Coding Companion for OB/GYN

A comprehensive illustrated guide to coding and reimbursement

2013
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Terms To Know
antepartum. Period of pregnancy between conception and the onset of labor.

CCI Version 17.3
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

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*with documentation

Medicare References: 100-3,220.5
**Explanation**
A radiograph is taken of the patient's chest from front to back (AP). Typically, this is done when the patient is too ill to stand or be turned to the prone position. The key element of this code is that it reports a single, frontal view.

**Explanation**
Films are taken of the patient's chest to include a frontal and side to side (lateral) view. This code specifically reports these two views.

**Explanation**
One or two views are taken of the pelvis. The most common view is from front to back (AP) with the patient lying supine with feet inverted 15 degrees to overcome the anteversion (or rotation) of the femoral necks. The pelvic girdle, femoral head, neck, trochanters, and upper femurs are also shown.

**Explanation**
A minimum of three films are taken of the pelvis, typically front to back (AP) with the patient lying supine. The patient's legs are placed in what is termed a "frogleg" lateral position, wherein the patient's feet are drawn up toward the buttocks, at which point the knees are allowed to drop down to the table with feet together. A third film may be taken with the patient lying on his or her side for a lateral view of the pelvis, as well as unilateral views of the hips, if necessary.

**Explanation**
Computed tomographic angiography (CTA) of the pelvis is performed with contrast materials and image postprocessing. CTA produces images of vessels to detect aneurysms, blood clots, and other vascular irregularities. Contrast medium is rapidly infused intravenously, at intervals, usually with an automatic injector, and the patient is scanned with thin section axial or spiral mode x-ray beams. The images are acquired with narrower collimation and reconstructed at shorter intervals than standard CT images. Three-dimensional images are generated and postprocessing reconstruction is done at a workstation on the scanner. CTA also provides information unavailable with conventional angiography, such as vessel wall thickness (mural thrombus) and the venous anatomy of a target organ and/or associated organs within the scan range. Noncontrast images, if performed, are also included in this procedure.

**Explanation**
Computed tomography directs multiple narrow beams of x-rays around the body structure being studied and uses computer imaging to produce thin cross-sectional views of various layers (or slices) of the body. It is useful for the evaluation of trauma, tumor, and foreign bodies as CT is able to visualize soft tissue as well as bones. Patients are required to remain motionless during the study and sedation may need to be administered as well as a contrast medium for image enhancement. These codes report an exam of the pelvis. Report 72192 if no contrast is used. Report 72193 if performed with contrast and 72194 if performed first without contrast and again following the injection of contrast.

**Explanation**
Magnetic resonance imaging (MRI) is a radiation-free, noninvasive, technique to produce high quality sectional images of the inside of the body in multiple planes. MRI uses the natural magnetic properties of the hydrogen atoms in our bodies that emit radiofrequency signals when exposed to radio waves within a strong electro-magnetic field. These signals are processed and converted by the computer into high-resolution, three-dimensional tomographic images. Patients with metallic or electronic implants or foreign bodies cannot be exposed to MRI. The patient must remain still while lying on a motorized table within the large, circular MRI tunnel. A sedative may be administered as well as contrast material for image enhancement. These codes report an exam of the pelvis. Report 72195 if no contrast is used. Report 72196 if performed with contrast and 72197 if performed first without contrast and again following the injection of contrast.

**Explanation**
Magnetic resonance angiography (MRA) is magnetic resonance imaging (MRI) that specifically visualizes blood vessels and blood flow to evaluate vascular disorders within the structure being studied. Unlike CT, it does not rely on the absorption of x-ray energy. Magnetic resonance imaging uses the natural magnetic properties of the hydrogen atoms in our bodies that emit radiofrequency signals when exposed to radio waves within a strong electro-magnetic field. These signals are processed and converted by the computer into high-resolution, three-dimensional tomographic images. Patients with metallic or electronic implants or foreign bodies cannot be exposed to MRA. The patient must remain still while lying on a motorized table within the large, circular MRI tunnel. A sedative may be administered as well as contrast material for image enhancement. This code reports an exam of the pelvis.

**Explanation**
Films are taken (minimum of two views) of the sacrum and the coccyx. The sacrum is a triangular bone located between the fifth lumbar vertebra and the coccyx. It is formed by five connected vertebræ and is wedged between the two innominate bones. The coccyx is the small bone at the very base of the spinal column, and is formed by the fusion of four vertebrae. The sacrum and the coccyx form the posterior (back) boundary of the pelvis. While anteroposterior (AP; front to back) and lateral (side) views are the most common views taken, this procedure is used for any two or more views reported.

**Explanation**
Films are taken of the abdominal cavity in one view from front to back. Because an abdominal x-ray usually precedes another diagnostic imaging procedure, it is not coded separately unless performed as a separately identifiable examination.
Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $32 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician’s office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician is on call or covering for another physician, the patient’s encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient's attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as “observation status” in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician “admitting” the patient for observation.

Codes 99224-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and preparation of the discharge records. It should not be used when admission and discharge are on the same date of service. As mentioned above, report codes 99234-99236 to appropriately describe same day observation services.

If a patient is in observation longer than one day, subsequent observation care codes 99224-99226 should be reported if the patient is discharged on the second day, observation discharge code 99217 should be reported. If the patient status is changed to inpatient on a subsequent date, the appropriate inpatient code, 99221-99223, should be reported.

Initial hospital care is defined as E/M services provided during the first hospital inpatient encounter with the patient by the admitting physician. (If a physician other than the admitting physician