:** You would link this to 666.12, but you would need to let the payer know the amount of work involved for this portion of the care. You may not use the prolonged physician codes since you’re not reporting an E/M service, but you can tell the payer that the uterine massage took 40 minutes and compare the work to code 99356 (*Prolonged physician service in the inpatient setting, requiring unit/floor time beyond the usual service; first hour*)
separately in addition to code for inpatient Evaluation and Management service).

Then you would report 57022 (Incision and drainage of vaginal hematoma; obstetrical/postpartum) linked to 665.71. This procedure includes the closure of the wound.

**Modifier issue:** When deciding what modifier to append to 57022, you have to decide whether this surgery qualifies as a return to the operation room. If so, you can apply modifier 78 (Unplanned return to the operating/procedure room by the same physician or other qualified healthcare professional following an initial procedure for a related procedure during the postoperative period). This implies the patient was taken out of the OR to a recovery room and then unexpectedly had to return to the OR.

When you’re filing claims with modifier 78, you shouldn’t expect to receive the full fee schedule reimbursement amount. Procedures billed with modifier 78 include only the service’s “intraoperative” portion, and carriers generally reimburse them at 65-80 percent of the full fee schedule value. In other words, if you report a procedure with modifier 78, you will not receive the portion of payment assigned to the pre- and post-operative care usually associated with that procedure.

If this surgery does not qualify for modifier 78, you would apply modifier 51 if your payer requires it. This will reduce your reimbursement for this procedure by a full 50 percent.

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