SOGH is dedicated to enhancing the safety and quality of OB/GYN Hospital Medicine by promoting excellence through education, coordination of hospital teams, and collaboration with healthcare delivery systems.
“CODE THIS!” (Case of the Month)
Missed Abortion, Retained POC with Chorioamnionitis treated with D&C

by Lori-Lynne A. Webb, CPC and Renee Allen, MD, FACOG
February 25, 2016

Case Excerpt (summary and narrative of actual case):

A 29 yo G1P0 at 18 3/7 weeks presented to the hospital for evaluation of decreased fetal movement at 0830. The patient reported persistent mucus discharge, moderate leakage of fluid, and mild contractions over the previous 2-3 days. A bedside ultrasound confirmed an intrauterine pregnancy at 18 weeks gestation with oligohydramnios and no fetal cardiac activity. The patient was 3-4 cm dilated and her temperature was 100.7 degrees Fahrenheit. She was informed of the findings, provided with support, and admitted to the OBGYN hospitalist service with diagnosis of intrauterine fetal demise at 18 weeks’ gestation and chorioamnionitis.

Misoprostol augmentation of labor was started and an epidural was placed. Gentamycin and clindamycin were ordered (the patient had a penicillin allergy). The patient progressed well and spontaneously delivered a male fetus of approximately 17 weeks gestational age. Her placenta also delivered spontaneously. However, examination of the placenta revealed a ragged appearance, so a second bedside ultrasound was performed which diagnosed retained products of conception. Attempts at manual evacuation of the uterus were unsuccessful and the patient was transferred to the L&D OR where a dilation & curettage was performed. A uterine cry was noted at the completion of the procedure which suggested a successful evacuation of the uterus. Evacuation was confirmed by a final, intraoperative, ultrasound. All three ultrasounds were performed by the Ob hospitalist caring for the patient.

If you were the Ob hospitalist in this case, how would you code and bill your services?

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Missed abortion is coded under ICD-10 as 002.1. The billing definition for missed abortion is “early fetal death, before completion of 20 weeks of gestation, with retention of dead fetus.” Chorioamnionitis is coded as O41.1220 and its billing definition is “a singleton gestation with chorioamnionitis occurring in the second trimester of pregnancy.” The second trimester is defined as “between equal to or greater than 14 weeks, and less than 28 weeks since the first day of the last menstrual period.” Under ICD-10, any pregnancy complication diagnosis code must be accompanied by a code in the Z3A family, which specifies the gestational age. In this case Z3A.18 denotes 18 weeks gestation.

Once the diagnosis codes are chosen, then an appropriate level E&M must be established to bill the history and physical. Any appropriate CPT codes should also be added to bill procedures.

The details of this case easily support using the E&M code 99223. The 99233 diagnosis code may be based either on a direct documentation of time spent on patient care or on thorough documentation of a comprehensive history, physical exam, and decision-making with plan of care. The time requirement documentation for the 99223 diagnosis code is “70 minutes were spent on this patient’s care, of which more than 50% was spent face-to-face, counseling her on the pregnancy prognosis and treatment options.” A 25 modifier may be used in this case to indicate that the E&M was a separate but significant part of the patient’s care that day. This is necessary because most CPT codes include payment for a routine preoperative H&P. However, when a patient’s care is complicated both an E&M visit and a CPT procedure code can be billed on the same day.

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Practice Matters

by Joanne Richards, MD
February 19, 2016

OB Hospitalist programs are a relatively new division of OB/GYN, evolving as the number of programs increase due to increasing demands. Hospitals in different communities have differing needs, calling for flexibility in what defines the role of an Ob/Gyn hospitalist in each program. Our program, the Obstetrix OB Hospitalist Group at Good Samaritan Hospital in San Jose, CA is meshed with the Mednax (formerly Obstetrix) MFM group in San Jose. Both the Ob/Gyn hospitalists, and the perinatologists (MFM) are employed by Mednax. Our OBGYN hospitalist program is also partially funded by Good Samaritan Hospital.

Unlike other hospitalist employers, Mednax is a national medical group comprised of neonatal, anesthesia, perinatology and pediatric physicians as well as OB Hospitalists. Benefits and compensation are corporate based, but our program is unique to the San Jose MFM group.

The San Jose, CA Ob/Gyn Hospitalist group began in January 2007 at Good Samaritan Hospital. It was designed by Dr. Alan Fishman, clinical director of the San Jose MFM group. Prior to 2007, our private physicians handled all the patients in their own call groups. They saw all OB triage and ED gynecology patients for their own groups as well as taking a rotational call for unassigned patients both in the ED and L&D. Other obstetricians or registered nurse first assistants (RNFA) provided surgical assistance. Before it was rolled out, Dr. Fishman met with the community Ob/Gyn physicians to discuss how the new program would interface with their current practices and how the use of hospitalists could benefit both physicians and patients. The Ob/Gyn hospitalists attended an eight hour orientation with the perinatologists and Mednax corporate office which detailed patient management, billing, call, and the general operational details of the program.

The program began in January, 2007 and has since expanded to encompass our current responsibilities. We are a group of four full time and two part time employees working with five perinatologists. Good Samaritan Hospital performs 300-400 deliveries per month. We have 14 labor rooms and 3 labor and delivery operating rooms. There is 24 hour dedicated OB anesthesia on the floor as well. The Ob/Gyn hospitalists provide 24hr/7 day coverage in 24hr shifts. We provide obstetric services for patients who do not have a provider on staff, coverage for any staff obstetrician who requests our services, including assistance in C-sections, and we provide emergency gynecological services to the unassigned gyn patients. We also perform in-hospital gyn consults for patients with no staff provider and make appropriate referrals for outpatient follow up. In addition, we are the first responders for all obstetrics and gynecological emergencies, including any unattended deliveries. Our group performs triage evaluation for all the perinatal patients presenting to the Obstetrics Emergency Department (OBED) as well as for patients of the private practices upon request. All OBED patients are required to be seen by a physician prior to discharge, except those presenting for labor evaluations. We have no outpatient responsibilities, so all patients are referred for appropriate follow-up prior to their
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Misoprostol augmentation of labor was started and an epidural was placed. Gentamycin and clindamycin were ordered (the patient had a penicillin allergy). The patient progressed well and spontaneously delivered a male fetus of approximately 17 weeks gestational age. Her placenta also delivered spontaneously. However, examination of the placenta revealed a ragged appearance, so a second bedside ultrasound was performed which diagnosed *retained products of conception*. Attempts at manual evacuation of the uterus were unsuccessful and the patient was transferred to the L&D OR where a *dilation & curettage* was performed. A uterine cry was noted at the completion of the procedure which suggested a successful evacuation of the uterus. Evacuation was confirmed by a final, intraoperative, ultrasound. All three ultrasounds were performed by the Ob hospitalist caring for the patient.

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discharge. Patients may return to their own physician, the MFM clinic (for the perinatal patients) or are referred to another physician or clinic.

As part of the MFM team, we help to admit and stabilize helicopter and ambulance transfers to the MFM service. We attend the delivery for the majority of the MFM patients and perform daily rounds with the perinatologist on all their patients. We also perform emergency gyn surgery and some scheduled D&C for the perinatology service.

We are part of the perinatology team and the perinatologists provide us with around the clock backup. If we are overextended or if we encounter any situation we’re not comfortable managing, the perinatologist provides assistance. We often work closely with MFM as many of our patients have acute and/or complicated conditions. A significant benefit of our close working relationship with the perinatologists is being constantly educated on current standards of practice for both high risk and normal pregnancies. It is an exciting and intellectually stimulating practice environment.

Since the program’s inception, there has been little turnover in employees. As such, the hospitalists are a tightly knit group. We not only work together as a team of professionals, we work together as friends. We support each other when personal crises arise; which makes for an incredibly cohesive group. Our group is dedicated to providing the best care possible. We run a very conscientious service that is staffed by very talented physicians. We also share a close relationship with the perinatologists, and have a cooperative relationship, not a subservient one.

Our group have elected to be paid hourly and so incentive compensation doesn’t apply. Our full time employees receive employee benefits, including a continuing education stipend. Our malpractice coverage is paid by Mednax. Since we receive hourly compensation, we do not have paid time off (PTO) or vacation pay.

Our program has already weathered nine years successfully and continues to evolve. The private physicians utilize our services regularly for coverage, OBED evaluations and surgery assists. They are very pleased with the program, as are the nursing staff and hospital administration. We are continuously supported and educated by the perinatologists with whom we work, and have a great relationship as a hospitalist group. We have a busy L&D unit and MFM/antepartum service; as well as accepting transports from other hospitals, so the job has a fair amount of stress. But at the end of the shift you can walk away knowing that you’ve helped improve the quality of care and safety of the patients we’ve served.
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