CHARTING FOR MIDWIVES
Part II

GETTING CREDIT FOR THE WORK YOU DO

Nancy Koerber, CPM, CPC
Clinical Documentation Improvement

Documentation with specificity is the foundation of accurate and appropriate selection of both ICD-10 and CPT codes

<table>
<thead>
<tr>
<th>Required Documentation Elements</th>
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</thead>
<tbody>
<tr>
<td>Trimester</td>
</tr>
<tr>
<td>Laterality</td>
</tr>
</tbody>
</table>
ICD-10
The Template for Medical Necessity

Trimester- 1st, 2nd, 3rd, Unspecified

Unspecified trimester should never be reported unless it is impossible to determine the trimester from the clinical record.

Gestational age by weeks

Code family Z3A.
This code should be added to most OB antepartum codes to delineate the current gestational age

Example: Z3A.10 (10 weeks gestation)
Z3A.38 (38 weeks gestation)
See code listing in ICD-10 for accurate list of Z3A codes
ICD-10 Codes

ICD-10 codes have between 3-7 alpha-numeric characters. They always begin with a letter that corresponds with specific categories of ICD-10.

Examples:
- O is for obstetrics
- P is for pediatrics
- N is for urology
- R is for signs and symptoms
- Z is for status codes (formerly V codes)

Each character space is reserved for a category of specificity related to the code family. In OB, these may be related to trimester, gestational age, severity, etc.

If there is no related criteria for that character space, the placeholder “x” is utilized in the code.

These placeholders are utilized when future expansion of codes is to occur.

When searching for a code, search using common key words to narrow your search. Once you find the general area, search by specificity. Always code to the most specific degree that the medical record indicates or with the information available.
7th Character in OB Coding

In OB coding, the 7th character connotes the number of the fetus. This is relevant to define the diagnosis more specifically when multiple gestations are present.

For single gestations, assign the 7th character as “0” for single gestations.

When the documentation in the record is insufficient to determine which fetus is affected and it is not possible to obtain clarification, or when it is not possible to clinically determine which fetus is affected, use unspecified.
OB Principal or 1st-Listed Diagnosis

**Code Family Z34**
Routine prenatal visits when no diagnoses are present 1st listed diagnosis.

*Do not use* with any codes from ICD-10 Chapter 15 codes ("O" codes from the Obstetrics sections). Those codes include pregnancy care with complications or high risk.

**Episodes when no delivery occurs**
The principal diagnosis should correspond to principal conditions of pregnancy. If there are more than one complication present, any complication code can be sequenced first.

**Episodes when delivery occurs**
The principal diagnosis should correspond to main circumstances or complications of delivery. In the case of a C/S, the diagnosis should correspond to principal complication of pregnancy.

**Code Family Z37 (Outcome of delivery)**
An outcome of delivery diagnosis code must be included whenever a delivery code is reported. Code family Z37-choose appropriate suffix codes. Maternal record. Do not add to newborn record.

**Pre-existing conditions vs pregnancy-induced conditions.**
Select codes that are specific to the difference between pre-existing or pregnancy-induced complications.
O80 Normal Delivery

Full term delivery of a single, healthy infant without any complications antepartum, during delivery or postpartum.

Always a principal diagnosis. Not to be used with any other code from Chapter 15 OB code- (“O”)

May be used if pregnancy complication was not present or relevant during the delivery.

Outcome of Delivery Code
Z37.0-Only appropriate code for O80
Single Live Birth
Example of ICD-10 Code Specificity

Abuse in a Pregnant Patient

Confirmed cases of abuses in a pregnant patient

Code Family O94

O94.3  Physical abuse complicating pregnancy, childbirth, childbirth, and puerperium

O94.4  Sexual abuse complicating pregnancy, childbirth, and puerperium

O94.5  Psychological abuse complicating pregnancy, childbirth and puerperium

This code should be sequenced first, followed any codes for associated injury due to physical, sexual or psychological abuse.
Newborn (Perinatal) P codes

Codes that are from Chapter 16 or P codes should not be used on the maternal record.

Codes from Chapter 15 or O codes should not be used on the newborn record.

**Principal Diagnosis for Birth Record**

Assign code from category Z38-Liveborn according to place of birth and type of delivery. This code is only used 1 x per newborn.

**Example:**

Z38.00 Single liveborn infant, born in hospital, delivered vaginally
Z38.01 Single liveborn infant, born in hospital, delivered by cesarean
Z38.1 Single liveborn infant, born outside of hospital
Z38.2 Single liveborn infant, unspecified as to place of birth

Diagnoses for signs/symptoms can be used when definitive diagnosis has not been established. Any diagnosis present from Chapter 16 should be sequenced first.
New Vs. Established Patients

New patient - A patient who has not received a face-to-face professional service from a provider, or a provider of the same specialty/subspecialty in a group practice, within the previous 36 months.

This is commonly known as the “three year rule.”
Where the patient is seen does not matter.
Evaluation and Management CPT Codes

Office Visits
Consultations
Observations
Inpatient Services
Prolonged Attendance
Preventive Care
Newborn Services
Counseling
**Evaluation and Management Office Visits**

<table>
<thead>
<tr>
<th>New Patients</th>
<th>Established Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>99211</td>
</tr>
<tr>
<td>99202</td>
<td>99212</td>
</tr>
<tr>
<td>99203</td>
<td>99213</td>
</tr>
<tr>
<td>99204</td>
<td>99214</td>
</tr>
<tr>
<td>99205</td>
<td>99215</td>
</tr>
</tbody>
</table>
Selecting Appropriate E/M Services

Upcoding on majority of claims is viewed as potential fraud.

Downcoding is viewed as negligent.

The Office of Inspector General considers downcoding to be just as incorrect as upcoding.

DO NOT assume all normal prenatal visits are 99214.

DO NOT bill everything as a 99213 so you won’t be accused of fraud.
Components That Define E/M Selection

- History
- Examination
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of Presenting Problem
- Time
History Levels

Problem-focused
Chief Complaint
Brief History of Present Illness

Expanded problem-focused
Chief Complaint
Brief History of Present Illness
Problem Pertinent System Review

Detailed
Chief Complaint
Extended History of Present Illness
Extended to Limited Review of Systems
Pertinent Past Health, Family, Social History
  (directly related to patient’s problem

Comprehensive
Chief Complaint
Extended History of Present Illness
Review of Systems Directly Related to Identified Problem, plus Review of Extra Body System
Complete Past Health, Family, Social
Exam Levels

Problem-focused
Limited exam of affected area or organ system

Expanded problem-focused
Limited exam of affected body area or organ system and other symptomatic or related organ system

Detailed:
Extended exam of affected body areas and other symptomatic or related organ system

Comprehensive:
General multi-system exam OR complete exam of signal organ system
Medical Decision Making

**Determine Complexity:**
Number of possible diagnoses, Number of management options

Amount and/or complexity of medical records, tests, and/or info that must be obtained, reviewed, and/or analyzed

Risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with patient’s presenting problem, diagnoses, procedure, and possible management options

**Straightforward**
**Low Complexity**
**Moderate Complexity**
**High Complexity**
<table>
<thead>
<tr>
<th># of Dx &amp; Options</th>
<th>Amt of Data Reviewed</th>
<th>Risk of Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

SF = Minimal
LC = Low
MC = Moderate
HC = High
# New Patient E/M Codes
**(Requires at Least 3 Components)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td><strong>Problem-focused history</strong>&lt;br&gt;<strong>Problem-focused exam</strong>&lt;br&gt;<strong>Straightforward medical decision-making</strong></td>
</tr>
<tr>
<td>99202</td>
<td><strong>Expanded problem-focused history</strong>&lt;br&gt;<strong>Expanded problem-focused exam</strong>&lt;br&gt;<strong>Straightforward medical decision-making</strong> (face-to-face 20 min)</td>
</tr>
<tr>
<td>99203</td>
<td><strong>Detailed history</strong>&lt;br&gt;<strong>Detailed exam</strong>&lt;br&gt;<strong>Low complexity medical decision-making</strong> (face-to-face 30 min)</td>
</tr>
<tr>
<td>99204</td>
<td><strong>Comprehensive history</strong>&lt;br&gt;<strong>Comprehensive exam</strong>&lt;br&gt;<strong>Moderate complexity medical decision-making</strong> (face-to-face 45 min)</td>
</tr>
<tr>
<td>99205</td>
<td><strong>Comprehensive history</strong>&lt;br&gt;<strong>Comprehensive exam</strong>&lt;br&gt;<strong>High complexity medical decision-making</strong> (face to face 60 min)</td>
</tr>
</tbody>
</table>
Established Patient
(Requires at Least 2 or 3 Components)

99211
May not require presence of provider or other qualified health professional. Presenting problem minimal. Typically 5 min. visit.

99212
- Problem-focused history
- Problem-focused exam
- Straightforward medical decision-making (face-to-face 10 min)

99213
- Expanded-focused history
- Expanded-focused exam
- Low complexity medical decision-making (face-to-face 15 min)

99214
- Detailed history
- Detailed exam
- Moderate complexity medical decision-making (face-to-face 25 min)

99215
- Comprehensive history
- Comprehensive exam
- High complexity medical decision-making (face-to-face 40 min)
Time-Based Billing

May be billed when:

Counseling and education take up > 50% of office visit

Must be medically necessary

If medical necessity component is reached, the provider may set aside the required elements of E/M to select the code, and instead, may use time-based billing.

Time-based billing requires all of the following documentation:

Must document that counseling and/or education was provided
Must document what information or issues were discussed—be succinct, but complete
Must state that > 50% of the office visit was spent on counseling and/or education
Must state the total min of the office visit and specifically then how much time was spent on counseling and/or education
Code selection is based upon the code which matches the minimum time spent in visit.

Most midwives will be able to justify using time-based billing when providing care to patients; however, be very sure to meet ALL documentation requirements listed above.
Global Billing
Maternal Care & Delivery

Required by most payers. Do not bill individual visits unless they specifically meet the guidelines for billing outside the global billing definition.

Services include:

Antepartum care
7-13 visits

Labor & Delivery

Postpartum Care
Antepartum Care

Pregnancy confirmation during a problem oriented or preventive visit is not considered part of the global billing antepartum component, and may be billed separately.

Antepartum care includes:
Initial history and physical exam, subsequent prenatal histories, exams, recording of weight, BP, FHT, routine urinalysis, abdominal palpation, monthly visits up to 28 weeks, bi-weekly to 36 wks., weekly until delivery. Any additional visits should be billed separately with appropriate ICD-10 code indicating medical necessity.

Conditions which may necessitate extra visits and can be billed separately are: cardiac, neuro problems, GDM, gest. HTN, pre-eclampsia, hyperemesis, preterm labor, problems complicating labor & delivery. Payers may deny this and require submission of documentation and/or appeal.
Labor & Delivery includes:

Admit to hospital or birth center, admission history and exam, management of uncomplicated labor, vaginal delivery with or without forceps, with or without episiotomy. Delivery of placenta.
Postpartum Care:
Postpartum care includes immediately after delivery through 45 days. Any services related to pregnancy, delivery, or any late effects during the postpartum care included in global. Lactation counseling visits are not included and may be billed separately.
Maternity Care & Delivery
Codes

59400
Routine obstetric care including antepartum, vaginal delivery with or without episiotomy or forceps, postpartum care

59409
Labor & delivery only

59410
Labor & delivery with postpartum care

59425
Antepartum care 4-6 visits

59426
Antepartum care 7+ visits
Prolonged Attendance

Add-on Codes

Prolonged attendance codes may be appended to E/M visits when the services provided required prolonged attendance. Must meet the medical necessity threshold.

99354  
Prolonged attendance for E/M service beyond the usual time component 1st hr. Document medical necessity with accompanying ICD-10 code.

99355  
Prolonged attendance for E/M service beyond the usual time component each additional 30 min. Document medical necessity with accompanying ICD-10 code.

Add-on codes cannot be billed alone. They must be billed immediately following an E/M code. Due to the time requirements, prolonged attendance codes should be appended to either a 99205 or 99215. There are special circumstances that can be considered, but these should only be billed after consultation with a certified coder.
Preventive Care Visits

Codes selected by New or Established Preventive Visits
Codes specified by age

New Preventive Visit Codes 99384, 99385, 99386, 99387
Established Preventive Visit Codes 99394, 99395, 99396, 99397

Insignificant or trivial problem or abnormality encountered in process of performing exam and which does not require additional work, SHOULD NOT be reported with additional E/M code.

If abnormality is encountered or pre-existing condition is addressed in process of performing preventive exam, and if the problem is significant enough to require additional work to perform key components of problem-oriented E/M visit, appropriate office code (99201-99215) SHOULD BE reported using “Modifier 25” appended to office visit E/M code.

PATIENT MUST BE INFORMED AND CONSENT-they are the arbiter of how their healthcare dollars are spent. Caution on billing split visits. It is a target for audits by the Office of Inspector General (OIG).
E/M Visits
Preventive Care Visit x 1

Make sure you use appropriate ICD-10 code

Stand-by codes should not be billed under normal conditions and providers working in the birth center or homebirth setting should avoid billing these codes.

They are for very high risk situations where a provider arranges for another provider to stand-by or assist in a situation that is accompanied by a high-risk scenario. The argument is made that if this is expected in an out-of-hospital setting, then transport is advised.

Stand-by codes cannot be billed for birth assistants or RNs presence at every birth.
Staying Out Of Trouble

Misconceptions and Errors

Do’s and Don’ts

DO consult with a certified coder and billing specialist regarding questions and training.

DO purchase coding books each year and become familiar with their construct and methodology.

DO attend workshops on coding, billing and documentation requirements.

DO provide oversight over billing staff or agencies. Providers are ultimately responsible for the accuracy of all claims filed.

DON’T scan a coding book and cherry-pick codes that appear to meet your needs to increase reimbursement. Each code is accompanied by a description as to its use and eligible provider.

DON’T rely on the advice of other providers as to how services can be coded and billed.

DON’T try to bill a facility fee for a homebirth or use of midwives’ car.
Resources

CMS.gov


Current procedural terminology (CPT), AMA, 2017


Healthcare Business Monthly, American Association of Professional Coders, 2017

American College of Obstetricians and Gynecologists, (ACOG), 2017

American Academy of Family Practice, (AAFP), 2017

Slager, Joan, CNM, CPC, Billing and coding tips and tools for midwives-is there a hole in your bucket?, Chapel Hill, NC, December 2016.

APPENDIX A

Coding Auditing Tools

Coding Example for 99203

Coding Example for 99204

Coding Example for 99213

Coding Example for 99214