THE KENNETH J. **RYAN RESIDENCY TRAINING PROGRAM**
IN ABORTION & FAMILY PLANNING

Billing and Coding 101

October 17, 2019 – Society of Family Planning Annual Meeting

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LARC Cases

Case 1: Complex IUD removal with hysteroscopy

Complex IUD removal with hysteroscopy of a retained IUD arm after office IUD removal

Operation: hysteroscopic removal of IUD fragment

Preoperative Diagnosis: retained IUD fragment
Postoperative Diagnosis: Same

Pathology/Indications/Findings: NL Ostia bilaterally; IUD fragment in R cervix
IUD fragment to pathology per hospital protocol

Procedure:
A surgical pause was performed in accordance with hospital regulations. No antibiotic was administered in the operating room prior to the procedure.

At the time of preop labs, her serum hCG is < 2 and a urine pregnancy test today is negative.

Following general anesthesia, the patient was examined in the lithotomy position. The uterus was felt to be small, firm, mobile with small adnexae. The patient was then prepped and draped in the usual sterile fashion.

An open-sided speculum was inserted and a single tooth tenaculum was placed on the anterior lip of the cervix. The cervix was serially dilated to Pratt 15. The 5mm scope was inserted using pressure for distention. Normal ostial and a uterine cavity were noted. The IUD fragment was noted protruding from the R cervical canal. The fragment was grasped with hysteroscopic graspers and the fragment was removed, intact, with a combination of traction in the opposite direction and fundally. Instruments were removed.

The patient was awakened and extubated and taken to the recovery room in stable condition.

Fluid deficit 30mL NS

Estimated blood loss was 5 mL.

A foreign body sweep was conducted

Attestation: I was present and scrubbed for the entire procedure.

Case 1 Coding Solution

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	58555, Hysteroscopy, diagnostic (separate procedure)		
	58301, Removal of intrauterine device (IUD)		
	58562, Hysteroscopy, surgical; with removal of impacted foreign body		
	ICD-10-CM Code Choices		
1	Z30.432, Encounter for removal of intrauterine contraceptive device		
2	T19.2XXA, Foreign body in vulva and vagina, initial encounter		
3	T19.3XXA, Foreign body in uterus, initial encounter		
4	T19.8XXA Foreign body in other parts of genitourinary tract, initial encounter		
5	T83.39XD, Other mechanical complication of intrauterine contraceptive device, subsequent encounter		
6	T83.39XA, Other mechanical complication of intrauterine contraceptive device, initial encounter		
7	T83.32XA, Displacement of intrauterine contraceptive device, initial encounter		
	HCPCS Codes		

Case 2: Office complex IUD removal with ultrasound guidance

This is a 29 y/o G8P7017 presenting for difficult IUD removal, referred by NP Awesome. She presented for IUD removal and strings were not seen. She had it placed immediately PP in December 2018. She does not like the heavy menses. LMP: October 4th. Periods are regular lasting about 8 days, heavy and cramping, using 5-6 pads daily most days. Ibuprofen helps menstrual cramping but not bleeding. Recent hemoglobin 10.8.

OB History: 2 vaginal deliveries, 5 c sections, 1 miscarriage
GYN History: Pap history: last year; no abnormal history; Previously treated for chlamydia.

PMH: History of gestational diabetes; obesity
PSH: cesarean delivery x 5

Social History: No smoking, alcohol, or recreational drug use. Feels safe at home.
Family History: noncontributory

Medications: copper IUD, ferrous sulfate

Review of Systems: A 14-point review of systems was negative except as per HPI.

Physical Exam: BP 110/80, HR 77, BMI 31.2

GENERAL: Well appearing
EYES: EOMI, Sclera non-icteric, pupils normal in size.
ENT: No rhinorrhea or lacrimation, normal nose.
CV: No edema.
RESPIRATORY: non-labored breathing, normal respiratory effort.
GASTROINTESTINAL: soft, nontender, nondistended, no hepatosplenomegaly, no masses, well healed Pfannenstiel scar
SKIN: warm, dry, no cyanosis, bruising, or rashes noted.
PSYCH: Alert & oriented x 3, normal mood and affect, speech clear, thoughts coherent, good eye contact.
NEURO: CN 2-12 grossly intact

ULTRASOUND PROCEDURE, NON-OB:
Indication: locate IUD
Approach: [_] transvaginal [X] transabdominal
Uterine dimensions: L 7.98 cm x W 4.75 cm x H 4.28 cm
Uterine position: AV
Endometrium: not easily measured due to IUD
IUD location: intrauterine, fundal - with T arms sitting in the endometrial canal and IUD shaft horizontal between ostia
Free fluid: [_] seen [x] not seen
Adnexa: [_] Normal [_] Abnormal [x] Not well visualized
Impression: IUD at fundus, intrauterine, rotated from usual position

PROCEDURE: Complex IUD removal with ultrasound guidance, paracervical block
MEDICATIONS: 1% lidocaine paracervical block drawn up and administered at bedside

PROCEDURE NOTE:
The patient was consented for removal of IUD, including risks of possible bleeding, infection, pain, damage to surrounding structures, including uterine perforation. A timeout was performed confirming the correct patient and procedure and that the appropriate equipment was present. A speculum was inserted. The IUD strings were not visualized. A cytobrush was inserted into the cervix and withdrawn in an attempt to pull the strings externally, but was unsuccessful. The cervix was then cleaned with betadine. 1mL 1% lidocaine paracervical block was administered at the anterior lip of the cervix. A tenaculum was placed on the anterior lip of the cervix. The remainder of the paracervical block was administered at the 4 and 8 o clock positions.

The IUD forceps were then inserted under ultrasound guidance into the cervical canal and we attempted to locate the strings. The strings were not located and the IUD was not able to be removed. The IUD forceps were then placed into the uterus under direct ultrasound visualization and the IUD was able to be removed under ultrasound guidance. All instruments were removed from the uterus, and the patient tolerated the procedure well. Hemostasis was noted at the end of the procedure.

EBL: 1mL
Complications: none

Ultrasound findings: successful removal of IUD

Assessment/Plan: Complex IUD removal; contraception counseling
#Complex IUD removal
- IUD was removed today without complication

#Contraception
-Discussed birth control methods and goals
-Would like to return to taking OCPs today
-Discussed how to take OCPs continuously, and what to do if missed dose
-Prescribed Sprintec plus refills

Attestation: I saw and evaluated the patient on the day of service, confirming the key portions of the history and physical examination findings. I was present during the ultrasound by the resident and reviewed the results. I discussed the case with the resident. I reviewed the resident's note and agree with the findings and plan as documented in the resident's note. I was present for the entire procedure.

Case 2 Coding Solution

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	99213, expanded problem focused hx or exam, low complexity MDM		
	99212, problem focused hx or exam, straightforward complexity MDM		
	58301, Removal of intrauterine device (IUD)		
	76998, Ultrasonic guidance, intraoperative		
	76856, Ultrasound, pelvic (nonobstetric), real time with image documentation; complete		
	76857, Ultrasound, pelvic (nonobstetric), real time with image documentation; limited		
	76830, transvaginal ultrasound		
ICD-10-CM Code Choices			
1	Z30.432, Encounter for removal of intrauterine contraceptive device		
2	T83.31XA, Breakdown (mechanical) of intrauterine contraceptive device, initial encounter		
3	T83.32XA, Displacement of intrauterine contraceptive device, initial encounter		
4	T83.39XA, Other mechanical complication of intrauterine contraceptive device, initial encounter		
5	Z30.011, Encounter for initial prescription of contraceptive pills		
HCPCS Codes			
	S4993, Contraceptive pills for birth control		

Case 3: Complex IUD insertion

Pt presents today for placement of Mirena IUD as previously decided. She reports no changes to her past medical, surgical, family, or social history since her last visit.

PROCEDURE
Risk, benefits and alternatives to IUD discussed with pt and informed consent obtained. A timeout was performed confirming the correct patient and procedure.

Bimanual exam was done which revealed a retroverted uterus that was non-tender and normal size and consistency. Speculum placed in vagina and cervix well visualized. Cervix cleaned with betadine X3. Single tooth tenaculum placed on posterior face of cervix, gentle traction applied. Uterine sound to 9 cm. Unable to pass Mirena IUD past the internal os into uterus. Tenaculum placed on anterior face of cervix and attempted placement of IUD, still unable to pass IUD. Attempted Kyleena IUD and unable to pass Kyleena IUD beyond 7cm. Sounded again and sounded at 9cm.

Dr. FP Complex was called into the room for assistance. She placed Mirena IUD at 7cm and did transvaginal US. Confirmed lower uterine segment/cervical IUD placement and IUD was removed. Pt tolerated procedure well. Minimal bleeding at tenaculum site.

Ultrasound report by Dr. FP Complex:

ULTRASOUND PROCEDURE, NON-OB:
Indication: post-IUD placement, confirm IUD position
Approach: [x] transvaginal [_] transabdominal
Uterine dimensions: L 9.65 cm x W 4.75 cm x H 4.28 cm
Uterine position: Retroverted
Endometrium: 0.49 cm
IUD location: LUS/cervix
Free fluid: [_] seen [x] not seen
Adnexa: [_] Normal [_] Abnormal [x] Not well visualized
Impression: Malpositioned IUD

Case 3 Coding Solution

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	58300, Insertion of intrauterine device (IUD)		
	58301, Removal of intrauterine device (IUD)		
	76830, Transvaginal ultrasound		
	ICD-10-CM Code Choices		
1	Z53.09, Procedure and treatment not carried out because of other contraindication		
2	Z30.430, Encounter for insertion of intrauterine contraceptive device		
3	Z30.432, Encounter for removal of intrauterine contraceptive device		
4	T83.32XA, Displacement of intrauterine contraceptive device, initial encounter		
5	Z30.433, Encounter for removal and reinsertion of intrauterine contraceptive device		
	HCPCS Codes		
	J7296, Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg		
	J7298, Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52 mg		
	A4550, Surgical trays		
	S4981, Insertion of levonorgestrel-releasing intrauterine system		

Who bills for the ultrasound? This provider or another provider?

Case 4: Laparoscopic removal of pelvic intrauterine device, new IUD placement

Preop diagnosis: Suspected perforated IUD
Postop diagnosis: Perforated IUD

Procedure: Laparoscopic removal of intraabdominal IUD; placement of new IUD

Findings: Grossly normal appearing tubes, uterus, ovaries. No evidence of pelvic adhesions. IUD perforated through the posterior wall in the mid plane of the uterus. No bleeding noted at the site. IUD removed intact. New IUD then placed under direct visualization and confirmed with US.

Indications: Pt is a 34 y/o who had an IUD placed 6 months ago. Recently she had some bleeding that was odd for her so she presented for exam and the strings were not noted. US was unable to find the IUD and an X-ray of the abdomen noted the IUD to be extra uterine. Due to this finding a diagnostic laparoscopy was recommended to remove the IUD. After further discussion, she desired to have another Mirena IUD placed. Informed consent was signed prior to the procedure.

Procedure in detail: The patient was taken to the operating room where GETA was obtained and found to be adequate. She was prepped and draped in the usual sterile fashion. She was positioned to the dorsal lithotomy position with yellow-fin stirrups.

A 5 mm umbilical skin incision was made. Through this a Veress needle was inserted into the abdominal cavity and CO2 started. The opening pressure was noted to be 4 mm of mercury. The abdomen was filled to a pressure of 15 mm Hg. The Veress needle was withdrawn. A 5 mm trocar sleeve was placed and the laparoscope inserted, confirming intraabdominal placement. A 5 mm skin incision was then made in the RLQ through this a second trocar sleeve was placed into the abdominal cavity using direct observation with the laparoscope. The above findings were noted, and the IUD was removed from the pelvis intact and without complication. At this point the RLQ port was removed and attention was turned to placing the new IUD.

A speculum was placed in the vagina and a single toothed tenaculum was placed on the anterior lip of the cervix. The uterine sound was used to measure the cervix and cavity under direct laparoscopic visualization, and this was 7.5 cm. The IUD was then placed, again under direct visualization from above. The strings were trimmed. Everything was removed from the vagina.

The gas was allowed to escape from the abdomen and the trocars were removed. The skin was closed with 4-0 Monocryl and Dermabond.
US was performed to confirm placement at the fundus.

There were no complications to the procedure. Blood loss was minimal. The patient went to the post anesthesia recovery room in stable condition.

Case 4 Coding Solution

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	58578, Unlisted laparoscopy procedure, uterus		
	49329, Unlisted laparoscopy procedure, abdomen, peritoneum and omentum		
	58300, Insertion of intrauterine device (IUD)		
ICD-10-CM Code Choices			
1	T83.39XA, Other mechanical complication of intrauterine contraceptive device, initial encounter		
2	Z30.433, Encounter for removal and reinsertion of intrauterine contraceptive device		
3	Z30.432, Encounter for removal of intrauterine contraceptive device		
4	Z30.430, Encounter for insertion of intrauterine contraceptive device		
HCPCS Codes			
	J7298, Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52 mg		
	S4981, Insertion of levonorgestrel-releasing intrauterine system		

Case 5: Complex implant removal procedure

Patient referred from Dr. Biceps for nonpalpable implant localization and removal.

Procedure: Contraceptive implant removal with ultrasound guidance

The informed consent process was completed with the patient. The procedure-specific permit was signed and witnessed. Risks discussed including but not limited to: excessive bleeding or bruising at removal site, infection, pain, damage to underlying neurovascular structures. Patient elected to proceed.

A timeout was performed confirming correct patient, correct procedure, and that the appropriate equipment was present.

Patient was placed in a supine position with her left arm raised to the level of the shoulder and flexed at the elbow. The implant was identified 5mm depth with ultrasound and there were no nearby vascular structures. The implant was marked with a surgical pen and the overlying skin was washed with chlorhexidine. Approximately 1 mL of 1% lidocaine was injected subdermally at the planned incision site. The local anesthesia effect was checked and noted to be adequate. A 4mm skin incision was made with a scalpel and the implant was removed intact with a hemostat and vasectomy clamp under ultrasound guidance without difficulty. A bandage was placed over the incision site and a dressing was applied. The patient tolerated the procedure well.

EBL: 1mL

Case 5 Coding Solution

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	11976, Removal, implantable contraceptive capsules		
	11982, Removal, non-biodegradable drug delivery implant		
	24200, Removal of foreign body, upper arm or elbow area; subcutaneous		
	76998, Ultrasonic guidance, intraoperative		
	76882 Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft tissue structure[s], or soft tissue mass[es]), real-time with image documentation		
ICD-10-CM Code Choices			
1	Z30.46, Encounter for surveillance of implantable subdermal contraceptive		
2	T85.628A, Displacement of other specified internal prosthetic devices, implants and grafts, initial encounter		
3	T85.898A, Other specified complication of other internal prosthetic devices, implants and grafts, initial encounter		
4	Z97.8, Presence of other specified devices		
HCPCS Codes			
	A4550, Surgical trays		

Abortion Cases

Case 6: Medication abortion with ultrasound follow up

OFFICE NOTE
Chief Complaint: pregnancy
20-year-old Gravida 1 Para 0 at 9.5 wks EGA by: LMP of 8/10/19

HPI
When she first suspected pregnancy: early October
When she was diagnosed pregnant: 10/11/19 by: home UPT
She's told about the pregnancy: Partner. Friend
She's told about the abortion decision: Partner. Friend.
Who is her support for the abortion? Friend
She comes to the office today with: No one

Unplanned pregnancy: Using contraception? Yes, type: condoms. Used consistently? No
Her main reason(s) for choosing the abortion: She is not emotionally ready to be a mother

Past Gynecologic History: Menses: Regular, x 4 days moderate. Cramps: None
Menarche: 12 yo; Coitarche: 18 yo; Raped/coerced sex : no Lifetime sexual partners male: 3
Sexual partners in last year: 2 STIs: CT dx 3/2010. ~2kws ago had STI testing that was neg per pt including HIV test neg. Abnormal Paps: None.

Past OB History G1

PMH: None.
Current Meds: None.
Allergies: Latex-asked/denied; No Known Drug Allergy; Peanuts. No iodine or shellfish allergy.
PSH: None.
Personal History: Patient lives with: mother. Education Level: in college freshman now
Working currently: no; Cigarette smoking: no; Alcohol drinking: no; Illicit drug use: no
Got pregnant with current partner? not now, was long distance (Chicago)
Domestic Violence with current partner? No; Domestic Violence with prior partner? no.

Family Hx: HTN.

ROS
Negative for: Neuro. Dental. CV. Pulm. Derm. Musc-skel. Psych
Positive for: ENT wears contacts. Endo, nausea and some vomiting in pregnancy, mild.

Vital Signs
BP:117/64, LUE, Sitting, HR: 86 b/min, Resp: 20 r/min, Temp: 36 C, Oral,
Height: 60 in, Weight: 119.5 lb, BMI: 23.3 kg/m2, Pain Scale: 0.
Physical Exam
GENERAL: Thin. No distress

MENTAL STATUS: Alert, normal MS. Answers all questions appropriately.
LUNGS: CTA bilaterally, no wheezes with forced expiration, respirations unlabored.
HEART: Regular rate without murmurs.
ABDOMEN: Soft, non-tender, no masses.

ULTRASOUND PROCEDURE, LESS THAN 14 WEEKS:
Approach: [x] transabdominal
Number of fetuses: 1
Gestational sac: [x] seen
Yolk sac: [x] seen
Embryo: [x] seen CRL _ cm = 9.5 weeks
Cardiac activity: seen
Placenta location: posterior
Amniotic fluid volume: [x] Normal
Uterine position: Anteverted
Adnexa: [x] Normal
Final gestational age: 9.5 weeks by [x] LMP + ultrasound

POC hemoglobin 13.2

COUNSELING:
The patient and I discussed her pregnancy options, including continuation of the pregnancy with parenthood or adoption, and termination of pregnancy. She plans to proceed with termination of pregnancy after considering her options as the pregnancy will have a profound negative impact upon her physical and/or mental health. We discussed medical versus surgical abortion, including the risks and benefits of each method of termination. The patient chose medical termination.

Contraceptive Counseling: The patient was counseled in detail about her contraceptive options. She says she wishes to postpone another pregnancy for ~5 years. In discussing her options, we focused on LARC. She is undecided at this time; will readdress at next encounter. Pt considering Ring.

PROCEDURE:
Medications in clinic
Mifepristone (Mifeprex) PO 200 mg, NDC 64875-001-01 taken at 10:42am
Misoprostol (Cytotec) 800 mcg, NDC 43386-0161-01 (200 mcg x4 units), given to patient to take at home

Informed consent was signed with the patient and she understood all the risks, benefits, and alternatives to the procedure including continuation of the pregnancy and adoption, and medical versus surgical termination of pregnancy. She understands the risks of medical abortion procedure failure resulting in a possible ongoing pregnancy and possible need for additional medication or surgical procedure.

Mifepristone with misoprostol use was reviewed including side effects of nausea, vomiting, diarrhea, fever, chills, and dizziness and encouraged hydration during medication use. A handout reviewing this information was given to the patient after review. She was instructed to call the clinic if these symptoms persisted beyond 24 hours after misoprostol administration. She was given emergency contact information for the clinic and on-call providers 24 hours a day 7 days a week.

She understands that the mifepristone is administered today in clinic followed by misoprostol administration at home in 24 to 48 hours after her mifepristone dose. Bleeding and cramping should occur 2-6 hours after misoprostol and it is normal to soak through 2 pads per hour for 2 hours. If her bleeding is more than this she was advised to contact the clinic or on-call provider. She was also advised to contact the clinic or on-call provider if her pain is severe even after taking pain medications for relief.

We discussed the importance of follow up to ensure completion of the medical termination of pregnancy.

Assessment

20-year-old Gravida 1 Para 0 at 9w5d wks EGA by LMP c/w office US. Patient requests termination of pregnancy and consents to abortion. Continued pregnancy is a threat to her emotional/psychological health.

Plan

- Blood drawn to check Rh. if negative, will call pt to have her come in tomorrow for RHOGAM. Pt aware of need for f/u if Rh Neg.
- STI screen: We will follow up on her cervical testing.
- Contraception: Given Rx: NuvaRing (contraceptive ring). She received an advance prescription for Plan B emergency contraception.

1st trimester Medical TOP: After counseling about her options of medical or surgical abortion, she chooses medical abortion. She signed the consent for medical abortion with mifepristone and misoprostol. The instructions for the regimen were reviewed with her in detail and she was given a copy to take home.

She was given 200 mg mifepristone (lot number: 09018, exp date: 11/2014) orally at 10:42am in the office.

She was given 4 of the 200 mcg tablets misoprostol for buccal administration at home in 24 to 48 hours.

She was given a prescription for Phenergan 25 mg PO Q 6 hr prn.

She was given a prescription for Ibuprofen 800 mg PO Q6-8 hours prn.

She was advised to return to office in one week for a follow up appointment.

Follow up appointment
CC: Follow up

HPI: 20-year-old G1 P0 for follow-up for a medical abortion. She was seen 1 week ago with IUP at 9 weeks. She had pregnancy options counseling and she proceeded with medical abortion. She had bleeding followed by cramping as described. She took ibuprofen for one day only. She had some clots day 2 after the miso and then tapered significantly. Today she reports minimal bleeding slowing down as expected and no pain.

For birth control she is interested in ring. Her Rh type is positive, therefore RhIG was not given.

PAST OBSTETRICAL, GYNECOLOGIC, MEDICAL, SURGICAL, FAMILY, SOCIAL HISTORY reviewed and unchanged since last visit on 10/10/19.

ROS: A 10-point review of systems was positive as per HPI, and was otherwise negative.

Exam: Vitals per chart
GENERAL: well appearing, in no acute distress.
EYES: EOMI, sclerae non-icteric, pupils normal in size
ENT: No rhinorrhea or lacrimation, normal nose.
CV: no edema.
RESPIRATORY: non-labored breathing, normal respiratory effort.
GENITOURINARY: Normal appearing external genitalia.
SKIN: warm, dry, no cyanosis, bruising, or rashes noted.
PSYCH: A&O x 3, normal mood and affect, speech clear, thoughts coherent, good eye contact.
NEURO: CN 2-12 grossly intact

ULTRASOUND PROCEDURE, PELVIC:
Indication: follow up
Approach: [x] transvaginal
Uterine dimensions: L 6.72 cm x W 4.99 cm x H 3.05 cm
Uterine position: AV
Endometrial thickness: 1.12 cm
Gestational sac: [x] not seen
Free fluid: [x] not seen
Adnexa: [x] Normal [_] Abnormal [_] Not well visualized
Impression: completed medication abortion

ASSESSMENT/PLAN
Completed medication abortion, no complications.
Patient is Rh positive. She plans NuvaRing for birth control. Advised her to start as she has not yet started it.
Return for well exam or prn.

Case 6 Coding Solution

Initial Encounter

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	99214, detailed hx and exam and moderate complexity MDM		
	99213, expanded problem focused hx and exam, low complexity MDM		
	99202, expanded problem focused hx and exam with straightforward MDM		
	99203, detailed hx and exam with low complexity MDM		
	76801, OB ultrasound <14 weeks		
ICD-10-CM Code Choices			
1	Z31.89, Encounter for other procreative management		
2	Z30.015, Encounter for initial prescription of vaginal ring hormonal contraceptive		
3	Z30.09, Encounter for other general counseling and advice on contraception		
4	Z64.0, Problems related to unwanted pregnancy		
5	Z33.2, Encounter for elective termination of pregnancy		
6	O36.80X0, Pregnancy with inconclusive fetal viability, not applicable or unspecified		
7	Z36.89, Encounter for other specified antenatal screening		
HCPCS Codes			
	S0190, Mifepristone, oral, 200 mg		
	S0191, Misoprostol, oral, 200 mcg		
	J3490, unclassified drug		
	J7303, Contraceptive supply, hormone containing vaginal ring, each		

Follow-up Encounter

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	99213, expanded problem focused hx and exam, low complexity MDM		
	99214, detailed hx and exam and moderate complexity MDM		
	76815, Ultrasound, pregnant uterus, limited		
	76830, Ultrasound, transvaginal		
	76817, Ultrasound, pregnant uterus, real time with image documentation, transvaginal		
ICD-10-CM Code Choices			
1	Z33.2, Encounter for elective termination of pregnancy		
2	Z09, Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm		
3	Z30.09, Encounter for other general counseling and advice on contraception		
4	Z30.015, Encounter for initial prescription of vaginal ring hormonal contraceptive		
5	Z36.2, Encounter for other antenatal screening follow-up		
HCPCS Codes			
	J7303, Contraceptive supply, hormone containing vaginal ring, each		

Case 7: First Trimester D&C abortion with immediate copper IUD insertion

CC: pregnancy options

This is a 23 year old G2 P1 who presents today for pregnancy options counseling.

Duration: LMP 8/8/19 = 10.0 weeks
Timing: Suspected pregnancy at the beginning of October and home UPT positive then
Location: Pelvis and lower abdomen
Associated symptoms (pain, bleeding, nausea, etc): Breast soreness
Context: She has excellent support from her best friend and family. She is feeling comfortable and relieved.
Modifying factors: She has considered her options including termination, adoption and parenting, and continuing the pregnancy would cause significant negative impact on her physical or mental health. No one has pressured her into this decision.

NPO since 10pm yesterday. Has a driver.

PAST OBSTETRICAL HISTORY: vaginal birth x1
PAST GYNECOLOGIC HISTORY: Menstrual cycles regular, q month, no problems. History of sexually transmitted diseases: none. History of abnormal Paps: none, last Pap last year. Previous birth control: OCPs.

PMH: None
PSH: None
FAMILY HISTORY: Non-contributory
SOCIAL HISTORY: married, cashier, no tob / etoh / drugs. Safe at home

ROS: A 10-point review of systems was completed by the patient and was negative except as per HPI.

Exam: Vitals and BMI noted
GENERAL: Well appearing
EYES: EOMI, Sclera non-icteric, pupils normal in size.
ENT: No rhinorrhea or lacrimation, normal nose, Mallampati class 1.
CV: Regular rate and rhythm, no edema.
RESPIRATORY: non-labored breathing, normal respiratory effort, no wheezes, rales, or ronchi.
ABDOMEN: Soft, nontender to palpation, no hepatosplenomegaly noted.
GENITOURINARY: Normal appearing external genitalia. Normal appearing vagina and cervix. Anteverted uterus 10 week size
SKIN: warm, dry, no cyanosis, bruising, or rashes noted.
PSYCH: Alert & oriented x 3, in good spirits, normal affect, speech clear, thoughts coherent, good eye contact.
NEURO: CN 2-12 grossly intact

ULTRASOUND PROCEDURE, OB, LESS THAN 14 WEEKS:
Approach: [x] transabdominal
Number of fetuses: 1
Gestational sac: [x] seen
Yolk sac: [x] seen
Embryo: [x] seen CRL _ cm = 9.5 weeks
Cardiac activity: seen
Placenta location: posterior
Amniotic fluid volume: [x] Normal
Uterine position: Anteverted
Adnexa: [x] Normal
Final gestational age: 9.5 weeks by [x] LMP + ultrasound

POC hemoglobin 13.2

COUNSELING:
We discussed pregnancy options which include continuation of the pregnancy with parenthood or adoption, and termination of pregnancy. The patient plans to proceed with termination of pregnancy after considering her options as the pregnancy will have a profound negative impact upon her physical or mental health. We discussed medical versus surgical abortion, including the risks and benefits of each method of termination. She chose surgical termination.

We discussed her comfort options during the procedure which include no sedation, oral sedation (minimal sedation), IV or moderate sedation. We discussed that for any sedation, she will need a driver and she cannot drive for the next 12 hours. We discussed that for IV sedation she cannot have had anything to eat per our guidelines. We discussed the risks and benefits and comfort experiences with each option. We discussed that all patients receive a paracervical block. She is eligible for all options. After discussing sedation options, she has chosen IV moderate sedation.

Today we also discussed birth control methods, including reversible and permanent methods. The methods we discussed included natural family planning, condoms, pills, patch, vaginal ring, sub-dermal implant, depo injection, intrauterine devices. The patient had all of her questions answered and decided to proceed with copper IUD for contraception.

ASSESSMENT/PLAN:
Unplanned pregnancy at 9 weeks, contraception, STD testing:

1. Options Counseling: Pregnancy evaluated as above, found to be 9 weeks. Patient participated in options counseling as above. She chose surgical termination in the office today.

2. Pregnancy termination at 9 weeks: Blood drawn today for Rh. Antibiotics given for antibiotic prophylaxis. After counseling patient chose D&C for termination which was uncomplicated. Warning precautions for return including bleeding and infection were reviewed with her and she was given emergency contact numbers in case of questions or complications.

3. Contraception: I discussed birth control methods with the patient as above and she elected to proceed with copper IUD which was placed immediately post-procedure.

4. STD screening: sent

PROCEDURE:
Surgical abortion at 9 weeks; placement of Paragard IUD

Medications
Doxycycline PO 200 mg
Ibuprofen PO 800 mg
Promethazine IV 25 mg

Moderate sedation:
Fentanyl IV 100 mcg
Midazolam IV 2 mg

Paracervical block: Lidocaine 1% 20 mL drawn up by provider and administered at bedside

Intra-procedure US used: No
Complications: None
Blood loss: 30 mL

Tissue Exam: Sent to Pathology: No
Decidual tissue seen; Gestational sac seen; Fetal fragments not seen
Estimated GA by tissue 9 weeks

PROCEDURE DETAILS
Informed consent was signed with the patient and she understood all the risks, benefits, and alternatives to the procedure. A timeout was performed to identify correct patient and procedure.

She was placed in the dorsal lithotomy position. A sterile speculum was placed into the vagina. Betadine was used to clean the cervix. Paracervical block as above was injected in the anterior lip of the cervix. A single tooth tenaculum was used to grasp the anterior lip of the cervix. The remaining paracervical block was injected at 4 and 8 o'clock.

The cervix was dilated with Pratt dilators to 27 French and the 9mm curette was then advanced into the uterine cavity. Several passes with the curette were made to evacuate the products of conception from the endometrial cavity. Good uterine cri was appreciated throughout the cavity at the end of the procedure. Products of conception were examined with gross inspection and all accounted for.

Attention was turned to the IUD insertion. The uterus was sounded to 9 cm. The IUD was inserted at the fundus using the manufacturer's inserter using sterile tip technique. The strings were trimmed to 2 cm.

The tenaculum was removed from the cervix and the tenaculum sites were hemostatic. The speculum was removed from the vagina.

The patient tolerated the procedure well. Discharge medication, education, counseling, and information sheet provided to patient prior to discharge.

Case 7 Coding Solution

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	99204/99214; comprehensive hx & PE with moderate MDM; detailed hx or PE with moderate MDM		
	99203/99214; detailed hx &PE with low complexity MDM; detailed hx or PE with moderate MDM		
	76801, Ob ultrasound < 14 weeks gestation		
	59840, Induced abortion, by dilation and curettage		
	59841, Induced abortion, by dilation and evacuation		
	58300, Insertion of intrauterine device (IUD)		
ICD-10-CM Code Choices			
1	Z30.430, Encounter for insertion of intrauterine contraceptive device		
2	Z30.014, Encounter for initial prescription of intrauterine contraceptive device		
3	Z30.09, Encounter for other general counseling and advice on contraception		
4	Z64.0, Problems related to unwanted pregnancy		
5	Z33.2, Encounter for elective termination of pregnancy		
6	O36.80X0, Pregnancy with inconclusive fetal viability, not applicable or unspecified		
7	Z36.89, Encounter for other specified antenatal screening		
HCPCS Codes			
	J7298, Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52 mg		
	J7300, Intrauterine copper contraceptive		

Possible other billable services with more information
36415 for blood draw if lab work is not billed under the practice ID. If one test is billed by practice but another is billed by an independent lab, 36415 will not be reimbursed as 36415 applies to collection of 1 or more samples.
99152/99153 for moderate sedation performed by surgeon by adding modifier -47 to surgical code. Procedure note would have to include who performed the moderate sedation and the length of time to be a billable service. If done by a different provider, the codes change to 99156/99157 and no modifier is required since a different provider is billing.

Case 8: Pregnancy of Unknown Location, requiring second D&C

CC: pregnancy options

This is a 23-year-old G2 P1 who presents today for pregnancy options counseling.

Duration: LMP 9/8/19 = 4.5 weeks
Timing: Suspected pregnancy yesterday when her period did not come and home UPT positive
Location: Pelvis and lower abdomen
Associated symptoms (pain, bleeding, nausea, etc): None
Context: She has excellent support from her best friend and family. She is feeling comfortable and relieved.
Modifying factors: She has considered her options including termination, adoption and parenting, and continuing the pregnancy would cause significant negative impact on her physical or mental health. No one has pressured her into this decision.
NPO since 10pm yesterday. Has a driver.

PAST OBSTETRICAL HISTORY: vaginal birth x1
PAST GYNECOLOGIC HISTORY: Menstrual cycles regular, q month, no problems. History of sexually transmitted diseases: none. History of abnormal Paps: none, last Pap last year. Previous birth control: OCPs.

PMH: None
PSH: None
FAMILY HISTORY: Non-contributory
SOCIAL HISTORY: married, cashier, no tob / etoh / drugs. Safe at home

ROS: A 10-point review of systems was completed by the patient and was negative except as per HPI.

Exam: Vitals and BMI noted
GENERAL: Well appearing
EYES: EOMI, Sclera non-icteric, pupils normal in size.
ENT: No rhinorrhea or lacrimation, normal nose, Mallampati class 1.
CV: Regular rate and rhythm, no edema.
RESPIRATORY: non-labored breathing, normal respiratory effort, no wheezes, rales, or ronchi.
ABDOMEN: Soft, nontender to palpation, no hepatosplenomegaly noted.
GENITOURINARY: Normal appearing external genitalia. Normal appearing vagina and cervix. Anteverted uterus 6 week size
SKIN: warm, dry, no cyanosis, bruising, or rashes noted.
PSYCH: Alert & oriented x 3, in good spirits, normal affect, speech clear, thoughts coherent, good eye contact.
NEURO: CN 2-12 grossly intact

ULTRASOUND PROCEDURE, OB, LESS THAN 14 WEEKS:
Approach: [x] transvaginal
Number of fetuses: 0
Gestational sac: [x] not seen - possible candidate structure 0.28 x 0.30 x 0.33 cm = MSD 0.3 cm
Yolk sac: [x] not seen
Embryo: [x] not seen
Endometrial thickness: 1.99 cm
Uterine position: Anteverted
Adnexa: [x] Normal
Free fluid: [x] not seen
IMPRESSION: Pregnancy of unknown location

COUNSELING:
We discussed pregnancy options which include continuation of the pregnancy with parenthood or adoption, and termination of pregnancy. The patient plans to proceed with termination of pregnancy after considering her options as the pregnancy will have a profound negative impact upon her physical or mental health.

We discussed that she has a pregnancy of unknown location. She is asymptomatic today. We discussed that this could represent an ectopic pregnancy, a normal intrauterine pregnancy, an abnormal intrauterine pregnancy. We discussed that abortion is an option in an asymptomatic person without a definitive intrauterine pregnancy, and that she may require additional follow up to ensure completion of the procedure including labs or additional clinic visits. We discussed medication versus aspiration abortion, including the risks and benefits of each method of termination. She chose surgical termination. We reviewed the symptoms of ectopic pregnancy, the on-call pager number, reasons to call the on-call doctor and reasons to go to the hospital. She expressed understanding.

We discussed her comfort options during the procedure which include no sedation, oral sedation (minimal sedation), IV or moderate sedation. We discussed that for any sedation, she will need a driver and she cannot drive for the next 12 hours. We discussed that for IV sedation she cannot have had anything to eat per our guidelines. We discussed the risks and benefits and comfort experiences with each option. We discussed that all patients receive a paracervical block. She is eligible for all options. After discussing sedation options, she has chosen no sedation as she has no driver.

Today we also discussed birth control methods, including reversible and permanent methods. The methods we discussed included natural family planning, condoms, pills, patch, vaginal ring, sub-dermal implant, depo injection, intrauterine devices. The patient had all of her questions answered and decided to proceed with condoms for contraception.

ASSESSMENT/PLAN:
Pregnancy of unknown location, desires termination today

1. Options Counseling: Patient participated in options counseling as above. She chose surgical termination in the office today.

2. D&C at 4 weeks: Blood drawn today for hCG. Antibiotics given for antibiotic prophylaxis. Warning precautions for return including bleeding and infection were reviewed with her and she was given emergency contact numbers in case of questions or complications. She should follow-up in 24 to 48 hours for repeat serum hCG. Telephone number verified in the chart; okay to leave VM. Follow-up in office based on hCG results.

3. Birth control method: I discussed birth control methods with the patient, and she elected to proceed with condoms.

4. STD screening: sent

PROCEDURE:
Dilation and curettage for pregnancy of unknown location

Medications
Doxycycline PO 200 mg
Ibuprofen PO 800 mg

Paracervical block: Lidocaine 1% 20 mL drawn up by provider and administered at bedside

Intra-procedure US used: No
Complications: None
Blood loss: 5 mL

Tissue Exam: Sent to Pathology: Yes
Decidual tissue: seen
Villi: not definitively seen; too small to definitively diagnose IUP

PROCEDURE DETAILS
Informed consent was signed with the patient and she understood all the risks, benefits, and alternatives to the procedure. A timeout was performed to identify correct patient and procedure.

She was placed in the dorsal lithotomy position. A sterile speculum was placed into the vagina. Betadine was used to clean the cervix. Paracervical block as above was injected in the anterior lip of the cervix. A single tooth tenaculum was used to grasp the anterior lip of the cervix. The remaining paracervical block was injected at 4 and 8 o'clock.

The cervix was dilated as to 21 French and the 7mm curette with MVA was then advanced into the uterine cavity. Several passes with the curette were made to evacuate the products of conception from the endometrial cavity. Good uterine cri was appreciated throughout the cavity at the end of the procedure. Products of conception were examined with gross inspection and sent to pathology.

The tenaculum was removed from the cervix and the tenaculum sites were hemostatic. The speculum was removed from the vagina.

The patient tolerated the procedure well. Discharge medication, education, counseling, and information sheet provided to patient prior to discharge.

Follow up for ongoing pregnancy

CC: Follow up

HPI: This is a 23yo G2P1 who returns after hCGs rising in the setting of undesired pregnancy of unknown location s/p D&C last week. No complaints today. Feeling well. No pain or bleeding. Minimal post procedure cramping.

PAST OBSTETRICAL, GYNECOLOGIC, MEDICAL, SURGICAL, FAMILY, SOCIAL HISTORY reviewed and unchanged since last visit on 10/7/19.

ROS

A 14-point review of systems including general, eyes, ears nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, neurologic, musculoskeletal, psychiatric, endocrine, hematologic, lymphatic, allergic/immunologic was positive for vaginal bleeding, seasonal allergies, constipation, and was otherwise negative.

Exam: Vitals per chart
GENERAL: Well appearing
EYES: EOMI, Sclera non-icteric, pupils normal in size.
ENT: No rhinorrhea or lacrimation, normal nose, Mallampati class 1.
CV: Regular rate and rhythm, no edema.
RESPIRATORY: non-labored breathing, normal respiratory effort, no wheezes, rales, or ronchi.
ABDOMEN: Soft, nontender to palpation, no hepatosplenomegaly noted.
GENITOURINARY: Normal appearing external genitalia. Normal appearing vagina and cervix. Anteverted uterus 6-week size
SKIN: warm, dry, no cyanosis, bruising, or rashes noted.
PSYCH: Alert & oriented x 3, in good spirits, normal affect, speech clear, thoughts coherent, good eye contact.
NEURO: CN 2-12 grossly intact

ULTRASOUND PROCEDURE, OB, LESS THAN 14 WEEKS:
Approach: [x] transvaginal
Number of fetuses: 0
Gestational sac: [x] seen
Yolk sac: [x] seen
Embryo: [x] seen CRL 0.30 cm = 6.0 weeks
Cardiac motion: [x] seen
Uterine position: Anteverted
Adnexa: [x] Normal
Free fluid: [x] not seen
IMPRESSION: 6.0 weeks IUP consistent with LMP, ongoing pregnancy

COUNSELING:
We discussed that her initial D&C was unsuccessful, and she has ongoing pregnancy. We discussed that her pregnancy options include continuation of the pregnancy with parenthood or adoption, and termination of pregnancy. The patient plans to proceed with termination of pregnancy after considering her options as the pregnancy will have a profound negative impact upon her physical or mental health. We discussed medical versus surgical abortion, including the risks and benefits of each method of termination. She chose surgical termination.

We discussed her comfort options during the procedure which include no sedation, oral sedation (minimal sedation), IV or moderate sedation. We discussed that for any sedation, she will need a driver and she cannot drive for the next 12 hours. We discussed that for IV sedation she cannot have had anything to eat per our guidelines. We discussed the risks and benefits and comfort experiences with each option. We discussed that all patients receive a paracervical block. She is eligible for sedation as she brought a driver today. After discussing sedation options, she has chosen IV sedation.

ASSESSMENT/PLAN:
Pregnancy termination at 6 weeks after unsuccessful D&C

1. Options Counseling: Patient participated in options counseling as above. She chose surgical termination in the office today.

2. D&C at 6 weeks: Rh positive. Antibiotics given for antibiotic prophylaxis. Warning precautions for return including bleeding and infection were reviewed with her and she was given emergency contact numbers in case of questions or complications. She should follow up as needed.

3. Birth control method: I discussed birth control methods with the patient and she elected to proceed with condoms.

4. STD screening: negative last week

PROCEDURE:
Surgical abortion at 6 weeks

Medications
Doxycycline PO 200 mg
Ibuprofen PO 800 mg

Moderate sedation
Fentanyl 50 mcg
Midazolam 2 mg

Paracervical block: Lidocaine 1% 20 mL drawn up by provider and administered at bedside

Intra-procedure US used: No
Post-procedure US: Confirmed empty uterus
Complications: None
Blood loss: 5 mL
Tissue Exam: Sent to Pathology: No
Decidual tissue: seen; Villi: seen; Gestational sac: seen
Estimated gestational age: 6 weeks

PROCEDURE DETAILS
Informed consent was signed with the patient and she understood all the risks, benefits, and alternatives to the procedure. A timeout was performed to identify correct patient and procedure.

She was placed in the dorsal lithotomy position. A sterile speculum was placed into the vagina. Betadine was used to clean the cervix. Paracervical block as above was injected in the anterior lip of the cervix. A single tooth tenaculum was used to grasp the anterior lip of the cervix. The remaining paracervical block was injected at 4 and 8 o'clock.

The cervix was dilated as to 21 French and the 7mm curette with MVA was then advanced into the uterine cavity. Several passes with the curette were made to evacuate the products of conception from the endometrial cavity. Good uterine cri was appreciated throughout the cavity at the end of the procedure. Products of conception were examined with gross inspection and all accounted for. The uterine stripe was thin at the completion of the case.

The tenaculum was removed from the cervix and the tenaculum sites were hemostatic. The speculum was removed from the vagina.

The patient tolerated the procedure well. Discharge medication, education, counseling, and information sheet provided to patient prior to discharge.

Case 8 Coding Solution

Initial Encounter

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	99204/99214; comprehensive hx & PE with moderate MDM; detailed hx or PE with moderate MDM		
	99203/99214; detailed hx &PE with low complexity MDM; detailed hx or PE with moderate MDM		
	76801, Ob ultrasound < 14 weeks gestation		
	76817, Ultrasound, pregnant uterus, real time with image documentation, transvaginal		
	59840, Induced abortion, by dilation and curettage		
	ICD-10-CM Code Choices		
1	Z30.018, Encounter for initial prescription of other contraceptives		
2	Z64.0, Problems related to unwanted pregnancy		
3	Z33.2, Encounter for elective termination of pregnancy		
4	Z36.87, Encounter for antenatal screening for uncertain dates		
5	Z36.89, Encounter for other specified antenatal screening		
	HCPCS Codes		

Possible coding for 36415 (see comments for case 7)

Subsequent Encounter

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	76817, Ultrasound, pregnant uterus, real time with image documentation, transvaginal		
	76801, Ob ultrasound < 14 weeks gestation		
	99214, detailed hx or PE with moderate MDM		
	59840, Induced abortion, by dilation and curettage		
	59812, Treatment of incomplete abortion, any trimester, completed surgically		
	ICD-10-CM Code Choices		
1	Z48.816, Encounter for surgical aftercare following surgery on the genitourinary system		
2	Z36.2, Encounter for other antenatal screening follow-up		
3	Z33.2, Encounter for elective termination of pregnancy		
4	O07.4, Failed attempted termination of pregnancy without complication		
	HCPCS Codes		

Case 9: EPL Case 1 – Office evaluation and D&C

CC: viability / possible missed

This is a 33-year-old G4 P1021 who presents today for OB triage follow up for viability check and possible miscarriage management options. She has had more cramping and spotting but does not think she passed the pregnancy.

Duration: LMP 8/8/19
Timing: The possible miscarriage was diagnosed when she went to OB triage with spotting and 4mm embryo was seen without cardiac motion. She was instructed to f/u in 1 week in clinic.
Location: Pelvis and lower abdomen
Associated symptoms (pain, bleeding, nausea, etc): Some spotting and cramping; still +preg symptoms although less than prior.
Context: She has excellent support from her spouse and family. She is feeling sad as she thinks this is likely a miscarriage.
Modifying factors: This was an unplanned but desired pregnancy.

NPO since 10pm yesterday. Husband is driving her just in case she needs procedure today.

PAST OBSTETRICAL HISTORY: vaginal birth x1; miscarriage x2
PAST GYNECOLOGIC HISTORY: Menstrual cycles regular, q month, no problems. History of sexually transmitted diseases: none. History of abnormal Paps: none, last Pap last year. Previous birth control: OCPs.

PMH: None
PSH: None
FAMILY HISTORY: Non-contributory
SOCIAL HISTORY: married, teacher, no tob / etoh / drugs. Safe at home

ROS: A 10-point review of systems was negative except as per HPI.

Exam: Vitals and BMI noted
GENERAL: Well appearing
EYES: EOMI, Sclera non-icteric, pupils normal in size.
ENT: No rhinorrhea or lacrimation, normal nose, Mallampati class 1.
CV: Regular rate and rhythm, no edema.
RESPIRATORY: non-labored breathing, normal respiratory effort, no wheezes, rales, or rhonchi.
ABDOMEN: Soft, nontender to palpation, no hepatosplenomegaly noted.
GENITOURINARY: Normal appearing external genitalia. Normal appearing vagina and cervix. Anteverted uterus 9 week size
SKIN: warm, dry, no cyanosis, bruising, or rashes noted.
PSYCH: Alert & oriented x 3, in good spirits, normal affect, speech clear, thoughts coherent.
NEURO: CN 2-12 grossly intact

ULTRASOUND PROCEDURE, OBSTETRIC, LESS THAN 14 WEEKS:
Approach: [x] transvaginal
Number of fetuses: 1
Gestational sac: [x] seen
Measurements, if applicable: L 2.54 cm x W 3.36 cm x H 4.59 cm. MSD = 3.50 cm
Yolk sac: [x] seen - ENLARGED 0.9 cm
Embryo: [x] not seen
Cardiac activity: NA
Placenta location: NA
Amniotic fluid volume: [NA] Normal
Uterine position: Anteverted
Adnexa: [x] Normal
Impression: missed abortion measuring 9.2 weeks

COUNSELING:
The patient and I discussed her miscarriage management options which include expectant management versus medical therapy versus surgical intervention with a D&C. We discussed the risks and benefits of each plan of care. The patient has decided to proceed with surgical management in clinic today. Consent forms were signed for the procedure. The patient understands the risks of infection, bleeding and possibly needing a blood transfusion, perforation causing possible damage to the uterus or surrounding structures/organs that could require further surgery and/or repair, retained products of conception, or inability to identify pregnancy tissue on gross examination needing further follow up after the procedure.

We discussed her comfort options during the procedure which include no sedation, oral sedation (minimal sedation), IV or moderate sedation. We discussed that for any sedation, she will need a driver and she cannot drive for the next 12 hours. We discussed that for IV sedation she cannot have had anything to eat per our guidelines. We discussed the risks and benefits and comfort experiences with each option. We discussed that all patients receive a paracervical block. She is eligible for all options available today. After discussing sedation options, she has chosen oral sedation.

Today we also discussed birth control methods, including reversible and permanent methods. The methods we discussed included natural family planning, condoms, pills, patch, vaginal ring, sub-dermal implant, depo injection, intrauterine devices, and sterilization methods of laparoscopic versus hysteroscopic approaches. The patient had all of her questions answered and decided to proceed with OCPs until she is ready to try again. Important information was given.

ASSESSMENT/PLAN:
Miscarriage diagnosis, options counseling and evacuation.

1. Options Counseling: Patient participated in options counseling as above. She chose surgical management for her miscarriage. D&C performed today without complication.

2. Miscarriage at 9 weeks, managed surgically: Rh type O positive. Antibiotics given for antibiotic prophylaxis. Warning precautions for return including bleeding and infection were reviewed with her and she was given emergency contact numbers in case of questions or complications.

3. Recurrent miscarriage: Discussed testing options. Blood drawn today by resident for microarray testing and POCs sent for diagnosis. Follow up for results in 3 weeks; plan MFM genetics consultation pending findings.

4. Birth control method: I discussed birth control methods with the patient, and she elected to proceed with OCPs. Important information reviewed and rx sent.

ATTESTATION:
Attestation: I saw and evaluated the patient on the day of service, confirming the key portions of the history and physical examination findings. I was present during the ultrasound by the resident and reviewed the results. I was present during the blood draw. I discussed the case with the resident. I reviewed the resident's note and agree with the findings and plan as documented in the resident's note. I was present for the entire procedure.

PROCEDURE:
Missed abortion at 9 weeks, managed surgically

Medications
Doxycycline PO 200 mg
Ketorolac IM 30 mg
Promethazine IM 25 mg
Oxycodone PO 10 mg
Lorazepam PO 2 mg

Paracervical block: Lidocaine 1% 20 mL drawn up by provider and administered at bedside

Intra-procedure US used: [ ]

Complications: None
Blood loss: 30 mL

Tissue Exam: Sent to Pathology: [x] Yes for karyotype/microarray
Decidual tissue seen; Gestational sac seen; Fetal fragments not seen
Estimated GA by tissue 9 weeks

PROCEDURE DETAILS
Informed consent was signed with the patient and she understood all the risks, benefits, and alternatives to the procedure. A timeout was performed to identify correct patient and procedure.

She was placed in the dorsal lithotomy position. A sterile speculum was placed into the vagina. Betadine was used to clean the cervix. Paracervical block as above was injected in the anterior lip of the cervix. A single tooth tenaculum was used to grasp the anterior lip of the cervix. The remaining paracervical block was injected at 4 and 8 o'clock.

The cervix was dilated as above and the curette was then advanced into the uterine cavity. Several passes with the curette were made to evacuate the products of conception from the endometrial cavity. Good uterine cri was appreciated throughout the cavity at the end of the procedure. Products of conception were examined with gross inspection and all accounted for.

The tenaculum was removed from the cervix and the tenaculum sites were hemostatic. The speculum was removed from the vagina.

The patient tolerated the procedure well. Discharge medication, education, counseling, and information sheet provided to patient prior to discharge.

Case 9 Coding Solution

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	99214, detailed hx or PE with moderate MDM		
	59820, Treatment of missed abortion, completed surgically; first trimester		
	76801, Ob ultrasound < 14 weeks gestation		
	76817, Ultrasound, pregnant uterus, real time with image documentation, transvaginal		
	36415, venipuncture		
ICD-10-CM Code Choices			
1	O02.1, Missed abortion		
2	Z30.011, Encounter for initial prescription of contraceptive pills		
3	Z30.09, Encounter for other general counseling and advice on contraception		
4	O26.21, Pregnancy care for patient with recurrent pregnancy loss, first trimester		
5	Z36.2, Encounter for other antenatal screening follow-up		
6	Z31.438, Encounter for other genetic testing of female for procreative management		
	Z3A.09, 9 weeks gestation of pregnancy		
HCPCS Codes			

Case 10: EPL Case 2 – Medical management of miscarriage, requiring D&C on follow up

CC: viability / possible missed

This is a 33-year-old G2 P1 who presents today for OB triage follow up for viability check and possible miscarriage management options. She has had more cramping and spotting but does not think she passed the pregnancy.

Duration: LMP 8/8/19
Timing: The possible miscarriage was diagnosed when she went to OB triage with spotting and 4mm embryo was seen without cardiac motion. She was instructed to f/u in 1 week in clinic.
Location: Pelvis and lower abdomen
Associated symptoms (pain, bleeding, nausea, etc): Some spotting and cramping; still +preg symptoms although less than prior.
Context: She has excellent support from her spouse and family. She is feeling sad as she thinks this is likely a miscarriage.
Modifying factors: This was an unplanned but desired pregnancy.

NPO since 10pm yesterday. Husband is driving her just in case she needs procedure today.

PAST OBSTETRICAL HISTORY: vaginal birth x1
PAST GYNECOLOGIC HISTORY: Menstrual cycles regular, q month, no problems. History of sexually transmitted diseases: none. History of abnormal Paps: none, last Pap last year. Previous birth control: OCPs.

PMH: None
PSH: None
FAMILY HISTORY: Non-contributory
SOCIAL HISTORY: married, teacher, no tob / etoh / drugs. Safe at home

ROS: A 10-point review of systems was negative except as per HPI.

Exam: Vitals and BMI noted
GENERAL: Well appearing
EYES: EOMI, Sclera non-icteric, pupils normal in size.
ENT: No rhinorrhea or lacrimation, normal nose, Mallampati class 1.
CV: Regular rate and rhythm, no edema.
RESPIRATORY: non-labored breathing, normal respiratory effort, no wheezes, rales, or ronchi.
ABDOMEN: Soft, nontender to palpation, no hepatosplenomegaly noted.
GENITOURINARY: Normal appearing external genitalia. Normal appearing vagina and cervix. Anteverted uterus 9 week size
SKIN: warm, dry, no cyanosis, bruising, or rashes noted.
PSYCH: Alert & oriented x 3, in good spirits, normal affect, speech clear, thoughts coherent, good eye contact.
NEURO: CN 2-12 grossly intact

ULTRASOUND PROCEDURE, OBSTETRIC, LESS THAN 14 WEEKS:
Approach: [x] transvaginal
Number of fetuses: 1
Gestational sac: [x] seen
Measurements, if applicable: L 2.54 cm x W 3.36 cm x H 4.59 cm. MSD = 3.50 cm
Yolk sac: [x] seen - ENLARGED 0.9 cm
Embryo: [x] not seen
Cardiac activity: NA
Placenta location: NA
Amniotic fluid volume: [NA] Normal
Uterine position: Anteverted
Adnexa: [x] Normal
Impression: missed abortion measuring 9.2 weeks

COUNSELING:
The patient and I discussed her miscarriage management options which include expectant management versus medical therapy versus surgical intervention with a D&C. We discussed the risks and benefits of each plan of care. The patient has decided to proceed with medical management. She understands the risks of medical management failure resulting in a possible retained pregnancy tissue and possible need for additional medication or surgical procedure.

We reviewed that research has found medical management with mifepristone and misoprostol together is significantly more effective at successful completion of the miscarriage than with misoprostol alone. We discussed that this is off label use of mifepristone, which is approved by the FDA for medication abortion. With this information, she would prefer to use both medications for medical management of her miscarriage.

Mifepristone with misoprostol use was reviewed including side effects of nausea, vomiting, diarrhea, fever, chills, and dizziness and encouraged hydration during medication use. A handout reviewing this information was given to the patient.

She understands that the mifepristone is administered today in clinic followed by misoprostol administration at home 24 hours after her mifepristone dose. Bleeding and cramping should occur after misoprostol and it is normal to soak through 2 pads per hour for 2 hours. If her bleeding is more than this, she was advised to contact the clinic or on-call provider. She was also advised to contact the clinic or on-call provider if her pain is severe even after taking pain medications for relief, or if she has a persistent fever. She was instructed to call the clinic if any of her symptoms persisted beyond 24 hours. She was given emergency contact information for the clinic and on-call providers 24 hours a day 7 days a week.

We discussed the importance of follow up to ensure passage of the miscarriage.

Medications
Mifepristone (Mifeprex) PO 200 mg, NDC 64875-001-01 administered at 10:00am

Misoprostol (Cytotec) 800 mcg, NDC 43386-0161-01 (200 mcg x4 units), given to patient to take in 24 to 48 hours per vaginal route

ASSESSMENT AND PLAN
Miscarriage diagnosis, options counseling

1. Options Counseling: Patient participated in options counseling. She chose medical management of her miscarriage. Mifepristone was administered today in clinic and medications dispensed as above.

2. Miscarriage at 9 weeks, managed medically: Rh type O positive. Warning precautions for return including bleeding and infection were reviewed with her and she was given emergency contact numbers in case of questions or complications. We made a plan for her to follow-up in 1-2 weeks at the clinic for follow up ultrasound.

Follow up

CC: Follow up

HPI: This is a 33yo G2P1 who returns for follow up for miscarriage managed medically with mifepristone and misoprostol. No complaints today. Feeling well. She had bleeding followed by cramping as described. She took ibuprofen for one day only. She did not pass as much tissue as she expected. Today she reports minimal bleeding and no pain.

PAST OBSTETRICAL, GYNECOLOGIC, MEDICAL, SURGICAL, FAMILY, SOCIAL HISTORY reviewed and unchanged since last visit on 10/7/19.

ROS
A 14-point review of systems was negative except as per HPI.

Exam: Vitals per chart
GENERAL: Well appearing
EYES: EOMI, Sclera non-icteric, pupils normal in size.
ENT: No rhinorrhea or lacrimation, normal nose, Mallampati class 1.
CV: Regular rate and rhythm, no edema.
RESPIRATORY: non-labored breathing, normal respiratory effort, no wheezes, rales, or ronchi.
ABDOMEN: Soft, nontender to palpation, no hepatosplenomegaly noted.
GENITOURINARY: Normal appearing external genitalia. Normal appearing vagina and cervix. Anteverted uterus 9 week size
SKIN: warm, dry, no cyanosis, bruising, or rashes noted.
PSYCH: Alert & oriented x 3, in good spirits, normal affect, speech clear, thoughts coherent.
NEURO: CN 2-12 grossly intact

ULTRASOUND PROCEDURE, OBSTETRIC, LESS THAN 14 WEEKS:
Approach: [x] transvaginal
Number of fetuses: 0
Gestational sac: [x] seen
Measurements, if applicable: L 2.84 cm x W 2.36 cm x H 5.59 cm. MSD = 3.60 cm
Yolk sac: [x] not seen
Embryo: [x] not seen
Cardiac activity: NA
Placenta location: NA
Amniotic fluid volume: [NA] Normal
Uterine position: Anteverted
Adnexa: [x] Normal
Impression: missed abortion measuring 9.3 weeks

COUNSELING:
We discussed that her medical management was unsuccessful, and she can try another round of misoprostol or proceed with surgical management with D&C. She chose surgical management.

We discussed her comfort options during the procedure which include no sedation, oral sedation (minimal sedation), IV or moderate sedation. We discussed that for any sedation, she will need a driver and she cannot drive for the next 12 hours. We discussed that for IV sedation she cannot have had anything to eat per our guidelines. We discussed the risks and benefits and comfort experiences with each option. We discussed that all patients receive a paracervical block. She is eligible for sedation as she brought a driver today. After discussing sedation options, she has chosen IV sedation.

ASSESSMENT/PLAN:
Missed abortion managed surgically

1. Options Counseling: Patient participated in options counseling as above after diagnosis of unsuccessful medical management of her miscarriage. She chose surgical management in the office today.

2. D&C at 9 weeks: Rh positive. Antibiotics given for antibiotic prophylaxis. Warning precautions for return including bleeding and infection were reviewed with her and she was given emergency contact numbers in case of questions or complications. She should follow up with her therapist and in the clinic in 2-4 weeks as desired.

PROCEDURE:
Missed abortion, managed surgically, at 9-10 weeks

Medications
Doxycycline PO 200 mg
Ibuprofen PO 800 mg
Promethazine 25 mg IV

Moderate sedation
Fentanyl 100 mcg
Midazolam 2 mg

Paracervical block: Lidocaine 1% 20 mL drawn up by provider and administered at bedside

Intra-procedure US used: No
Post-procedure US: Confirmed empty uterus
Complications: None
Blood loss: 30 mL

Tissue Exam: Sent to Pathology: No
Decidual tissue: seen; Villi: seen; Gestational sac: seen
Estimated gestational age: 9 weeks

PROCEDURE DETAILS
Informed consent was signed with the patient and she understood all the risks, benefits, and alternatives to the procedure. A timeout was performed to identify correct patient and procedure.

She was placed in the dorsal lithotomy position. A sterile speculum was placed into the vagina. Betadine was used to clean the cervix. Paracervical block as above was injected in the anterior lip of the cervix. A single tooth tenaculum was used to grasp the anterior lip of the cervix. The remaining paracervical block was injected at 4 and 8 o'clock.

The cervix was dilated to 31 French and the 10mm curette with electric aspiration was then advanced into the uterine cavity. Several passes with the curette were made to evacuate the products of conception from the endometrial cavity. Good uterine cri was appreciated throughout the cavity at the end of the procedure. Products of conception were examined with gross inspection and all accounted for.

The tenaculum was removed from the cervix and the tenaculum sites were hemostatic. The speculum was removed from the vagina.

The patient tolerated the procedure well. Discharge medication, education, counseling, and information sheet provided to patient prior to discharge.

Case 10 Coding Solution

Initial Encounter

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	99214, detailed hx or PE and moderate complexity MDM		
	99213, expanded problem focused hx or PE, low complexity MDM		
	76817, OB transvaginal ultrasound		
	76801, OB ultrasound <14 weeks		
ICD-10-CM Code Choices			
1	O02.1, Missed abortion		
2	Z36.2, Encounter for other antenatal screening follow-up		
3	Z30.09, Encounter for other general counseling and advice on contraception		
4	O36.80X0, Pregnancy with inconclusive fetal viability, not applicable or unspecified		
5	Z36.89, Encounter for other specified antenatal screening		
HCPCS Codes			
	S0190, Mifepristone, oral, 200 mg		
	S0191, Misoprostol, oral, 200 mcg		
	J3490, unclassified drug		

Surgical Encounter

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	99214, detailed hx and exam and moderate complexity MDM		
	99215, comprehensive hx or PE and high complexity of MDM		
	76817, OB transvaginal ultrasound		
	76801, OB ultrasound <14 weeks		
	59820, Treatment of missed abortion, completed surgically; first trimester		
ICD-10-CM Code Choices			
1	O02.1, Missed abortion		
2	Z36.2, Encounter for other antenatal screening follow-up		
3	Z36.89, Encounter for other specified antenatal screening		
4	Z30.09, Encounter for other general counseling and advice on contraception		
HCPCS Codes			

Moderate sedation is listed as performed but we do not know who did this, the surgeon or another physician so it is not billable with the information we have.
There was mention of a post procedure ultrasound, but this is not billable as it was done to check the success of the procedure

Case 11: EPL Case 3 – ultrasound guidance by another provider

Preoperative and Postoperative Diagnosis: Missed AB

Procedure Performed: Ultrasound-guided dilation and curettage

Assistant: Dr. Bones, radiology, using ultrasound guidance

Findings: There is a 7- to 8-week size intrauterine pregnancy gestational sac. There is no fetal heart motion noted. The sac was removed in toto and this was all visualized during the ultrasound guidance. At this point the procedure was discontinued, specimens were removed, isolated on the table by the surgeon were rinsed and then placed in 2 media to be sent off for high-resolution karyotype studies. No implants, drains or packings.

Procedure in Detail: The patient was brought to the OR and was placed on the table in supine position. She was then given LMA anesthesia and then the legs were placed in stirrups with her perineum exposed. She was prepped and draped in a sterile fashion and Dr. Bones brought the ultrasound onto the field and using transabdominal ultrasound, identified the uterus.

The speculum was then placed in the vagina, exposing the cervix, and the cervix was then grasped with a single tooth tenaculum. Then, starting dilation with 19 French, the dilation was increased all the way to 27 French. The dilators were identified in the cervical and endometrial canal on ultrasound. Then, removing the dilator and replacing with a 9mm suction curette which was then attached to the suction machine and the suction was applied at 35 mm. The sac itself was gone in one instant. The areas that were having hyperlucency suggesting decidualized tissue were then vacuumed down and then the procedure was discontinued. The curette was removed. Ultrasound showed that the sac was gone in toto. The D&C was then discontinued, and the ultrasound guidance was stopped.

The surgeon rinsed the trap with normal saline and the trap was placed on the back table. All tissues were brought out, placed on Telfa and then these were rinsed in normal saline. There was an area of white tissue with a lot of villi noted that was consistent with gestational sac with villi and then the remaining tissues showed fetal membranes attached with what was darker decidualized maternal tissues. Representative samples of the decidualized tissue were submitted to the karyotype and all of the tissues noted to be bright to white and more consistent with fetal villi were then sent off in the same container.

The patient was then awakened and taken to the recovery room in satisfactory condition. Discharge instruction have been given prior and then postop to the husband in attendance. The patient is B negative; husband states he is O negative over all these years, and no RhoGAM was given.

Case 11 Coding Solution

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	59820, Treatment of missed abortion, completed surgically; first trimester		
	76998, intraoperative ultrasound guidance		
ICD-10-CM Code Choices			
1	O02.1, Missed abortion		
2	Z36.2, Encounter for other antenatal screening follow-up		
HCPCS Codes			

Case 12: Outpatient consultation for D&E, D&E procedure in office

Outpatient Consultation

Referring Physician: Carla Mouse

The patient is a 27-year-old G1 @ 21.6 wks by LMP consistent with first trimester ultrasound who presents to discuss options for termination of pregnancy. Planned desired pregnancy, prenatal care with Dr Mouse. Abnormal first trimester screen followed by normal karyotype on amnio (46 XX).

Anatomy u/s revealed:
Biometric measurements reflect a slight lag in interval growth. Decreased amniotic fluid is noted. Fetal anatomy appears grossly normal for this gestational age, although exam is quite limited by diminished amniotic fluid volume and fetus in vertical plane. Echogenic bowel is noted. The placenta is in anterior / low to mid location. A three-vessel umbilical cord is seen. Umbilical artery Doppler flow is normal with SD ratio of 2.78. No adnexal pathology is noted. 1.3 x 0.9 cm anterior intramural myoma is noted. Cervix is long and closed.

She had a follow up ultrasound by Dr Minnie U/S= 19 wks. Anterior lower segment fibroid 1.7cm. Asymmetric IUGR. Low AFI

Review of Systems: Constitutional: No fevers or chills. HEENT: No headaches or dizziness. Lymphatic: No axillary or supraclavicular lymphadenopathy. No inguinal or femoral lymphadenopathy. Respiratory: No shortness of breath. Cardiovascular: No chest pain or palpitations. GI: No nausea, vomiting, diarrhea or constipation. GU: No hematuria or dysuria. Musculoskeletal: No complaints. Skin: No lesions. Neuro/Psych: No complaints

PMH: Denies
PSH: Denies
Meds: None
Allergies: NKDA
OB/GYN History: Regular menses 12/q28/3-4 days; no history of abnormal pap; no history of STDs. She is G1.
Social History: No smoking, tobacco or drug use. Married
Family History: Nil contributory

Physical Examination: Vital Signs: Blood pressure is 114/78, weight 133 lbs.
HEENT: Mucous membrane is pink and moist.
Neck: There is no thyromegaly.
Chest: Clear to auscultation bilaterally.
Cardiovascular System: Heart regular rate and rhythm. No murmurs auscultated.
Abdomen: Soft and nontender. There is no rebound or guarding.
Pelvic Exam: Deferred.

TRANSABDOMINAL ULTRASOUND PROCEDURE, GREATER THAN 14 WEEKS:
Number of fetuses: 1
Cardiac activity: seen, 143 bpm
Placenta location: anterior not low-lying
Uterus: anterior LUS fibroid measuring 1.9 x 2.1 cm
BPD: _ cm = 21.0 weeks
AC: _ cm = 19.0 weeks
FL: _ cm = 19.5 weeks
Amniotic fluid volume: [_] Normal [x] Abnormal - OLIGOHYDRAMNIOS
Maternal adnexa: [_] Normal [_] Abnormal [x] Not well visualized
Intracranial anatomy: [_] Normal [_] Abnormal [x] Not well visualized – due to fluid
Spinal anatomy: [_] Normal [_] Abnormal [x] Not well visualized – due to fluid
4 chamber heart: [_] Normal [_] Abnormal [x] Not well visualized – due to fluid
Umbilical cord insertion: [_] Normal [_] Abnormal [x] Not well visualized – due to fluid
Final gestational age: 21.6 weeks by [_] Ultrasound alone [x] LMP not consistent with ultrasound - IUGR

COUNSELING:
We discussed pregnancy options which include continuation of the pregnancy with parenthood or adoption, and termination of pregnancy. The patient plans to proceed with termination of pregnancy after considering her options as the pregnancy will have a profound negative impact upon her physical or mental health. We discussed medical induction abortion versus surgical D&E abortion, including the risks and benefits of each method of termination. She chose surgical termination.

Assessment: This is a 27 y.o G1 at 21 WBD, 19 WBS with asymmetric IUGR and now oligohydramnios almost anhydramnios. She has been extensively counselled by multiple providers and she and her partner have decided to terminate. We discussed alternatives such as induction as well which she declined. She desires to terminate by D&E. Informed consent was obtained for dilatation and evacuation. All risks were discussed with the patient, including bleeding, infection, rarely perforation which could include a blood transfusion, a second operation and rarely even a hysterectomy. The patient verbalized understanding of all these possible complications and wished to proceed.

Osmotic were placed today under aseptic condition using a paracervical block with 15 cc of 1% Lidocaine. The patient tolerated this portion of the procedure extremely well.
In addition, digoxin was administered intrafetally under aseptic technique. The patient was given both written and verbal instructions and what to expect tonight. She will return for D and E on Wednesday. Informed consent was also obtained for a blood transfusion.

We discussed that medical students and residents will be involved in her preoperative, intraoperative, and postoperative care, and she has agreed with their participation. Blood was drawn today for standard labs and the patient was given prescriptions.

Regarding work up, Dr Mouse has started immune work up and TORCH. We will send a specimen for karyotype and placenta to pathology separately. We discussed that autopsy will not be possible due to the nature of D&E procedure. IOL discussed as an option which she declined. Unless anomalies very gross we may not see at D&E.

Total Encounter Evaluation time 60mins; >50% counseling and coordination of care

Attestation: I saw and evaluated the patient on the day of service, confirming the key portions of the history and physical examination findings. I was present during the ultrasound by the resident and reviewed the results. I discussed the case with the resident. I reviewed the resident's note and agree with the findings and plan as documented in the resident's note.

PROCEDURE: Placement of cervical osmotic dilators
Medications
Ibuprofen PO 800 mg
Doxycycline PO 200 mg

Paracervical block:
Lidocaine 1%: 20 mL drawn up by provider and administered at bedside

Procedure in detail:
Informed consent was signed with the patient and she understood all the risks, benefits, and alternatives to the procedure including pain and cramping, bleeding, rupture of membranes, labor onset, uterine perforation, damage to surrounding structures, and advised that she proceed with D&E once dilators are placed due to the cervical dilation they will cause. A timeout was performed to identify correct patient and procedure.

She was placed in the dorsal lithotomy position. A sterile speculum was placed into the vagina. Betadine was used to clean the cervix. A single tooth tenaculum was used to grasp the anterior lip of the cervix. A 20 mL paracervical block of 1% Lidocaine was administered.

3 Dilapan and 4 laminaria were inserted into the cervix. 1 vaginal gauze was placed in the vagina. The tenaculum was removed from the cervix and hemostasis was assured. The speculum was removed from the vagina. The patient tolerated the procedure well.

PROCEDURE: Intrafetal digoxin injection
Informed consent was signed with the patient and she understood all the risks, benefits, and alternatives to the procedure including infection, pain and cramping, bleeding, rupture of membranes, labor onset, uterine perforation, damage to surrounding structures. A timeout was performed to identify correct patient and procedure.

The abdomen was prepped with chloraprep. Under direct ultrasound guidance, a 22g spinal needle was used to inject 4mL (1mg) of digoxin into the fetal thorax without complications. The patient tolerated the procedure well.

Attestation: I was present for the entire time for the above procedures.

Office D&E report

Pre-Operative Diagnosis:
1. A 27- year-old G1, at 19 weeks by scan and 21 weeks by dates.
2. Severe asymmetric intrauterine growth restriction.

Post-Operative Diagnosis:

2. Severe asymmetric intrauterine growth restriction.

Operation Title(s): 1. Termination of pregnancy with standard dilation and evacuation.
2. Exam under anesthesia.
3. Ultrasound guidance.
4. Paracervical block.
5. Laminaria removal.

Surgeon: Dr. Tom
Anesthesia: Moderate sedation with 150 mcg fentanyl + 4 mg midazolam; ketorolac 30 mg IV
Pre-Operative Medication(s): Lidocaine 1%, 20 mL admixed with 4 units vasopressin

Indications For The Procedure: This is a 27-year-old woman with a desired pregnancy. She has developed asymmetric intrauterine growth restriction, which has been profound, resulting in almost anhydramnios. The etiology of this is unclear, but she has been counseled by multiple physicians as to the poor prognosis, and after extensive counseling, decided to terminate her pregnancy. Risks, benefits, and alternatives were reviewed with the patient in detail.

Findings: The cervix was approximately 1.5 cm dilated. Minimal amniotic fluid was noted. There were no gross anomalies, but this is, however, limited, as this was a dilation and evacuation procedure. Fetal demise was confirmed before starting the procedure.

Procedure In Detail: The patient was taken to the procedure room with IV running, after informed consent was obtained. Moderate sedation was administered. Before starting the procedure, the osmotic dilators and sponges were removed, which had been placed on the previous day in the clinic, and all were accounted for.

A bivalve speculum was placed in the vagina. The cervix was visualized and prepped with povodine-iodine and the anterior lip grasped with a ring forceps. A paracervical block was placed with 20 mL of 1% lidocaine, with vasopressin added.

Under direct ultrasound guidance, amniotomy was performed with a #12 suction curette and minimal amount of fluid was drained. Using a Bierer forceps, under direct ultrasound guidance, the products of conception were evacuated in multiple passes. The suction curette was re-

passed, and all the remaining contents were removed. Ultrasound confirmed a thin endometrial stripe.

We examined the products of conception and noted all fetal parts present, as well as the placenta. Oxytocin 30 units was given intravenously during the procedure. The uterus was well contracted. Hemostasis was assured. All instruments were removed. The patient tolerated the procedure well. There were no complications. The patient tolerated the procedure well.

Specimen(s): 1. Placenta was submitted separately to Pathology. 2. Products of conception. 3. Specimen for karyotype. 4. A segment of the placenta was collected for Dr. Mouse, for IUGR study. The patient had given consent for this preoperatively. 5. We also collected specimens of skin, lung, and placenta to submit for additional IUGR studies, as requested by Genetics.

Estimated Blood Loss: 50 mL.
Complication(s): None.

Case 12 Coding Solution

Initial Consultation Encounter

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	99214, detailed hx or PE and moderate MDM		
	99215, comprehensive hx or PE and high complexity MDM		
	76805, OB ultrasound > 14 weeks		
	76816, OB ultrasound, follow-up		
	59866, Multifetal pregnancy reduction(s) (MPR)		
	59897, Unlisted fetal invasive procedure, including ultrasound guidance, when performed		
	59200, Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)		
	ICD-10-CM Code Choices		
1	Z33.2, Encounter for elective termination of pregnancy		
2	O36.5920, Maternal care for other known or suspected poor fetal growth, second trimester, not applicable or unspecified		
2	O41.02X0, Oligohydramnios, second trimester, not applicable or unspecified		
4	Z36.2, Encounter for other antenatal screening follow-up		
5	Z3A.19, 19 weeks gestation of pregnancy		
6	Z3A.21, 21 weeks gestation of pregnancy		
	HCPCS Codes		
	J1160,Injection, digoxin, up to 0.5 mg		

Office D&E

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	59840, Induced abortion, by dilation and curettage		
	59841, Induced abortion, by dilation and evacuation		
	76998, intraoperative ultrasound guidance		
	ICD-10-CM Code Choices		
1	Z33.2, Encounter for elective termination of pregnancy		
2	O36.5920, Maternal care for other known or suspected poor fetal growth, second trimester, not applicable or unspecified		
3	O41.02X0, Oligohydramnios, second trimester, not applicable or unspecified		
4	Z3A.19, 19 weeks gestation of pregnancy		
5	Z3A.21, 21 weeks gestation of pregnancy		
	HCPCS Codes		

Case 13: Outpatient H&P for D&E; hospital admission; D&C of placenta; LNG-IUS

Outpatient History & Physical

Patient presents for surgical clearance H&P

HPI: Patient came with + pregnancy. Patient had been taking OCPs for birth control but irregularly as she had difficulty keeping up with daily method. Patient found out she was pregnant with home test. She initially went to a local clinic for dilation and curettage but was found to be too far along. She was referred to a tertiary care clinic for a dilation and evacuation but was then referred to UNIVERSITY given cardiac risk with h/o AV canal repair. She had been seeking care for over 6 wks now.

Ultrasound done at first clinic showed a pregnancy at about 18-19 wks. Patient at this time is requesting dilation and evacuation given financial strain and difficult living situation. She does not feel able to support a new pregnancy adequately at this time. Her congenital cardiac anomaly has been repaired and is currently stable but it has been a while since her last ECHO. She does not wish to continue a pregnancy when she is ill-prepared for obstetric morbidity.

PMH: H/o mitral insufficiency resultant from AVSD repair 1988
PSH: S/p AV canal repair at 4 years old.
ObHx: G4P1021. C/S for heart disease. Induced AB x2. Irregular menses. Menarche 11yo.
Meds: none
All: NKDA
SH: Lives with husband and in-laws. No T/E/D. Works as receptionist.
FH: grandparents with DM, HTN, MI, stroke. No h/o cancers.

PE:
Ht 5'1'', Wt 194, BP 132/90, T 98.2, P 97, BMI 36
Gen: NAD; CV: RRR, 3/6 mid systolic murmur; Pulm: CTAB; Abd: soft, gravid, NT with Pfannenstiel scar; Pelvic: NEFG, nulliparous cervix, 20wk ut, no adnexal masses

Bedside ultrasound today: BPD 21+5, HC 20+3, AC 20+2, FL 19+6
EGA 20+4 wks +cardiac motion 160s posterior placenta, no previa

ECHO 4/17: reported separately. No evidence of signif MR

A/P: 21 yo G4P1021 at 20+4wks by today's scan desiring termination. All options including HR OB care, adoption/ foster care, and TOP were reviewed. After careful consideration of all options she chooses TOP by D+E. R/B/A were reviewed including surgical and anesthesia risks. Consents were signed for osmotic dilator insertion, intrafetal digoxin injection, D&E, blood transfusion.

- Given cardiac history, Rx for Ampicillin 1g x1 6hrs after procedure given. Pt will get 1 dose of amp/gent intraop given AV canal repair, per cards. Echo recently done showing minimal mitral insufficiency and mild tricuspid regurgitation. Patient, otherwise clear for D&E per cards.

- Patient counseled re BCM options. Mirena IUD to be placed intraop after D&E

MEDICATIONS:
Ibuprofen 800 mg PO
Lorazepam 2 mg PO
Doxycycline 200 mg PO

PROCEDURES:
Intrafetal digoxin injection:
Abdomen prepped sterilely and under direct ultrasound guidance 2.0 mg intracardiac digoxin injected. Pt tolerated well. No complications.

Cervical osmotic dilators:
A sterile speculum was placed. Betadine used to clean the cervix. Tenaculum placed. 20mL 1% lidocaine paracervical block administered. 4 laminaria and 2 sponges placed. Pt tolerated well and no complications.

Attestation:
Pt seen and examined with Dr. Resident. I agree with the resident's findings and the plan of care we formulated together as documented in the resident's note. I performed the ultrasound, intra-fetal injection and placement of laminaria as described above.

Operative Report

Pre-Operative Diagnosis:
1. Intrauterine pregnancy at 20+4 weeks.
2. History of AV canal repair.
3. Multiparous, desires Mirena intrauterine device.

Post-Operative Diagnosis: same

Operation Title(s): 1. Examination under anesthesia.
2. Paracervical block.
3. Suction curettage under ultrasound guidance.
4. Intraoperative ultrasound.
5. Removal of vaginal sponges
6. Placement of Mirena intrauterine device

Surgeon:
Assistant Surgeon(s):
Anesthesia: GETA, 20cc 1% lidocaine with vasopressin.
Urine Output: Unable to record.
Iv Fluids: 1600 cc normal saline.

Description of Findings and Tissues Removed: On examination under anesthesia, 20-week size anteverted uterus, 2cm dilated cervix. The patient was admitted night before procedure for increased pain and likely rupture of membranes. Patient was scheduled as 1st procedure of day but delivered in bed in the preop holding area 20 minutes before going back to OR. Products of conception consistent with demised 20wk gestation was delivered intact. Patient was given Ampicillin/Gentamicin in the OR prior to the start of her procedure given history of AV canal repair. Placental tissue not identified.

Indications: This is a 24 yo G4P1021 with a 20+4 wks intrauterine pregnancy for termination of pregnancy. The patient delivered in bed prior to a scheduled D&E but has retained placental tissue. Patient elects to proceed with dilation and curettage prior to inserting IUD after review of all R/B/A.

Description of Procedure: She was then taken to the Operating Room where she was placed under GETA without complications and antibiotics running. She was placed in the dorsal lithotomy position using candy-cane stirrups. She was then prepared and draped in the normal sterile fashion. 2 sponges were removed. A bivalve speculum was inserted into the vagina and ring forceps was used to grasp the anterior lip of the cervix. A paracervical block was applied using 20cc of 1% lidocaine with vasopressin. Suction curettage was performed with a curved 12 mm curved cannula in order to aspirate uterine contents under direct ultrasound guidance. The endometrial stripe was noted to be thin and a sharp gritty texture was felt circumferentially with the suction curettage. The entire procedure was done under ultrasound guidance.

The Mirena IUD was removed from its inserter and placed at the fundus with ease using ring forceps under direct ultrasound guidance. Strings were trimmed at the cervix. Instruments were removed and excellent hemostasis noted at the end of the procedure.

Prior to the end of the procedure, the patient also received 40 milliunits of Pitocin through her IV fluids as well as Methergine 0.2 mg IM x1. Products of conception were examined and all fetal parts were identified. The patient was stable and sent to the Recovery Room. The products of conception were to be sent to Pathology. The patient's blood type was O positive, and so will not require RhoGam.

Patient was instructed to follow up with Dr. Mickey in 2 weeks. Patient received ampicillin/gentamicin preop in OR and an Rx for ampicillin 1g PO x1 to take 6hrs after procedure given history of AV canal repair. She tolerated the procedure well. Sponge, lap, and needle counts were correct x2 at the end of the procedure.

The attending, Dr. Mickey, was present and scrubbed for the entire procedure.
Specimen(s): POCs
Estimated Blood Loss: minimal
Complication(s): none

Case 13 Coding Solution

Initial Encounter

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	99214, detailed hx or PE, moderate MDM		
	59897, Unlisted fetal invasive procedure, including ultrasound guidance, when performed		
	59200, Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)		
	ICD-10-CM Code Choices		
1	Z33.2, Encounter for elective termination of pregnancy		
2	Z87.74, Personal history of (corrected) congenital malformations of heart and circulatory system		
3	Z86.79, Personal history of other diseases of the circulatory system		
4	Z64.0, Problems related to unwanted pregnancy		
5	I34.0, Nonrheumatic mitral (valve) insufficiency		
6	I36.1, Nonrheumatic tricuspid (valve) insufficiency		
	HCPCS Codes		
	J1160, Injection, digoxin, up to 0.5 mg		

Can the bedside ultrasound be billed based on the documentation?

Hospital D&E

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	59841, Induced abortion, by dilation and evacuation		
	59840, induced abortion, by dilation and curettage		
	59856, Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation		
	59812, Treatment of incomplete abortion, any trimester, completed surgically		
	58300, Insertion of intrauterine device (IUD)		
	76998, Ultrasonic guidance, intraoperative		
	ICD-10-CM Code Choices		
1	Z33.2, Encounter for elective termination of pregnancy		
	O07.4, Failed attempted termination of pregnancy without complication		
2	Z87.74, Personal history of (corrected) congenital malformations of heart and circulatory system		
3	Z86.79, Personal history of other diseases of the circulatory system		
4	Z64.0, Problems related to unwanted pregnancy		
5	I34.0, Nonrheumatic mitral (valve) insufficiency		
6	I36.1, Nonrheumatic tricuspid (valve) insufficiency		
7	Z30.430, Encounter for insertion of intrauterine contraceptive device		
	HCPCS Codes		
	J7298, Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52 mg		

Case 14: Induction Abortion with Digoxin

The patient is 24-5/7 weeks pregnant and presents to the hospital for termination of pregnancy due to lethal fetal anomalies.

14a: The patient underwent fetal digoxin injection and received mifepristone 200mg PO in the office prior to the induction. She then came to labor and delivery where she received misoprostol vaginally every 3 hours until delivery. She had an uncomplicated delivery and recovery and was discharged.

Coding for Scenario A

Check all those you think would be billable

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	outpatient encounter		
	initial inpatient encounter		
	59897, Unlisted fetal invasive procedure, including ultrasound guidance, when performed		
	59850, Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;		
	59409, Vaginal delivery only (with or without episiotomy and/or forceps);		
	prolonged inpatient services		
	discharge day management		
ICD-10-CM Code Choices			
1	Z33.2, elective abortion		
2	O35.----, Maternal care for known or suspected fetal abnormality and damage		
HCPCS Codes			
	J1160, Injection, digoxin, up to 0.5 mg		
	S0190, Mifeprstone		
	S0199, Medically induced abortion by oral ingestion of medication including all associated services and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion) except drugs		

14b: The patient underwent fetal digoxin injection and received mifepristone 200mg PO in the office prior to the induction. She then came to labor and delivery where she received a Foley bulb and oxytocin until delivery. She had an uncomplicated delivery and recovery and was discharged.

Coding for Scenario B

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	outpatient encounter		
	initial inpatient encounter		
	59897, Unlisted fetal invasive procedure, including ultrasound guidance, when performed		
	59855, Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines;		
	59409, Vaginal delivery only (with or without episiotomy and/or forceps);		
	59899, Unlisted procedure, maternity care and delivery		
	prolonged inpatient services		
	discharge day management		
ICD-10-CM Code Choices			
1	Z33.2, elective abortion		
2	O35.----, Maternal care for known or suspected fetal abnormality and damage		
HCPCS Codes			
	J1160, Injection, digoxin, up to 0.5 mg		

Case 15: Pre-abortion procedures with Office Delivery

Office visit, 8:00 AM

Diagnoses: CNS FETAL MALFORMATION IN PREG
Reason for Visit: LAMINARIA
Vitals - Last Recorded
BP 112/74; Ht5'8"; Wt 165 lbs. LMP: OB 10/25/19
BMI Data Body Mass Index Body Surface Area 25.09 (kg/m^2) 1.89 (m^2)

Progress Notes
S: Pt presents for repeat laminaria placement. States nothing fell out overnight. More upset today than yesterday; events sinking in. Has second appointment at MFM later this morning. Unsure if she has felt movement and not looking too closely. States she forgot to take her antibiotics but began them this morning.

Procedure note:
Patient examined, 2 sponges and 9 laminaria removed.
Patient examined: cervix 3 cms
Speculum inserted
Vagina and cervix prepped with betadine
Anterior lip of cervix grasped with single tooth tenaculum
13 laminaria inserted into cervix
4 betadine-soaked sponges inserted into vagina
NO misoprostol inserted into vagina
Patient tolerated procedure well. Instructions given.

For D&E tomorrow, aware to call me for any concerns, ROM or labor. Will have repeat digoxin if fetus not demised on today's MFM exam.

Same day, 3:30 PM – Patient returns to office

Pt returns for management of labor in the setting of planned second trimester termination for significant CNS abnormalities. Patient had received intra-amniotic digoxin yesterday and had confirmation of fetal demise on MFM office visit this morning. Patient had received first day of laminaria and had been dilated to 3 cms. 13 laminaria placed back in cervix due to patient's strong desire for intact D&E for genetic pathology evaluation.

PROCEDURE NOTE:
Pt appears uncomfortable contractions q 4-5 min, 13 laminaria removed and 3 sponges removed. Cervix 3 cm with a bulging bag. I spent 30 minutes with the patient discussing current options including transferring her to the hospital for early planned D&E, removing the laminaria and monitoring contractions. The patient elected on hospital transfer, but while I was coordinating this, I was called to see patient who c/o of pain while in the bathroom.

Non viable female fetus delivered, cord clamped and cut, with minimal bleeding. The pt did not want to see the fetus, which was wrapped respectfully. The delivery took approximately 10 minutes. Pt transferred to the procedure room, RN assisted with uterine massage.

Plan reviewed for delivery of the placenta. Options of transfer to hospital vs 30 minutes of office management with an IV and cytotec per rectum. Pt wanted to avoid a hospital trip. Dr Great present to manage the third stage/placental delivery.

Discussed options for management of placental removal. Patient received 1000 mcg cytotec rectally after confirmation of no history of asthma. Fundal massage given. Patient began having moderately brisk vaginal bleeding so immediate D&C is now the best course. During phone call to arrange transfer to hospital for immediate D&C for retained placenta, patient delivered placenta with Dr. Quick in attendance. Fundal massage continued, patient experienced immediate decrease in bleeding and discomfort. Hand-held ultrasound brought into bedside and performed. Uterine stripe 1.45 cms with no evidence of retained placenta. Fundal massage continued. The delivery of placenta and patient monitoring lasted 50 minutes

After 90 minutes of observation, IV removed, and patient released to home with precautions. Will continue antibiotic to completion, pain medicines prn, anxiety medicines prn. Will follow up on Thursday for confirmatory ultrasound to ensure no retained POCs.

Fetus and placenta brought to hospital for subsequent transfer to the care of Dr. Microscope at Other Hospital who is a forensic genetic pathologist.

Three hours of direct patient care occurred in the office setting of which 40 minutes was spent in counseling and coordination of care and pre-delivery care, and 2 hours 20 minutes spent on prolonged services involving delivery of fetus and placenta plus observation post delivery. One RN was with patient at all times and three physicians participated in her care in the office during the three hours of delivery, placental delivery and post-delivery stabilization.
Patient discharged home at 6:30 PM

Case 15 Coding Solution

Same day procedures

Select all procedures you believe should be billed

CPT Choice	CPT Code Choices	Modifier	ICD Choice
	59855, Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines;		
	99215, comp hx or PE with high complexity MDM, 40 minutes typical face-to-face time		
	99214, detailed hx or PE with moderate MDM, 25 minutes typical face-to-face time		
	99354, first hour prolonged outpatient services		
	99355, each add 30 minutes prolonged outpatient services		
	59200, Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)		
	99360, IV infusion for hydration, first hour		
	99361, IV infusion for hydration, each add 1 hour		
	99365, IV infusion, first hour		
	99366, IV infusion, each add 1 hour		
	bedside ultrasound		
ICD-10-CM Code Choices			
1	Z33.2, termination of pregnancy		
2	O35.0XX0, Maternal care for (suspected) central nervous system malformation in fetus, not applicable or unspecified		
HCPCS Codes			
	J3490, unlisted drug		
	A4550, surgical trays		
	99070 (supplies over an above those normally provided)		

Answer Key with Rationale for Correct Coding

Case 1

- Case includes an Attestation by teaching physician so add GC modifier to procedure code
- Not a simple removal of IUD Complication code for IUD is listed first as most relevant reason for removal, followed by Z code for IUD removal
  - T83.39X- includes leakage, obstruction, perforation, or protrusion of IUD
  - T38.32X- includes malposition or missing string of IUD
  - No CPT modifier is required on hysteroscopic procedure because the code for the attempted removal on day 1 has 0 global days.
    - If partial removal had taken place on same date of service only the hysteroscopic removal is reported, but if the work was significant a modifier -22 might be supported

Best Coding Choice: **58562-GC linked to T83.39XA and Z30.432**

Case 2

- E/M service not billable as patient is stated as presenting toe IUD removal.
  - Contraceptive counseling is not separately documented in a manner that would support an E/M code selection (key components or counseling time).
    - If it had been the diagnostic linkage for the E/M would be Z30.011
  - The "S" code would only be reported if the practice dispensed the contraceptive pill and this code is only used by BC/BS and some Medicaid programs.
- A transabdominal ultrasound is performed and all of the requirements for 76856 (complete) are met.
  - A modifier -26 would be added to 76856 as the facility owns the equipment.
  - Ultrasound guidance was performed and what was visualized was documented, but code 76998 is bundled into 76856. A modifier -59 is placed on the bundled code to bypass this edit. A modifier -26 is not required on 76998 as it has no technical component
- As this is a teaching physician case, a modifier -GC is also required on the billed services performed by the resident under teaching physician direction.

Best Coding Choice **58301-GC, 76856-26-GC, 76998-59-GC, linked to T83.32XA and Z30.432**

Case 3

- Insertion failed twice so your only option is 58300.
  - This procedure was not scheduled as removal of old IUD with insertion of a new one so 58300 and 58301 would not be appropriate to bill.
  - Modifier choice is -52 because considerable work was done to complete the procedure
    - Payer will determine reimbursement based on described work
  - Modifier -53 would only be reported when only the surgical prep or any anesthesia had been provided before discontinuing the procedure.
    - This modifier usually only reimburses 10% of the allowable.

    - A surgical tray (A4550) is included in the procedure.
- The S code is a BC/BS code that may also be used by some Medicaid programs. It would be billed in lieu of 58300.
- Correct diagnosis is T83.32XA because there were lost strings. Secondary code is Z code for IUD removal.
- Only Dr. FP Complex can bill for the ultrasound
- Issue with insertion of two IUDs
    - Payers will not reimburse for them as they were not successfully inserted, but if it is practice or facility policy to report the supply codes so best option is to contact manufacturer for replacements

Best Coding Choice: **58300-52 linked to T83.32XA and Z30.430**

Case 4

- CPT requires that if there is no specific laparoscopic code for the procedure performed, you must report the procedure as an unlisted laparoscopic code so 49329 is the only choice.
    - No RVUs or standard fee set for this code usually. Good comparison for this is 49320, diagnostic laparoscopy (5.14 work RVUs and a 45-minute typical operative time, a 99213 for postop visit, and discharge day management built in).
    - If unlisted code is denied, always appeal.
- Diagnostic coding is T38.39 as primary for code 49329 because of IUD was displaced and Z30.433 since the encounter was both for the removal and insertion of an IUD. T38.39 would not be linked to 58300.
- Bill for the IUD insertion with 58300 but add a modifier -51 for a multiple procedure as there are no bundling issues with 49329 and 58300.
- S4981 is a BC/BS procedure and may be required instead of 58300 for the insertion instead of
- The correct code for the IUD supply is J7298.
    - Only report this code if you, the provider, are supplying the IUD. In a facility setting, the supply would be reported per facility policy, but would not go out on the provider claim for services.

Best Coding Choice: **49329 linked to T83.39XA and Z30.433 and 58300-51 linked to Z30.433 plus J7298**

Case 5

- The correct code is 11982 since this appears not be the removal of Norplant capsules
    - Norplant capsule removal is reported with 11976
    - A surgical tray would be included in the payment for the procedure
- Ultrasound guidance is documented correctly and can be billed in addition
- Diagnostic coding links removal of the implant (Z30.46) with code 11982 and the displacement of the implant (T85.628A) with the guidance.

- If the documentation had included information about how difficult it was to remove the implant over an above the usual work, a modifier -22 might be supported for code 11982.

Best Coding Choice: **11982 linked to Z30.46 and 76998 linked to T85.628A**

Case 6

Encounter 1

- This was a medical abortion encounter documented as a level 3 established patient or level 2 new patient encounter. A new patient visit level is determined by the lowest documented key component of the 3 required, while an established patient is determined by the lowest of 2 documented key components with MDM required as one of them.
  - Documentation supports a detailed history, expanded problem-focused exam and low complexity of medical decision making (given 2 management options, lab and ultrasound performed/ordered and moderate risk.)
  - If counseling time had been documented, the level of service might be different
    - Where documentation supports that more that 50% of the total face-to-face time was spent on counseling with total time indicated and content of the counseling described in detail.
    - 99214: 25 typical minutes, 99215: 60 typical minutes; 99203: 30 typical minutes, 99204: 45 typical minutes, 99205: 60 typical minutes
  - Diagnostic link for E/M is Z33.2, encounter for termination of pregnancy as medication to start the abortion was administered at this visit. Secondary codes can be Z64.0 (unwanted pregnancy) and Z30.015 (initial prescription of vaginal ring).
- Abdominal ultrasound <14 weeks performed and documented.
  - Modifier -26 may be required if provider does not own the equipment (our assumption here)
  - Linking diagnosis will be Z36.89, antepartum screening.
- No evidence that NuvaRing was dispensed during visit.
- Medication was dispensed in the office but only BC/BS has specific codesfor reporting them. Since both were dispensed report both S codes. The alternative is J3490
  - S0190, Mifepristone, oral, 200 mg
  - S0191, Misoprostol, oral, 200 mcg

Best Coding Choice: **99213/99202-25, linked to Z33.2, Z64.0 and Z30.015; 76801-26 linked to Z36.89; S0190 and S0191, or J3490 linked to Z33.2 (if a Dx is required)**

Encounter 2

- The follow-up visit is an established patient visit 99213 based on a detailed history, expanded problem focused exam (10 bulleted elements), and low complexity of MDM (2 dx options, ultrasound only, and patient recovering).
  - Modifier -25 required because of ultrasound performed at the visit.
  - Diagnostic coding is Z09, follow-up care and Z30.9 for review of contraceptive option
- Transvaginal OB ultrasound performed
  - Per CPT you code the intent of the exam rather than the finding when deciding between a gyn or OB ultrasound

    - Modifier -26 required if provider does not own equipment
    - Diagnostic link is Z36.2, follow-up ultrasound
- No evidence that NuvaRing was dispensed at second visit

Best Coding Choice: **99213-25 linked to Z09 and Z30.9; 76817-26 linked to Z36.2**

Case 7

- Documentation supports a level 4 E/M service whether she is a new or established patient (not known).
    - Modifier -25 must be reported to indicate that procedure was separate and significant from the two minor procedures and ultrasound performed
    - Diagnostic links for the E/M are Z64.0, and Z30.9 as she presented for options and contraceptive counseling initially.
- A transabdominal ultrasound <14 weeks was performed and documented.
    - A modifier -26 would be required if provider does not own the equipment
- A paracervical block was performed but is not separately billable as it is local anesthesia.
    - Moderate sedation, when performed by the surgeon who also has an independent trained observer present, can be billed by adding a modifier -47 to the surgical code and reporting the moderate sedation codes that apply (99152/99153).
        - This information is missing from this documentation
- Surgical procedures are 59840 and 58300
    - A modifier -51 should be added to 58300
    - Diagnostic linkage for 59840 is Z33.2 and for 58200, Z30.430
- Code 36415 may be allowed by the payer if the lab is not directly affiliated with the physician practice. Collecting specimens for inhouse labs is included in the lab reimbursement.

Best Coding Choice: **99204/99214-25, linked to Z64.0 and Z30.09, 59840 linked to Z33.2, 58300-51 linked to Z30.430, 76801-26 linked to Z36.89**

Case 8

Initial Encounter

- Documentation supports a level 4 E/M service whether she is a new or established patient (not known).
    - Modifier -25 must be reported to indicate that procedure was separate and significant from the two minor procedures and ultrasound performed
    - Diagnostic links for the E/M are Z64.0, and Z30.9 as she presented for options and contraceptive counseling initially.
- A transvaginal OB ultrasound was performed and documented.
    - A modifier -26 would be required if provider does not own the equipment
    - The ultrasound is linked to Z36.87, uncertain dates. Uterine size is 6 weeks, LMP is 4.5 weeks

- Surgical code is 59840 despite finding of unknown pregnancy location as intent is to terminate.
  - Diagnostic linkage is Z33.2, elective termination.

Best Coding Choice: **99204/99214-25 linked to Z33.2, Z64.0, Z30.018, 59840 linked to Z32.2, 76817-26 linked to Z36.87**

Follow-up Surgery

- E/M cannot be billed because it took place within the global period of 59840 and it is related to evaluation of surgical complications
- The transvaginal ultrasound is billed and linked to Z36.2 as it is a follow-up
  - A modifier -26 would be required if provider does not own the equipment
- Repeating the procedure 59840, as the fetus is still present
  - Modifier -78 must be added for the return to surgery for a related procedure
    - Modifier -76 would not be correct as it is only reported for procedures repeated on the same date of service
  - Diagnostic linkage is O07.4 rather than Z33.2 because the first attempt failed.
    - A Z3A code denoting fetal age is not required with codes for abortion.

Best Coding Choice: **59840-78 linked to O07.4, 76817-26 linked to Z36.2**

Case 9

- A separate and significant level 4 established patient visit is documented
  - A modifier -57 is required as the procedure to be performed has a 90-day global period
  - A modifier -25 is also required since an ultrasound was also performed
  - Diagnostic linkages for this visit are missed abortion, recurrent pregnancy loss and initial prescription of OCPs
- The OB transvaginal ultrasound was performed by the resident with teaching physician supervision
  - A modifier -26 would be added to code if the provider does not own the equipment
  - Diagnostic linkage is Z36.2 as this is a follow-up
- The surgery performed is billed without a modifier a diagnosis of missed abortion, recurrent pregnancy loss
- As this is a teaching physician case, a modifier -GC is also required on the billed services performed by the resident under teaching physician direction.
- The blood draw can be billed as the test is being sent out to a lab for microassay
  - Diagnostic linkage is Z31.438, genetic testing

Best Coding Choice: **99214-57-25-GC linked to O02.1, O26.21, Z3A.09, Z30.011, 76817-26-GC linked to Z36.2, 59820-GC linked to O02.1, 36415-51-GC linked to Z31.438**

Case 10

Initial Encounter

- A level 4 established patient encounter is documented for this initial encounter
  - A modifier -25 is required since an ultrasound was performed
  - Diagnostic linkage is missed abortion
- An OB transvaginal ultrasound was performed
  - Diagnostic linkage would be Z36.2, follow-up ultrasound.
  - A modifier -26 would be required if the provider did not own the equipment
- The drugs were dispensed so either the "S" codes or the J code would be reported

Best Coding Choice: **99214-25 linked to O02.1, 76817-26 linked to Z36.2, S0190 and S0191 or J3490**

Surgical Encounter

- A level 4 established patient encounter is documented for this initial encounter
  - A modifier -57 is required as the procedure to be performed has a 90 day global period
  - A modifier -25 is required since an ultrasound was also performed
  - Diagnostic linkage is missed abortion
- The surgical procedure D&C for a first trimester missed abortion
- An OB transvaginal ultrasound was performed
  - Diagnostic linkage would be Z36.2, follow-up ultrasound.
  - A modifier -26 would be required if the provider did not own the equipment
- The ultrasound mentioned in the procedure note cannot be billed as it was done to check the surgeon's work
- The moderate sedation noted in the chart cannot be reported without more information: who performed it and how long did it take.

Best Coding Choice: **99214-57-25 linked to O02.1, 76817-26 linked to Z36.2, 59820 linked to O02.1**

Case 11

- The surgical procedure is 59820 linked to O02.1
- The ultrasound guidance cannot be reported as it was performed by Dr. Bones
  - Dr. Bones will have to prepare his own documentation about the ultrasound guidance to support billing for it

Best Coding Choice: **59820 linked to O02.1**

Case 12

Initial Evaluation

- E/M evaluation is documented as a level 4 outpatient consultation based on the stated total face-to-face time and counseling time and content.
  - Diagnostic linkage Z33.2 for elective termination plus additional codes denoting small-for-dates and oligohydramnios with Z3A code for the weeks gestation

- Modifier -25 is required as ultrasound and 0-day procedures were performed at the time of the visit
- When procedures are performed in addition to an E/M service and the selection of the E/M is based on counseling time, make sure the documentation is clear that that the total time excludes the procedure time!

- Surgical procedures are 59897 and 59200-51
  - Possible comparison codes to share with payer for unlisted code 59897: MFR (59866 with 3.99 work RVUs), cordocentesis (59012 with 3.44 work RVUs), or amniocentesis with guidance (59001 with 3.00 work RVUs)
- Transvaginal OB ultrasound performed and documented
  - Modifier -26 will be required if provider does not own the equipment
  - Diagnostic linkage is Z36.2 as this is a follow-up ultrasound
- As this is a teaching physician case, a modifier -GC is also required on the billed services performed by the resident under teaching physician direction.

Best Coding Choice: **99244-25-GC linked to Z33.2 and O36.5920, Z3A.21, 76816-26-GC linked to Z36.2, 59897-GC and 59200-51-GC linked to Z33.2, O36.5120, Z3A.21**

Second Day Office Surgery

- As there are no global days attached to the procedures performed the day before, no modifier is required on the surgical code 59421
  - Diagnostic linkage Z33.2 for elective termination plus additional codes denoting small-for-dates and oligohydramnios with Z3A code for the weeks gestation
  - Removal of the laminaria would not be reported as removal is inherent in the placement
- There is no mention in the procedure note that a resident was involved so a -GC modifier would not be reported.
- Ultrasound guidance is documented and is linked to the same diagnosis codes as reported with the surgical code.

Best Coding Choice: **59421-GC and 76998 GC linked to Z33.2, O36.5120, O41.02X0, Z3A.21**

Case 13

Outpatient Clearance

- The documentation describes a clearance for surgery exam with reaffirmation that patient desires a D&E, and election of post D&E Mirena placement.
- The planned procedure is a 10-day global procedure and the clearance visit and H&P the day before the surgery is not included as part of the surgical reimbursement per Medicare guidelines.
  - A -GC modifier is required on the E/M because it was performed by the resident under direct supervision of the teaching physician
- Procedures performed by the teaching physician were intrafetal injection with digoxin, laminaria placement, and bedside ultrasound
  - Possible comparison codes to share with payer for unlisted code 59897: MFR (59866 with 3.99 work RVUs), cordocentesis (59012 with 3.44 work RVUs), or amniocentesis with guidance (59001 with 3.00 work RVUs)

- A GC modifier is not required on the procedures
    - A modifier -51 would be added to 59200
    - Report also the digoxin injected with J1160
    - Diagnostic linkage will be Z33.2 with either history codes for her cardiac condition or "I" codes for her current mild condition to further explain the reason for the abortion
- Beside ultrasound is only reportable if there is a hard copy image and the approach is known (not documented).

Best Coding Choice: 2 equally correct options:
- **99214-25-GC, 59897 and 59200-51 linked to Z33.2, Z64.0, Z86.7, Z87.74; J1160**
- **99214-25-GC, 59897 and 59200-51 linked to Z33.2, Z64.0, I34.0, I36.1; J1160**

Inpatient Procedure
The scheduled D&E turned into a delivery with D&C
- Because she delivered and had laminaria placed, you can now report 59856 (7.79 work RVUs) which includes all of the work done including the D&C.
    - This code has a 90-day global period which includes preoperative clearance, H&P and hospital admission so the **99214 will no longer be billed on day 1**.
    - **59200 will no longer be billed on day 1**; this code includes all the services provided during the hospital stay.
    - Requires a GC modifier as attestation statement indicates Dr. Resident performed the procedure under the direct supervision of the teaching physician, Dr. Mickey.
    - IUD supply is not reported by provider unless required by hospital protocol.
- Ultrasound guidance documented for both the procedure and IUD insertion, but can only be billed once per surgical session.
    - Modifier -26 is not reported as this code does not have a technical component.

Best Coding Choice**:**
Day 1: 59897 on day one;
Day 2: 59856-GC, linked to Z33.2, O07.4, Z86.7/Z87.74 or I34.0/I36.1; 58300-51-GC linked to Z30.430, 76998-GC, linked to Z33.2 and Z30.430

Case 14

Scenario 14A
- Separate billing for the intrafetal injection of digoxin with 59897
    - Can bill J code for Digoxin and S code for Mifepristone
    - Diagnostic linkage is Z33.2 with secondary code for O35.--- for fetal anomaly
- Inpatient admission plus documented prolonged services for delivery.
    - Outpatient E/M care would be added to inpatient admission work
        - Global induced abortion codes do not apply because 1) the injection of digoxin was not intraamniotic, and 2) no laminaria were placed
    - Modifier -25 added to admission code since procedure is being billed
    - Diagnostic linkage for all services is Z33.2, O35.---

- No “S” code for vaginal Misoprostol and no procedure code for vaginal insertion
  - If billable report as J3490
- Report discharge management service if patient discharged on day 2
- ACOG has in the past recommended billing the delivery code 59409 in this instance instead of E/M services after 20 weeks gestation.
  - Always check with payer policy before doing so.
  - Diagnostic linkage is Z33.2, O35.---
  - This option means only the fetal injection and Mifepristone supply can be billed separately

Best Coding Choice: **99221/99222 (hosp admit), 99356/99357 (inpatient prolonged services), 99238/99239 (discharge management)**

Scenario 14B

- Coding is identical to scenario 14B with one exception
  - Also report the Foley insertion by reporting the unlisted code 59899.
    - The comparison code might be 51702, Insertion of temporary indwelling bladder catheter; simple (eg, Foley) (.50 work RVUs).
    - Some payers may deny the procedure, but it you don’t bill, you miss reimbursement opportunity
  - Induction with oxytocin is not usually a billable service by the provider unless they personally started the IV and were in attendance the whole time.
- If reporting delivery code 59409 all services are included except intrafetal injection and S code for Mifepristone.

Case 15

Because laminaria were placed and the patient ended up delivering in the office rather than having the D&E you have 2 coding options:

**59409 should not be billed as it is only reported for facility deliveries.

Option 1

- Code 59855 (6.43 work RVUs)
  - 59855 valued based on the facility, not office place of service
  - Not all practice expenses may be reimbursed adequately
  - Diagnostic linkage Z33.2, O35.0XX0

Option 2

- E/M service plus prolonged outpatient services
  - Note documented 3 hours of direct patient care
    - 40 minutes of basic care related to presenting with labor, removal of the laminaria options discussion, coordinating care and delivery of fetus.
      - Equates to 99215 (2.11 work RVUs)
      - Modifier -25 is required
    - 140 minutes of prolonged service time; 99354 x 1 (2.33 work RVUs), 99355 x 3 (1.77 work RVUs per each 30 minutes for 5.31 work RVUs)

        - 50 minutes for discussion of options of placenta delivery, monitoring patient, coordinating transfer, and then delivering placenta;
        - 90 minutes of observation following placenta delivery to discharge home
    - Diagnostic linkage is Z33.2, O35.0XX0
        - 99070 or A4550 for supplies
        - Bill J3490 for rectal Cytotec
- bedside ultrasound probably can't be billed as we don't know the approach or whether there was a hard copy image (required).
- 59200 linked to Z33.2, O35.0XX0 (.79 work RVUs)
- IV administration can be billed as it was an office expense but start and stop times must be documented.

Best Coding Choice: **99215-25, 99354 x 1, 99355 x 3, 59200, linked to Z33.2, O35.0XX0**