Coding the Ob scan
Joshua A. Copel, MD
Professor, Obstetrics-Gynecology & Pediatrics
Yale School of Medicine

Objectives
At the conclusion of this presentation you will be able to:
1. Code your scans more accurately
2. Understand new CPT & ICD codes

Disclosures
• Member of AMA
• No financial conflicts
• Depend on insurance companies for income
• Contribution to my salary from Yale Corporation for being a Professor: $0

Bona fides
• SMFM Coding Committee 10+ years
• Medical Director, Medical Billing Compliance, Yale Medical Group
  – Largest academic multispecialty practice in New England
  – 3rd largest in US

Coding in Ob Sonography
The Bibles:
- CPT book sets rules (the what)
- ICD book the reasons (the why)
- Descriptions imperfect
Coding in Ob Sonography

“When I use a word,” Humpty Dumpty said in rather a scornful tone, “it means just what I choose it to mean - neither more nor less.”

Lewis Carroll, Through the Looking Glass

Harry Truman

People say, “Give ‘em hell, Harry.”
I never give them hell.
I just tell the truth and they think it’s hell.

Coding in Ob Sonography

• Codes assigned by CPT Committee of AMA
• Representation from ACOG, ACR, AIUM
• Changes proposed from members

Coding in Ob Sonography

• If accepted, Relative Value Units (RVUs) assigned by Relative Value Committee (RUC) after polling practitioners
• RVUs are based on average work
• Budget neutrality often an issue in assigning RVUs
• RVUs used by some payors to determine reimbursement

Coding in Ob Sonography

Modifiers
• -22 Unusual complexity (good luck)
• -26 Professional component
  – Facility bills “-TC”
• Bill global only if all 3 of these are true:
  – YOU own or lease the machine, and
  – YOU own or rent the space, and
  – YOU employ the sonographer
• Otherwise you MUST use -26!

Base RVU Assignments
Professional Component only

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>76805</td>
<td>Basic scan</td>
<td>1.00</td>
</tr>
<tr>
<td>76810</td>
<td>Multiple*</td>
<td>0.97</td>
</tr>
<tr>
<td>76815</td>
<td>Limited</td>
<td>0.65</td>
</tr>
<tr>
<td>76816</td>
<td>Follow-up*</td>
<td>0.85</td>
</tr>
<tr>
<td>76801</td>
<td>1st trimester</td>
<td>0.99</td>
</tr>
<tr>
<td>76802</td>
<td>1st tri multiple*</td>
<td>0.83</td>
</tr>
<tr>
<td>76811</td>
<td>Comp. Fetal survey</td>
<td>1.90</td>
</tr>
<tr>
<td>76812</td>
<td>Comp. Fetal survey*</td>
<td>1.78</td>
</tr>
<tr>
<td>76817</td>
<td>Ob transvag</td>
<td>0.76</td>
</tr>
</tbody>
</table>

*per fetus
SMFM Statement on 76811

Because this new code will be assigned more RVUs than the basic obstetrical sonogram (76805), the SMFM believes that the new code describes an examination involving significantly more work, and requiring greater expertise than that required for 76805. Additionally, sophisticated equipment, rather than typical office level ultrasound machines, will be required to obtain the necessary imaging detail.

SMFM Statement on 76811

“The level of expertise required to perform this examination can generally only be obtained through the extended education beyond residency that is acquired in a fellowship in Maternal-Fetal Medicine or Radiology... Use of this code by general obstetricians should be the exception rather than the rule.”

FAQs

Q: If I have a low risk patient and do a REALLY thorough scan, can I bill 76811 instead of 76805?

A: Unfortunately no. Code the indication, not the procedure

FAQs

Q: But my compliance office says that’s fraud!

A: They’re wrong. Code the indication, not the scan

Relevant concept: medical necessity, same as for E&M codes
<table>
<thead>
<tr>
<th>FAQs</th>
<th>FAQs</th>
</tr>
</thead>
</table>
| • Q: Do I have to sign my charts? | • Q: Do I have to sign my charts?  
• A: Really?  
No, I mean REALLY? |
| I scan my diabetics and hypertensives regularly for growth and always do a thorough examination of fetal anatomy. How do I code? | I scan my diabetics and hypertensives regularly for growth and always do a thorough examination of fetal anatomy. How do I code?  

Answer: 76816, those are follow up exams. |
<table>
<thead>
<tr>
<th>FAQs</th>
<th>FAQs</th>
</tr>
</thead>
</table>
| How should I code Ductus Venosus Doppler? | Can I assign 740-759 series codes as a secondary code when a fetal anomaly is found?  
Answer: Codes from Chapter 14 Congenital Anomalies (740-759.9) should not be reported as a maternal codes  
Use codes from the 655.xx series  
These codes on maternal record give the mother the anomaly |
| Answer: it s a freebie.  
Relax, you’re not doing that in isolation, are you? |
Coming Attraction

- October 1, 2015: ICD-10
- Used in rest of world
- ICD.9 ~14,500 codes
- ICD.10 has ~70,000!

Key changes

- ICD 9 3-5 character, mostly numeric
- ICD 10 Alpha-numeric, up to 7 characters
- Inclusion of trimesters in many codes; others number the fetus being examined

Format

- First character always a letter
  - Ch 14 (N) GU system
  - Ch 15 (O) Pregnancy, childbirth & puerperium
- Second character always a number
- Characters 3-7 either letter or number
- Example: O9A.311 Physical abuse complicating pregnancy, first trimester

Deciphering

- Format AAA.BBBC
- AAA= Category
- BBB= Etiology, anatomic site, severity
- C = severity (or # of multiple for us)
- Placeholder character X
  -

More codebreaking

- Some codes require 7th character for multiples
- 0 = not applicable, ie only 1 fetus
- 1-5 = fetus number
- 9 = other fetus(es) beyond #5
- Must report code from O30 category which designates placentation

Examples

- O36: maternal care for other fetal problems
  - suspected placental insufficiency, 3rd tri
- O40: polyhydramnios
  - O40.3xx0 Polyhydramnios, 3rd tri, single fetus
New term: GEMS
• General Equivalence Mapping
• “A sentence translated from English to Chinese may not be able to capture the full meaning of the original because of fundamental differences in the structure of the language. Likewise, a code set may not be able to seamlessly link the codes in one set to identical counterparts in the other code set.”

GEMS rules
• There are no rules
• Variable number of new codes
• Arranged according to different “axes”

Unequal axes of classification
Classified by stage of pregnancy: ICD-10-CM
• 026.851 Spotting complicating pregnancy, 1st tri
• 026.852 Spotting complicating pregnancy, 2nd tri
• 026.853 Spotting complicating pregnancy, 3rd tri
• 026.859 Spotting complicating pregnancy, unspecified trimester

Classified by episode of care: ICD-9-CM
• 649.50 Spotting complicating pregnancy, unspecified episode of care
• 649.51 Spotting complicating pregnancy, delivered
• 649.53 Spotting complicating pregnancy, antepartum

ICD-10 rules
• Some similar to ICD-9
• Chapter 17 Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
• Codes from this chapter are not for use on maternal or fetal records

Our areas of interest
Chapter 14 (N) contains
• “Inflammatory diseases of female pelvic organs,”
• “Noninflammatory disorders of female genital tract”
Endometriosis

N80.0 Endometriosis of uterus
Adenomyosis
N80.1 Endometriosis of ovary
N80.2 Endometriosis of fallopian tube
N80.3 Endometriosis of pelvic peritoneum
N80.4 Endometriosis of rectovaginal septum and vagina
N80.5 Endometriosis of intestine
N80.6 Endometriosis in cutaneous scar
N80.8 Other endometriosis
N80.9 Endometriosis, unspecified

Pregnancy - Chapter 15

Codes from this chapter are for use for conditions related to or aggravated by the pregnancy, childbirth, or by the puerperium (maternal causes or obstetric causes)

- Trimesters are counted from the first day of the last menstrual period. They are defined as follows:
  - 1st trimester: <14 + 0
  - 2nd trimester: 14 + 0 - < 28 + 0
  - 3rd trimester: 28 + 0 until delivery

- Use additional code from category Z3A, Weeks of gestation, to identify the specific week of the pregnancy (Z3A.36 for 36 weeks' gestation)

Actual screen shot

O19.5 Pre-existing essential hypertension complicating pregnancy, childbirth and the puerperium
Any condition in ICD specified as a reason for obstetric care during pregnancy, childbirth or the puerperium
O19.6 Pre-existing essential hypertension complicating pregnancy, first trimester
O19.7 Pre-existing essential hypertension complicating pregnancy, second trimester
O19.8 Pre-existing essential hypertension complicating pregnancy, third trimester
O19.9 Pre-existing essential hypertension complicating pregnancy, unspecified trimester
O19.02 Pre-existing essential hypertension complicating childbirth
O19.03 Pre-existing essential hypertension complicating the puerperium

How about ultrasound?

- "Congenital" only used in relation to uterine anomalies
- "Defect" only used for coagulation defects

Look familiar?

O35.0 Maternal care for (suspected) central nervous system malformation in fetus
O35.1 Maternal care for (suspected) chromosomal abnormality in fetus
O35.2 Maternal care for (suspected) hereditary disease in fetus
O35.3 Maternal care for (suspected) damage to fetus from viral disease in mother
O35.4 Maternal care for (suspected) damage to fetus from alcohol
O35.5 Maternal care for (suspected) damage to fetus by drugs
O35.6 Maternal care for (suspected) damage to fetus by radiation
O35.7 Maternal care for (suspected) damage to fetus by other medical procedures
O35.8 Maternal care for other (suspected) fetal abnormality and damage
O35.9 Maternal care for (suspected) fetal abnormality and damage, unspecified

Conclusions

- Looks like its going to happen this time, though AMA still fighting
- You should be preparing now
- EHR selection should be complete (you want that for Meaningful Use $$)
- Talk to vendor about conversion
Coding in Ob Sonography

Additional resources:
• Society for Maternal-Fetal Medicine Coding Manual (© SMFM, 2001).
  – Available at <www.smfm.org>
• ACOG “CPT Coding in Obstetrics & Gynecology”
  Both updated annually

“I’m so glad we’ve had this little talk, Earl!”