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INTRODUCTION

In the United States, *Current Procedural Terminology*, Fourth Edition (CPT-4) is a standard national coding system for reporting physician or other qualified healthcare provider (QHP) services. CPT® procedure codes identify the cognitive, procedural, and material services provided to patients. Codes and their descriptive terminology are developed and copyrighted by the American Medical Association (AMA).

In 2000, the CPT Code Set was designated by the Department of Health and Human Services as the national coding standard for physician and QHP professional services and procedures under the Health Insurance Portability and Accountability Act (HIPAA). All financial and administrative health care transactions sent electronically must use the CPT code set.

CHANGES IN CPT CODES

CPT-4 is not a static document. Revisions, often significant ones, are made each year to keep pace with changes in medicine and medical practice. Therefore, it is critical that providers purchase a new CPT-4 book each year to ensure that he or she is reporting the most current codes. CPT books may be purchased through ACOG’s Distribution Center (1-800-762-2264) or from ACOG’s website (sales.acog.org) as well as from many commercial vendors.

The process of developing or revising a code reported by obstetrician-gynecologists has six basic steps.

1. **ACOG’s Committee on Health Economics and Coding** reviews a request for a new code or revision of a current code. The request may originate from outside ACOG (e.g., from a related medical specialty society, an individual physician, or qualified health care professional (QHP), or from industry) or be proposed by the Committee itself. If the Coding Committee agrees that a code should be added or revised, an ACOG member develops a proposal, including a detailed description of all pre-, intra-, and post-operative services typically included in the procedure.

2. **The Committee forwards the proposal to the AMA CPT Editorial Panel.** The Panel includes representatives from medical specialty societies, AMA, the American Hospital Association, commercial insurers, and the Centers for Medicare and Medicaid Services (CMS). The Editorial Panel may accept, reject or request changes in ACOG’s proposal.

3. **If the proposal is accepted, ACOG then surveys its membership** to determine the provider work and the practice expenses associated with the new or revised code. This data is then translated into a recommendation for Relative Value Units (RVUs). Medicare and many other payers use these RVUs to determine the payment for the procedure.

4. **ACOG’s Subcommittee for the Relative Value Scale Update Committee recommends RVUs** for the new or revised procedure to the AMA/Specialty Relative Value Scale Update Committee (RUC). The RUC may adopt or modify ACOG’s proposal.

5. **The RUC recommends RVUs** for the new or revised procedure to CMS, which makes the final determination. The RVUs are published in a Federal Register on or around November 1st each year.

6. **The new or revised code is added to CPT** in January of the next year.
ACOG RESOURCES

PUBLICATIONS

The following coding publications are available from ACOG’s distribution center (1-800-762-2264). The resources can also be ordered on ACOG’s website bookstore (sales.acog.org).

OB/GYN CODING MANUAL: COMPONENTS OF CORRECT PROcedural CODING WITH THUMB DRIVE
This 500+ page book and thumb drive provides important information to assist physicians and QHPs in correctly coding for surgical procedures commonly performed by obstetrician-gynecologists. Each code is listed with services that are included/excluded in the procedure’s global surgical package. This includes the bundling information for each code, both from Medicare’s National Correct Coding Initiative (CCI), and for non-Medicare patients; information from ACOG’s clinical vignettes. This allows coders to compare the bundling issues between Medicare and non-Medicare patients. Information about whether Medicare will reimburse for assistants or co-surgeons for the procedure and other Medicare payment indicators is also included. This information may be useful in preparing appeals to third party payers. Also included in the manual are sections on modifiers, and a discussion of relative value units. The book and thumb drive are revised annually.

ICD-10/CPT GYNECOLOGY AND OBSTETRIC QUICK REFERENCE CODING GUIDE
Available as laminated sheets, the ICD-10/CPT Quick Reference Coding Guide includes official CPT® and ICD-10-CM codes with abbreviated descriptions for the most commonly reported Obstetrics and Gynecology procedures and diagnoses (one each for Obstetrics and Gynecology codes).

ICD-9-CM/ICD-10-CM GYNECOLOGIC AND OBSTETRICAL DIAGNOSIS CODE CROSSWALKS
Available as double-sided, laminated sheets, the ICD-9-CM/ICD-10-CM Gynecologic and Obstetrical Crosswalks include the most commonly reported ICD-9-CM OB/GYN-related diagnoses cross walked to the appropriate new ICD-10–CM codes.

OTHER CODING RESOURCES

ACOG CODING WORKSHOPS
ACOG’s enormously popular coding workshops teach Fellows and their staff about appropriate coding and billing practices. These workshops cover the effective use of the International Classification of Diseases Tenth Clinical Modification (ICD-10-CM) and the Current Procedural Terminology (CPT) coding systems as they pertain to obstetrics and gynecology. If accompanied by the Fellow, office staff and mid-level providers may also attend.

The 2016 workshops may consist of up to four modules. Fellows may attend one, two, three or all four modules. Each module lasts 4 - 7 hours and covers the following topics:

- **Module I** – E/M Services and Medicare’s Documentation Guidelines
- **Module II** – Gynecologic Surgical Coding
- **Module III** – Obstetric Coding
- **Module IV** – ICD-10 (Hands-On) Diagnosis Coding Practicum
The 2016 Coding Workshops will be held in following locations:

- February 25-28, 2016 New Orleans, LA
- March 10-13, 2016 San Diego, CA
- March 31-April 3, 2016 Orlando, FL
- April 22-24, 2016 Chicago, IL
- June 10-12, 2016 Atlanta, GA
- June 24-26, 2016 Las Vegas, NV
- July 8-10, 2016 Austin, TX
- July 29-31, 2016 Seattle, WA
- September 9-11, 2016 Memphis, TN
- September 16-18, 2016 Arlington, VA/DC
- October 7-9, 2016 Santa Fe, NM

Fellows may register for these workshops online at www.acog.org/Education_and_Events. For more information, contact the ACOG Coding Department at 202-863-2498 or HealthEconomics@acog.org.

**ACOG Webcasts**
ACOG presents a series of Webcasts that are offered at 1:00-2:30 pm Eastern Time on the second Tuesday of every other month. Topics include Coding, Practice Management, and Professional Liability. Recordings of past webcasts are also available on a pay per view basis. The following is the schedule of Coding topics for 2016.

- February 9, 2016 Billing for the Global OB Package
- April 12, 2016 CPT Modifiers and the Global Surgical Package
- June 14, 2016 Correct Coding for Infertility Diagnosis & Treatment
- August 9, 2016 Clinical Documentation Improvement and EMRs
- October 11, 2016 Coding for Wound Repair: Post-Operative and Postpartum
- December 13, 2016 Preview of New Codes and Medicare Changes for 2017

Additional information on these and other webcast topics is available at: http://www.acog.org/Education_and_Events.

**ACOG’S Listserv**
ACOG’s Department of Health Economics and Coding offers a free monthly e-mail news service, The Practice Management and Coding Update. The update includes effective coding tips, practice management advice, information about regulatory issues that affect your practice, and the latest news on what ACOG is doing to help address your reimbursement concerns and improve your practice environment. You may subscribe to the newsletter on the ACOG Website on the Practice Management and Managed Care page or by using the following link:
http://www.acog.org/About_ACOG/ACOG_Departments/Practice_Management_and_Managed_Care/Practice_Management_Update_Newsletter
ACOG INTERNET ACCESS

The Health Economics and Coding Department webpage includes a list of coding resources and timely announcements concerning coding and reimbursement issues. Also posted on this site are the most recent Medicare Relative Value Units charts for codes reported by ob/gyns, the Correct Coding Initiative (CCI) edit charts, Evaluation and Management services documentation templates and an intake history form developed by the ACOG Committee on Health Economics and Coding. ICD-10 general information, updates, and links can also be accessed from the Coding page. The Health Economics and Coding page may be accessed from the ACOG website home page by clicking on the Practice Management tab.

Accessing this sites is easy. If you are not registered, you must first register on the website by filling out the on-line registration form. Next, sign in by clicking on the member access button and insert your username and password.

The sites is accessed through http://www.acog.org/About-ACOG/ACOG-Departments/Coding.

ACOG CODING ASSISTANCE

Fellows and their staff are able to submit specific OB/GYN coding questions to ACOG Coding Assistance by registering for our New Ticket Database at https://acogcoding.freshdesk.com or by fax (202-484-7480). Registration is free, quick and easy!

Registered database users will have access to a wide variety of new features in the ACOG Coding Ticket Database including a Coding Committee knowledge base (FAQ), searchable tickets, Coding Questions of the Month, easier ticket submission and tracking and much, much, more!

When submitting a request, please include your physician name or member number on your request so that the request may be appropriately prioritized. Questions submitted without an ACOG member name or number will be assumed to be from a non-member.

Please do not include any identifiable Protected Health Information in your e-mail or fax.

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CHAPTER 1: USE OF CPT-4

CPT-4 (Current Procedural Terminology, Fourth Edition) consists of six sections and an index, each with its own rules and conventions. It is essential that providers and coding staff understand these conventions and rules in order to code correctly for their services.

CPT consists of Category I, Category II, and Category III codes. Category I codes are 5-digit numeric codes developed and copyrighted by the American Medical Association. They comprise the primary set of codes used to describe the cognitive, procedural, and material services provided by a provider’s practice to patients and are the primary focus of this publication.

CATEGORY I CODES
CPT’s category I codes consist of 6 sections, each divided into subsections, headings and subheadings, and an index. The 6 sections are:

- Evaluation and Management (E/M) Services (99201-99499)
- Anesthesia (00100-01999, 99100-99140)
- Surgery (10021-69990)
- Radiology (including Nuclear Medicine and Diagnostic Ultrasound) (70010-79999)
- Pathology and Laboratory (including Reproductive Medicine Procedures) codes (80047-89398)
- Medicine (except Anesthesiology) (90281-99199 and 99500-99607)

Each section begins with guidelines specific to the codes in that section. In addition, many subsections and headings have guidelines that apply only to codes in that specific subsection or heading.

SUBSECTIONS
Each section is divided into subsections. The subsections may be defined by:

- Anatomic area (e.g., Female Genital System is a subsection of the Surgery section)
- Procedure (e.g., Urinalysis is a subsection of the Pathology and Laboratory section) OR
- Condition (e.g., Critical Care Services is a subsection of the Evaluation and Management section).

The sections most useful to obstetrician-gynecologists are the Surgery section (which includes subsections for the Female Genital System and Maternity Care and Delivery) and the Evaluation and Management Services (E/M) section. However, obstetricians and gynecologists are not restricted to codes in these sections and can report codes from other sections and subsections as appropriate.

HEADINGS AND SUBHEADINGS
Each subsection is further divided into headings and subheadings. For example, the E/M section is divided into different types of services according to either the place of service such as, Office or other Outpatient Services and Hospital Inpatient Services or the type of service (e.g., Consultations and Prolonged Services).

The subsection, Female Genital System, is divided into headings according to anatomic site (e.g., Vagina and Cervix Uteri). Each heading is divided into subheadings according to the service being provided (e.g., Excision and Repair).

The subsection Maternity Care and Delivery is divided into headings according to the type of service such as, Antepartum Services, Cesarean Delivery, and Abortion.
UNLISTED ENCOUNTER OR PROCEDURE
A physician or (QHP) may provide a service or perform a procedure not described by a current CPT-4 code. In this case, physicians or QHP’s may report an unlisted procedure code from the appropriate subsection. For example, in the Female Genital System section, the Corpus Uteri subsection includes code 58579 (unlisted hysteroscopy procedure, uterus) and the Oviduct/Ovary subsection includes code 58679 (unlisted laparoscopy procedure, oviduct, ovary). Claims using unlisted procedure codes should be submitted as a paper claim with a special report attached describing the service and, if appropriate, a copy of the operative or encounter report.

CATEGORY II CODES
These codes are used to collect information about the quality of care being provided, using nationally established performance measures. These optional codes are updated biannually in January and July. The most current listing may be found at http://www.ama-assn.org/go/cpt. Category II codes should not be used as a substitute for existing Category I codes.

An example of these codes is:
0500F Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care...)

CATEGORY III CODES
These codes are used to collect specific data to assess the clinical efficacy, utilization, and outcomes for emerging technology, services, and procedures. These codes are updated quarterly. A current listing may be found at http://www.ama-assn.org/go/cpt. Category III codes must be used if available instead of an unlisted Category I code.

An example of these codes is:
0071T Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue

INDEX
The alphabetic index in the back of the CPT book is used to find the correct Category I code within the body of CPT. Main terms are listed by:

• Procedure or service (eg, hysterectomy)
• Name of organ or organ system (eg, uterus)
• Conditions (e.g., leiomyomata)
• Symptoms (e.g., hemorrhage)
• Synonyms (e.g., miscarriage and missed abortion)
• Eponyms (e.g., Marshall-Marchetti-Krantz Procedure)
• Abbreviations (e.g., LTH)

Thus, there may be several ways to find a specific procedure or service in the CPT index. A main term may be followed by indented terms that are more specific. For example, a partial entry for the main term "Hysterectomy" reads:
Hysterectomy
  Abdominal
    Radical........................................58210
    Resection of Ovarian Malignancy........58951, 58953-58956

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Cesarean
  after Cesarean Delivery.......................59525
  with Closure of Vescicouterine Fistula....51925

GENERAL CODING GUIDELINES
Codes submitted to payers should reflect the most accurate code for the service and follow CPT’s coding guidelines.
  • Do not select a code using only the CPT index. The index may list one code, several codes or a range of codes after a term. For example, code 58210 is defined in the index only as a “radical abdominal hysterectomy.” However, the body of the CPT book defines this code as “radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s).” With this additional information, the user can evaluate whether this is the correct code to report in this instance.
  • Select the most specific code. The code must be the most accurate description of the service provided and be consistent with coding conventions and guidelines.
  • Read any notes, instructions or other explanatory statements printed under subsections, headings or subheadings and before and after codes.
  • Know the bundling and unbundling rules used by CPT, your commercial payers, and Centers for Medicare and Medicaid Services (CMS).

CPT CONVENTIONS
Coding conventions, terms, and punctuation in CPT assist in selection of the most appropriate code. The conventions discussed below are: semicolons; parentheses; symbols; modifiers; and unlisted procedures.

SEMICOLONS
CPT uses the semicolon as a kind of shorthand to avoid repeating words and phrases. For example, CPT lists:
  57510  Cautery of cervix; electro or thermal
  57511  cryocautery, initial or repeat
  57513  laser ablation

Codes 57511 and 57513 both include the part of code 57510 that precedes the semicolon "cautery of cervix". Therefore:
  • The full description for code 57511 is: Cautery of cervix; cryocautery, initial or repeat.
  • The full description for code 57513 is: Cautery of cervix; laser ablation.

PARENTHESES
Parenthetical statements either: 1) provide additional guidance to help the user select the correct code; or 2) indicate that some codes from previous editions of CPT have been deleted. For example, these statements follow code 57556:
  (For insertion of intrauterine device, use 58300)
  (For insertion of any hemostatic agent or pack for control of spontaneous non-obstetrical hemorrhage, see 57180)
Symbols
Many of the code numbers or phrases use symbols (e.g., •, ▲, +, ○, ◦, ▲) to provide additional information to the coder. In most cases, these symbols precede a code number.

• A bullet means that the code is new for the current year. Appendix B of the CPT book provides a summary of new code additions, deletions and revisions.

▲ A triangle or delta sign means that the code description has been revised in the current year. See Appendix B of CPT for a summary of revised changes.

+ A plus sign means that the code is an "add-on" code and therefore does not require a modifier 51 (multiple procedure). Add-on codes are only reported with other codes. They are never reported alone. A summary of CPT add-on codes is listed in Appendix D of the CPT book.

○ This symbol means that the code is a "modifier 51 exempt" code and therefore the modifier is not required even when multiple procedures were performed. Appendix E lists a summary of CPT codes exempt from modifier 51.

⊙ This symbol means that the codes for moderate (conscious) sedation (99143 - 99145) are not reported in addition to these codes. A summary of CPT codes that include moderate (conscious) sedation can be found in Appendix G.

▼ Arrows may be found before and after phrases, sentences or whole paragraphs. The arrows enclose wording that is either new or has been revised in the current year.

✓ This symbol means that the vaccine product code had not been approved by the FDA at the time the latest CPT book was published. Refer to Appendix K of the CPT book for a summary of these codes.

# The hash symbol represents resequenced codes that do not appear in numeric order within the CPT book. This symbol was introduced in 2010. A summary of resequenced codes can be found in Appendix N.

O This symbol signifies reinstated or recycled codes. This symbol was introduced in 2010.

Modifiers
Modifiers are two-character appendages numbers that are added to the end of either an Evaluation and Management Services (E/M) code or a procedure code. Modifiers are used to indicate to the insurer that special circumstances occurred during this patient encounter. Correct use of modifiers can significantly impact physician’s reimbursement for services.

Modifiers added to E/M codes are discussed in Chapter 2. Modifiers added to procedure codes are discussed in Chapter 3. A complete list of modifiers is in Appendix A of CPT.
CHAPTER 2: PROBLEM-ORIENTED EVALUATION AND MANAGEMENT SERVICES

Face-to-face encounters with patients are reported using Evaluation and Management codes (known as E/M codes). E/M services are either:

- Problem-oriented visits (e.g., for the diagnosis and treatment of illness, disease and symptoms); or
- Preventive visits (e.g., when the patient has no current symptoms or diagnosed illness).

These are discussed in Chapter 3.

Reporting and documenting these services correctly can greatly impact a practice’s income and protect the practice in the event of a claims review by Medicare or a commercial payer.

DEFINITIONS

E/M services codes are reported depending on the setting (outpatient or inpatient), whether the provider has seen the patient before (new or established patient), and the type of service (consultation, observation, etc.). The various types of services are discussed later in this chapter.

OUTPATIENT OR INPATIENT

CPT defines these terms as follows:

- A patient is an outpatient until she is admitted to a health care facility as an inpatient. Outpatient areas include a physician’s office, emergency departments, observation areas, and outpatient surgical centers.
- A patient is an inpatient if she has been admitted to a health care facility.

NEW OR ESTABLISHED PATIENTS

CPT defines these terms as follows:

- A new patient has not received any professional services from the physician/QHP or another physician/QHP of the exact same specialty and subspecialty who belongs to the same group practice within the past three years
- An established patient has received professional services from the physician/QHP or another physician/QHP of the exact same specialty and subspecialty who belongs to the same group practice within the past three years

KEY COMPONENTS AND LEVELS OF SERVICE

Both Medicare and CPT rely primarily on three key components (history, physical examination and medical decision making) to define the various levels of E/M services. Medicare and CPT use the same definitions of history and medical decision making but different definitions for the physical examination.

In some cases, E/M services can be reported using time spent with the patient. Reporting services using time is discussed later in this chapter.
KEY COMPONENT: HISTORY

Definition
The history key component is comprised of four elements: chief complaint; history of present illness; review of systems; and past, family and social history. Except for the chief complaint, each element is further defined in Table 2-1 using a numbered list of factors that are included in the history elements. Both CPT and Medicare use these same elements.

<table>
<thead>
<tr>
<th>History Elements</th>
<th>Definitions/List of Factors Included in Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief complaint (CC)</td>
<td>Statement of symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually in the patient’s own words.</td>
</tr>
</tbody>
</table>
| History of present illness (HPI)             | 1. Location  
|                                              | 2. Quality  
|                                              | 3. Severity  
|                                              | 4. Duration  
|                                              | 5. Timing  
|                                              | 6. Context  
|                                              | 7. Modifying factors  
|                                              | 8. Associated signs and symptoms                                                                             |
| Review of systems (ROS)                      | 1. Constitutional (e.g., fever, weight loss)  
|                                              | 2. Eyes  
|                                              | 3. Ears, nose, mouth & throat  
|                                              | 4. Cardiovascular  
|                                              | 5. Respiratory  
|                                              | 6. Gastrointestinal  
|                                              | 7. Genitourinary  
|                                              | 8. Musculoskeletal  
|                                              | 9. Integumentary (skin and/or breast)  
|                                              | 10. Neurological  
|                                              | 11. Psychiatric  
|                                              | 12. Endocrine  
|                                              | 13. Hematologic/lymphatic  
|                                              | 14. Allergic/immunologic                                                                                     |
| Past, family and social history (PFSH)       | 1. **Past history** - Past experiences with illnesses, operations, injuries, medications, compliance and treatments. |
|                                              | 2. **Family history** - Review of medical events in patient’s family, including diseases that may be hereditary or place her at risk. |
|                                              | 3. **Social history** - Age appropriate review of past and current activities including marital status, employment, drug & alcohol use, education and sexual history. |

Documenting a Level of Service
CPT uses descriptive terms such as “detailed” or “problem-focused” to describe the different levels of E/M services but does not define these terms.

Medicare requires documentation of a specific number of the factors listed in Table 2-1. Specific documentation requirements are listed in Table 2-2. The criteria for documenting history of present illness, review of systems, and past, family and social history must all be met or exceeded in order to report that level of service. For example, in order to report a detailed history, the provider must document a chief complaint, an extended history of present illness (4 or more numbered elements or 3 or more chronic or inactive conditions), an extended review of systems (2-9 numbered systems) and 1 element of either past, family, or social history.
TABLE 2-2: DOCUMENTING E/M SERVICES: HISTORY AND PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>Level of Service</th>
<th>History</th>
<th>Physical Examination Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CC</td>
<td>HPI*</td>
</tr>
<tr>
<td>Problem focused</td>
<td>Required</td>
<td>Brief (1-3 elements)</td>
</tr>
<tr>
<td>Expanded problem focused</td>
<td>Required</td>
<td>Brief (1-3 elements)</td>
</tr>
<tr>
<td>Detailed</td>
<td>Required</td>
<td>Extended (≥4 elements OR ≥3 chronic or inactive conditions)</td>
</tr>
</tbody>
</table>
| Comprehensive          | Required | Extended (≥4 elements OR ≥3 chronic or inactive conditions) | Complete (10 systems) | Complete (≥2 elements) | General multi-system exam or complete exam of single organ system + other symptomatic or related areas | ≥8 body areas/organ systems | All bullets - Constitutional & gastrointestinal systems  
1 bullet each - Neck, respiratory, cardio-vascular, lymphatic, skin, neurologic/psychiatric systems |

*Terms in parentheses indicate Medicare requirements for the element. Other terms are CPT requirements.

PHYSICAL EXAMINATION

Definitions
Medicare’s 1995 and 1997 Documentation Guidelines include specific body areas/organ systems that may be examined. The 1997 Guidelines use bullets within the body areas/organs systems to further define the examination being performed.

The criteria listed for the 1997 Guidelines below are from the single system examination for the female genitourinary system that is part of these guidelines.
TABLE 2-3: ELEMENTS WITHIN PHYSICAL EXAMINATION KEY COMPONENT

<table>
<thead>
<tr>
<th>CPT: Elements of Key Component</th>
<th>Medicare: Elements of Key Component</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body Areas:</strong></td>
<td><strong>1995 Guidelines</strong></td>
</tr>
<tr>
<td>1. Abdomen</td>
<td>1. Abdomen</td>
</tr>
<tr>
<td>2. Back including spine</td>
<td>2. Abdomen</td>
</tr>
<tr>
<td>3. Chest including breast and axillae</td>
<td>3. Chest including breast and axillae</td>
</tr>
<tr>
<td>4. Each extremity</td>
<td>4. Each extremity</td>
</tr>
<tr>
<td>5. Genitalia/groin/ buttoks</td>
<td>5. Genitalia/groin/ buttoks</td>
</tr>
<tr>
<td>6. Head including face</td>
<td>6. Head including face</td>
</tr>
<tr>
<td><strong>Organ Systems:</strong></td>
<td><strong>1997 Guidelines</strong></td>
</tr>
<tr>
<td>1. Cardiovascular</td>
<td>1. Constitutional</td>
</tr>
<tr>
<td>2. Ears/nose/mouth/throat</td>
<td>• Record 3 vital signs*</td>
</tr>
<tr>
<td>3. Eyes</td>
<td>• General appearance of pt (development, nutrition, body habitus, deformities, attention to grooming)</td>
</tr>
<tr>
<td>5. Genitourinary</td>
<td>• Examine thyroid (eg, enlargement, tenderness, mass)</td>
</tr>
<tr>
<td>6. Hematologic/lymphatic/immunologic</td>
<td>• Examine neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)</td>
</tr>
<tr>
<td>7. Musculoskeletal</td>
<td>3. Respiratory</td>
</tr>
<tr>
<td>8. Neurologic</td>
<td>• Assess respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)</td>
</tr>
<tr>
<td>9. Psychiatric</td>
<td>• Auscultate lungs (eg, breath sounds, adventitious sounds, rubs)</td>
</tr>
<tr>
<td>10. Respiratory</td>
<td>4. Cardiovascular</td>
</tr>
<tr>
<td>11. Skin</td>
<td>• Auscultate heart (note sounds, abnormal sounds &amp; murmurs)</td>
</tr>
<tr>
<td></td>
<td>• Examine peripheral vascular system—observe (eg, swelling, varicosities) &amp; palpate (eg, pulses, temp, edema, tenderness)</td>
</tr>
<tr>
<td></td>
<td>5. Lymphatic</td>
</tr>
<tr>
<td></td>
<td>• Palpate nodes (neck, axillae &amp;/or groin &amp;/or other locations)</td>
</tr>
<tr>
<td></td>
<td>6. Skin</td>
</tr>
<tr>
<td></td>
<td>• Inspect/palpate skin &amp; subq tissue (eg, rashes, lesions, ulcers)</td>
</tr>
<tr>
<td></td>
<td>7. Neurological/psychiatric</td>
</tr>
<tr>
<td></td>
<td>• Briefly assess orientation (ie, time, place and person)</td>
</tr>
<tr>
<td></td>
<td>• Briefly assess mood &amp; affect (eg, depression, anxiety, agitation)</td>
</tr>
<tr>
<td></td>
<td>8. Gastrointestinal</td>
</tr>
<tr>
<td></td>
<td>• Examine abdomen (note presence of masses &amp; tenderness)</td>
</tr>
<tr>
<td></td>
<td>• Examine liver and spleen</td>
</tr>
<tr>
<td></td>
<td>• Obtain stool sample for occult blood test, when indicated</td>
</tr>
<tr>
<td></td>
<td>• Examine for presence/absence of hernia</td>
</tr>
<tr>
<td></td>
<td>9. Genitourinary</td>
</tr>
<tr>
<td></td>
<td>• Inspect/palpate breasts (eg, masses or lumps, tenderness, symmetry, nipple discharge)</td>
</tr>
<tr>
<td></td>
<td>• Perform digital rectal exam including sphincter tone, presence of hemorrhoids, rectal masses</td>
</tr>
<tr>
<td></td>
<td>• Examine external genitalia (eg, general appearance, hair distribution, lesions)</td>
</tr>
<tr>
<td></td>
<td>• Examine urethral meatus (eg, size, location, lesions, prolapse)</td>
</tr>
<tr>
<td></td>
<td>• Examine urethra (eg, masses, tenderness, scarring)</td>
</tr>
<tr>
<td></td>
<td>• Examine bladder (eg, fullness, masses, tenderness)</td>
</tr>
<tr>
<td></td>
<td>• Examine vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)</td>
</tr>
<tr>
<td></td>
<td>• Examine cervix (eg, general appearance, lesions, discharge)</td>
</tr>
<tr>
<td></td>
<td>• Examine uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support)</td>
</tr>
<tr>
<td></td>
<td>• Examine adnexa/parametria (eg, masses, tenderness, organo-megaly, nodularity)</td>
</tr>
<tr>
<td></td>
<td>• Examine anus and perineum</td>
</tr>
</tbody>
</table>

*Medicare’s 1997 physical exam defines vital signs as documentation of any 3 of the following: sitting or standing blood pressure; supine blood pressure; pulse rate and regularity; respiration; temperature; height; or weight. These can be measured and recorded by ancillary staff.
Documenting a Level of Service
CPT uses descriptive terms such as “expanded problem-focused” or “comprehensive” to describe the different levels for the physical exam, but does not define these terms.

Medicare’s 1995 Guidelines require a specific number of the body areas/organ systems listed in Table 2-3 for each level of service but do not define exactly what must be examined within each area. Medicare’s 1997 Guidelines require a specific number of the elements or bullets listed in Table 2-3 for each level of service. Providers can use whichever set of documentation guidelines is most advantageous.

Table 2-2 describes the documentation required under CPT and Medicare rules in order to report a specific level of service. ACOG’s Committee on Health Economics and Coding has developed templates to assist with documentation using the 1995 and 1997 Medicare guidelines. These templates are available on ACOG’s website on the Coding page (www.acog.org).

MEDICAL DECISION MAKING
Definition
Both CPT and Medicare define the medical decision-making key component as including three elements (number of diagnoses or management options, amount and/or complexity of data to be reviewed, and risk of complications and/or morbidity or mortality). These elements are listed below in Table 2-4. The definitions of these elements were extracted from the Medicare Documentation Guidelines. These elements are designed to reflect the complexity of establishing a diagnosis and/or selecting a management option.

<table>
<thead>
<tr>
<th>Elements of Key Component</th>
<th>Definitions of Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of diagnoses or management options</td>
<td>Number and types of problems addressed&lt;br&gt;Complexity of establishing a diagnosis&lt;br&gt;Management decisions made by the provider</td>
</tr>
<tr>
<td>2. Amount and/or complexity of data to be reviewed</td>
<td>Types of diagnostic testing ordered or reviewed&lt;br&gt;Need to obtain previous records&lt;br&gt;Need to obtain history from other source(s)</td>
</tr>
<tr>
<td>3. Risk of complications and/or morbidity or mortality</td>
<td><strong>Presenting problems</strong> and the risk related to the disease process anticipated between the present encounter and the next one&lt;br&gt;<strong>Diagnostic procedures</strong> and the risk during and immediately following the procedure&lt;br&gt;<strong>Possible management options</strong> and the risk during and immediately following the treatment</td>
</tr>
</tbody>
</table>

Documenting a Level of Service
CPT uses descriptive terms such as “moderate” or “limited” to describe the different elements of medical decision making, but does not define these terms. Neither CPT nor Medicare requires documentation of a specific number of elements. Providers should document the diagnoses and management options considered and/or ruled out, data received and reviewed, and the potential risk for the patient in order to support the level of medical decision making selected.

Table 2-5 describes the specific medical decision making elements required to report a specific level of service.
TABLE 2-5: DOCUMENTING E/M SERVICES: MEDICAL DECISION MAKING

<table>
<thead>
<tr>
<th>Level of Service</th>
<th># of Diagnoses or Management Options</th>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Risk of Complications and/or Morbidity or Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

Two of the three required elements must be met or exceeded in order to report a specific level of service. For example, a physician or QHP may document limited diagnoses/management options, an extensive amount of data reviewed, and that the patient had a low risk of complications. This would be low complexity medical decision-making.

Medicare has provided some specific examples of services that would represent different levels of the risk element within the medical decision making component. Table 2-6 provides examples of services that are considered minimal, low, moderate or high levels of risk. This table is an abridged version of one included in Medicare's 1995 and 1997 documentation guidelines. The complete table is available on ACOG’s website.

Providers may have an entry in only one column, two columns or in all three or have multiple entries in a single column. The physician should select the highest level of overall risk.

TABLE 2-6: EXAMPLES OF LEVELS OF RISK IN MEDICAL DECISION MAKING

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedures(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>1 Self-limited/minor problem (eg, cold, insect bite, tinea corporis)</td>
<td>Imaging studies—ultrasound, EKG</td>
<td>Rest, Elastic bandages</td>
</tr>
<tr>
<td>Low</td>
<td>&gt;2 Self-limited/minor problems</td>
<td>Imaging studies with contrast—non-cardiovascular, eg, barium enema</td>
<td>Minor surgery—no identified risk factors, Drugs—over-the-counter</td>
</tr>
<tr>
<td></td>
<td>1 chronic illness—stable, eg, non-insulin dependent diabetes</td>
<td>Biopsies—skin or superficial needle</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute illness or injury—uncomplicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>Undiagnosed new problem with uncertain prognosis—eg, breast lump</td>
<td>Imaging studies with contrast—No identified risk factors</td>
<td>Minor surgery—identifiable risk factors, Major surgery—elective with no identifiable risk factors, Drugs—management of prescription drugs</td>
</tr>
<tr>
<td></td>
<td>&gt;1 chronic illnesses—with mild exacerbation/progression, or side effects of treatment</td>
<td>Diagnostic endoscopies with no identifiable risk factors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute illness with systemic symptoms</td>
<td>Biopsies—deep needle or incisional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute injury—complicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>&gt;1 chronic illnesses—severe exacerbation/progression/side effects of treatment</td>
<td>Imaging studies with contrast—identified risk factors</td>
<td>Major surgery—elective with identifiable risk factors OR emergency surgery, Drugs—therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td>Acute illnesses or injuries posing threat to life/bodily function</td>
<td>Diagnostic endoscopies with identified risk factors</td>
<td></td>
</tr>
</tbody>
</table>
REPORTING E/M SERVICES USING TIME
In most circumstances, time is used only as a reference and does not influence code selection. However, under some circumstances time will determine the level of E/M service. The provider may:

- Perform a physical exam and obtain a history, but spend more than 50% of the total time with the patient providing counseling OR
- Spend all of the time during the visit providing counseling for a patient and/or her family.

When time is used to determine the level of service, the provider must document:

- The total length of time spent with the patient AND
- The fact that more than 50% of that time was spent in counseling and/or coordination of care AND
- The content of the counseling and/or coordination of care activities.

Counseling is defined as a discussion with a patient and/or her family about:
- Diagnostic results, impressions and/or recommended studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction AND
- Patient and family education

MEASURING TIME
Time is measured differently depending on the setting in which the services were provided.

- **Office/outpatient**: Measure the total time that the physician or QHP spent face-to-face with the patient and/or family, including time spent obtaining a history, performing a physical exam, and counseling the patient.

- **Inpatient**: Measure the total time that the physician or QHP spent both face-to-face with the patient and on the patient’s floor or unit, including time spent in establishing and/or reviewing the patient’s chart, examining the patient, writing notes, and communicating with other professionals and with the patient’s family.

Many, but not all, E/M codes list “typical times” in their descriptions. When using time to determine the E/M level of service, the time documented in the patient’s record must match this “typical time.” If the code description does not include time, the service is reported using the key components.
LEVELS OF E/M SERVICE

After assessing the level of complexity of each component, the selected code category will need to be matched with its proper code level. The following charts show the documentation requirements for E/M code categories reported by obstetrician-gynecologists or other QHP. The charts include both Medicare and CPT definitions. Some categories require that the criteria for all three key components be met, while others require only two key components. Some categories can be reported using time alone while others cannot.

OFFICE OR OUTPATIENT SERVICES

These codes include new patient services codes (99201-99205) and established patient services codes (99211-99215). Tables 2-7 and 2-8 summarize the documentation requirements for these codes.

### TABLE 2-7: OFFICE OR OTHER OUTPATIENT SERVICES - NEW PATIENT

(Document either all 3 key components [history, exam & medical decision making] at the required level OR time spent counseling with patient if appropriate)

<table>
<thead>
<tr>
<th></th>
<th>99201</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levels</td>
<td>Problem-Focused</td>
<td>Expanded Problem-Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>CC</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>HPI</td>
<td>1-3 elements</td>
<td>1-3 elements</td>
<td>≥4 elements OR ≥3 chronic or inactive conditions</td>
<td>≥4 elements OR ≥3 chronic or inactive conditions</td>
<td>≥4 elements OR ≥3 chronic or inactive conditions</td>
</tr>
<tr>
<td>ROS</td>
<td>Not Required</td>
<td>1 system</td>
<td>2-9 systems</td>
<td>10-14 systems</td>
<td>10-14 systems</td>
</tr>
<tr>
<td>PFISH</td>
<td>Not Required</td>
<td>Not Required</td>
<td>1 element</td>
<td>3 elements</td>
<td>3 elements</td>
</tr>
</tbody>
</table>

**Physical Examination**

<table>
<thead>
<tr>
<th></th>
<th>Problem-focused</th>
<th>Expanded Problem-focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995 Guidelines</td>
<td>1 system</td>
<td>2-4 systems</td>
<td>5-7 systems</td>
<td>≥8 systems</td>
<td>≥8 systems</td>
</tr>
<tr>
<td>1997 Guidelines</td>
<td>1-5 elements</td>
<td>6-11 elements</td>
<td>≥12 elements</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

**Medical Decision Making**

<table>
<thead>
<tr>
<th></th>
<th>Straightforward</th>
<th>Straightforward</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dx/mgmt options</td>
<td>Minimal</td>
<td>Minimal</td>
<td>Limited</td>
<td>Multiple</td>
<td>Extensive</td>
</tr>
<tr>
<td>Data reviewed</td>
<td>Minimal or None</td>
<td>Minimal or None</td>
<td>Limited</td>
<td>Moderate</td>
<td>Extensive</td>
</tr>
<tr>
<td>Risk</td>
<td>Minimal</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

**Face-to-Face Time**

<table>
<thead>
<tr>
<th></th>
<th>10 minutes</th>
<th>20 minutes</th>
<th>30 minutes</th>
<th>45 minutes</th>
<th>60 minutes</th>
</tr>
</thead>
</table>

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TABLE 2-8: OFFICE OR OTHER OUTPATIENT SERVICES - ESTABLISHED PATIENT
(Document any 2 of 3 key components [history, exam & medical decision making] at the required level OR time spent counseling the patient if appropriate)

<table>
<thead>
<tr>
<th></th>
<th>99211*</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levels</td>
<td>Not Required</td>
<td>Problem-Focused</td>
<td>Expanded Problem-Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>CC</td>
<td>Not Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>HPI</td>
<td>Not Required</td>
<td>1-3 elements</td>
<td>1-3 elements</td>
<td>≥4 elements OR ≥3 chronic or inactive conditions</td>
<td>≥4 elements OR ≥3 chronic or inactive conditions</td>
</tr>
<tr>
<td>ROS</td>
<td>Not Required</td>
<td>Not Required</td>
<td>1 system</td>
<td>2-9 systems</td>
<td>10-14 systems</td>
</tr>
<tr>
<td>PFHS</td>
<td>Not Required</td>
<td>Not Required</td>
<td>Not Required</td>
<td>1 element</td>
<td>2 elements</td>
</tr>
<tr>
<td><strong>Physical Examination</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levels</td>
<td>Not Required</td>
<td>Problem-Focused</td>
<td>Expanded Problem-Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>1995 Guidelines</td>
<td>Not Required</td>
<td>1 system</td>
<td>2-4 systems</td>
<td>5-7 systems</td>
<td>≥8 systems</td>
</tr>
<tr>
<td>1997 Guidelines</td>
<td>Not Required</td>
<td>1-5 elements</td>
<td>6-11 elements</td>
<td>≥12 elements</td>
<td>Comprehensive</td>
</tr>
<tr>
<td><strong>Medical Decision Making</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levels</td>
<td>Not Required</td>
<td>Straight-forward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Dx/mgmt options</td>
<td>Not Required</td>
<td>Minimal</td>
<td>Limited</td>
<td>Multiple</td>
<td>Extensive</td>
</tr>
<tr>
<td>Data reviewed</td>
<td>Not Required</td>
<td>Minimal or None</td>
<td>Limited</td>
<td>Moderate</td>
<td>Extensive</td>
</tr>
<tr>
<td>Risk</td>
<td>Not Required</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td><strong>Face-to-Face Time</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typical Times</td>
<td>5 minutes supervision*</td>
<td>10 minutes</td>
<td>15 minutes</td>
<td>25 minutes</td>
<td>40 minutes</td>
</tr>
</tbody>
</table>

*Physician must be in the office during the E/M service.

INPATIENT SERVICES

These codes include initial hospital care codes (99221-99223), inpatient care services, including admission and discharge services codes (99234-99236), and subsequent hospital care codes (99231-99233). Documentation requirements for these codes are summarized in Tables 2-9 and 2-10. Hospital discharge services codes (99238-99239) are reported using time alone and are not included in these tables.

Medicare rules state that if a patient is an inpatient for less than 8 hours on the same day, only an initial hospital care code (99221-99223) is reported. However, if she is an inpatient for more than 8 hours but discharged on the same date, a same day admission and discharge services code (99234-99236) is reported.
### TABLE 2-9: INITIAL HOSPITAL CARE AND SAME DAY ADMIT/DISCHARGE

(Document All 3 key components [history, exam & medical decision making] at the required level OR time spent counseling the patient if appropriate)

<table>
<thead>
<tr>
<th></th>
<th>99221</th>
<th>99222</th>
<th>99223</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Hospital Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Same Day Admit/Discharge</strong></td>
<td>99234</td>
<td>99235</td>
<td>99236</td>
</tr>
<tr>
<td><strong>History</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levels</td>
<td>Detailed OR Comprehensive</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>CCI</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>HPI</td>
<td>≥4 elements OR ≥3 chronic or inactive conditions</td>
<td>≥4 elements OR ≥3 chronic or inactive conditions</td>
<td>≥4 elements OR ≥3 chronic or inactive conditions</td>
</tr>
<tr>
<td>ROS</td>
<td>≥2 systems</td>
<td>10-14 systems</td>
<td>10-14 systems</td>
</tr>
<tr>
<td>PFSH</td>
<td>≥1 element</td>
<td>3 elements</td>
<td>3 elements</td>
</tr>
<tr>
<td><strong>Physical Examination</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levels</td>
<td>Detailed OR Comprehensive</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>1995 Guidelines</td>
<td>5 - 7 systems</td>
<td>≥8 systems</td>
<td>≥8 systems</td>
</tr>
<tr>
<td>1997 Guidelines</td>
<td>≥12 or Comprehensive</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td><strong>Medical Decision Making</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levels</td>
<td>Straightforward OR Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Dx/mgmt options</td>
<td>Minimal or Limited</td>
<td>Multiple</td>
<td>Extensive</td>
</tr>
<tr>
<td>Data reviewed</td>
<td>None, Minimal or Low</td>
<td>Moderate</td>
<td>Extensive</td>
</tr>
<tr>
<td>Risk</td>
<td>Minimal or Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td><strong>Floor/Unit Time</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Hospital Care</td>
<td>30 minutes</td>
<td>50 minutes</td>
<td>70 minutes</td>
</tr>
<tr>
<td>Same Day Admit/Discharge</td>
<td>Codes cannot be reported using time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 2-10: SUBSEQUENT HOSPITAL CARE

(Document any 2 of 3 key components [history, exam & medical decision making] at the required level OR time spent counseling the patient if appropriate)

<table>
<thead>
<tr>
<th></th>
<th>99231</th>
<th>99232</th>
<th>99233</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interval History</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levels</td>
<td>Problem-Focused</td>
<td>Expanded Problem-Focused</td>
<td>Detailed</td>
</tr>
<tr>
<td>CC</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>HPI</td>
<td>1-3 elements</td>
<td>1-3 elements</td>
<td>≥4 elements OR ≥3 chronic or inactive conditions</td>
</tr>
<tr>
<td>ROS</td>
<td>Not Required</td>
<td>1 system</td>
<td>2-9 systems</td>
</tr>
<tr>
<td>PFSH</td>
<td>Not Required</td>
<td>Not Required</td>
<td>Not Required</td>
</tr>
<tr>
<td><strong>Physical Examination</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levels</td>
<td>Problem-Focused</td>
<td>Expanded Problem-Focused</td>
<td>Detailed</td>
</tr>
<tr>
<td>1995 Guidelines</td>
<td>1 system</td>
<td>2-4 systems</td>
<td>≥5 systems</td>
</tr>
<tr>
<td>1997 Guidelines</td>
<td>1-5 elements</td>
<td>6-11 elements</td>
<td>≥12 elements</td>
</tr>
<tr>
<td><strong>Medical Decision Making</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levels</td>
<td>Straightforward OR Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Dx/mgmt options</td>
<td>Minimal or Limited</td>
<td>Multiple</td>
<td>Extensive</td>
</tr>
<tr>
<td>Data reviewed</td>
<td>None, Minimal or Low</td>
<td>Moderate</td>
<td>Extensive</td>
</tr>
<tr>
<td>Risk</td>
<td>Minimal or Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td><strong>Floor/Unit Time</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typical Times</td>
<td>15 minutes</td>
<td>25 minutes</td>
<td>35 minutes</td>
</tr>
</tbody>
</table>
If a provider initiates diagnostic and/or therapeutic services at the time of a consultation, both the consultation and the procedure code may be reported. Providers should add modifier 25 (significant, separately identifiable E/M service on the same day as a procedure) to the E/M service to indicate that a separately identifiable evaluation was performed in addition to the procedure.

**Consultations**

A consultation code is reported when one physician or other appropriate source requests an opinion or advice from another provider regarding the evaluation and management of a specific problem. The request and the consultation must be documented. The consulting provider must send the requesting provider a written report of his or her findings.

Consultation codes include services for outpatient consultations codes (99241-99245) and initial inpatient consultations codes (99251-99255). Follow-up outpatient or inpatient consultations are reported using office or subsequent inpatient codes. See chapter 7 for more information on the consultation reporting changes effective since 2010. Documentation requirements for these codes are summarized in Table 2-11.

**TABLE 2-11: INITIAL INPATIENT OR OUTPATIENT CONSULTATION**

**NEW OR ESTABLISHED PATIENT**

(Document **either all 3 key components** [history, exam & medical decision making] at the required level OR time spent counseling with patient if appropriate)

<table>
<thead>
<tr>
<th>Office/Outpatient</th>
<th>99241</th>
<th>99242</th>
<th>99243</th>
<th>99244</th>
<th>99245</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient</strong></td>
<td>99251</td>
<td>99252</td>
<td>99253</td>
<td>99254</td>
<td>99255</td>
</tr>
<tr>
<td><strong>Levels</strong></td>
<td>Problem-Focused</td>
<td>Expanding Problem-Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td><strong>CC</strong></td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>HPI</strong></td>
<td>1-3 elements</td>
<td>1-3 elements</td>
<td>≥4 elements OR ≥3 chronic or inactive conditions</td>
<td>≥4 elements OR ≥3 chronic or inactive conditions</td>
<td>≥4 elements OR ≥3 chronic or inactive conditions</td>
</tr>
<tr>
<td><strong>ROS</strong></td>
<td>Not Required</td>
<td>1 system</td>
<td>2-9 systems</td>
<td>10-14 systems</td>
<td>10-14 systems</td>
</tr>
<tr>
<td><strong>PFSh</strong></td>
<td>Not Required</td>
<td>Not Required</td>
<td>1 element</td>
<td>3 elements</td>
<td>3 elements</td>
</tr>
<tr>
<td><strong>Physical Examination</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Levels</strong></td>
<td>Problem-Focused</td>
<td>Expanding Problem-Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td><strong>1995 Guidelines</strong></td>
<td>1 system</td>
<td>2-4 systems</td>
<td>5-7 systems</td>
<td>≥8 systems</td>
<td>≥8 systems</td>
</tr>
<tr>
<td><strong>1997 Guidelines</strong></td>
<td>1-5 elements</td>
<td>6-11 elements</td>
<td>≥12 elements</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td><strong>Medical Decision Making</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Levels</strong></td>
<td>Straight-forward</td>
<td>Straight-forward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td><strong>Dx/mgmt options</strong></td>
<td>Minimal</td>
<td>Minimal</td>
<td>Limited</td>
<td>Multiple</td>
<td>Extensive</td>
</tr>
<tr>
<td><strong>Data reviewed</strong></td>
<td>Minimal or None</td>
<td>Minimal or None</td>
<td>Limited</td>
<td>Moderate</td>
<td>Extensive</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
<td>Minimal</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td><strong>Typical Time</strong></td>
<td>15 minutes</td>
<td>30 minutes</td>
<td>40 minutes</td>
<td>60 minutes</td>
<td>80 minutes</td>
</tr>
<tr>
<td><strong>Office/Outpatient</strong> (Face-to-face)</td>
<td>20 minutes</td>
<td>40 minutes</td>
<td>55 minutes</td>
<td>80 minutes</td>
<td>110 minutes</td>
</tr>
</tbody>
</table>

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OBSERVATION CARE
Observation services are reported when a patient has been designated to be in "observation status" in a hospital.

Observation care codes include services for initial observation care (99218-99220) and same day admission and discharge from observation care (99234-99236). Codes 99234-99236 are reported for services on the same day for either inpatient or observation services.

Documentation requirements for these codes are summarized in Table 2-12. The observation care discharge code (99217), used when the discharge is on a different date than the admission, is not reported using either time or key components and is not included in these tables.

Medicare has special requirements for patients admitted to observation care but discharged on the same date. If the patient is in observation status for less than 8 hours, only an initial observation care code (99218-99220) is reported. If, however, the patient is in observation status for more than 8 hours but is discharged on the same date, a same day admission and discharge code (99234-99236) is reported.

For 2012, CPT has revised the initial observation codes, 99218–99220 to include typical times. Code 99218 has a typical time of 30 minutes, code 99219 has a typical time of 50 minutes and code 99220 now has a typical time of 70 minutes. These typical times mirror the times associated with the Hospital Inpatient Services codes (99221–99223).

<table>
<thead>
<tr>
<th>Initial Observation Care</th>
<th>99218</th>
<th>99219</th>
<th>99220</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same Day Admit/Discharge</td>
<td>99234</td>
<td>99235</td>
<td>99236</td>
</tr>
</tbody>
</table>

**History**

<table>
<thead>
<tr>
<th>Levels</th>
<th>Detailed OR Comprehensive</th>
<th>Comprehensive</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCI</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>HPI</td>
<td>≥4 elements OR ≥3 chronic or inactive conditions</td>
<td>≥4 elements OR ≥3 chronic or inactive conditions</td>
<td>≥4 elements OR ≥3 chronic or inactive conditions</td>
</tr>
<tr>
<td>ROS</td>
<td>≥2 systems</td>
<td>10-14 systems</td>
<td>10-14 systems</td>
</tr>
<tr>
<td>PFHS</td>
<td>≥1 element</td>
<td>3 elements</td>
<td>3 elements</td>
</tr>
</tbody>
</table>

**Physical Examination**

<table>
<thead>
<tr>
<th>Levels</th>
<th>Detailed OR Comprehensive</th>
<th>Comprehensive</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995 Guidelines</td>
<td>5-7 systems</td>
<td>≥8 systems</td>
<td>≥8 systems</td>
</tr>
<tr>
<td>1997 Guidelines</td>
<td>≥12 elements OR Comprehensive</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

**Medical Decision Making**

<table>
<thead>
<tr>
<th>Levels</th>
<th>Straightforward OR Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dx/mgmt options</td>
<td>Minimal or Limited</td>
<td>Multiple</td>
<td>Extensive</td>
</tr>
<tr>
<td>Data reviewed</td>
<td>None, Minimal or Low</td>
<td>Moderate</td>
<td>Extensive</td>
</tr>
<tr>
<td>Risk</td>
<td>Minimal or Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

**Typical Time**

<table>
<thead>
<tr>
<th>Initial Observation Care</th>
<th>30 minutes</th>
<th>50 minutes</th>
<th>70 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same Day Admit/Discharge Observation Care</td>
<td>Codes 99234-99236 cannot be reported using time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TWO E/M SERVICES IN THE SAME DAY
Sometimes, a patient is seen in one setting, such as the physician’s office or observation care, and then admitted to the hospital by the same provider on the same day. In these cases, only one E/M service code is reported. The code reported includes the total of the provider’s work for that day in both settings.

E/M SERVICES MODIFIERS
Table 2-13 summarizes the modifiers used with E/M services.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td><strong>Unrelated E/M service:</strong> E/M service provided by the surgeon during a global surgical period.</td>
<td>A postoperative service was provided during the global surgical period. Diagnosis code indicates the service is unrelated to the original surgical procedure.</td>
</tr>
<tr>
<td>25</td>
<td><strong>Significant, Separately Identifiable E/M Service:</strong> E/M service provided on the same day as a procedure or other service.</td>
<td>E/M service and a procedure on same day. The E/M service may have led to the decision to perform the procedure or may have involved the evaluation of a problem unrelated to the procedure. Medicare states that this modifier is used when the decision to perform minor surgery is made on the day of or day before the surgery. For major surgery, see modifier 57. Two E/M Services on the same day. Each service must be significant and separately identifiable. Primarily used when a preventive visit and problem-oriented visit are provided on the same day. See chapter 3.</td>
</tr>
<tr>
<td>32</td>
<td><strong>Mandated Services:</strong> A consultation and/or related services required by a third party payer, governmental, legislative or regulatory entity.</td>
<td>E/M service was required by insurer; e.g., a second opinion.</td>
</tr>
<tr>
<td>57</td>
<td><strong>Decision for Surgery:</strong> An E/M Service resulted in the initial decision to perform a surgical procedure.</td>
<td>The decision to perform the surgery was made during this E/M service. Medicare states that this modifier is used when the decision is made to perform major surgery on the day of or day before the surgery. For minor surgery, see modifier 25.</td>
</tr>
</tbody>
</table>
CHAPTER 3: PREVENTIVE MEDICINE AND
MEDICARE SCREENING SERVICES

DEFINITION OF PREVENTIVE SERVICES
Preventive medicine services are reported for comprehensive E/M services provided to patients who have no current symptoms or diagnosed illness. Preventive codes are used to report annual "well woman" examinations and include:

- Counseling/anticipatory guidance/risk factor reduction interventions
- Age and gender appropriate comprehensive history
- Age and gender appropriate comprehensive physical examination including in most cases but not limited to
  - gynecological exam
  - breast exam
  - collection of a Pap smear specimen
- Discussions about the status of previously diagnosed stable conditions
- Ordering of appropriate laboratory/diagnostic procedures and immunizations
- Discussions about issues related to the patient’s age or lifestyle

Preventive medicine codes (99381-99387 and 99391-99397) differ in several ways from problem-oriented E/M services. Preventive codes: do not require a chief complaint, history of present illness or medical decision making; cannot be reported using time; and may be performed in any setting. CMS E/M Documentation Guidelines do not apply to preventive services codes.

Medicare and other payers have different rules for reporting and reimbursing for these services. Physicians should check with their specific commercial carrier about their rules.

ADVANCED BENEFICIARY NOTIFICATION
Medicare screening services are limited to a specific frequency (e.g., once every 2 years, once every year). A physician may not know whether a patient is eligible for a screening service in a given year. If she is not eligible, the service will be denied. Therefore, the physician should ask the patient to sign an advance beneficiary notice of non-coverage (ABN) using the form provided by Medicare. For more information on Medicare’s ABN form, visit http://www.cms.gov/BNI/. Claims for Medicare patients should be submitted with the appropriate HCPCS modifier as described below.

- **GA** modifier indicates that a required ABN form has been signed and is on file. (Waiver of liability statement issued as required by payer policy, individual case)
- **GZ** modifier indicates that an ABN form has not been signed. (Item or service expected to be denied as not reasonable and necessary)
- **GX** modifier indicates that a voluntary ABN has been signed for a non-covered service. This modifier may be reported for services formerly reported with the Notice of Exclusion from Medicare Benefits (NEMB) form. The NEMB form has been discontinued. (Notice of liability issued, voluntary under payer policy)
- **GY** modifier indicates that the service provided is not a covered Medicare benefit. The service is being reported to Medicare in order to receive a denial. (Item or service statutorily excluded, does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit)

Using the appropriate modifier ensures that the patient will receive the correct information on her Explanation of Benefits (EOB). For example, when a service is reported with a GY modifier, the EOB will state that it is not covered and therefore the patient’s responsibility.
ANNUAL WELLNESS VISITS
CMS reimburse for two services:
1. The patient’s first annual wellness visit, which is distinct from and must occur at least 12 months after the patient’s “Welcome to Medicare” physical AND
2. Subsequent annual wellness visits

Personalized Prevention Plan Services (PPPS) are an essential part of the AWV service and include the following components:
- Establish or update the individual’s medical and family history
- List the individual’s current medical providers and suppliers and all prescribed medications
- Record measurements of height, weight, body mass index, blood pressure and other routine measurements
- Detect any cognitive impairment
- Establish or update a screening schedule for the next 5 to 10 years including screenings appropriate for the general population, and any additional screenings that may be appropriate because of the individual patient’s risk factors
- Furnish personalized health advice and appropriate referrals to health education or preventive services

Medicare Part B will pay for the initial and subsequent annual wellness visits providing personalized prevention plan services that are furnished to an eligible beneficiary by a qualified provider.

The following codes will be reported for annual wellness visits:
- G0438 - Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit
- G0439 - Annual wellness visit; includes a personalized prevention plan of service (PPPS), subsequent visit

Per the 2011 Physician Fee Schedule Final Rule, practitioners furnishing a preventive medicine E/M service that does not meet the requirements for the Initial Preventive Physical Examination (IPPE) or the annual wellness visit (AWV) should continue to report one of the preventive medicine E/M services CPT codes (99381 - 99397) if required and as appropriate to the patient’s circumstances, and these codes continue to be non-covered by Medicare.

Reporting, as always, will depend upon the services actually performed. However, it is suggested not to report these multiple services at the same visit since CMS has indicated that typically, preventive service codes are not billed on the same date as the AWV.

ACOG’s Committee on Coding and Nomenclature believes that it is unlikely that most ob-gyn practices will offer the AWV or IPPE. As a result, they have developed a letter template that can be used to help explain to patients that they should seek appointments for these visits with their primary care physicians. This letter can be viewed at the end of this document.
Screening Services

NOTE: The frequency of coverage for screening services described below has not changed as a result of the advent of Medicare coverage for annual wellness visits.

Collection of Screening Pap smear Specimen
Medicare reimburses for collection of a screening Pap smear every two years in most cases.

This service is reported using HCPCS code Q0091 (Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory). Both the deductible and co-pay/coinsurance are waived for the laboratory’s interpretation of the test.

The collection is reimbursed every year if the patient meets Medicare’s criteria for high risk. Following are the only criteria that are accepted by Medicare to indicate a high risk patient:

- Woman is of childbearing age AND
  - Cervical or vaginal cancer is present (or was present) OR
  - Abnormalities were found within last 3 years OR
  - Is considered high risk (as described below) for developing cervical or vaginal cancer
- Woman is not of childbearing age AND she has at least one of the following:
  - High risk factors for *cervical and vaginal cancer*
    - Onset of sexual activity under 16 years of age
    - Five or more sexual partners in a lifetime
    - History of sexually transmitted diseases (including human papilloma virus and/or HIV infection)
    - Fewer than 3 negative or any Pap smears within previous 7 years
    - DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy

Screening Pelvic Exam
Medicare reimburses for a screening pelvic examination every two years in most cases.

This service is reported using HCPCS code G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination). If the patient meets Medicare’s criteria for high risk, the examination is reimbursed every year. These criteria are the same as the ones listed above for the collection of screening Pap smear specimen. The diagnosis codes for Pap smear collection and screening pelvic exam are listed below.

A screening pelvic examination (HCPCS code G0101) should include documentation of at least seven of the following eleven elements:

1. Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge
2. Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses
3. External genitalia (for example, general appearance, hair distribution, or lesions)
4. Urethral meatus (for example, size, location, lesions, or prolapse)
5. Urethra (for example, masses, tenderness, or scarring)
6. Bladder (for example, fullness, masses, or tenderness)
7. Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystoceles, or rectoceles)
8. Cervix (for example, general appearance, lesions or discharge)
9. Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support)
10. Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity) and/or
11. Anus and perineum

HCPCS code G0101 includes only the above examination elements. It does not include the many other services normally included in a comprehensive preventive visit.

**Diagnostic Coding for the Collection of a Pap smear Specimen and the Screening Pelvic Exam**

Both the collection of the screening Pap smear specimen (Q0091) and screening pelvic exam (G0101) are reported with one of the following ICD-10-CM diagnosis codes:

- Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings
- Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings
- Z12.4 Encounter for screening for malignant neoplasm of cervix
- Z12.72 Encounter for screening for malignant neoplasm of vagina
- Z12.79 Encounter for screening for malignant neoplasm of other genitourinary organs
- Z12.89 Encounter for screening for malignant neoplasm of other sites
- Z77.9 Other contact with and (suspected) exposures hazardous to health
- Z91.89 Other specified personal risk factors, not elsewhere classified

Collection of a diagnostic Pap smear (performed due to illness, disease, or symptoms indicating a medically necessary reason) is included in the physical examination portion of a problem-oriented E/M service and is not reported or reimbursed separately.

Often, both the G0101 and Q0091 are provided during the same visit. An example follows.

**Example 1:** Collection of a screening Pap smear (Q0091) reported with the screening pelvic examination (G0101):

<table>
<thead>
<tr>
<th>Bill to:</th>
<th>HCPCS Codes</th>
<th>ICD-10 Codes</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>G0101-GA</td>
<td>Z12.4, Z12.72, Z12.79, Z12.89,</td>
<td>$34.60</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Z77.9 or Z91.89</td>
<td></td>
</tr>
<tr>
<td>Q0091-GA</td>
<td></td>
<td>Z12.4, Z12.72, Z12.79, Z12.89,</td>
<td>$40.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Z77.9 or Z91.89</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>N/A</td>
<td>N/A</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>Total amount billed</td>
<td></td>
<td></td>
<td>$74.60</td>
</tr>
</tbody>
</table>

The assumption is that the physician in this example provided only Medicare covered services with no additional preventive care.

The GA modifier indicates that an ABN has been signed and is on file. Note that the charges listed in the example above are Medicare allowable amounts but do not include the geographical adjustment factor.

The patient is not initially billed for either of these services since Medicare covers them. Both the deductible and co-pay/coinsurance are waived.
**Preventive Medicine Service Provided at the Time of Covered Screening Service**

A preventive medicine exam, as described by CPT-4 codes (99384 – 99397), includes a comprehensive age and gender appropriate history, examination, counseling/anticipatory guidance/risk-factor reduction interventions, and the ordering of appropriate immunization(s) and laboratory/diagnostic procedures. Sometimes these other elements are performed during the same visit as the Medicare covered services, particularly G0101 and Q0091. The following pie chart illustrates this circumstance.

![Preventive Medicine Services Pie Chart]

Medicare will reimburse for the shaded parts of the pie (the collection of the Pap smear and the pelvic exam). The remaining portions of the preventive service are billed to the patient. The amount paid by Medicare is subtracted from the physician’s usual fee for a preventive service. The remaining amount is the patient’s responsibility. This is referred to as a “carve out,” meaning that Medicare’s covered portion of the preventive service is carved out of the total preventive service. The amount reimbursed by Medicare and the amount reimbursed by the patient will equal the physician’s usual fee.

**Example 2:** The “carve out” method for reporting the screening pelvic examination (G0101) with other preventive medicine care:

<table>
<thead>
<tr>
<th>Bill to:</th>
<th>CPT/HCPCS Code(s)</th>
<th>ICD-10 Code(s)</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>99397-GY</td>
<td>Z01.411, Z01.419</td>
<td>$ 65.40</td>
</tr>
<tr>
<td>Medicare</td>
<td>G0101-GA</td>
<td>Z01.411, Z01.419, Z77.09 or Z91.89</td>
<td>$ 34.60</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>$100.00</td>
</tr>
</tbody>
</table>

The physician’s usual charge for the preventive visit (99397) is $100. The total billed to the patient and to Medicare equals the physician’s usual charge for the preventive service.

The GA modifier indicates that a required ABN has been signed and is on file. Modifier GY is reported for a service that is not a Medicare covered benefit. The service is being reported to Medicare to receive a denial. The patient is responsible for the preventive service less the Medicare carve out amount.
**Example 3:** Preventive visit reported with screening pelvic examination (G0101) and collection of a screening Pap smear specimen (Q0091):

<table>
<thead>
<tr>
<th>Bill to:</th>
<th>CPT/HCPCS Code(s)</th>
<th>Possible ICD-10 Code(s)</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>99397-GY</td>
<td>Z01.411 or Z01.419</td>
<td>$ 25.40</td>
</tr>
<tr>
<td>Medicare</td>
<td>G0101-GA</td>
<td>Z01.411, Z01.419, Z77.9 or Z91.89</td>
<td>$ 34.60</td>
</tr>
<tr>
<td></td>
<td>Q0091-GA</td>
<td>Z01.411, Z01.419, Z77.9 or Z91.89</td>
<td>$ 40.00</td>
</tr>
<tr>
<td>Total billed</td>
<td></td>
<td></td>
<td>$100.00</td>
</tr>
</tbody>
</table>

The physician’s usual charge for the preventive visit (99397) is $100. The total billed to the patient and to Medicare equals the physician’s usual charge.

The GA modifier indicates that a required ABN has been signed and is on file. Modifier GY is reported for a service that is not a Medicare covered benefit. The service is being reported to Medicare to receive a denial. The patient is responsible for the preventive service less the Medicare carve out amount and can be billed at the time of service for the portion not covered by Medicare.

**Medicare Screening Service at the Time of Covered E/M Services**
Medicare will reimburse separately for covered screening services (e.g., G0101, Q0091) when performed at the same encounter as a covered E/M service, such as a problem-oriented visit (codes 99201-99215). The level of E/M service reported is based solely on the evaluation of the problem.

**Example 4:** Covered problem-oriented visit reported with a screening pelvic examination (G0101) and collection of a screening Pap smear specimen (Q0091).

<table>
<thead>
<tr>
<th>Bill to:</th>
<th>CPT/HCPCS Code(s)</th>
<th>Possible ICD-10 Code(s)</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>99213-25</td>
<td>Problem diagnosis</td>
<td>$ 61.20</td>
</tr>
<tr>
<td></td>
<td>G0101-GA</td>
<td>Z12.4, Z12.72, Z12.79, Z12.89, Z77.9, or Z91.89</td>
<td>$ 34.60</td>
</tr>
<tr>
<td></td>
<td>Q0091-GA</td>
<td>Z12.4, Z12.72, Z12.79, Z12.89, Z77.9, or Z91.89</td>
<td>$ 40.00</td>
</tr>
<tr>
<td>Patient</td>
<td>N/A</td>
<td>N/A</td>
<td>$135.80</td>
</tr>
</tbody>
</table>

The GA modifier indicates that a required ABN has been signed and is on file. Modifier 25 indicates that the E/M service was significant and separately identifiable and not part of the pelvic examination or collection of the Pap smear.

The patient is not billed for her portion (i.e., deductible and co-pay for the problem visit) until Medicare has processed the claim. The diagnosis code for the patient’s problem, signs or symptoms should be linked to the E/M service (99213). The level of service for the E/M visit will depend on what was performed and documented.
Other Medicare Preventive Services
Following are brief descriptions of other preventive services covered by Medicare and sometimes provided by obstetrician/gynecologists.

Seasonal Influenza Vaccine and Administration
For Medicare beneficiaries, the seasonal influenza vaccine is usually administered once a year during the fall or winter months. Additional influenza vaccines (i.e., the number of doses of a vaccine and/or the type of influenza vaccine) are covered by Medicare when medically necessary. Influenza vaccine plus its administration is a covered Part B benefit. Influenza vaccine is NOT a Part D covered drug.

For the administration of the vaccine report the following HCPCS code:

- G0008 - Administration of influenza virus vaccine

For the Influenza Virus Vaccine the following codes are reported for this service:

- 90653 - Influenza vaccine, inactivated, subunit, adjuvanted, for intramuscular use
- 90654 - Influenza virus vaccine, split virus, preservative-free, for intradermal use
- 90655 - Influenza virus vaccine, trivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
- 90656 - Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
- 90657 - Influenza virus vaccine, trivalent, split virus, when administered to children 6-35 months of age, for intramuscular use
- 90660 - Influenza virus vaccine, live, for intranasal use
- 90662 - Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
- 90672 - Influenza virus vaccine, quadrivalent, live, for intranasal use
- 90673 - Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
- 90686 - Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
- 90688 - Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use
- Q2034 - Influenza virus vaccine, split virus, for intramuscular use (Agriflu)
- Q2035 - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (AFLURIA)
- Q2036 - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLULAVAL)
- Q2037 - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLUVIRIN)
- Q2038 - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
- Q2039 - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)

ICD-10-CM diagnosis code Z23 (Encounter for immunization) is appropriate when reporting these services. Both the deductible and copay/coinsurance are waived.
**Bone Mass Measurements**
Medicare covers bone mass measurements every two years for qualified individuals. Both the deductible and copay/coinsurance are waived.

A “qualified individual” meets at least one of these medical indications:
- Estrogen-deficient and at clinical risk for osteoporosis
- Vertebral abnormalities
- Receiving (or expecting to receive) glucocorticoid (steroid) therapy for more than 3 months
- Has a diagnosis of primary hyperparathyroidism
- Being monitored to assess the response to or efficacy of an FDA – approved osteoporosis drug therapy

Medicare may pay for more frequent screenings when medically necessary. Examples include, but are not limited to, the following medical circumstances:
- Monitoring beneficiaries on long-term (more than 3 months) glucocorticoid (steroid) therapy
- Confirming baseline BMMs to permit monitoring of beneficiaries in the future

**Procedure Codes**
Medicare allows the physician to choose the screening test. The CPT/HCPCS coding options are:
- 77078 - Computed tomography, bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
- 77080 - Dual energy x-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
  - 77081 - Appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
- 77697 - Ultrasound bone density measurement and interpretation, peripheral site(s), any method
- G0130 - Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites, appendicular skeleton (peripheral; e.g., radius, wrist, heel)

**Diagnosis Codes**
Local carriers determine the ICD-9-CM diagnostic codes that they will accept as supporting these indications. The test must be ordered by a physician or a qualified non-physician practitioner who is treating the patient. Qualified non-physician practitioners include physician assistants, nurse practitioners, clinical nurse specialists, and nurse-midwives. The test results must be required as part of the patient’s evaluation and/or formulation of a treatment plan

**Mammography Screening**
Medicare covers one baseline screening mammogram for women aged 35-39 or women 40 years or older once every 12 months. CPT code 77057 (Screening mammography, bilateral [two view film study of each breast]) is reported if a standard screening mammogram is performed. Medicare also covers computer aided detection (CAD) technology services when it is performed in addition to standard mammography. This service is reported using CPT add-on code +77052 (Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography) in addition to code 77057.
Medicare also covers tomosynthesis services when it is performed in addition to standard mammography. This service is reported using CPT add-on code 77063 (Screening digital breast tomosynthesis, bilateral) in addition to code 77057. Use this as an add-on code to G0202 when tomosynthesis is used in addition to 2-D mammography. Both the deductible and co-pay/coinsurance are waived for this service.

In April 2001, Medicare began to cover and provide additional payment for the use of digital technology for screening and diagnostic mammography studies. HCPCS code G0202 (Screening mammography, producing direct digital image, bilateral, all views) was developed to be reported for a screening full-field digital (FFDM) mammogram. ICD-10-CM diagnosis code(s) Z12.31 (Encounter for screening mammogram for malignant neoplasm of breast) should be linked to the appropriate CPT-4 mammography code reported. Both the Medicare deductible and co-pay/coinsurance are waived for this service.

A diagnostic mammogram (when the patient has an illness, disease or symptoms indicating the need for a mammogram) is covered whenever it is medically necessary.

**Colorectal Cancer Screening**
Medicare covers one screening fecal-occult blood test for women 50 years and older once every 12 months. The attending physician must submit a written order for the test. The deductible and coinsurance do not apply to this test.

Since January 1, 2007, guaiac based screening has been reported to Medicare using CPT code 82270 rather than deleted HCPCS code G0107. The descriptor for CPT code 82270 reads “Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or single triple card for consecutive collection).” Therefore the patient must complete the test by taking samples from consecutive stools.

As an alternative to the guaiac-based fecal occult blood test, (FOBT), reported with CPT-4 code 82270, Medicare also covers screening performed by immunoassay. It is reported to Medicare using HCPCS code G0328 (Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous determinations). The number of specimens required depends on the individual manufacturer’s instructions. However, Medicare will pay for only one covered FOBT per year, either 82270 or G0328, but not both.

The ICD-10-CM diagnosis code reported is either Z12.12 (Encounter for screening for malignant neoplasm of rectum) or Z12.11 (Encounter for screening for malignant neoplasm of colon).

**Initial Preventive Physical Examination**
This examination (referred to as the IPPE or “Welcome to Medicare Exam”) covers specific services for new Medicare beneficiaries. The exam is payable once in a lifetime, and only if provided within the first twelve months of the beneficiary’s first Part B coverage period. The deductible and co-pay/coinsurance is waived.
The service may be provided by a physician or qualified non-physician provider (e.g., physician assistants (PA), nurse practitioners (NP), and clinical nurse specialists (CNS).

The IPPE includes the following:

**Medical and social history:** Review of patient’s history with particular attention to modifiable risk factors for disease.

**Depression Risk Assessment:** Review of the patient’s risk factors for depression, including current or past experience with depression or other mood disorders. Patients cannot have a current diagnosis of depression. The provider may use one of the standardized screening tests designed for this purpose and recognized by national medical professional organizations.

**Functional ability and level of safety:** The provider may select from screening questions or standardized questionnaires designed for the purpose of reviewing, at a minimum; hearing impairment, daily living, fall risk, and home safety. The screening tools provided for the IPPE should be recognized by national medical professional organizations.

**Examination:** Measurements and tests including measurement of the patient’s height, weight, body mass index, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on her medical and social history and current clinical standards.

**End of Life Planning (Upon an individual’s consent):** End-of-life planning is defined as verbal or written information regarding: (1) an individual’s ability to prepare an advance directive (AD) in the case that an injury or illness causes the individual to be unable to make health care decisions, and (2) whether or not the physician is willing to follow the individual’s wishes as expressed in the AD.

**Education, Counseling, and Referral Based on Previous 5 components:** Provided as appropriate, based on the results of the first five elements of the IPPE.

**Education, Counseling, and Referral Based on Other Preventive Services:** Brief written plan such as a checklist should be provided to the patient for obtaining appropriate screening and other preventive services which are separately covered under Medicare Part B benefits (e.g., screening services described above, vaccinations, diabetes self-management, glaucoma screening, and medical nutrition therapy).

- **Optional Electrocardiogram:** Performance and interpretation by provider or by referral provider.

**NOTE:** Although the EKG is an optional service, if the physician or NPP cannot perform the EKG in the office suite, alternative arrangements can be made with an outside entity. However, if performed, the primary care provider must incorporate the results of the EKG into the beneficiary’s medical record.

For the purposes of the IPPE benefit, “medical history” is defined as:

- Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatment
- Current medications and supplements, including calcium and vitamins
- Family history, including a review of medical events in the patient’s family, including diseases that may be hereditary or place the individual at risk
For the purposes of this benefit, “social history” is defined as:
   History of alcohol, tobacco, and illicit drug use
   Diet
   Physical activities

The following HCPCS codes are used to report these services:
   G0402 - Initial preventive physical examination; face-to-face visit, services limited
to new beneficiary during first (12) months of Medicare enrollment
   G0403 - Electrocardiogram, routine ECG with at least 12 leads; performed as a
screening for the initial preventive physical examination with interpretation
and report
   G0404 - Tracing only, without interpretation and report, performed as a component
of the initial preventive physical examination
   G0405 - Interpretation and report only, performed as a component of the initial
preventive physical examination

The ICD-10-CM diagnosis code reported is Z00.00 (Encounter for general adult medical
examination without abnormal findings) or Z00.01 (Encounter for general adult medical
examination with abnormal findings).

Other covered preventive, screening or problem-oriented services may be performed at the
same encounter as the IPPE. These are reported using the appropriate codes. If reporting
an E/M service, add a modifier 25 to the problem E/M code. The documentation for the
problem-oriented portion of the encounter must support the level of service reported.

Diabetes Screening
The diabetes screening tests include a fasting blood glucose test, post-glucose challenge
tests, and either an oral glucose tolerance test with a glucose challenge of 75 grams of
sugar for non-pregnant adults or a 2-hour post-glucose challenge test alone. This
screening is covered twice within a 12-month period.

Individuals are eligible for the benefit if they have the following risk factors:
   Hypertension (High blood pressure)
   Dyslipidemia (History of abnormal cholesterol and triglyceride levels)
   Obesity (body mass index 30 kg/m2 or more)
   Previous identification of an elevated impaired fasting glucose or glucose tolerance OR
   • Have at least two of the following risk factors: Overweight (body mass index
greater than 25 kg/m2, but less than 30)
   • A family history of diabetes
   • A history of gestational diabetes mellitus or delivery of a baby weighing
   greater than 9 pounds 65 years of age or older

Two screening tests per year are covered for individuals who have been diagnosed with
pre-diabetes or one screening per year if previously tested but not diagnosed with pre-diabetes
or if never tested. Pre-diabetes is defined as a fasting glucose level of 100-125 mg/dL,
or a 2 hour post-glucose challenge of 140-199 mg/dL.
Patients previously diagnosed as diabetic are not covered for this screening service.

Medicare covers these tests when reported with ICD-10-CM diagnosis code Z13.1 (Encounter for screening for diabetes mellitus) and one of the following CPT codes:

- 82947 - Glucose; quantitative, blood (except reagent strip)
- 82950 - Glucose; post glucose dose (includes glucose)
- 82951 - Glucose; tolerance test (GTT), three specimens (includes glucose)

**Cardiovascular Screening Blood Tests**

This benefit provides a blood test for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of this disease. Three clinical laboratory tests are covered—total cholesterol, high density lipoprotein (HDL), and triglycerides. These tests are covered once every five years and can be ordered as one of each individual test or combination as a panel.

The tests must be ordered by a treating physician and used in the management of the patient. Laboratories must offer physicians the ability to order a lipid panel without the direct low density lipoprotein (LDL) measurement. However, if the screening lipid panel results illustrate a triglycerides level that indicates the need for a direct LDL measurement, the physician may order this test.

Report procedure codes for lipid panel (80061) or the individual codes for the tests included in the panel (82465, 84478, or 83718). Report a diagnosis code from the series V81.0-V81.2 (special screening for cardiovascular diseases).

**Behavioral Interventions Counseling**

**Tobacco Use Counseling**

**Cessation Counseling**

Medicare covers counseling for tobacco cessation for outpatients and for inpatients. Inpatients are covered only if counseling for tobacco use is not the primary reason for the patient’s hospital stay. Medicare covers 2 cessation attempts per year. Cessation counseling benefits are for individuals who:

- Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease
- Competent and alert at the time of counseling **AND**
- Receives counseling furnished by a qualified or other Medicare-recognized practitioner

The counseling during an E/M service must be either intermediate or intensive. Intermediate counseling is 2 to 3 sessions of 3 to 10 minutes each. Intensive counseling is 4 sessions of more than 10 minutes each. Minimal counseling involving sessions lasting less than 3 minutes is considered part of an E/M service and is not reimbursed separately. Each attempt may include a maximum of four intermediate or intensive counseling sessions. The total annual benefit is for 8 sessions in a 12 month period.

Services may be provided by a physician, physician assistant, nurse practitioner, clinical nurse specialist, qualified psychologist or clinical social worker. CMS does not currently have specific training requirements, but may in the future. The counseling must be provided face-to-face with the patient.
These services are reported using CPT-4 code 99406 (intermediate, E/M counseling service) or code 99407 (intensive, E/M counseling service). Documentation must include sufficient information to adequately demonstrate that Medicare coverage conditions were met for providing the service.

The diagnosis code should reflect the condition the patient has that is adversely affected by tobacco use or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by tobacco use.

**Preventive Counseling**

Effective Jan 1, 2011, CMS provides a benefit for counseling to prevent tobacco use for outpatient and hospitalized Medicare beneficiaries. These counseling benefits are for individuals who:
- Use tobacco but have no tobacco-related disease
- Are competent and alert at the time that the counseling is provided
- Whose counseling is provided by a qualified physician or other Medicare-recognized practitioner

The following codes are reported for this service:
- G0436 - Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes
- G0437 - Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes

Diagnosis codes that should be reported for this service are ICD-10-CM codes F17.2– (Nicotine dependence) and Z87.891 (Personal history of nicotine dependence). Both the deductible and co-pay/coinsurance are waived for this service.

For more information on tobacco cessation counseling, view the MLN Matters article at: http://www.cms.gov/MLNMattersArticles/downloads/MM7133.pdf

**Alcohol Reductions and Misuse**

All Medicare beneficiaries are eligible for alcohol screening. Medicare beneficiaries, who test positive (those who misuse alcohol but whose levels of patterns of alcohol consumption do not meet criteria for alcohol dependence) are eligible for counseling if:
- They are competent and alert at the time that counseling is provided; **AND**
- Counseling is furnished by qualified primary care physicians or other primary care practitioner in a primary care setting

Alcohol dependence is defined as at least three of the following:
- Tolerance
- Withdrawal symptoms
- Impaired control
- Preoccupations with acquisition and/or use
- Persistent desire or unsuccessful efforts to quit
- Sustains social, occupational, or recreational disability **OR**
- Use continues despite adverse consequences **AND**
• Who are competent and alert at the time that counseling is provided **AND**
• Whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting

The initial screening may be reported using code:

- G0442 - Annual alcohol misuse screening, 15 minutes

Medical records must document all coverage requirements. For those who screen positive, 4 times per year may be reported using code:

- G0443 - Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes.

Both the deductible and copay/coinsurance are waived for this type of counseling.

**Screening for Depression**
Medicare covers screening for depression annually; therefore 11 full months must elapse following the month in which the last annual depression screening took place. If counseling is provided, it must be provided by a qualified primary physician or other primary care practitioner that has staff-assisted depression care support who can facilitate and coordinate referrals to mental health treatment. There are several screening tools available for depression. CMS does not specify which depression screening tools should be used, since that decision is at the discretion of the clinician in the primary care setting. Both the deductible and copay/coinsurance are waived if conditions of coverage are met.

This type of screening is only covered in the following places of service:

- Office
- Outpatient Hospital
- Independent clinic
- A state or local public health clinic

The following HCPCS code is used to report this service:

- G0444 - Annual depression screening, 15 minutes

**Intensive Behavioral Therapy for Obesity**
Certain screening services are considered reasonable and necessary for the prevention or early detection of an illness or disability. Obesity is directly or indirectly associated with many chronic diseases, such as cardiovascular disease, musculoskeletal conditions, and diabetes. Due to those risk factors, Medicare covers beneficiaries diagnosed with obesity; defined as a body mass index (BMI) ≥ 30 kg/m².

Medicare beneficiaries with obesity, who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner and in a primary care setting, are allowed:

- One face-to-face visit every week for the first month
- One face-to-face visit every other week for months 2-6
- One face-to-face visit every month for months 7-12, if certain requirements are met.
A reassessment of obesity and a determination of the amount of weight loss must be provided at the six month visit. To be eligible for additional face-to-face visits occurring once a month for an additional 6 months, beneficiaries must have lost at least 3kg. For beneficiaries who do not achieve a weight loss of at least 3 kg during the first 6 months, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.

The following HCPCS code is used to report this service:

- G0447- Face-to-face behavioral counseling for obesity, 15 minutes
- G0473- Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes

Diagnosis code(s) Z68.3- (Body mass index (BMI) 30-39, adult) or Z68.4- (Body mass index (BMI) 40 or greater, adult) are appropriate when reporting these services. Both the deductible and copay/coinsurance are waived for this type of intense therapy if conditions of coverage are met.

**High Intensity Behavioral Counseling (HIBC) and Sexually Transmitted Infections (STI) Screening**

**High Intensity Behavioral Counseling (HIBC)**
Medicare will cover High Intensity Behavioral Counseling (HIBC) to prevent STIs in addition to screening for Sexually Transmitted Infections (STIs) - specifically chlamydia, gonorrhea, syphilis, and hepatitis B.

Coverage for HIBC consist of up to two individual, 20- to 30-minute, face-to-face counseling sessions annually for Medicare beneficiaries to prevent STIs for all sexually active adolescents and for adults at increased risk for STIs. This service is covered for sexually active adolescents and adults at increases risk for STIs and referred by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting. One annual occurrence of screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant. Up to two occurrences per pregnancy of screening for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening. One occurrence per pregnancy of screening for syphilis in pregnant women; up to two additional occurrences in the third trimester and at delivery if at continued increased risk for STIs. One occurrence per pregnancy of screening for hepatitis B in pregnant women; one additional occurrence at delivery if at continued increased risk for STIs.

The high/increased risk individual sexual behaviors, based on the USPSTF guidelines, include any of the following:

- Multiple sex partners
- Using barrier protection inconsistently
- Having sex under the influence of alcohol or drugs
- Having sex in exchange for money or drugs
- Age (24 years of age or younger and sexually active for women for chlamydia and gonorrhea)
- Having an STI within the past year
- IV drug use (hepatitis B only) AND
- In addition, for men – men having sex with men (MSM) and engaged in high-risk sexual behavior, but no regard to age.
STI
Social factors within the community that contribute to STIs should also be considered when
determining high/increased risk for chlamydia, gonorrhea, syphilis, and in recommending
HIBC. High/increased risk sexual behavior for STIs is determined by how the primary care
provider assesses the patient’s sexual history, which is normally part of any complete medical
history. This screening requires the appropriate Food and Drug Administration (FDA)
approved/cleared laboratory tests when ordered by the primary care provider. The tests
must be used consistent with FDA approved labeling and in compliance with the Clinical
Laboratory Improvement Act (CLIA) regulations and performed by an eligible Medicare
provider for these services.

The following link provides additional information on the increased risk for STIs found in
Publication 100-03, Section 210.10:

The following CPT/HCPCS codes are used to report these services:
• 86631 - Antibody; Chlamydia
• 86632 - Antibody; Chlamydia, IgM
• 87110 - Culture, chlamydia, any source
• 87270 - Infectious agent antigen detection by immunofluorescent technique;
  Chlamydia trachomatis
• 87320 - Infectious agent antigen detection by enzyme immunoassay technique,
  qualitative or semiquantitative, multiple-step method; Chlamydia trachomatis
• 87490 - Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia
  trachomatis, direct probe technique
• 87491 - Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia
  trachomatis, amplified probe technique
• 87810 - Infectious agent antigen detection by immunoassay with direct optical
  observation; Chlamydia trachomatis
• 87590 - Infectious agent detection by nucleic acid (DNA or RNA); Neisseria
  gonorrhoeae, direct probe technique
• 87591 - Infectious agent detection by nucleic acid (DNA or RNA); Neisseria
  gonorrhoeae, amplified probe technique
• 87850 - Infectious agent antigen detection by immunoassay with direct optical
  observation; Neisseria gonorrhoeae
• 87800 - Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms;
  direct probe(s) technique (Combined chlamydia and gonorrhea testing)
• 86592 - Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART)
• 86593 - Syphilis test, non-treponemal antibody; quantitative
• 86780 - Antibody; Treponema pallidum
• 87340 - Infectious agent antigen detection by enzyme immunoassay technique,
  qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen
  (HBsAg)
• 87341 - Infectious agent antigen detection by enzyme immunoassay technique,
  qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen
  (HBsAg) neutralization
ICD-10-CM diagnosis codes Z11.3 (Encounter for screening for infections with a predominantly sexual mode of transmission) AND Z72.89 (Other problems related to lifestyle) should be reported for chlamydia, gonorrhea, and syphilis screening in women at increased risk for STIs who are not currently pregnant.

For screening for chlamydia and gonorrhea in pregnant women at increased risk for STIs report ICD-10-CM diagnosis codes:

- Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission AND
- Z72.89 Other problems related to lifestyle AND
- Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester
- Z34.01 Encounter for supervision of normal first pregnancy, first trimester
- Z34.02 Encounter for supervision of normal first pregnancy, second trimester
- Z34.03 Encounter for supervision of normal first pregnancy, third trimester OR
- Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester
- Z34.81 Encounter for supervision of other normal pregnancy, first trimester
- Z34.82 Encounter for supervision of other normal pregnancy, second trimester
- Z34.83 Encounter for supervision of other normal pregnancy, third trimester OR
- O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester
- O09.91 Supervision of high risk pregnancy, unspecified, first trimester
- O09.92 Supervision of high risk pregnancy, unspecified, second trimester
- O09.93 Supervision of high risk pregnancy, unspecified, third trimester

For screening for syphilis in pregnant women, report:

- Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission
- Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester
- Z34.01 Encounter for supervision of normal first pregnancy, first trimester
- Z34.02 Encounter for supervision of normal first pregnancy, second trimester
- Z34.03 Encounter for supervision of normal first pregnancy, third trimester AND
- Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester
- Z34.81 Encounter for supervision of other normal pregnancy, first trimester
- Z34.82 Encounter for supervision of other normal pregnancy, second trimester
- Z34.83 Encounter for supervision of other normal pregnancy, third trimester OR
- O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester
- O09.91 Supervision of high risk pregnancy, unspecified, first trimester
- O09.92 Supervision of high risk pregnancy, unspecified, second trimester
- O09.93 Supervision of high risk pregnancy, unspecified, third trimester

For screening for syphilis in pregnant women at increased risk for STIs, report:

- Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission
- Z72.89 Other problems related to lifestyle AND
- Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester
- Z34.01 Encounter for supervision of normal first pregnancy, first trimester
- Z34.02 Encounter for supervision of normal first pregnancy, second trimester
- Z34.03 Encounter for supervision of normal first pregnancy, third trimester OR
• Z34.80  Encounter for supervision of other normal pregnancy, unspecified trimester
• Z34.81  Encounter for supervision of other normal pregnancy, first trimester
• Z34.82  Encounter for supervision of other normal pregnancy, second trimester
• Z34.83  Encounter for supervision of other normal pregnancy, third trimester  OR
• O09.90  Supervision of high risk pregnancy, unspecified, unspecified trimester
• O09.91  Supervision of high risk pregnancy, unspecified, first trimester
• O09.92  Supervision of high risk pregnancy, unspecified, second trimester
• O09.93  Supervision of high risk pregnancy, unspecified, third trimester

For screening for hepatitis B in pregnant women, report:
• Z11.59  Encounter for screening for other viral diseases AND
• Z34.00  Encounter for supervision of normal first pregnancy, unspecified trimester
• Z34.01  Encounter for supervision of normal first pregnancy, first trimester
• Z34.02  Encounter for supervision of normal first pregnancy, second trimester
• Z34.03  Encounter for supervision of normal first pregnancy, third trimester  OR
• O09.90  Supervision of high risk pregnancy, unspecified, unspecified trimester
• O09.91  Supervision of high risk pregnancy, unspecified, first trimester
• O09.92  Supervision of high risk pregnancy, unspecified, second trimester
• O09.93  Supervision of high risk pregnancy, unspecified, third trimester

For screening for hepatitis B in pregnant women at increased risk for STIs, report:
• Z11.59  Encounter for screening for other viral diseases AND
• Z72.89  Other problems related to lifestyle AND
• Z34.00  Encounter for supervision of normal first pregnancy, unspecified trimester
• Z34.01  Encounter for supervision of normal first pregnancy, first trimester
• Z34.02  Encounter for supervision of normal first pregnancy, second trimester
• Z34.03  Encounter for supervision of normal first pregnancy, third trimester  OR
• Z34.80  Encounter for supervision of other normal pregnancy, unspecified trimester
• Z34.81  Encounter for supervision of other normal pregnancy, first trimester
• Z34.82  Encounter for supervision of other normal pregnancy, second trimester
• Z34.83  Encounter for supervision of other normal pregnancy, third trimester  OR
• O09.90  Supervision of high risk pregnancy, unspecified, unspecified trimester
• O09.91  Supervision of high risk pregnancy, unspecified, first trimester
• O09.92  Supervision of high risk pregnancy, unspecified, second trimester
• O09.93  Supervision of high risk pregnancy, unspecified, third trimester

Both the deductible and copay/coinsurance are waived for this type of screening if conditions of coverage are met.

NOTE: The use of the correct diagnosis code(s) on the claims is imperative to identify these services as preventive services and to show that the services were provided within the guidelines for coverage as preventive services. The patient’s medical record must clearly support the diagnosis of high/increased risk for STIs and clearly reflect the components of the HIBC service provided – education, skills training, and guidance on how to change sexual behavior as required for coverage.
Screening for Human Immunodeficiency Virus
HIV screening is recommended for all adolescents and adults at risk for HIV infection, as well as all pregnant women. CMS covers both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for Medicare beneficiaries at increased risk for HIV infection per USPSTF guidelines.


Medicare covers beneficiaries for HIV screening as follows:

➢ An annual voluntary HIV screening for beneficiaries at increased risk for HIV infection per USPSTF guidelines

**NOTE:** Eleven full months must elapse following the month in which the previous test was performed in order for a subsequent test to be covered.

➢ Three voluntary HIV screenings of pregnant Medicare beneficiaries;

(1) When the diagnosis of pregnancy is known,
(2) During the third trimester, and
(3) At labor, if ordered by the woman’s physician

**NOTE:** A maximum of three tests will be covered for each pregnancy beginning with the date of the 1st test.

ICD-10-CM diagnosis codes Z11.59 (Encounter for screening for other viral diseases) as primary and Z72.89 (Other problems related to lifestyle) as secondary may be reported for this screening. Pregnant patients would also have a pregnancy status code reported (such as Z34.– or O09.9-), in addition to the appropriate Z11.59 as primary and Z34.–, Z34.8- or O09.9- as appropriate.

Patients with any known prior diagnosis of HIV-related illness are not eligible for this screening test.

The following three HCPCS codes are reported for this service:

1. G0432 - Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening
2. G0433 - Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 AND/OR HIV-2, screening, AND/OR
3. G0435 - Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2 screening.

More information on HIV screening may be found in the MLN Matters article at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6786.pdf.
**Modifier 33**

Modifier 33 was created to allow providers to identify preventive services that are not subject to cost-sharing.

Only specific screening services require modifier 33 and those services only require the modifier when they are provided during a visit whose primary purpose is not preventative. If the primary purpose of the visit is preventative, and screening services are provided, no cost sharing is required for the services provided during the visit. In this case, the modifier is not required.

For separately reported services specifically identified as preventive, the modifier should not be used.
<table>
<thead>
<tr>
<th>Possible Procedure/ HCPCS Codes</th>
<th>Coverage</th>
<th>Patient Criteria</th>
<th>Patient Financial Responsibility</th>
<th>Provider Criteria</th>
<th>Possible Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0101</td>
<td>Every 2 years</td>
<td>Low risk</td>
<td>No Co-pay</td>
<td>None stated</td>
<td>Z12.4, Z12.72, Z12.79 Z12.89, Z01.411, Z01.419 Z7.7.9, Z91.89</td>
</tr>
<tr>
<td></td>
<td>Annually</td>
<td>High risk</td>
<td>No Part B deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q0091</td>
<td>Every 2 years</td>
<td>Low risk</td>
<td>No Co-pay</td>
<td>None stated</td>
<td>Z12.4, Z12.72, Z12.79 Z12.89, Z01.411, Z01.419 Z7.7.9, Z91.89</td>
</tr>
<tr>
<td></td>
<td>Annually</td>
<td>High risk</td>
<td>No Part B deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>82270, G0328</td>
<td>Annually</td>
<td>&gt;50 years old</td>
<td>No Co-pay</td>
<td>None stated</td>
<td>Determined by Local Carriers*</td>
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<tr>
<td>77057, +77052, G0202</td>
<td>Age 35-39 one baseline ≥40; Annually</td>
<td>≥35</td>
<td>No Co-pay</td>
<td>No Part B deductible</td>
<td>Test ordered by physician or qualified non-physician practitioner who is treating the patient. Determined by Local Carriers*</td>
</tr>
<tr>
<td>77078, 77080, 77081, 76977 G0130</td>
<td>Once every 24 months</td>
<td>Patients at risk</td>
<td>No Co-pay</td>
<td>No Part B deductible</td>
<td>Test ordered by physician or qualified non-physician practitioner who is treating the patient. Determined by Local Carriers*</td>
</tr>
<tr>
<td>G0402, G0403, G0404, G0405</td>
<td>Once in a lifetime</td>
<td>Within first 12 months of Medicare coverage</td>
<td>No Co-pay</td>
<td>No Part B deductible</td>
<td>Test ordered by physician or qualified non-physician practitioner who is treating the patient. Determined by Local Carriers*</td>
</tr>
<tr>
<td>G0438</td>
<td>Once in a lifetime</td>
<td>All Medicare beneficiaries who have not received IPPE or AWV within past 12 months</td>
<td>No Co-pay</td>
<td>No Part B deductible</td>
<td>Test ordered by physician or qualified non-physician practitioner who is treating the patient. Determined by Local Carriers*</td>
</tr>
<tr>
<td>G0439</td>
<td>Annually</td>
<td>Patients at risk</td>
<td>No Co-pay</td>
<td>No Part B deductible</td>
<td>Test ordered by physician or qualified non-physician practitioner who is treating the patient. Determined by Local Carriers*</td>
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<tr>
<td>82947, 82950, 82951</td>
<td>Twice in 12 month period</td>
<td>Patients at risk</td>
<td>No Co-pay</td>
<td>No Part B deductible</td>
<td>None stated Z13.1</td>
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<tr>
<td>82465, 84478, 83718, 80061</td>
<td>Every 5 years</td>
<td>All Medicare beneficiaries w/out signs of heart disease</td>
<td>No Co-pay</td>
<td>No Part B deductible</td>
<td>Test must be ordered by physician and used in management of patient Z13.6</td>
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<tr>
<td>99406, 99407</td>
<td>2 cessation attempts in 12 month period (1 attempt = up to 4 sessions)</td>
<td>Patient has condition or is receiving treatment that is being adversely affected by tobacco use</td>
<td>No Co-pay</td>
<td>No Part B deductible</td>
<td>Provided by a physician, physician assistant, nurse practitioner, clinical nurse specialist, qualified psychologist or clinical social worker Use code indicating patient’s condition or treatment affected by tobacco use F17.2–, Z87.891</td>
</tr>
<tr>
<td>G0436, G0437</td>
<td>2 cessation attempts in 12 month period (1 attempt = up to 4 sessions)</td>
<td>Patient uses tobacco (asymptomatic)</td>
<td>No Co-pay</td>
<td>No Part B deductible</td>
<td>Provided by a physician, or other Medicare recognized practitioner</td>
</tr>
<tr>
<td>G0432, G0433, G0435</td>
<td>Annually, 3 times per pregnancy</td>
<td>All adolescents and adults at risk, All Pregnant women</td>
<td>No Co-pay</td>
<td>No Part B deductible</td>
<td>Test must be ordered by physician at labor Z11.59, Z72.89 Z34- OR for pregnant women 09.9-</td>
</tr>
</tbody>
</table>

### SUMMARY OF MEDICARE SCREENING SERVICES
## SUMMARY OF MEDICARE SCREENING SERVICES (continued)

<table>
<thead>
<tr>
<th>Possible Procedure/HCPCS Codes</th>
<th>Coverage</th>
<th>Patient Criteria</th>
<th>Patient Financial Responsibility</th>
<th>Provider Criteria</th>
<th>Possible Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90654, 90655, 90656, 90657, 90660, 90662, Q2034-Q2039, G0088</td>
<td>Once per influenza season</td>
<td>All Medicare beneficiaries</td>
<td>No Co-pay No Part B deductible</td>
<td>None stated</td>
<td>Z23</td>
</tr>
<tr>
<td></td>
<td>Additional flu shots if medically necessary</td>
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<td></td>
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<tr>
<td><strong>Seasonal Influenza Virus Vaccine and Administration</strong></td>
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<tr>
<td><strong>Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0442</td>
<td>Annually</td>
<td>All Medicare beneficiaries</td>
<td>No Co-pay No Part B deductible</td>
<td>Qualified primary care physicians or other primary care practitioners in a primary care setting</td>
<td>Determined by Local Carriers*</td>
</tr>
<tr>
<td>G0443</td>
<td>Four times per year for G0443</td>
<td>Medicare beneficiaries who misuse alcohol but whose levels of consumption do not meet the criteria for dependence are eligible for counseling</td>
<td>No Co-pay No Part B deductible</td>
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<tr>
<td><strong>Screening for Depression</strong></td>
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</tr>
<tr>
<td>G0444</td>
<td>Annually</td>
<td>All Medicare beneficiaries</td>
<td>No Co-pay No Part B deductible</td>
<td>Qualified primary care physicians or other primary care practitioners in a primary care setting that has staff-assisted depression care supports in place</td>
<td>Determined by Local Carriers*</td>
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</tr>
<tr>
<td><strong>High Intensity Behavioral Counseling (HIBC) to Prevent STIs and Screening for Sexually Transmitted Infections (STIs)</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0445</td>
<td>Annually</td>
<td>Sexually active adolescents and adults at increased risk for STIs: HIBC consisting of individual, 20 to 30 minute, face-to-face counseling sessions</td>
<td>No Co-pay No Part B deductible</td>
<td>Referred by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting</td>
<td>Z11.3, Z72.89, Z34.00, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, O09.90, O09.91, O09.92, O09.93, Z11.59</td>
</tr>
<tr>
<td>86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87590, 87591, 87850, 87800, 86592, 86593, 86780, 87340, 87341</td>
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<tr>
<td><strong>Intensive Behavioral Therapy (IBT) for Obesity</strong></td>
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</tr>
<tr>
<td>G0447</td>
<td>One visit every week for the first month; one visit every other week for 2-6 months; and one visit every month for 7-12 months)</td>
<td>Medicare beneficiaries with obesity BMI ≥ 30 kg/m² who are competent and alert at the time of counseling</td>
<td>No Co-pay No Part B deductible</td>
<td>Qualified primary care physicians or other primary care practitioners in a primary care setting</td>
<td>Z68.30-Z68.39, Z68.41-Z68.45</td>
</tr>
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</tbody>
</table>
CHAPTER 4: GLOBAL SURGICAL PACKAGE

MEDICARE AND CPT GLOBAL SURGICAL PACKAGES
The global surgical package includes all the usual services furnished before, during and after a procedure has been performed. CPT and Medicare, as well as some individual insurers, have their own definition of the global surgical package. CPT has a single definition of the general global surgical package. Medicare has different definitions for major and minor procedures. Table 4-1 compares the two global package definitions.

<table>
<thead>
<tr>
<th>TABLE 4-1: COMPARISON OF CPT AND MEDICARE GLOBAL SURGICAL PACKAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Types of Services</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Services During Preoperative Period</strong></td>
</tr>
<tr>
<td>Pre-op days included in global package</td>
</tr>
<tr>
<td>Related E/M Services</td>
</tr>
<tr>
<td>Related or unrelated significant, separately identifiable E/M service</td>
</tr>
<tr>
<td>Intraoperative Services</td>
</tr>
<tr>
<td>Anesthesia performed by surgeon</td>
</tr>
<tr>
<td>Operation itself</td>
</tr>
<tr>
<td>Complications treated by surgeon</td>
</tr>
<tr>
<td><strong>Services During the Post-Operative Period</strong></td>
</tr>
<tr>
<td>Post-op days included in global package</td>
</tr>
<tr>
<td>Routine E/M Services</td>
</tr>
<tr>
<td>Treatment of complications</td>
</tr>
<tr>
<td>Treatment of other conditions</td>
</tr>
</tbody>
</table>

Modifiers are used to indicate that a specific service is not included in the global surgical package and should be reimbursed separately. Surgical modifiers are defined in Table 4-2.

It is important to know the differences between Medicare and CPT rules and which rules a specific payer uses. For example, Dr. Herman performed an abdominal hysterectomy (58150) on his patient, Lily. However, 20 days after the surgery, she returned to Dr. Herman’s office for treatment of a wound infection. If she is a Medicare patient, Dr. Herman cannot report this visit, because Medicare will only reimburse for treatment of complications requiring a return to the operating room. Most other third-party payers, however, will reimburse for this visit.
INTRAOPERATIVE SERVICES
Medicare and CPT rules are fairly straightforward concerning which preoperative and postoperative services are included in Medicare’s and CPT’s global surgical packages. The rules for intraoperative services are not as clear. The following is an overview of bundling and unbundling, CPT’s separate procedures and Medicare’s Correct Coding Initiative (CCI) and exceptions to these bundling rules.

BUNDLING AND UNBUNDLING
Bundling is the inclusion of lesser procedures in the payment for a more comprehensive procedure performed during the same session. Only the comprehensive procedure is reported on the claim form. For example, lysis of filmy adhesions is a lesser procedure bundled into a myomectomy.

Unbundling is the separate reporting of two or more services that should have been reported as a single service. An example is billing separate codes for a bilateral salpingo-oophorectomy (58720), omentectomy (49255), and total abdominal hysterectomy (58150) for a patient with a malignancy, instead of the code which includes all these procedures in its description 58956 - (Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy).

Sometimes the bundles are obvious, such as when the smaller procedure is explicitly listed in the code description of a more comprehensive procedure, as in the above example.

In other instances, the bundling is not so obvious. For example, a pelvic examination under anesthesia code (57410) is included in the payment for gynecologic procedures, even though it is not specifically listed in the code descriptions.

Medicare lists the services it considers bundled in its Correct Coding Initiative (CCI). CPT indicates the services it considers bundled by adding the phrase “separate procedure” in parentheses after the code’s description. The bundling rules under the CCI are not always the same as CPT’s separate procedures rules. Each of these bundling methods is discussed below.

To assist providers in understanding some of these bundling guidelines, ACOG has developed the Ob/Gyn Coding Manual, Components of Correct Procedural Coding. This manual identifies the services included and not included in the global surgical packages for procedures commonly performed by ob/gyns both for Medicare and non-Medicare patients.

CPT’S SEPARATE PROCEDURES
CPT’s separate procedure codes are services that are considered to be lesser services commonly (but not always) considered an integral component of another more comprehensive procedure. If the separate procedure is the only one being performed during that surgical session, it can be reported. If the separate procedure is performed as an integral component of another procedure performed at the same surgical session, it is not reported. However, if the separate procedure is distinct from the other service(s) performed, it may be reported.

MEDICARE’S CORRECT CODING INITIATIVE
Medicare's Correct Coding Initiative (CCI) is CMS response to variations in the bundling practices among its carriers. The CCI is intended to ensure that all Medicare carriers throughout the U.S. are consistent in their bundling and unbundling of services.

The guiding principle of the CCI is that all services integral to accomplishing a procedure are bundled into the primary service and are therefore a component part of the comprehensive code. Only the comprehensive procedure is reported.
A service is considered bundled into another procedure when the service:
- Represents the standard of care in accomplishing the overall procedure
- Is necessary to successfully accomplish the comprehensive procedure (that is, failure to perform the service may compromise the success of the procedure) and
- Is not separate and unrelated to the comprehensive procedure.

CCI edits are pairs of CPT-4 or HCPCS Level II codes that ordinarily are not separately payable. That is, the codes are considered bundled.

The edits are applied to services billed by the same provider for the same patient on the same date of service. All Medicare claims are processed against the CCI edits.

The edits are applied to services billed by the same provider for the same patient on the same date of service. All Medicare claims are processed against the CCI edits.

**ACOG CCI FORMAT**

To assist Fellows and their staff, ACOG has developed a CCI chart that is updated quarterly and posted on the member side of its website (www.acog.org). The following is an explanation of how to use this chart.

<table>
<thead>
<tr>
<th>57550-May Be Paid</th>
<th>57555-May Be Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Never Paid</strong></td>
<td><strong>Never Paid</strong></td>
</tr>
<tr>
<td>12001 12002 12004 12005 12006 12007 12011 12013 12014 12015 12016 12017 12018 12020 12021</td>
<td>12001 12002 12004 12005 12006 12007 12011 12013 12014 12015 12016 12017 12018 12020 12021</td>
</tr>
<tr>
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<td>12031 12032 12034 12035 12036 12037 12041 12042 12044 12045 12046 12047 12051 12052 12053</td>
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<td>13152 13153 36000 36400 36405 36406 36410 36420 36425 36430 36440 36600 36640 37202 43752</td>
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<tr>
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<td>94200 94250 94680 94681 94690 94770 95812 95813 95816 95819 95822 95829 95955 96360 96365</td>
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<td>96372 96374 96375 96376 99211 99212 99213 99214 99215 99217 99218 99219 99220 99221 99222</td>
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<td>99252 99253 99254 99255 99291 99292 99304 99305 99306 99307 99308 99309 99310 99315 99316</td>
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<td>99334 99335 99336 99337 99347 99348 99349 99350 99354 99375 99377 99378</td>
<td>99334 99335 99336 99337 99347 99348 99349 99350 99354 99375 99377 99378</td>
</tr>
<tr>
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<td><strong>Never Paid</strong></td>
</tr>
<tr>
<td>0213T 0216T 0228T 0230T 51701 51702 51703 57410 57420 57452 57500 57530 57800 58100 62310</td>
<td>0213T 0216T 0228T 0230T 51701 51702 51703 57410 57420 57452 57500 57530 57800 58100 62310</td>
</tr>
<tr>
<td>62311 62318 62319 64400 64402 64405 64408 64410 64412 64413 64415 64416 64417 64418 64420</td>
<td>62311 62318 62319 64400 64402 64405 64408 64410 64412 64413 64415 64416 64417 64418 64420</td>
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</tr>
<tr>
<td>64508 64510 64511 64520 64530 69990 99148 99149 99150 P9612</td>
<td>64508 64510 64511 64520 64530 69990 99148 99149 99150 P9612</td>
</tr>
</tbody>
</table>

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The first fourteen shaded rows list the bundles for comprehensive code 57550 (Excision of cervical stump, vaginal approach). The fifteen unshaded rows list the codes bundled into comprehensive code 57555 (Excision of cervical stump, vaginal approach; with anterior and/or posterior repair).

For code 57550, the bundles are as follows:

**57550-May Be Paid.** The codes in the right hand column are code pairs (either component or mutually exclusive codes) that are considered bundled into comprehensive code 57550. In some instances, and with an appropriate modifier, these codes may be payable when performed on the same date as 57550.

**Never Paid.** The codes in the right hand column are code pairs (either component or mutually exclusive codes) that will never be reimbursed by Medicare when performed on the same date as 57550 even if a modifier is used.

The CCI edits reflect code combinations frequently reported to CMS. They are not intended to identify all codes that should be considered included in the comprehensive code. CPT coding guidelines should always be considered when reporting multiple procedures on the same day. **Note:** CCI edits are revised on a quarterly basis. Specific code pair combinations may be revised based on CMS claims experience and specialty society input.

Providers should check the chart for each code being billed to Medicare to determine if the procedures are bundled.

**Basic CCI Guidelines**

The CCI uses these criteria to decide which services should be bundled:

- Standards of medical/surgical practice. The lesser procedure:
  - Represents the standard of care in accomplishing the comprehensive procedure
  - Is necessary to successfully accomplish the procedure (failure to perform the lesser service may compromise the success of the comprehensive one)
  - Is not a separately identifiable procedure unrelated to the comprehensive one
  - Medical/surgical package definitions as defined in Table 4-1
- CPT descriptions indicating a comprehensive/lesser service (e.g., partial vulvectomy and complete vulvectomy)
- Sequential procedures (e.g., an attempted laparoscopy followed by an open procedure). This is referred to as “most extensive procedure” rule
- CPT separate procedure codes

**Exceptions to Bundling Rules**

Sometimes a separate procedure or CCI edit is performed with another procedure and may or may not be a distinct reportable service, depending on the circumstances. The exceptions are not always the same under CCI and CPT rules.

A CPT separate procedure code can be reported in addition to another service performed at the same session if the two procedures are documented as unrelated and distinct.

Bundles listed in the CCI fall into two categories: those that may, under special circumstances, be reported together; and those that may never be reported together. The CCI available on ACOG’s website indicates the categories for each code pair.
Following are examples of exceptions to the bundling rules:

**Example 1:** Dr. Ricardo performed a colposcopy with biopsy and endocervical curettage code (57454) on his patient Lucy following an abnormal Pap smear result. While performing the colposcopy, Dr. Ricardo noted a vaginal polyp, which he removed code (57100, separate procedure code).

Under CPT rules, these procedures can be reported together since they are independent and unrelated, even though code 57100 is a separate procedure code. A different ICD-10-CM code is linked to each procedure code and a modifier 59 (to indicate that the procedures are distinct) is added to code 57100.

Under CCI rules, code 57100 is listed as bundled into 57454, but may be reported under special circumstances. A different ICD-10-CM code is linked to each code and a modifier 59 is added to code 57100.

**Example 2:** Dr. Lavern performed a biopsy on the right ovary code (58900, separate procedure) and removed the left ovary code (58940) on her patient Shirley.

Under CPT rules, these procedures can be reported together since they involved different ovaries, even though code 58900 is a separate procedure code. A different ICD-10-CM code is linked to each code and a modifier 59 (to indicate that the procedures are distinct) is added to code 58900.

Under CCI rules, these procedures are not listed as bundled and will be reimbursed. Modifiers LT and RT would be added to indicate that different ovaries were involved.

If both procedures had been performed on the same ovary, only code 58940 (the most extensive procedure) would be reported under either CPT or CCI rules.

**Example 3:** Dr. Jethro performed a paravaginal defect repair (57284) and enterocele repair (57268, separate procedure) on his patient Daisy.

Under CPT rules, these procedures may be reported together even though code 57268 is a separate procedure code. A different ICD-10-CM code is linked to each code and a modifier 59 (to indicate that the procedures are distinct) is added to code 57268. If the procedure is performed to prevent formation of an enterocele, then code 57268 is not reported.

Under CCI rules, these procedures are bundled and will never be reimbursed when performed at the same session, even with distinct diagnoses and a modifier 59.

**Surgical Services Modifiers**

Modifiers used with surgical services may indicate circumstances that occurred intra-operatively. Other modifiers indicate circumstances occurring before or after the surgery itself and relate to the global surgical package. These modifiers are summarized on Table 4-2. Modifiers used with E/M services codes are described in Chapter 2.
## TABLE 4-2: SURGICAL SERVICES MODIFIERS

<table>
<thead>
<tr>
<th>Modifiers and Their Descriptions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>More Than or Less Than Usual Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Increased Procedural Services:</strong> The work necessary to provide a service is substantially greater than typically required for the procedure. No other code is more accurate.</td>
<td>Submit special report with the claim to describe the unusual services and increase fee appropriately. Note: This modifier should not be appended to an E/M service.</td>
</tr>
<tr>
<td><strong>Bilateral Procedure:</strong> Unless otherwise identified in the listing a unilateral procedure is performed on both sides on identical organs (e.g., tubes or ovaries).</td>
<td>Most procedures reported by ob/gyns are considered bilateral and would not use this modifier.</td>
</tr>
<tr>
<td><strong>Reduced Services:</strong> Procedure is partially reduced or eliminated (e.g., unsuccessful) at the provider’s discretion.</td>
<td><strong>Partially reduced:</strong> The provider does not perform all the components included in the code description. <strong>Unsuccessful:</strong> One procedure is attempted but unsuccessful. Another procedure is then performed during that same session. See also modifier 53.</td>
</tr>
<tr>
<td><strong>Discontinued Procedure:</strong> The provider elects to terminate a surgical or diagnostic procedure due to extenuating circumstances or those that threaten the well being of the patient.</td>
<td>One procedure is attempted but unsuccessful. No other procedure is performed during that same session. Modifier is not used to report the elective cancellation of a procedure prior to anesthesia induction or surgical preparation in the operating suite. See also modifier 52.</td>
</tr>
<tr>
<td><strong>One Provider Provided Only Part of the Global Surgical Package</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Surgical Care Only</strong></td>
<td>Most commercial insurers do not recognize these modifiers. Submit a cover letter with the claim to explain the special circumstances.</td>
</tr>
<tr>
<td><strong>Postoperative Management Only</strong></td>
<td>Medicare recognizes these modifiers when the providers: have documented a formal transfer of care; are within the same group practice but of different specialties; or are in different group practices and do not have a covering relationship.</td>
</tr>
<tr>
<td><strong>Preoperative Management Only:</strong> This modifier is rarely reported by ob/gyns.</td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 4-2: SURGICAL SERVICES MODIFIERS (CONTINUED)

<table>
<thead>
<tr>
<th>Modifiers and Their Descriptions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MORE THAN ONE PROCEDURE DURING THE SAME SURGICAL SESSION</strong></td>
<td></td>
</tr>
</tbody>
</table>
| 51 Multiple Procedures | The highest valued code is reported first on the claim form without a modifier. Modifier 51 is added to second, third, etc. codes.  
There is no expectation that the payer will bundle the services. |
| 59 Distinct Procedural Service: The procedures are provided during different sessions or patient encounters; different procedures or surgeries; performed on different sites or organ systems; use separate incisions/excisions; performed on separate lesions; or are separate injuries. | Modifier most often used for CPT separate procedure codes or codes bundled by Medicare’s Correct Coding Initiative.  
There is an expectation that the services might be bundled under either CPT or Medicare rules but, in this specific case, the services are each reportable. |

| **ADDITIONAL PROCEDURE(S) DURING POST-operative PERIOD** | |
| 58 Stage or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During Postoperative Period: Procedure was planned or anticipated (staged); more extensive than the original procedure; or for therapy following a surgical procedure. | The additional service is related to but is not a complication of the original surgery.  
Under Medicare rules, this service begins a new global surgical package. |
| 76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional | Modifier 76 clarifies that this is not a duplicate claim. |
| 77 Repeat Procedure or Another Physician or Other Qualified Health Care Professional | |
| 78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period | Indicates to Medicare that this procedure required a return to the operation room and therefore is payable.  
Medicare reimburses only for the intra-operative portion of the related service. This service does not begin a new global surgical package. |
| 79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Post-Operative Period | Treatment may or may not require a return to the operating room.  
Under Medicare rules, this service begins a new global surgical package. |
<table>
<thead>
<tr>
<th>Modifiers and Their Descriptions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>More than one Provider in the Operating Room</strong></td>
<td></td>
</tr>
<tr>
<td>62 Two Surgeons (Co-Surgeons): Two surgeons work together as primary surgeons performing distinct part(s) of a procedure described by a single CPT code.</td>
<td>Both surgeons report the same code with a modifier 62, document an operative report for their portion of the procedure and provide pre- and post-operative care.</td>
</tr>
<tr>
<td>80 Assistant Surgeon: One surgeon is primary while another surgeon assists.</td>
<td>The primary surgeon reports the appropriate code without a modifier. The assistant surgeon reports the same code with this modifier. The assistant does not need to document a separate operative report or provide pre- and post-operative care.</td>
</tr>
<tr>
<td>82 Assistant Surgeon (when qualified resident surgeon not available): One surgeon is primary while another surgeon assists. Services provided in teaching facility.</td>
<td>Medicare will not reimburse for an assistant at surgery in a teaching facility that has an organized residency program in that specialty unless: an exceptional medical circumstance exists; the primary surgeon has an across-the-board policy of never utilizing residents; or other specific situations exist (e.g., all residents were serving as assistants in other surgeries at the time).</td>
</tr>
<tr>
<td>AS Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Services for Assistant-at-Surgery</td>
<td>Medicare will reimburse for these services if the assistant surgical services would have been covered if provided by a physician. The non-physician assistant must have a Medicare provider number. Some other payers will also reimburse for these services.</td>
</tr>
</tbody>
</table>
CHAPTER 5: GLOBAL OBSTETRIC PACKAGE

DEFINITION OF GLOBAL OBSTETRIC PACKAGE
CPT’s obstetric global package includes all services provided in uncomplicated maternity cases, including routine antepartum care, delivery, and postpartum care. Some commercial carriers may not follow CPT’s rules, so it is important to have information about a specific carrier’s global obstetric package prior to providing services. Table 5-1 summarizes the codes used for reporting obstetric care.

ANTEPARTUM SERVICES
CPT includes these antepartum services in the global obstetric package:
- Initial and subsequent history
- Physical examinations
- Recording of weight, blood pressures, fetal heart tones
- Routine dipstick analysis
- Monthly visits up to 28 weeks (5-6 visits)
- Biweekly visits to 36 weeks (4 visits)
- Weekly visits from 36 weeks until delivery (3-4 visits)

Antepartum care includes the services normally provided in uncomplicated pregnancies. Routine obstetrical care typically includes approximately 13 antepartum visits.

DELIVERY SERVICES
CPT includes these delivery services in the global obstetric package:
- Admission to the hospital (including the admitting history and physical exam)
- Management of uncomplicated labor
- Vaginal or cesarean delivery (with or without episiotomy, forceps or vacuum extraction)
- Delivery of the placenta
- Routine inpatient care immediately following the delivery

According to ACOG, the following services are also included:
- Induction of labor (unless the obstetrician personally starts the IV and sits with the patient during the infusion)
- Insertion of cervical dilator on day of delivery (code 59200)
- Simple removal of cerclage (not under anesthesia)

POSTPARTUM SERVICES
CPT includes these postpartum services in the global ob package:
- Recovery room visit
- Uncomplicated inpatient hospital visits
- Uncomplicated outpatient visits until six weeks
- Discussion of contraception
- Removal of sutures (if appropriate)

The postpartum period normally lasts until six weeks following delivery.
GLOBAL OBSTETRIC PACKAGE CODES
These global services (antepartum, delivery and postpartum care) are reported using these codes:
5940  Routine ob care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59510 Routine ob care including antepartum care, cesarean delivery, and postpartum care
59610 Routine ob care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
59618 Routine ob care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

SERVICES OUTSIDE THE GLOBAL OBSTETRIC PACKAGE
Some services performed during the antepartum, delivery and postpartum care can be reported separately.

ADDITIONAL ANTEPARTUM SERVICES
Antepartum care that can be reported in addition to the global obstetric code include:
• Services to treat conditions unrelated to the pregnancy
• Services to treat complications of the pregnancy
• Ultrasound procedures (see chapter 6)

Treatment of Conditions Unrelated to Pregnancy
Services to treat conditions unrelated to the pregnancy are reported with an E/M service code at the time they are rendered. The appropriate E/M code should be linked to a diagnosis that identifies the unrelated condition. Examples of these conditions are urinary tract infection or upper respiratory infections. At the end of the pregnancy, a global obstetric code is reported.

Treatment of Complications of the Pregnancy
Additional visits (over the usual 13) to treat complications of the pregnancy are reported after the patient has delivered. These visits may be performed in the physician’s office or in a facility (e.g., patient is admitted to observation or as an inpatient). The additional visits for the complications must be linked to an appropriate diagnosis code. Examples of these conditions are gestational diabetes and placenta previa.

If the patient is admitted to observation or inpatient care and then delivers within 24 hours of the admission, the services are not reported.

Monitoring of High Risk Patients
Sometimes the provider will see a patient for additional visits (more than 13) to monitor her for a possible problem that never materializes. Examples of possible problems that might result in additional visits are: a complication in a previous pregnancy, such as pre-eclampsia, or a previous spontaneous abortion. If such a “high risk” patient is seen more often than usual but no complications develop, the additional visits are not reported separately. Only a global obstetric package code is reported.

ADDITIONAL DELIVERY SERVICES
Examples of delivery care excluded from global service codes include:
• External cephalic version
• Insertion of cervical dilator by provider prior to day of delivery E/M services (e.g., observation, inpatient services, critical care) if provided more than 24 hours before the delivery

These services must be linked to an appropriate diagnosis code. Providers can report the additional services at the same time as the global package code.

**ADDITIONAL POSTPARTUM SERVICES**

Examples of postpartum care excluded from global service codes include:

• Treatment of postpartum complications
• Treatment of conditions not related to routine postpartum care

These services must be linked to an appropriate diagnosis code. If the treatment is for a related condition and requires an unplanned return to the operating room, modifier 78 (Unplanned return to operating room/procedure room by the same provider following initial procedure for a related procedure during the postoperative period) is added to the procedure code. If the treatment is reported with an E/M services code, no modifier is needed.

**PROVISION OF LESS THAN GLOBAL OBSTETRIC PACKAGE**

Sometimes, a provider will not perform all the maternity care and delivery services to a patient. This may be because the patient moves, the provider transfers care for a patient to a specialist, or the patient miscarries early in the pregnancy. A similar problem occurs when a patient changes insurers during her pregnancy. Under these circumstances, the provider reports the non-global obstetric codes:

• Antepartum care only codes (59425 or 59426)
• Delivery only codes (59409, 59514, 59612, or 59620)
• Delivery plus postpartum care (59410, 59515, 59614, and 59622).

**ANTEPARTUM SERVICES PROVIDED BY TWO PHYSICIANS**

When two providers perform part of the patient’s antepartum care, each reports the appropriate code for the number of visits he or she provided. Code 59425 is reported for 4-6 total visits. Code 59426 is reported for 7 or more visits. If the provider performs fewer than 4 visits, he or she reports an E/M visit code for each encounter.

**DELIVERY SERVICES ONLY/DELIVERY PLUS POSTPARTUM CARE**

When a provider performs only the delivery, then he or she reports the appropriate delivery only code. If the provider has also performed some but not all of the antepartum care, then he or she can report an antepartum care only code and a delivery only code.

If the provider performed the delivery and the postpartum care without any antepartum care, then he or she reports the appropriate delivery plus postpartum care code.

In the past, ACOG stated that the inpatient postpartum services were included in the delivery only codes. However, in 2006 the ACOG Committee on Health Economics and Coding, reexamined the vignettes for the delivery-only codes and found that the values assigned to these codes did not include the provider work for inpatient postpartum care. This reexamination clarifies that the delivery only codes (59409, 59514, 59612 and 59620) do not include inpatient postpartum care. Yet, the delivery with postpartum care codes (59410, 59515, 59614 and 59622) include both inpatient and outpatient postpartum care.
**Postpartum Care Only**
Sometimes a provider will provide only postpartum care for a patient. This is reported using code 59430 (postpartum care only). This code includes only postpartum outpatient care, not postpartum inpatient care.

**Patient Changes Insurance During Her Pregnancy**
When a patient changes insurers during the maternity care, each insurer is billed for part of the antepartum care code (59425 or 59426). The delivery and postpartum codes are reported to the insurer covering the patient during this period. Note that some insurers have different rules. Providers should check with their specific insurers.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Routine Antepartum Services</th>
<th>Routine Delivery Services</th>
<th>Routine Postpartum E/M Services (Through 6 weeks after delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E/M code</td>
<td>1-3 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59425</td>
<td>4-6 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59426</td>
<td>7 or more visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59430</td>
<td></td>
<td></td>
<td>Inpatient Care</td>
</tr>
<tr>
<td>59400</td>
<td>Approximately 13 visits</td>
<td>Vaginal</td>
<td>E/M services for 2 days postpartum</td>
</tr>
<tr>
<td>59409</td>
<td></td>
<td>Vaginal</td>
<td></td>
</tr>
<tr>
<td>59410</td>
<td></td>
<td>Vaginal</td>
<td>E/M services for 2 days postpartum</td>
</tr>
<tr>
<td>59510</td>
<td>Approximately 13 visits</td>
<td>Cesarean</td>
<td>E/M services for 4 days postpartum</td>
</tr>
<tr>
<td>59514</td>
<td></td>
<td>Cesarean</td>
<td></td>
</tr>
<tr>
<td>59515</td>
<td></td>
<td>Cesarean</td>
<td>E/M services for 4 days postpartum</td>
</tr>
<tr>
<td>59610</td>
<td>Approximately 13 visits</td>
<td>VBAC</td>
<td>E/M services for 2 days postpartum</td>
</tr>
<tr>
<td>59612</td>
<td></td>
<td>VBAC</td>
<td></td>
</tr>
<tr>
<td>59614</td>
<td></td>
<td>VBAC</td>
<td>E/M services for 2 days postpartum</td>
</tr>
<tr>
<td>59618</td>
<td>Approximately 13 visits</td>
<td>Repeat Cesarean</td>
<td>E/M services for 4 days postpartum</td>
</tr>
<tr>
<td>59620</td>
<td></td>
<td>Repeat Cesarean</td>
<td></td>
</tr>
<tr>
<td>59622</td>
<td></td>
<td>Repeat Cesarean</td>
<td>E/M services for 4 days postpartum</td>
</tr>
</tbody>
</table>
MULTIPLE GESTATION DELIVERY REPORTING

Multiple gestation creates potential complications for pregnancies, may involve more provider work when procedures are performed, and often complicates the coding of some services.

CPT often provides instructions on reporting services for multiples. For example, some of the obstetrical ultrasound codes have a paired add-on code that is reported for the additional fetuses (e.g., CPT codes 76801, +76802). Other codes have parenthetical notes to indicate reporting the same code for each gestation with a modifier for each additional fetus (e.g., 76816). See Chapter 6 for more information on ultrasound reporting.

For other services, multiple gestation coding instructions are not specified. As an example, when an amniocentesis, non-stress test, or biophysical profile is performed on twins, it is frequently twice the work because each fetus must be clearly documented. Coding choices will be to report the service with modifier 22 (increased procedural service), report the service twice, or report the service once, but indicate a unit quantity of two. Since payer requirements vary, providers should check with their specific payers for how they would like these services reported.

Coding for twin or multiple gestation deliveries is more straightforward per CPT guidelines. However, third-party payers may ignore requests for additional reimbursement for services performed for multiples unless there is adequate documentation to substantiate the additional work performed. Multiple gestation deliveries should be reported as follows:

Both vaginal: 59400 or 59610 for Twin A and 59409-59 or 59612-59 for Twin B. This method of coding communicates that one global maternity package is being reported along with an additional vaginal delivery (without antepartum care and without postpartum care).

One vaginal and one cesarean: 59510 or 59618 for Twin B and 59409-51 or 59612-51 for Twin A. This communicates that both a cesarean and a vaginal birth were performed.

Both cesarean: 59510 or 59618 only because only one cesarean incision was performed. If the cesarean was significantly more difficult due to the multiple gestation, modifier 22 should be added to the delivery code. An operative and special report should also be submitted with the claim that describes the significant additional work.

INTERRUPTION OF PREGNANCY AND STILLBIRTH

ACOG’s Committee on Health Economics and Coding states that an abortion after 20 weeks 0 days is reported using a delivery code. However, some state legislatures have legally defined the difference between a miscarriage and a stillbirth by the number of gestational weeks or by gram weight of the fetus. This legal definition may determine which CPT-4 codes are selected.

When reporting a global delivery code, it may be appropriate to add modifier 52 (reduced services) to the global code if the number of antepartum visits is substantially less than 13. Table 5-2 summarizes coding for terminations of pregnancy.
## Interruption of Pregnancy

### Termination of Pregnancy Coding

<table>
<thead>
<tr>
<th>Possible Diagnosis Codes &amp; Description</th>
<th>Possible Procedure Codes &amp; Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Missed Abortion/Fetal Demise (In Utero)</strong></td>
<td></td>
</tr>
<tr>
<td>O02.1 Missed Abortion or early fetal death Before completion of 20 weeks of gestation, with retention of dead fetus OR</td>
<td>Surgical Abortion</td>
</tr>
<tr>
<td>O36.4X Maternal care for intrauterine death</td>
<td>59820 Prior to 14 weeks 0 days</td>
</tr>
<tr>
<td></td>
<td>59821 14 weeks 0 days up to 20 weeks 0 days</td>
</tr>
<tr>
<td></td>
<td>Non-Surgical Abortion</td>
</tr>
<tr>
<td></td>
<td>59850-59852 By injections</td>
</tr>
<tr>
<td></td>
<td>Delivery Code Prior to 20 weeks 0 days</td>
</tr>
<tr>
<td></td>
<td>After 20 weeks 0 days</td>
</tr>
<tr>
<td></td>
<td>59855-59857 By suppositories</td>
</tr>
<tr>
<td></td>
<td>Delivery code Prior to 20 weeks 0 days</td>
</tr>
<tr>
<td></td>
<td>After 20 weeks 0 days</td>
</tr>
<tr>
<td></td>
<td>E/M code Spontaneous /Other Medical Abortion</td>
</tr>
<tr>
<td></td>
<td>Delivery code Prior to 20 weeks 0 days</td>
</tr>
<tr>
<td></td>
<td>After 20 weeks 0 days</td>
</tr>
<tr>
<td></td>
<td>E/M code + Spontaneous + delivery of placenta</td>
</tr>
<tr>
<td></td>
<td>59414 Prior to 20 weeks 0 days</td>
</tr>
<tr>
<td></td>
<td>Delivery code After 20 weeks 0 days</td>
</tr>
</tbody>
</table>

| **Complete (Spontaneous) Abortion** | |
| O03.5 Genital tract and pelvic infection following complete or unspecified spontaneous abortion OR | E/M code Prior to 20 weeks 0 days |
| O03.6 Delayed or excessive hemorrhage following complete or unspecified spontaneous abortion OR | |
| O03.7 Embolism following complete or unspecified spontaneous abortion OR | |
| O03.8- Other and unspecified complications following complete or unspecified spontaneous abortion OR | |
| O03.9 Complete or unspecified spontaneous abortion without complication | |

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### Termination of Pregnancy Coding

<table>
<thead>
<tr>
<th>Possible Diagnosis Codes &amp; Description</th>
<th>Possible Procedure Codes &amp; Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete (Spontaneous) Abortion</td>
<td></td>
</tr>
<tr>
<td>O03.0 Genital tract and pelvic infection following incomplete spontaneous abortion OR</td>
<td>59812 Prior to 20 weeks 0 days</td>
</tr>
<tr>
<td>O03.1 Delayed or excessive hemorrhage following incomplete spontaneous abortion OR</td>
<td>Delivery code 20 weeks 0 days or more</td>
</tr>
<tr>
<td>O03.2 Embolism following incomplete spontaneous abortion OR</td>
<td></td>
</tr>
<tr>
<td>O03.3- Other and unspecified complications following incomplete spontaneous abortion OR</td>
<td></td>
</tr>
<tr>
<td>O03.4 Incomplete spontaneous abortion without complication</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Induced Termination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Surgical Abortion</td>
</tr>
<tr>
<td>O04.5 Genital tract and pelvic infection following (induced) termination of pregnancy</td>
<td>59840 By D&amp;C – Any trimester</td>
</tr>
<tr>
<td>O04.6 Delayed or excessive hemorrhage following (induced) termination of pregnancy OR</td>
<td>59841 By D&amp;E 14 weeks 0 days up to 20 weeks 0 days</td>
</tr>
<tr>
<td>O04.7 Embolism following (induced) termination of pregnancy OR</td>
<td>59841-22 20 weeks 0 days or more</td>
</tr>
<tr>
<td>O03.8- (Induced) termination of pregnancy with other and unspecified complications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Surgical Abortion</td>
</tr>
<tr>
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</table>
CHAPTER 6: ULTRASOUND CODING

Ultrasound coding can be divided into gynecologic examination, obstetric examinations, and radiological guidance procedures.

GYNECOLOGIC ULTRASOUND EXAMINATIONS
The elements included in obstetric ultrasounds are specifically defined, however, the gynecological ultrasounds are not. Coding depends on the approach used, extent of service and documentation (e.g., image documentation and written report).

REPORTING GUIDELINES
CPT provides the following guidelines for reporting non-obstetrical ultrasounds:

“Use of ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation, and final, written report, is not separately reportable.”

This implies that non-obstetrical ultrasound codes are not reported when:

- An ultrasound is used as a means to perform a component of a physical examination
- If the ultrasound equipment does not produce a hard copy or permanent digital image

TRANSEPTAL ULTRASOUND EXAMINATIONS
Code 76856 is reported for a complete transabdominal ultrasound. This includes a description of the uterus, adnexal structures and any pelvic pathology, and measurements of uterus, adnexal structures, endometrium, and bladder (when applicable).

Code 76857 is reported for a transabdominal limited or follow-up ultrasound. This is a focused examination limited to the assessment of one or more elements listed in code 76856 and/or re-evaluation of one or more pelvic abnormalities found in a previous ultrasound exam.

TRANSVAGINAL ULTRASOUND EXAMINATIONS
Code 76830 is reported for a transvaginal ultrasound. It is used to report imaging of uterus, tubes, ovaries and pelvic structures as indicated.

Code 76831 is reported for a saline infusion sonohysterography, including color flow Doppler when performed. This code uses a transvaginal approach. The introduction of saline or contrast material for the sonohysterogram is reported using code 58340. If a physician performs both the introduction and the radiologic supervision and interpretation, he or she reports both codes 58340 and 76831. Code 76830 is not reported with code 76831.

OBSTETRIC ULTRASOUND EXAMINATIONS
Obstetric ultrasound codes are very specific about the services included. These services may be abdominal ultrasound, vaginal ultrasound, or biophysical profiles.
**Transabdominal Ultrasound Examinations**

Codes 76801-76816 use a transabdominal approach. Table 6-1 summarizes the components of these obstetric ultrasound codes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Extent of Evaluation</th>
<th>Trimester*</th>
<th>Gestation</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1st</td>
<td>2nd</td>
<td>3rd</td>
</tr>
<tr>
<td>76801</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>76802</td>
<td>X</td>
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<tr>
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<td>X</td>
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<td>76828</td>
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</tbody>
</table>

Three of the codes in Table 6-1 are CPT add-on codes, used only in cases of multiple gestations. No modifier 51 is needed. Code +76802 is reported only with 76801; +76810 is reported only with 76805; and +76812 is only reported with 76811.
Complete Ultrasounds (Maternal and Fetal Evaluations)—First Trimester Codes (76801-76802)

These codes include:
  • Supervision of sonographer performing the examination
  • Determination of the number of gestational sacs and fetuses
  • Gestational sac/fetal measurements appropriate for gestation
  • Survey of visible fetal and placental anatomic structure
  • Qualitative assessment of amniotic fluid volume/gestational sac shape
  • Examination of maternal uterus and adnexa
  • Preparation of the report for the medical record

Complete Ultrasounds (Maternal and Fetal Evaluation)—Second and Third Trimesters (76805-76810)

These codes include:
  • Supervision of sonographer performing the examination
  • Determination of the number of fetuses and amniotic/chorionic sacs
  • Measurements appropriate for gestational age
  • Survey of intracranial/spinal/abdominal anatomy
  • Evaluation of the four chambered heart
  • Assessment of the umbilical cord insertion site
  • Survey of placenta location and amniotic fluid assessment
  • When visible, examination of maternal adnexa
  • Preparation of the report for the medical record

Detailed Fetal Anatomic Examination (76811-76812)

These codes include:
  • All components of 76805 and 76810 PLUS:
  • Detailed anatomic evaluation of:
    o The fetal brain/ventricles and face
    o Heart/outflow tracts and chest anatomy
    o Abdominal organ specific anatomy
    o Number/length/architecture of limbs
  • Detailed evaluation of:
    o Umbilical cord
    o Placenta
    o Other fetal anatomy as clinically indicated
  • Preparation of the report for the medical record

Note: Codes 76811 and 76812 are reported when performed for a known or suspected fetal anomaly. These codes are not reported for routine screening.
Nuchal Translucency Measurement (76813 - 76814)

These codes include:
- Supervision of sonographer performing the examination
- Orientation of transducer to mid-sagittal view of the embryo
- Crown-rump measurement
- Observation of embryo at high magnification until the embryonic neck is in a neutral position and spontaneous embryonic movement allows for differentiation between the outer edge of nuchal skin and the amnion
- At least three separate measurements for the shortest distance between the inner edges of nuchal translucency
- Comparison of the largest measurement from an acceptable image to crown-rump length and gestational age specific medians
- Preparation of the report for the medical record

Limited Ultrasound Examination (76815)

These codes include:
- Supervision of sonographer performing the examination
- Interpretation of the examination limited to a “quick-look” assessment of one or more of the following key elements:
  - Fetal position
  - Fetal heart beat
  - Placental location
  - Qualitative amniotic fluid volume
- Preparation of the report for the medical record

Follow-up Ultrasound Examination (76816)

This code includes:
- Supervision of sonographer performing the examination
- Either of the following:
  - Reassessment of fetal size and interval growth and amniotic fluid volume OR
  - Re-evaluation of one or more fetal anatomic abnormalities previously demonstrated on ultrasound
- Preparation of the report for the medical record

Transvaginal Obstetric Ultrasound (76817)

This code may include:
- Evaluation of the embryo(s) and gestational sac(s)
- Evaluation of the maternal uterus, adnexa, and/or the cervix
- This code also includes:
  - Supervision of sonographer performing the examination
  - Preparation of the report for the medical record
Fetal Biophysical Profile; with Non-Stress Testing (76818)

These codes include:
- Supervision of sonographer performing the examination
- Fetal non-stress test
- Fetal breathing movements (one or more episodes of rhythmic fetal breathing movements of 30 seconds or more within 30 minutes)
- Fetal movements (three or more discrete body or limb movements within 30 minutes)
- Fetal tone (one or more episodes of fetal extremity extension with return to flexion)
- Quantification of amniotic fluid volume
- Preparation of the report for the medical record

Fetal Biophysical Profile; without Non-Stress Testing (76819)

These codes include:
- Supervision of sonographer performing the examination
- Fetal breathing movements (one or more episodes of rhythmic fetal breathing movements of 30 seconds or more within 30 minutes)
- Fetal movement (three or more discrete body or limb movements within 30 minutes)
- Fetal tone (one or more episodes of extension of a fetal extremity with return to flexion)
- Quantification of amniotic fluid volume
- Preparation of the report for the medical record

Doppler Velocimetry, Fetal; Umbilical Artery (76820)

This code includes:
- Supervision of sonographer performing the examination
- Visualization of a segment of umbilical cord
- Placement of a duplex Doppler sampling gate over a portion of the umbilical artery most perpendicular to the axis of the gate
- Recording of 2-4 waveforms during period when fetus is inactive and fetal breathing is absent
- Measurement of peak systolic and end diastolic frequency shift using electronic calipers
- Obtaining average of the results of 2-4 waveforms
- Comparison of specific normal values to gestational age
- Preparation of the report for the medical record

Doppler Velocimetry, Fetal; Middle Cerebral Artery (76821)

This code includes:
- Supervision of sonographer performing the examination
- Location of fetal head and anterior wing of the sphenoid bone using real time ultrasonics
- Placement of a pulsed Doppler gate over the middle cerebral artery near its origin from the Circle of Willis
Doppler Velocimetry, Fetal; Middle Cerebral Artery (76821) (continued)

These codes include:

- Adjustment of transducer probe orientation or gate orientation to ensure angle of insonance is close to zero degrees
- Obtaining of 2-4 measurements
- Recording of highest velocity
- Comparison of peak systolic velocity to gestational age specific norms
- Preparation of the report for the medical record

Echocardiography, Fetal, Cardiovascular System, Real Time with Image Documentation (2D), with or without M-mode Recording; (76825)

These codes include:

- Supervision of sonographer performing the examination
- Imaging of the fetus to identify fetal orientation and the fetal cephalic/caudal ends, extremities, and spine
- Determination of fetal situs (fetal visceral orientation)
- Evaluation of all parts of the heart including:
  - Venous connections
  - Chambers
  - Competence and movement of valves
  - Great arterial connections
- Evaluation of cardiac function with M mode (and/or spectral Doppler when indicated)
- Preparation of the report for the medical record

Echocardiography, Fetal, Cardiovascular System, Real Time with Image Documentation (2D), with or without M-mode Recording; Follow-up or Repeat Study (76826)

This code includes:

- Supervision of sonographer performing the examination
- Assessment of cardiac function and evaluation of the heart rate anomaly (e.g., frequency of runs of supraventricular tachycardia in the fetus) pertinent to the
- Preparation of the report for the medical record

Doppler Echocardiography, Fetal, Pulsed Wave and/or Continuous Wave with Spectral Display; Complete (76827)

This code may include:

- Supervision of sonographer performing the examination
- Identification of vessels to be studied
- Placement of Doppler cursor over vessels using real-time guidance and optimizing appearance of Doppler waves
- Performance of appropriate index measurements to quantify results
- Assessment of amniotic fluid volume
- Preparation of the report for the medical record
Echocardiography, Fetal, Pulsed Wave and/or Continuous Wave with Spectral Display; Follow-up or Repeat Study (76828)

These codes include:
- Supervision of sonographer performing the examination
- Identification of vessels to be studied
- Placement of Doppler cursor over vessels using real-time guidance and optimizing appearance of Doppler waves
- Performance of appropriate index measurements to quantify results.
- Preparation of the report for the medical record

**Note:** The CPT guidelines clearly state that a transvaginal and transabdominal ultrasound code may be reported for the same encounter. Some payers initially may pay for either the transvaginal or transabdominal approach but not both. It may be helpful to attach the modifier 59 (distinct procedural service) to the transvaginal code (i.e., 76805, 76817-59). However, some payers may require a modifier 51 (multiple procedures) on the transvaginal code instead of a modifier 59.

**ULTRASOUND GUIDANCE PROCEDURES**

The physician may report both an ultrasound procedure code and an ultrasound guidance code if he or she performed both. The obstetrician can also report both services if his or her assistant or sonographer performed the guidance while the obstetrician performed the actual procedure.

For some procedures, a specific guidance code is listed. An example is code 59000 (amniocentesis) and code 76946 (ultrasound guidance for amniocentesis). If guidance is used but there is no specific code, report 76998 (ultrasonic guidance, intraoperative) or 76999 (unlisted ultrasound procedure (e.g., diagnostic, interventional)). For other procedures, the guidance is included in the ultrasound code and not reported separately. For example, all fetal surgery codes include ultrasound guidance.

**ULTRASOUND DOCUMENTATION**

CPT includes the following definition of results, tests, interpretations and reports:

*“Results are the technical component of a service. Testing leads to results; results lead to interpretation. Reports are the work product of the interpretation of numerous test results.”*

In order to report an ultrasound code, there must be a separate, final written report with interpretation of the findings of the radiological procedure. All diagnostic ultrasound examinations require permanently recorded images with measurements when such measurements are clinically indicated. The report and interpretations should be stored in the medical record. These instructions also mean that a brief summary within the documentation of an E/M service is insufficient to justify reporting an ultrasound code. The summary would be considered a component of the E/M service.
MODIFIERS AND ULTRASOUND PROCEDURES

If an ultrasound procedure is performed in the physician’s office, either by the physician or an employee, and the physician owns the equipment, the appropriate code is reported without a modifier.

If an ultrasound procedure is performed in a hospital or other facility setting, it may be appropriate to use a modifier. Table 6-2 summarizes these modifiers.

Table 6-2: Ultrasound Modifiers
Service Provided in a Hospital or Other Facility

<table>
<thead>
<tr>
<th>Modifiers</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>26 Professional Component: This modifier is used when the physician component is reported separately.</td>
<td>Used by the physician to report his or her supervision and/or performance of the ultrasound examination, the interpretation, and the written report.</td>
</tr>
<tr>
<td>TC Technical Component. This modifier is used when the technical component is reported separately.</td>
<td>Used by the facility to report the costs of the equipment, technician and supplies.</td>
</tr>
</tbody>
</table>
Consultations: Non-Medicare
In 2016 CPT made editorial revisions to the subheading Consultations which revised the circumstances under which consultation codes may be reported. In conjunction with this revision, the E/M Services Guidelines section now includes a definition of “Transfer of Care”.

Transfer of Care
CPT states: “Transfer of care is the process whereby a physician or other qualified health care professional (QHP) who is providing management for some or all of a patient’s problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services.” CPT further explains that the transferring physician or other QHP is no longer providing care for these problems although care may be continued for other conditions when appropriate.

The provider who has agreed to accept transfer of care before evaluating the patient should not report consultation codes. Rather he or she should report the following:

    Outpatient Services: New or established patient codes (99201-99215)
    Inpatient Services: Subsequent hospital care (99231-99233)

If the receiving provider must evaluate the patient prior to the decision to accept the patient in transfer, then he or she can report either an outpatient or inpatient consultation service code (99241-99255).

Consultation Services
Consultations are a type of E/M service provided at the request of another physician or other appropriate source. The two circumstances in which consultation services can be reported are:

- A provider is asked to provide an opinion/services for a specific condition or problem OR
- A provider must determine whether to accept the ongoing management of a patient’s entire care or for the care of a specific condition or problem.

Criteria
- Request by a provider or other appropriate source for one of the two circumstances noted above
- Documentation of either the verbal or written request must be in the medical record and can be documented by either the requesting or consulting provider.
- Documentation of the consultant’s opinion and any services ordered or performed must be in the patient’s medical record
- The consulting provider must send a written report to the requesting party describing his or her findings and any services ordered or performed
The following CPT instructions preceding the consultation codes further clarify when consultation codes can be reported.

- “A ‘consultation’ initiated by a patient and/or family, and not requested by a provider or other appropriate source (e.g., physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech-language pathologist, psychologist, social worker, lawyer, or insurance company), is not reported using the consultation codes but may be reported using the office visit, home service, or domiciliary/rest home care codes.”
- “If a consultation is mandated, e.g., by a third-party payer, modifier 32 should also be reported.”

Modifier 32 is defined as follows in CPT:

- Mandated Services: Services related to mandated consultation and/or related services (e.g., third party payer, governmental, legislative or regulatory requirement) may be identified by adding the modifier 32 to the basic procedure.

**Consultations: Medicare**

As of January 1, 2010, Medicare no longer recognizes consultation codes. A 2006 report from the Office of Inspector General (OIG) indicated that Medicare allowed approximately $1.1 billion more in 2001 than it should have for services billed as consultations. CMS cited continued concerns regarding the distinction between transfer of care and consultation services despite ongoing work with the AMA to improve guidance and instructions for consultation services.

Providers providing consultation services to Medicare patients should report the E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. Documentation should include the request for the evaluation and the results should be communicated back to the requesting provider. All services must follow the E/M Documentation Guidelines which were addressed in chapter 2. The following explains different rules for reporting consultations services to Medicare.

**Outpatient Services**

When an evaluation is performed in the outpatient setting, the provider should report the appropriate new or established E/M codes (99201-99215). New patient codes cannot be reported if the provider has provided any professional services to the patient in the previous three years. Follow-up visits are reported using the appropriate level established patient codes (99211-99215).

If the highest levels of codes are reported (99205, 99215), the documentation must clearly support the level of service selected as well as meet all of the elements of the code description.
Inpatient Services
In the inpatient setting, any provider who performs an initial evaluation may report an initial inpatient code (99221-99223). The admitting provider should append modifier “AI” (Principle Provider of Record) to the initial inpatient code. The modifier is used to differentiate the provider who oversees the patient’s care from others who may be providing specialty care. Any “consultant” or “specialist” seeing the patient reports the initial inpatient code without the modifier. Subsequent inpatient services are reported using codes 99231-99233. The modifier is not required for subsequent care codes.

Outpatient Services Followed by Inpatient Admission
If a provider performs a Level 5 office visit several days prior to an inpatient admission and on the day of admission provides less than a comprehensive history and physical, he or she may report the office visit at the level of service provided and the initial hospital care code at the lowest level of service (99221). If the patient was seen in the office and admitted to the hospital on the same day, then only the initial inpatient care code is reported.

If the patient had not been seen in the office prior to the consultation or did not receive a comprehensive history and examination in the office, then the requirements for the initial inpatient care codes must be met and documented.

Evaluation Requests within the Same Group
Medicare may pay for an inpatient or outpatient E/M code if a provider in a group requests an E/M service from another provider in the same group. The receiving provider must have expertise in a specific medical area beyond that of the requesting provider’s knowledge. Documentation should support the reason for the evaluation, the medical necessity of the service, and the E/M code reported.

This is a Medicare payment policy and will not necessarily be adopted by other non-Medicare payers. Check with your payers regarding their consultation reporting criteria. For other coding updates and more information on consultation reporting visit the ACOG website (www.acog.org).
CPT/HCPCS Changes for 2016
The Current Procedural Terminology, Fourth Edition, (CPT-4) code set for 2016 includes a few updates of interest to ob-gyns. As in previous years, extensive new instructions and guidelines have been added to the CPT manual to help clarify coding in a variety of situations. This new guidance is in addition to new, revised and deleted CPT codes for 2016. These changes took effect January 1, 2016.

HIPAA requires insurers to accept new procedure codes beginning on January 1st.

The American Medical Association CPT Editorial Panel approved these changes for 2016.

NEW, REVISED, AND DELETED CODES

EVALUATION AND MANAGEMENT

Prolonged Services
The section guidelines for Prolonged Services (CPT codes 99354-99357) have been updated to define and clarify reporting for prolonged services with direct patient contact. Direct patient contact is considered face to face contact and includes additional non-face to face services on the floor or unit during the same session. This service is reported in addition to the primary evaluation and management service.

New Codes

Prolonged Clinical Staff Services with Physician or Other Qualified Health Care Professional (QHP) Supervision

New prolonged services codes have been implemented for outpatient services provided by clinical staff when they are supervised by physicians or QHPs. This service is reported in addition to the primary evaluation and management service.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99415</td>
<td>Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)</td>
</tr>
<tr>
<td>99416</td>
<td>Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service)</td>
</tr>
</tbody>
</table>

Notes:
Codes 99415 and 99416 may not be reported for more than two simultaneous patients
Facilities may not report these codes
Preventive Medicine Services
The section guidelines for preventive medicine services (CPT codes 99381-99397) have been updated to define and clarify reporting of Behavior Change Intervention codes (99406-99409) on the same day as an evaluation and management (E/M) service.

Codes 99401-99404, 99411, and 99412 (Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (individual or group setting) should be provided at a separate encounter from preventive medicine services reported with codes 99381-99397, since codes 99381-99397 include counseling/anticipatory guidance and risk factor reduction interventions based on the age and gender of the patient.

The guidelines also specifically state that when an E/M service is provided in conjunction with these codes, modifier 25 should be appended to the E/M service.

Surgery
Codes 57155 and 58346
A note was added beneath codes 57155 (Insertion of uterine tandem and/or vaginal ovoids for clinical radiology) and 58346 (Insertion of Heyman capsules for clinical brachytherapy) identifying the appropriate codes for insertion of radioelement sources or ribbons. The new instruction reads: (For insertion of radioelement sources or ribbons, see 77761-77763, 77770, 77771, and 77772).

Radiology
GUIDELINES
The guidelines have been updated throughout CPT to clarify and standardize documentation requirements for the written report. This is stated as: “A written report signed by the interpreting individual should be considered an integral part of a radiologic procedure or interpretation. Please see the guidelines regarding Imaging Guidance in each individual section.”

CPT language has been clarified with regards to CPT descriptors for radiography services to indicate that “images” refers to those acquired in either an analog (i.e., film) or digital (i.e., electronic) manner.

Breast, Mammography
The guidelines for code 77057 have been revised to remove the term “film” as part of an effort to use more current and appropriate terminology throughout CPT.

New Codes
Fetal Magnetic Resonance Imaging (MRI)
Two new codes have been established to report fetal magnetic resonance imaging (MRI).

74712 - Magnetic resonance (e.g., proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation

74713 - Magnetic resonance (e.g., proton) imaging, fetal, including placental and maternal pelvic imaging when performed; each additional gestation (List separately in addition to code for primary procedure)
PATHOLOGY AND LABORATORY / MOLECULAR PATHOLOGY
Organ or Disease-Oriented Panels
New Code(s)

**Obstetric Panel**
A new obstetric panel code has been added to the Organ or Disease-Oriented Panels subsection of CPT. This code was developed in response to prenatal screening initiatives for HIV infection. This code includes all tests included as part of code 80055 (obstetric panel), plus; HIV-1 antigen(s), with HIV-2 antibodies, single result (87389). CPT code 80055 (obstetric panel not including HIV screening) is still valid and may be ordered if HIV screening is not requested.

80081 - Obstetric panel (includes HIV testing)

CPT CATEGORY III CODES
The Category III Codes introduction section was updated to include clarifying language regarding services in this section as follows:

“The inclusion of a service or procedure in this section does not constitute a finding of support, or lack thereof, with regard to clinical efficacy, safety, applicability to clinical practice, or payer coverage.”

New Category III codes were developed to report radiofrequency transcervical uterine fibroid ablation with ultrasound guidance and tactile breast imaging.

0404T - Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency
0422T - Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral

HCPCS LEVEL II CODES
Effective January 1, 2016, CMS has discontinued use of HCPCS code J7302 for 52 mg levonorgestrel-releasing IUDs. There are now two 52 mg dosage, levonorgestrel-releasing intrauterine contraceptive systems (IUS), approved for use in the U.S. These systems may be reported with one of the following HCPCS level II codes.

J7297 - (Levonorgestrel-releasing intrauterine contraceptive system, 52mg, 3 year duration [Liletta]) OR
J7298 - (Levonorgestrel-releasing intrauterine contraceptive system, 52mg, 5 year duration [Mirena])