



Society for
Maternal • Fetal
Medicine

MFM PROCEDURES



Spring SMFM Coding Course 2022

San Diego, CA



Learning Objectives



1. Select the correct set of codes for amniocentesis and CVS
2. Select the correct set of codes for PUBS/IUT
3. Choose the right ICD-10 indication for diagnostic procedures
4. Be familiar with other complex procedure codes
5. Be familiar with inpatient procedure codes



The “Needle” Procedures



May 2018 Tip



Amniocentesis



59000 Amniocentesis; diagnostic

- The physician aspirates fluid from the amniotic sac for diagnostic purposes
- Using ultrasonic guidance, the physician inserts an amniocentesis needle through the abdominal wall into:
 - The interior of the pregnant uterus, and
 - Directly into the amniotic sac to collect amniotic fluid for separately reportable analysis

**** Older code – ultrasound is NOT included *****



CPT instructions for guidance



- “Ultrasound guidance procedures also require **permanently recorded images** of the site to be localized, as well as a documented description of the localization process, **either separately** or **within the report of the procedure** for which the guidance is utilized.”



Amniocentesis



76946 Ultrasonic guidance for amniocentesis, imaging supervision and interpretation

- Office setting: 59000 & 76946
- Facility setting: 59000 & 76946-26





Scenario



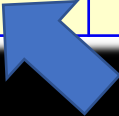
- Due to an abnormal NIPT screen, Carly desires amniocentesis with ultrasound guidance at 18 weeks
- How would this service be billed?



Billing the amnio



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E).										22. RESUBMISSION CODE		ORIG REF. NO.		
A.	;			B.	O28.1			C.	Z3A.18			D.		
E.				F.				G.				H.	23. PRIOR AUTHORIZATION NUMBER	
I.				J.				K.				L.		
24.A. DATE(S) OF SERVICE				B.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.	G.	I.	J.	
From				To	POS	(Explain Unusual Circumstances)				DX POINTER	\$ CHARGES	DAYS/ UNITS	ID QUAL	RENDERING PROVIDER N°
MM	DD	YY	MM	DD	YY	CPT				MODIFIER				
						11	59000			ABC				NPI
						11	76946	-26		ABC				NPI



Add -26 if facility setting

ICD-10 Codes

O28.1

Z3A.18

ICD-10 Description

Abnormal biochemical finding on antenatal screening of mother

18 weeks gestation



Diagnosis Code Options



Z36 series

- Z36.0 Encounter for antenatal screening for chromosomal anomalies
- Z36.1 Encounter for antenatal screening for raised alphafetoprotein level
- Z36.2 Encounter for other antenatal screening follow-up
- Z36.3 Encounter for antenatal screening for malformations
- Z36.4 Encounter for antenatal screening for fetal growth retardation
- Z36.5 Encounter for antenatal screening for isoimmunization



Diagnosis Code Options



Z36 series

- Z36.8- Encounter for other antenatal screening
 - Z36.81 Encounter for antenatal screening for hydrops fetalis
 - Z36.82 Encounter for antenatal screening for nuchal translucency
 - Z36.83 Encounter for fetal screening for congenital cardiac abnormalities



Diagnosis codes continued



O28 series

Abnormal findings on antenatal screening of mother

- O28.0 Abnormal hematological finding on antenatal screening of mother
- O28.1 Abnormal biochemical finding on antenatal screening of mother
- O28.2 Abnormal cytological finding on antenatal screening of mother
- O28.3 Abnormal ultrasonic finding on antenatal screening of mother
- O28.4 Abnormal radiological finding on antenatal screening of mother
- O28.5 Abnormal chromosomal and genetic finding on antenatal screening of mother
- O28.8 Other abnormal findings on antenatal screening of mother
- O28.9 Unspecified abnormal findings on antenatal screening of mother



Amnioentesis for Twins



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E).										22. RESUBMISSION CODE		ORIG REF. NO.			
A.	Z36.1			B.	O28.1			C.	O30.042		D.	Z3A.18			
E.				F.				G.			H.	23. PRIOR AUTHORIZATION NUMBER			
I.				J.				K.			L.				
24.A. DATE(S) OF SERVICE						B.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.	G.	I.	J.
From						POS	(Explain Unusual Circumstances)				DX POINTER	\$ CHARGES	DAYS/ UNITS	ID QUAL	RENDERING PROVIDER N*
MM	DD	YY	MM	DD	YY		CPT	MODIFIER							
						22	59000			ABCD				NPI	
						22	76946	26		ABCD				NPI	
						22	59000	59		ABCD					
						22	76946	26, 59		ABCD					

ICD-10 Codes

Z36.1
O28.1
O30.042
Z3A.18

ICD-10 Description

Encounter for antenatal screening for raised alphafetoprotein level
Abnormal biochemical finding on antenatal screening of mother
Dichorionic/diamniotic twins, 2nd trimester
18 weeks gestation



Amnio-reduction

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59001 Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)

- The physician aspirates fluid from the amniotic sac for therapeutic purposes

**** Newer code - Ultrasound is **not** billed separately, because the value of the guidance is built into the code ****



Umbilical Vein Sampling (PUBS/Cordo)



59012 Cordocentesis (intrauterine), any method

- The removal of blood from the fetal umbilical cord for diagnostic purposes
- The physician inserts an amniocentesis needle through the abdominal wall into both:
 - The cavity of the pregnant uterus
 - The umbilical vessels to obtain fetal blood
- This may be accomplished with a transplacental or transamniotic approach (any method)

**** Older code – Ultrasound NOT included; bill separately ****



PUBS/Cordo



76941 Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging, supervision and interpretation

- Office setting: 59012 & 76941
- Facility setting: 59012 & 76941-26





PUBS/Cordo



- Diagnoses
 - Report the sign(s)/symptom(s)/condition(s) that warrant the testing service
 - If nothing fits:
 - **Z36.0 Encounter for antenatal screening for chromosomal anomalies**



Intrauterine transfusion (IUT)



36460 Transfusion, intrauterine, fetal

- The physician performs a blood transfusion to a fetus, using:
 - A separately reportable ultrasound guidance to locate the umbilical vein
 - A needle is directed through the abdominal wall into the amniotic cavity
 - The umbilical vein is pierced and fetal blood is exchanged with transfused blood



Intrauterine fetal transfusion



76941 Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation

- Office setting: 36460 & 76941
- Facility setting: 36460 & 76941-26



Intrauterine fetal transfusion



- Diagnoses
 - Report the sign(s)/symptom(s)/condition(s) that warrant the service
 - O36.01-- Maternal care for anti-D [Rh] antibodies
 - O36.09-- Maternal care for other rhesus isoimmunization
 - O36.11-- Maternal care for Anti-A sensitization
 - O36.19-- Maternal care for other isoimmunization
 - O36.2-X- Maternal care for hydrops fetalis



Chorionic villus sampling



59015 Chorionic villus sampling, any method

- The physician aspirates tissue from the placenta for diagnostic purposes
- Physician inserts an aspiration device:
 - Transvaginally, or
 - Transabdominally
- A sample of the placenta (chorionic villus) is aspirated to obtain placental cells for analysis for chromosomal abnormalities

**** Older code – ultrasound NOT included ****



Chorionic villus sampling



76945 Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation

- Office setting: 59015 & 76945
- Facility setting: 59015 & 76945-26





Chorionic villus sampling



- Diagnoses
 - Report the sign(s)/symptom(s)/condition(s) that warrant the testing service
 - If nothing fits: **Z36.0 Encounter for antenatal screening for chromosomal anomalies**



Other fetal procedures



59070 **Transabdominal amino infusion, including ultrasound guidance**

59072 **Fetal umbilical cord occlusion, including ultrasound guidance**

59074 **Fetal fluid drainage (ex. Bladder, thorax, abdomen, ovary) including ultrasound guidance**





Other fetal procedures



- Each of these includes the ultrasound guidance
- Diagnoses
 - Report the sign(s)/symptom(s)/condition(s) that warrant the service



Other fetal procedures



- **59076 Fetal shunt placement, including ultrasound guidance**
 - Using ultrasound guidance, assesses the fetal position
 - Advances the shunt and needle assembly through abdominal and uterine walls
 - Once in the amniotic cavity, directs the shunt assembly to the needed location
 - Monitors the maternal and fetal status following the procedure



Fetal shunt placement



- This includes the ultrasound guidance
- Diagnoses
 - Report the sign(s)/symptom(s)/condition(s) that warrant the service



KCL/Saline/MTX Injections with TOP

-
59850 KCL + SVD Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines
- 59851 KCL + D&E Induced abortion, by one or more intra-amniotic injections (amniocentesis injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation and
- 59852 KCL + hysterotomy Induced abortion, by one or more intra-amniotic injections (amniocentesis- injections), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed intra-amniotic injection)



Pregnancy termination diagnoses



- Elective: **Z33.2**

- Other: **O35.0XX-**
O35.1XX-
O35.8XX-
And many others...



KCL/Saline/MTX without TOP



- What if you as the MFM perform only the KCL/Saline/MTX intraamniotic injection and then refer back to the Ob provider for the rest of the care?

59897: unlisted fetal invasive procedure includes ultrasound guidance

Provider performs a fetal invasive procedure while the patient is pregnant or at the time of delivery that is not represented by any of the standard and active CPT[®] codes available



July 2019 Tip



Multifetal Pregnancy Reduction(s)



59866 Multifetal pregnancy reduction(s)

- Performed to eliminate one or more fetuses of a multiple pregnancy
- Done in an attempt to increase the viability of the remaining fetuses
- Fetuses usually eliminated in this procedure until only a twin or triplet pregnancy remains
- Physicians most often use ultrasound guided, (**76942** or **76998**) intracardiac injection of potassium chloride to reduce the number of fetuses
- Code reported once, regardless of the number of fetuses addressed





Multifetal Pregnancy Reduction(s)



- Probable diagnoses:
 - O30.122 Triplet pregnancy with 2 or more monoamniotic fetuses, 2nd trimester
 - O30.222 Quadruplet pregnancy with 2 or more monoamniotic fetuses, 2nd trimester



Cerclage



Cerclage



- **59320** Cerclage of cervix, during pregnancy; vaginal
- **59325** Cerclage of cervix, during pregnancy; abdominal
- Laparoscopic?
 - **59898** Unlisted laparoscopy procedure
 - See advice later



Cerclage



- The reimbursement values for the cerclage codes are based on the assumption that it is an “early” prophylactic cerclage
- The values are not consistent with “rescue” cerclages
 - The only way to receive higher levels of reimbursement is to apply the 22 modifier



Other services?



- What if something is done for which no code exists?
 - 59897 Unlisted fetal invasive procedure, including ultrasound guidance, when performed
 - 59898 Unlisted laparoscopy procedure, maternity care and delivery
 - 59899 Unlisted procedure, maternity care and delivery



Other services?



- The “up” side
 - There is always a code for *everything* you do
- The “down” side
 - These codes have no assigned values
 - Claims must be submitted manually (often on paper)
- Recommendation:
 - Make a reasonable request for reimbursement
 - Provide a comparable code with a value and make the case



Laser/TTTS management



Laser ablation, TTTS



- The current recommended CPT code for laser ablation of communicating vessels in twin-twin transfusion syndrome is unlisted code 59897, unlisted fetal invasive procedure and this CPT code includes ultrasound guidance





Laser ablation, TTTS



- There is a HCPCS “S” code specifically for this procedure (S2411).
- The code description reads: ***Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome.***
 - “S” codes are used by the Blue Cross/Blue Shield Association (BCBSA) and Health Insurance Association of America (HIAA) to report drugs, services, and supplies for which there are no national codes. Most payers do not recognize the “S” codes.



Laser ablation, TTTS



- These procedures are rarely reimbursed by the insurance companies
- The best way to handle this is to collect the money directly from the patient if the payer does not cover such services
- Alternatively, bill the CPT code 59897 as previously mentioned and build the supply cost into the fee



Labor & Delivery



Fetal monitoring on L&D



- **59050** Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation
- **59051** Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; interpretation only





Fetal Monitoring/IUPC/FSE

- This is only if you are CONSULTING (ie for a midwife, NP or other general OB provider)
- You must provide a written report/documentation of what you did:
 - Application of internal fetal scalp electrode
 - Application of internal uterine pressure catheter
 - Recommendations for the attending provider
- “Interpretation only” STILL requires a report
- Facility type typically should be code 11 or 12 (hospital)
- Place of service code should be “21” (L&D)
- Procedure is limited to use during labor within 48 hours before delivery
- Reimbursable only ONCE per pregnancy (180 days)



Fetal Monitoring/IUPC/FSE



- If an attending provider is performing the entire intrapartum delivery and uses an IUPC or FSE, then it is bundled with the delivery itself
- However, if the intrapartum attending provider calls in a specialist to perform or consult on the fetal monitoring, these codes become billable charges for the “consulting physicians”
- Note that codes 59050 and 59051 do not specifically state the usage of only an IUPC or FSE, but simply “fetal monitoring”



Fetal Monitoring/IUPC/FSE



- In addition to the fetal monitoring, the actual “consultation” E&M can also be billed
- May need to determine if your payers will pay with a “consultation” code or if they would require a hospital based subsequent outpatient or inpatient code
- If NO internal monitors are placed, then can consider this an NST:
 - That interpretation service should be coded to capture the consultant physicians’ work for the NST (59025-26)



External Version



- **59412 External cephalic version, with or without tocolysis**
 - Purpose to convert the fetus prior to delivery from a breech or transverse position to cephalic position
- Code can be billed whether or not the version is successful
 - No modifier is necessary



External Version



- Common coding patterns
 - 76815-26 (Limited ultrasound **prior to procedure** to verify position)
 - 59025-26 (NST, **prior to procedure**, assess fetal well-being)
 - **59412** (Procedure, successful or unsuccessful)
 - 76815-26-76 (Limited ultrasound **post procedure** to verify position)
 - 59025-26-76 (NST, **post procedure**, assess fetal well-being)
- If a second version is necessary, report 59412-76



Coding for external version



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E).										22. RESUBMISSION CODE			ORIG REF. NO.		
A.	O32.1XX0			B.	Z3A.37			C.				D.			
E.				F.				G.				H.			
I.				J.				K.				L.			
24.A. DATE(S) OF SERVICE						B.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.	G.	I.	J.
From		To				POS	(Explain Unusual Circumstances)				DX POINTER	\$ CHARGES	DAYS/ UNITS	ID QUAL	RENDERING PROVIDER N°
MM	DD	YY	MM	DD	YY		CPT	MODIFIER							
						22	76815	26		AB				NPI	
						22	59025	26		AB				NPI	
						22	59412			AB					
						22	76815	26, 76		AB					
						22	59025	26, 76		AB					

ICD-10 Codes

O32.1XX0

Z3A.37

ICD-10 Description

Maternal care for breech presentation

18 weeks gestation



Internal Podalic Version



- At present there is not a specific CPT for when an internal podalic version is performed prior to delivering the fetus
- Depending on the degree of difficulty when converting the fetal position prior to delivery, you may consider utilizing the Modifier 22 (increased procedural service)
 - When the work required to provide a service is substantially greater than typically required, it may be identified by adding Modifier 22 to the usual procedure code



Internal Podalic Version



- Documentation must support the substantial additional work and the reason for the additional work (i.e. increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required)
- When submitting a claim to the payer with the Modifier 22, it is necessary that you drop the claim to paper and attach the supporting documentation



EXIT Procedure



- **(EX utero Intrapartum Treatment)** encompasses a multidisciplinary approach to situations in which airway obstruction is anticipated in the fetus
 - Utero-placental circulation is maintained to avoid neonatal hypoxemia while intubation is attempted. The fetus is delivered via C- Section and the cord is not cut until after the fetus has been intubated.
- Depending on the additional time involved, complexity, etc with supporting documentation the Modifier 22 would be attached to the appropriate cesarean code



Laceration Repairs



- **59300 Episiotomy Repair**

- Not for use by attending physician (i.e., delivering physician)
- If the physician performed the delivery, the laceration repair will likely be included in the global service-unless it was a 3rd-degree or 4th-degree laceration



Laceration Repairs



- For repair of third or fourth degree lacerations, refer to the integumentary portion of the CPT surgical section
- Repair codes are intermediate or complex
- Repair codes include “genitalia” (but also forehead, cheeks, chin, axilla!!)
 - Delivery or operative report must reflect the length (in cm) of the repair
 - Intermediate Repair
 - 12041 2.5cm or less
 - 12042 2.5cm to 7.5cm
 - Complex Repair
 - 13131 2.5cm or less
 - 13132 2.6cm to 7.5cm



Laceration Repair Modifiers



- Done at time of vaginal delivery
 - Add modifier 59 (separate procedure) to the repair code
- Done later, patient taken to OR
 - Add modifier 78 (return to OR) to the repair code



Laceration Repairs



- Alternatively, consider adding Modifier 22 (increased procedural service) to the appropriate delivery code for the documented significant additional work involved with the repair
- If using this option, remember...the claim must be dropped to paper and the operative note attached and submitted to the payer



Coding laceration repairs



- 28 yo G₁P₀ with fetal macrosomia - vaginal delivery at 39 weeks, complicated by 4th degree tear
 - 4 options to bill:
 1. Append modifier 22 to the global or delivery only code
 2. Code under surgical section depending on size and depth (12041-12042 for intermediate repair, 13131-13132 for complex repair)
 3. If laceration repair done at time of the vaginal delivery, attach modifier -59 (separate procedure) to the repair
 4. If patient was brought back to the OR for the repair, attach modifier -78 (return to operating room for a related procedure during the postoperative period)



Coding laceration repairs



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E.	F.		G.	H.		23. PRIOR AUTHORIZATION NUMBER							
I.	J.		K.	L.									
24.A. DATE(S) OF SERVICE						B.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	I.	J.
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MM	DD	YY	MM	DD	YY		CPT	MODIFIER					
						21	59514	22	ABCD				NPI
OR													
						21	59514		ACD				NPI
						21	13131	59 or 78	B				NPI



Return to OR



- **49002 Reopening of recent laparotomy**
 - Use for re-opening of cesarean incision
 - For example, for evacuation of hematoma
 - Attach Modifier 78 (return to the operating room for a related procedure during the postoperative period)



QUESTIONS

About MFM procedures?