OB Professional Coding

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Objectives

During this presentation we will discuss:

- Services included in the global period for OB care for CPT coding
- Additional OB services that may be performed
- ICD-10 guidelines related to OB care

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Definitions

TERMS	DEFINITIONS
Antepartum	Time from conception until delivery or childbirth w/regard to the mother
Peripartum	Last month of pregnancy to 5 months postpartum
Postpartum / Puerperium	Immediately after delivery thru the first 6 weeks
Elderly Obstetric patient	35 years or older at time of delivery
Young Obstetric patient	Less than 16 years old at time of delivery
Post-term Pregnancy	Pregnancy longer than 40 weeks up to 42
Prolonged Pregnancy	Beyond 42 weeks of pregnancy

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Global OB Care

The global OB care includes initiation of the prenatal record, prenatal care, delivery and post-natal care

A visit for pregnancy confirmation during a problem-oriented or preventive visit is NOT considered a part of antepartum care and should be reported with the appropriate E/M code

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Antepartum Care

Includes:

- Initial visit in order to “begin” the OB chart, for this current pregnancy
  - Patient could be an established patient within the practice, but usually a distinction is made for a new pregnancy
- If complications arise throughout the pregnancy and additional services are performed, they should be coded separately

- Follow-up visits to provider in order to check the pregnancy progress including:
  - Monthly visits up to 28 weeks gestation
  - Biweekly visits up to 36 weeks gestation
  - Weekly visits until delivery

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Antepartum Care

- A typical prenatal visit includes the following:
  - Recordings of weight
  - Blood pressures
  - Fetal heart tones
  - Routine urinalysis
- Other visits or services provided during this timeframe should be coded separately

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Antepartum Care

What if complications arise?

- If complications arise during a patient's pregnancy and non-routine care is provided, separate E/M codes may be reported

- Documentation must support the medical necessity of the additional, non-routine OB visits and E/M coding guidelines should be reference for coding these visits

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Pregnancy Care Not Completed

The following codes should be reported when only Antepartum or Postpartum care is provided:

- 1-3 Antepartum visits- Report the appropriate E/M code
- Antepartum care only; 4-6 visits- 59425
- Antepartum care only; 7 or more visits- 59426
- Postpartum care only- 59430

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Delivery

Includes:

- Admission, including H&P
- Management of uncomplicated labor
- Vaginal or Cesarean delivery
  - With or without episiotomy
  - With or without forceps
- Daily hospital visits until discharge

Medical complications, including medical problems complicating labor and delivery management may be reported separately

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Delivery CPT Coding

Delivery CPT Codes include several options. Here are some questions to ask yourself before coding the delivery services:

- Was the patient seen for her entire global OB care, or only a portion of care?
- What type of delivery was performed?
- Were any other services performed before or after delivery?

Let’s look at each delivery section

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Vaginal Delivery

- 59400 is the global vaginal delivery code
  - Includes antepartum care
  - Includes vaginal delivery
  - Includes postpartum care

- 59409 is reported when the only care provided is a vaginal delivery
  - Neither prenatal care nor postpartum care is provided

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Vaginal Delivery

- 59410 is reported when care is provided for a vaginal delivery and postpartum care
  - No prenatal care was provided

* Episiotomy and/or forceps are included in all vaginal deliveries

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Vaginal Delivery

- 59412 is reported for an external cephalic version procedure
  - Includes tocolysis (contraction suppression drug) if used
  - Code in addition to delivery code(s)

- 59414 is reported for the delivery of the placenta
  - Occurs after an unattended delivery

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Cesarean Delivery

- 59510 is the global C-section delivery code
  - Includes antepartum care
  - Includes cesarean delivery
  - Includes postpartum care

- 59514 is reported when the only care provided is a C-section delivery
  - Neither prenatal care nor postpartum care is provided

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Cesarean Delivery

- 59515 is reported when care is provided for a C-section delivery and postpartum care
  - No prenatal care was provided

- + 59525 is reported for a hysterectomy after a C-section:
  - Includes subtotal or total
  - Only reported with the following codes: 59510, 59514, 59515, 59618, 59620 and 59622

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Delivery After Previous Cesarean Delivery

- A VBAC is the term commonly used to refer to a vaginal birth after previous cesarean delivery

- There are a set of codes to use when a VBAC is successful and a separate set to use if the VBAC is unsuccessful, meaning another C-section is performed

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Delivery After Previous Cesarean Delivery

Successful VBAC:

- 59610 is the global VBAC delivery code
  - Includes antepartum care
  - Includes vaginal delivery
  - Includes postpartum care
- 59612 is reported when the only care provided is a VBAC delivery
  - Neither prenatal care nor postpartum care is provided
- 59614 is reported when care is provided for a VBAC delivery and postpartum care
  - No prenatal care was provided

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Delivery After Previous Cesarean Delivery

Unsuccessful VBAC:

- 59618 is the global C-section code
  - Includes antepartum care
  - Includes cesarean delivery
  - Includes postpartum care
- 59620 is reported when the only care provided is a C-section
  - Neither prenatal care nor postpartum care is provided
- 59622 is reported when care is provided for a C-section and postpartum care will also be provided
  - No prenatal care was provided

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Multiple Gestations

	CPT Codes
Twins, both delivered vaginally	59400 (Global OB Care) 59409-51 (Delivery only)
Twins, one delivered vaginally and one via C-section	59510 (Global OB Care) 59409-51 (Delivery only)
Twins, both delivered via C-section *Only one C-section is performed, regardless of how many so only one code should be reported*	59510 (Global OB Care) If delivery is documented as being significantly more complicated, modifier 22 may be appended

Coders are encouraged to check individual payer guidelines

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Delivery for Multiples

- Coders are encouraged to check with individual payers regarding coding additional services for twins or higher order multiples.
- Some will want these billed with modifier 22 and some will want them billed on multiple lines with modifier 59 on the subsequent lines.
- Still others will want them billed on one line with the quantity increased (2 for twins, 3 for triplets, etc.)

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Let’s Code

Code the following scenario:

Patient presents for delivery, after being followed by the attending provider for her entire pregnancy. After laboring for 30 hours, the decision was made to perform a cesarean delivery and a healthy baby is delivered.

What is the global delivery code that should be reported?

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Let’s Code

Answer:

59510- Routine obstetric care, including antepartum care, cesarean delivery and postpartum care

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Postpartum

- Postpartum care begins with delivery
- Includes uncomplicated hospital visits
- Office visits until 6 weeks post-delivery

Problems not related to the pregnancy and complications of the pregnancy may be reported separately

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Antepartum and Fetal Invasive Services

- Additional services provided during pregnancy should be reported separately, which could include:
  - Amniocentesis: 59000, 59001
    - Small amount of fluid from the amniotic sac
    - Diagnostic or therapeutic
  - Cordocentesis: 59012
    - Sample of blood from the fetal umbilical cord
    - AKA- PUBS

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Antepartum and Fetal Invasive Services

- Chorionic villus sampling (CVS): 59015
  - Sample of chorionic villi
  - Same information obtained as an Amnio

- Fetal contraction stress test: 59020
  - Contractions induced to monitor fetal response
  - Usually during 3rd trimester
  - Report TC modifier for technical portion
  - Report 26 modifier for professional portion
  - Report without modifier is performing both the technical and professional portions

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Antepartum and Fetal Invasive Services

- Fetal non-stress test: 59025
  - Fetal response to its own activity is monitored
  - Report TC modifier for technical portion
  - Report 26 modifier for professional portion
  - Report without modifier is performing both the technical and professional portions

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Antepartum and Fetal Invasive Services

- Fetal scalp blood sampling: 59030
  - Performed during active labor
  - Diagnostic
  - If samples are repeated:
    - Report modifier 76 if repeated by the same physician
    - Report modifier 77 if repeated by another physician

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Antepartum and Fetal Invasive Services

- Fetal monitoring during labor by consultant (non-attending physician): 59050, 59051
  - Consultant services
  - Report 59050 if the patient is supervised
  - Report 59051 if consultant is only providing an interpretation (no supervision)
- Transabdominal amnioinfusion: 59070
  - Fluid is infused into the amniotic sac
  - Includes ultrasound guidance

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Antepartum and Fetal Invasive Services

- Fetal Umbilical Cord Occlusion: 59072
  - Umbilical cord is ligated, occluded or compressed
  - Includes ultrasound guidance
- Fetal Fluid Drainage: 59074
  - Built-up fetal fluid is drained
  - Includes ultrasound guidance
- Fetal Shunt Placement: 59076
  - Shunt is placed so fluid doesn’t build up
  - Drains into the amniotic sac
  - Includes ultrasound guidance

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Antepartum and Fetal Invasive Services

- Ultrasounds: 76801-76828
  - Not found in the antepartum section of the CPT book
  - Are reported separately
  - Ultrasound guidance is NOT reported when the CPT code description includes this service
    - Example- last slide CPT codes 59070-59076 include ultrasound guidance
- Transfusion: 36460
  - Also not in the antepartum section of the CPT book
  - Found in the Cardio section
  - Blood transfusion on a fetus still in utero

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Excision

- Hysterotomy: 59100
  - Removal of embryo or hydatidiform mole
  - Rare procedure

- Curettage, postpartum: 59160
  - Endometrial lining is scrapped
  - Controls bleeding
  - Treats obstetric lacerations
  - Removes any remaining placental tissue

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Excision

Treatment of ectopic pregnancy:

- Coded based on approach
  - Abdominal/vaginal- 59120-59140
    - Further coded based on the location of the ectopic and additional services performed
      - 59120- tubal or ovarian, requiring salpingectomy and/or oophorectomy
      - 59121- tubal or ovarian, without salpingectomy and/or oophorectomy
      - 59130- abdominal pregnancy
      - 59136- interstitial uterine- includes partial resection of uterus
      - 59140- cervical- with evacuation

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Excision

Treatment of ectopic pregnancy:

- Coded based on approach
  - Laparoscopic 59150-59151
    - Further coded based on additional services performed
      - 59150- without salpingectomy and/or oophorectomy
      - 59161- with salpingectomy and/or oophorectomy

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Introduction and Repair

Insertion of cervical dilator: 59200

- Several methods may be used to dilate the cervix
- Only billable if the delivery occurs on another day
- When patient delivers the same day, this service is included in the delivery

Episiotomy: 59300

- Performed by a provider other than the attending
- When performed by the attending physician, this service is included in the delivery

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Introduction and Repair

Cerclage: 59320, 59325

- Sutures placed into the cervix to delay delivery
- Usually to treat an incompetent cervix
- Coded based on how sutures are placed:
  - 59320- vaginally
  - 59325- abdominally

Hysterorrhaphy- 59350

- Repair of the uterus
- Laceration or rupture during pregnancy

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Abortion

- Abortion- the expulsion of the products of conception (POC) from the uterus
- Medical treatment of spontaneous abortion
  - Report E/M codes (99201-99233)
- Incomplete abortion: 59812
  - Uterus isn’t completely emptied of the POC
  - Completed surgically
  - Any trimester

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Abortion

Missed abortion: 59820-59821

- Prolonged retention of a fetus that died during the 1st half of the pregnancy
- Completed surgically
- 1st trimester: 59820
- 2nd trimester: 59821

Septic Abortion: 59830

- Intrauterine infection is present
- Completed surgically

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Abortion

Induced abortion

Therapeutic (medical reasons) and elective (at the request of the woman) may be classified as an induced abortion

- D&C: 59840
  - Dilation and curettage
  - Sharp or suction
- D&E: 59841
  - Dilation and evacuation
  - Uterus manually evacuated

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Abortion

- One or more intra-amniotic injections: 59850
  - With D&C and/or evacuation: 59851
  - With hysterotomy: 58852
  - CPT 59200 can be reported if cervical dilator is inserted
  - Includes hospital admission and visits
- One or more vaginal suppositories: 59855
  - With D&C and/or evacuation: 59856
  - With hysterotomy: 59857
  - Includes hospital admission and visits

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Other Procedures

- Multifetal pregnancy reduction(s): 59866
  - Selective reduction
  - Goal is to have a twin or triplet pregnancy remaining
- Uterine evacuation and curettage for hydatidiform mole: 59870
  - To treat a hydatidiform mole
  - If done via hysterotomy, see 59100
- Removal of cerclage suture under anesthesia: 59871
  - Anesthesia- other than local
  - If performed at the time of delivery, this is included in the delivery

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Other Procedures

- Unlisted fetal invasive procedure: 59897
- Unlisted laparoscopic procedure: 59898
- Unlisted procedure: 59899
  - As in other sections of the CPT book, unlisted codes should be reported when no other CPT code exists for the procedure being performed.
  - The procedure note may have to be supplied for these services to be paid.
  - Check with individual payers for guidance.

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Let's Code

Code the following scenario:

- Ms. Smith presented to her OB's office during her second trimester with an incompetent cervix and required a vaginally-placed cerclage.
- She presents at 39 weeks in active labor and the attending physician removes the cerclage prior to delivery. The patient delivers a healthy baby vaginally. The attending provider saw the patient for all of her prenatal care and will also provide her postpartum care.

What CPT code(s) are reported for the cerclage removal and the vaginal delivery?

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Let's Code

Only the delivery code can be reported

59400- Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care

Since delivery occurred following the cerclage removal, it is considered part of the delivery code and isn't separately reported.

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ICD-10 Coding Guidelines

Chapter 15 codes:

- Take sequencing priority over other chapter codes
- Codes from other chapters may be reported additionally
- Only used on the Mother's record
- Conditions being addressed are considered as affecting the pregnancy, unless documented otherwise
- In order to report Z33.1, the provider must document that the condition being treated is incidental and not affecting the pregnancy

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ICD-10 Coding Guidelines

Chapter 15 codes:

- Additional code from category Z3A should also be reported
  - Indicates weeks of gestation
  - Not reported for:
    - Codes O00-O08
    - Z33.2
    - Postpartum conditions

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Examples

- Example: 23-year-old G1P2, currently 8 weeks pregnant. Presents for stubbed & bruised big toe. Pregnancy is incidental to the current issue at hand and isn't addressed at today's visit.

- Example: 21-year-old G1P1, currently 12 weeks pregnant patient has a cough.

- Example: 25-year-old G1P1, currently 14 weeks pregnant. Patient is actively smoking cigarettes.

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ICD-10 Coding Guidelines

- Most chapter 15 ICD-10 codes use a final character that indicates the trimester.
- Trimester character assignment is based on provider documentation for the current encounter. The unspecified trimester 5th digit is only used when documentation doesn't specify (rare).
  - 1st trimester- less than 14 completed weeks 0 days
  - 2nd trimester- 14 completed weeks 0 days to less than 28 completed weeks 0 days
  - 3rd trimester- 28 completed weeks 0 days until delivery
- When the classification does not provide an obstetric code with an "in childbirth" option, it is appropriate to assign a code describing the current trimester.

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ICD-10 Coding Guidelines

- For those inpatient stays when the patient develops complications and during that stay the trimester changes, the trimester that the complication originated in will be the trimester used for code assignment and not the subsequent trimester or trimester at discharge.

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ICD-10 Coding Guidelines

- Fetus Identification Character
- Some Chapter 15 categories require a 7th character to identify which fetus is affected by the condition
- Assign 7th character 0:
  - For single gestation
  - Insufficient documentation to determine which fetus is affected
  - Not possible to clinically determine which fetus is affected
  - Used on categories O31, O32, O33.3-O33.6, O35, O36, O40, O41, O60.1, O60.2, O64 and O69

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ICD-10 Coding Guidelines

Routine outpatient prenatal visits with no complications/conditions:

- Z34.x Encounter for supervision of normal pregnancy
  - First listed only code
  - Do not use codes from Ch.15 with this code. If the patient has complications or conditions that are being addressed or treated, use Ch.15 codes instead

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ICD-10 Coding

Prenatal outpatient visits for high-risk patients:

- O09.x Supervision of high-risk pregnancy
  - First listed code – When visit is for routine prenatal care. This is not a first list only code so if the patient presents with other high-risk conditions this can be a secondary code
  - Can code additional Ch.15 codes as needed
  - Intended for use only during the prenatal period
  - If no complications are present at labor or delivery, assign code O80 (encounter for full-term uncomplicated delivery)

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ICD-10 Coding Guidelines

- For episodes when no delivery occurs, the primary code should be for the condition which necessitated the visit.
- For episodes when delivery occurs:
  - The condition prompting the admission should be reported as primary
  - If multiple reasons prompted the admission, the one most related to the delivery should be sequenced first
  - Any complications of the delivery should be reported as additional codes
  - If the patient is admitted for a condition that results in a c-section, that condition should be reported as primary
  - If the admission was unrelated to the condition resulting in a c-section, the condition related to the admission should be reported as primary

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ICD-10 Coding Guidelines

Outcome of Delivery

- This category is used as an additional code to indicate the outcome of the delivery
- Category Z37 should be reported on every maternal record when delivery occurs
- Should not be reported for subsequent visits nor on the newborn record

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ICD-10 Coding Guidelines

Pre-Existing Conditions vs Complication

- Before assigning codes from Chapter 15, it's important to know if the condition being treated is a pre-existing (existed prior to pregnancy) or have occurred as a result of the pregnancy (pregnancy-induced)
- For categories that do not distinguish between pre-existing or pregnancy-induced, the code can be used for either

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ICD-10 Coding Guidelines

- Covid-19
  - During pregnancy, childbirth or the puerperium, when COVID-19 is the reason for admission/encounter, code O98.5- as the principal/first-listed diagnosis, and code U07.1, COVID-19, and the appropriate codes for associated manifestation(s) as additional diagnoses.
  - If the reason for admission/encounter is unrelated to COVID-19 but the patient tests positive for COVID-19 during the admission/encounter, the appropriate code for the reason for admission/encounter should be sequenced as the principal/first-listed diagnosis, and codes O98.5- and U07.1, as well as the appropriate codes for associated COVID-19 manifestations, assigned as additional diagnoses.

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ICD-10 Coding Guidelines

Pre-Existing HTN

- If using category O10 and the patient also has hypertension heart and/or hypertensive CKD, a secondary code must also be reported from the hypertension category (I11, I12, I13) to specify the type of heart failure or chronic kidney disease

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Let's Code

- Ms. Jones presents to her OB provider and has hypertensive heart and CKD.
- She is currently 20 weeks pregnant and is without heart failure.
- Her CKD is documented as stage 2.
- All conditions are currently stable.

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Let’s Code

1. O10.312
2. I13.10
3. N18.2
4. Z3A.20

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ICD-10 Coding Guidelines

Fetal Conditions Affecting the management of the mother

- Only assigned when the condition actually modifies the management of the mother
  - Diagnostic studies
  - Additional observation
- The fact that a fetal condition exists isn't enough to assign these categories (O35, O36). The condition MUST affect the management of the mother
- If in utero surgery is performed, a code from O35 should be reported to identify the fetal condition.
- No code from Chapter 16 should be reported on the mother's record to identify a fetal condition.

* ICD-10-CM Section O35 added approximately 175 new codes in 2023*

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ICD-10 Coding Guidelines

HIV Infection

- Patient's seen for HIV-related illness should receive a primary diagnosis from category O98.7- followed by additional codes to describe the illness.
- Asymptomatic HIV patients should be assigned a code from category O98.7- and code Z21

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ICD-10 Coding Guidelines

Pre-Existing Diabetes:

- A patient with diabetes should be assigned a primary diagnosis from category O24- followed by the appropriate Chapter 4 diabetes codes (E08-E13)

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ICD-10 Coding Guidelines

Gestational Diabetes:

Pregnancy-induced diabetes

- Subcategory O24.4 should be reported and no other code from category O24 should be used with a code from O24.4
- Codes from subcategory O24.4 include diet-controlled, insulin controlled and controlled by oral hypoglycemic drugs
- Long-term use of insulin (Z79.4), long-term use of oral hypoglycemic drugs (Z79.84) nor long-term use of injectable non-insulin antidiabetic drugs (Z79.85) should be assigned with subcategory O24.4, as these codes state how the diabetes is being controlled.
- If gestational DM patient is controlled with both diet and hypoglycemic drugs, only a code from "controlled by oral hypoglycemic drugs should be reported"

An abnormal glucose tolerance test in pregnancy is assigned a code from subcategory O99.81

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ICD-10 Coding Guidelines

Sepsis and Septic Shock

- Sepsis complicating abortion, pregnancy and childbirth and the puerperium, a code for the specific type of infection should be assigned as an additional code.
- Report R65.2 if severe sepsis is documented, along with additional codes for any associated organ dysfunction.

Puerperal Sepsis

- Code O85 should be assigned with a secondary code to identify the causal organism.
- Other sepsis should not be assigned for puerperal sepsis.
- If severe sepsis is documented, R65.2 category should also be assigned, along with any organ dysfunction codes.

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ICD-10 Coding Guidelines

- Alcohol, tobacco, and drug use
- Anytime a patient uses alcohol, tobacco and/or drug a code from those categories should be reported.
- Additional codes should also be reported for any manifestations of the substance use.

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ICD-10 Coding Guidelines

- Poisoning, toxic affects, adverse affects and underdosing
- Subcategory O9A.2 should be reported as the primary diagnosis.
- An additional code from the injury, poisoning, toxic affect, adverse affect or underdosing code should be reported (S00-T88, except T74 and T76)
- An additional code should be reported for the specific condition being caused

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ICD-10 Coding Guidelines

- Social Determinants of Health (SDOH)
  - Codes describing problems or risk factors related to social determinants of health (SDOH) should be assigned when this information is documented.
  - These codes should be assigned only when the documentation specifies that the patient has an associated problem or risk factor.
  - SDOH ICD-10 codes can be found in categories Z55-Z65

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ICD-10 Coding Guidelines

Normal Delivery:

- O80 should always be the primary diagnosis
- Reported for patients with full-term normal delivery of a single, healthy infant
- Not reported if any other Chapter 15 code is reported
- Should be reported if patient had a complication during pregnancy that resolved prior to delivery

The only outcome of delivery code that can be reported with O80 is Z37.0-single live birth

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ICD-10 Coding

Postpartum Care:

- Z39.2 – Encounter for routine postpartum follow-up. (Postpartum is immediately after delivery thru the first 6 weeks)
- **Excludes 1** care for postpartum complication – see Alphabetic Index (Puerperal, puerperium)
- Per Excludes 1 note, if the patient's encounter is in the postpartum period and they are receiving care for a postpartum condition, omit code Z39.2 and instead code the encounter with Ch.15 codes.
- Additional guideline notes - Ch. 15 codes can be used to describe pregnancy related complications/conditions after the peripartum or postpartum period has ended *when* the provider documents that the condition is pregnancy related.

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ICD-10 Coding Guidelines

- Sequelae of complication
- Code O94
- Use additional code from category O08 to identify any associated complication (O08-O08.9)
- Should be sequenced after the condition resulting from the sequelae

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ICD-10 Coding Guidelines

Termination of pregnancy

- Z33.2 is reported when an attempted abortion results in a live birth, along with a code from category Z37 for the outcome of the delivery
- Follow-up encounters for retained POC are coded as O34.4 (incomplete abortion w/o complication) or O07.4 (failed attempt at termination)
- If the patient develops a specific complication associated with the abortion, a code from O03 or O07 categories should be reported
- For hemorrhage post elective abortion, assign code O04.6, Delayed or excessive hemorrhage following (induced) termination of pregnancy. Do not assign code O72.1, other immediate postpartum hemorrhage, as this code should not be assigned for post abortion.
- Do not assign code Z33.2, Encounter for elective termination of pregnancy, when the patient experiences a complication post elective abortion.

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ICD-10 Coding Guidelines

- Abuse in pregnant patients
- Subcategory O9A.3, O9A.4 and O9A.5:
  - Suspected cases of abuse
  - Confirmed cases of abuse
  - Used as primary code
  - Additional code should be reported for any associated injury
- Report an additional code to identify the perpetrator (Y07.-)

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Take Aways

- Coders are encouraged to know the ICD-10-CM guidelines as they relate to OB coding
- Coders should be aware that payers sometimes have their own policies for OB cases

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References

- Current Procedural Terminology, 2022 American Medical Association
- ICD-10-CM 2023

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