Prevention of Fetal Alcohol Spectrum Disorder Coding Basics

The Centers for Disease Control and Prevention (CDC) urges pregnant women not to drink alcohol during pregnancy. Per the CDC, there is no known safe amount, time, or type of alcohol to drink while pregnant. Exposure to alcohol during pregnancy may result in a range of lifelong disorders known as fetal alcohol spectrum disorders including growth deficiencies, facial abnormalities, central nervous system impairments, behavioral disorders, and impaired intellectual development. The Fetal Alcohol Spectrum Disorders (FASD) Prevention Program is a Centers for Disease Control and Prevention (CDC) funded initiative of the American College of Obstetricians and Gynecologists (ACOG). The FASD Prevention Program aims to provide obstetrician-gynecologists with the resources and tools they need to communicate with their patients about alcohol use during pregnancy. FASD is preventable.

Diagnostic Coding

General

The International Statistical Classification of Diseases (ICD) diagnosis codes support the medical necessity for performing a service. The physician must clearly indicate the reason(s) for all the services rendered to ensure the selection of the most specific code.

Correct coding implies that the code selection is:

- The most accurate description of “what” was performed and “why” it was performed
- Supported by documentation in the medical record
- Consistent with coding conventions and guidelines

When selecting ICD-10-CM diagnostic code(s) for an encounter, the diagnostic code(s) must support the clinical need (medical necessity) for the service as described by the Current Procedural Terminology (CPT) code linked to the diagnosis.

Basic Guidelines for Diagnosis Coding

- Code to the highest degree of specificity.
- Code to the highest degree of certainty.
- Link the diagnosis code to the procedure code (CPT) on the claim.
- Sequence the diagnoses, reporting the primary diagnosis first, followed by the secondary, etc.
- Code only diagnoses relevant for the current encounter.

Diagnostic Codes to Appear on Maternal Record (ONLY)

Conditions that affect the management of pregnancy, childbirth, and the puerperium are classified to categories O00 through O9A in chapter 15 of ICD-10-CM. Chapter 15 codes take

precedence over codes from other chapters, but codes from other chapters may be used as additional codes when needed to provide more specificity or to provide more complete picture of the patient's condition. Codes from chapter 15 of ICD-10-CM refer to the mother only and are assigned only on mother's record. Chapter 15 codes are never assigned on the newborn's record.

Alcohol Use Screening

The ICD-10-CM diagnosis code that may be reported for alcohol screening is **Z13.89, Encounter for screening for other disorder.**
Another code that could be reported **is Z02.83, Encounter for blood-alcohol and blood-drug test (use additional code for findings of alcohol or drugs in blood (R78.-))**.

The "-" used in this document indicates that an additional character or characters are required for appropriate code selection.

Symptoms, Signs, and Ill-defined Conditions

Code Description	*Code*
Finding of alcohol in blood (use additional external cause code (Y90.-), for detail regarding alcohol level)	R78.0

Alcohol Use During Pregnancy

For any pregnancy case in which the mother uses alcohol during the pregnancy and postpartum, codes from subcategory **O99.31-, Alcohol use complicating pregnancy, childbirth and puerperium**, should be assigned. A secondary code from category **F10.-, Alcohol related disorders** (discussed below), should also be assigned to identify manifestations of the alcohol use.

Alcohol Use, Abuse and Dependence Codes

A code from code section F10.- would be reported for a diagnosis of alcohol use, abuse, or dependence. Mental, Behavioral and Neurodevelopmental Disorders (F01-F99) codes are found in Chapter 5 of ICD-10-CM. Possible ICD-10 codes linked to the counseling and office visit code as follows:

Code Description	*Code*
Alcohol use, unspecified	F10.9-
Alcohol abuse	F10.1-
Alcohol dependence	F10.2-

Per ICD-10-CM Guidelines, only one code should be assigned to identify the pattern of use based on the following hierarchy:

- If both use and abuse are documented, assign only the code for abuse
- If both abuse and dependence are documented, assign only the code for dependence
- If use, abuse and dependence are all documented, assign only the code for dependence
- If both use and dependence are documented, assign only the code for dependence

Personal History of Alcohol Abuse and Dependence

Code Description	*Code*
Personal history of other mental and behavioral disorders	Z86.59

Family History of Alcohol Abuse and Dependence

Code Description	*Code*
Family History of Alcohol Abuse and Dependence	Z81.1

Alcohol Abuse Counseling

Code Description	*Code*
Alcohol abuse counseling and surveillance of alcoholic (use additional code for alcohol abuse or dependence (F10.-)	Z71.41

The following ICD-10-CM changes will become effective 10-01-2017 (Maternal Record)

For Z36.-, Encounter for antenatal screening of mother:

Code Description	*Code*
Encounter for antenatal screening for chromosomal anomalies	Z36.0
Encounter for antenatal screening for malformations	Z36.3
Encounter for antenatal screening for fetal growth retardation	Z36.4
Encounter for antenatal screening for congenital cardiac abnormalities	Z36.83
Encounter for antenatal screening for other specified antenatal screening	Z36.89
Encounter for antenatal screening for other genetic defects	Z36.8A

Procedure Coding

Procedure codes such as Evaluation and Management (E/M) codes are a method of documenting what service or procedure was performed. The most appropriate E/M code to select will depend on whether the encounter was for screening or treatment of the condition.

If the encounter was for screening the patient, report a preventive medicine code. These codes are selected according to the time spent in face-to-face counseling with the patient. Whether or not these codes will be reimbursed by the payer will vary. Possible procedure codes are the following:

Code Description	*Code*
- Preventive medicine, individual counseling	99401-99404
- Preventive medicine, group counseling	99411-99412

Specific CPT codes have been developed for alcohol abuse counseling. These services are reported as follows:

Code Description	*Code*
- Alcohol and/or substance abuse, structured (e.g., AUDIT, DAST), and brief intervention (SBI) service; 15 to 30 minutes (Do not report services of less than 15 minutes with 99408)	99408
- Alcohol and/or substance abuse, structured (e.g., AUDIT, DAST), and brief intervention (SBI) service; Greater than 30 minutes (Do not report 99409 in conjunction with 99408. Use 99408 or 99409 only for initial screening and brief intervention)	99409

If the encounter was for treatment for a patient with a diagnosis of alcohol use, abuse or dependence, report an office or other outpatient E/M code. These codes list a “typical time” in the code descriptions. Codes with typical times listed may be reported based on time, rather than the key E/M components of history, examination, and medical decision- making. If the health care provider spends more than 50% of the visit counseling the patient, the E/M code may be selected based on time. Time spent providing face-to-face counseling with the patient must be documented in the medical record. The record should document total time and that either all the encounter or more than 50% of the total time was spent counseling the patient. The patient record must also provide details on the topics discussed. Possible procedure codes are the following:

Code Description	*Code*

- New patient, office, or other outpatient visit 99201-99205
- Established patient, office, or other outpatient visit 99211-99215

Medicare:
Alcohol Reductions and Misuse

All Medicare beneficiaries are eligible for alcohol screening. Medicare beneficiaries, who test positive (those who misuse alcohol but whose 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 practitioners in a primary care setting.

The initial screening may be reported using HCPCS code:

Code Description	*Code*
Annual alcohol misuse screening, 15 minutes	G0442

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

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

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

There is no time interval indication between counselling sessions in the guidelines.

Other Medicare Codes:

Code Description	*Code*
Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes	G0396
Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention greater than 30 minutes	G0397

Effective 01-01-2017, CMS uses laboratory CPT codes 80305-80307 for drug screening:

Code Description	*Code*

Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, (e.g., immunoassay); capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service	80305
Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, (e.g., immunoassay); read by instrument assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service	80306
Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA,ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography , (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service)	80307

Medicaid Codes

Code Description	*Code*
Alcohol and/or drug screening	H0049
Alcohol and/or drug service, brief intervention, per 15 min	H0050

Preventive Services

Preventive Medicine Services are a type of E/M service that does not require a chief complaint. There are two types of preventive services. Preventive Medicine Evaluation and Management services are reported as follows:

Code Description

Initial comprehensive preventive evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, **new patient**;

Code	*Age Group*
99384	adolescent (age 12-17 years)
99385	18-39 years
99386	40-64 years

Code Description

Initial comprehensive preventive evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, **established patient**;

Code	*Age Group*
99394	adolescent (age 12-17 years)
99395	18-39 years
99396	40-64 years

These codes are used to report annual well-woman examinations. The code is determined by the age of the patient and whether she is considered a new or established patient to the physician, practice, or both. Preventive Medicine Services codes include the following:

- A comprehensive history and examination
- Counseling/anticipatory guidance/risk factor reduction interventions
- Ordering of appropriate immunizations or laboratory/diagnostic procedures, and
- Treatment of insignificant abnormalities

Since counseling, anticipatory guidance, and risk factor reduction interventions are an included part of the typical preventive service visit, additional counseling codes, if reported, may not be reimbursed.

Medicare does not cover Preventive Services encounters as described by CPT codes 99384-99396.

As noted earlier, Preventive Services also include codes for **Counseling Risk Factor Reduction and Behavioral Change Intervention.** These services are reported with CPT codes 99401-99412. These counseling codes are used to report services for promoting health and preventing illness and injury. That is, the patient has no current symptoms or diagnosed illnesses.

This counseling must be provided at a separate encounter from the preventive medicine services encounter described by codes 99384-99396. The counseling codes are selected according to the time spent counseling the patient. For example: A patient comes in for pregnancy counseling, or to discuss diet and exercise. The physician spends 30 minutes with the patient and reports CPT code 99402 (preventive medicine counseling; approximately 30 minutes). If a separate and distinct problem-oriented E/M service is also provided, it may be reported separately. It is helpful to link a different/distinct diagnosis code to the problem service.

Counseling Risk Factor Reduction and Behavioral Change Intervention codes are not reported when the physician counsels an individual patient with symptoms or an established illness. In this case, a problem-oriented E/M service, from CPT code section, 99201-99215, is reported.

Behavioral change interventions are for persons who have a behavior that is often considered an illness itself, such as alcohol or substance abuse. Any E/M service reported on the same day must be distinct, and the time spent providing counseling services may not be used as a basis for the E/M code selection.

For counseling groups of patients for a specific issue/condition, see code 99078 (Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions).

Prenatal care could be billed using global package codes or separately.

GLOBAL PACKAGE CODES

CPT global obstetric package codes are:

59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

Third-party payers have different policies concerning how they want obstetric services reported. Some of these different policies are described below.

EACH SERVICE CODED SEPARATELY

Some payers require that each service be reported separately. Possible variations are:

- A separate claim is submitted for each service as it occurs;
- One claim is submitted each trimester that lists all the services provided during that trimester; OR
- One claim is submitted after delivery but each service is listed separately.

BY TRIMESTER

Some payers require that services be submitted separately for each trimester.

Any additional services reportable outside the global obstetric package are included on the claim for the trimester during which the services were provided.

AFTER DELIVERY

Some payers require that services be submitted only after the baby has been delivered. They may require a diagnosis from the Z37 series (outcome of delivery) on the claim.

USING HCPCS CODES

Many state Medicaid programs require that services be submitted using HCPCS Level II codes. These codes are usually submitted on a service-by-service basis. HIPAA requires all payers to use the same set of HCPCS codes. An example of these codes is H1000 (prenatal care, at-risk assessment).