Billing for Early and Long-term Follow-up Postpartum Visits (2019)

ACOG Postpartum Toolkit

Codes for Specific Services
The following is detailed information on coding for specific postpartum services.

- Counseling
- Chronic Diseases Involving the Cardiovascular and Renal Systems
- Immunization
- Intimate Partner Violence
- Long-Term Follow-up from Pregnancy Complications
- Newborn Care
- Postpartum Depression
- Returning to Work and Paid Leave
- Substance Use: Opioid Use, Alcohol Use, and Tobacco Use
- Support Teams for New Mothers
Counseling

The correct Evaluation and Management (E/M) code will depend on whether the encounter was for screening or treatment of the disease. If the encounter was for screening for a patient without symptoms, 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 will vary.

Possible procedure codes are:
• 99401–99404 Preventive medicine, individual counseling
• 99411–99412 Preventive medicine, group counseling

Counseling codes list “typical times” in their descriptions. The times noted in the Current Procedural Terminology (CPT®) descriptions are only averages and represent a range of times that may be higher or lower depending on actual clinical circumstances. In most cases, time is used only as a reference and does not influence code selection. Sometimes, a physician may perform a physical examination and obtain a history, but may spend either
• more than 50% of the total time with the patient providing counseling or
• the entire visit providing counseling for a patient and/or their families.

In these cases, the level of service may be determined using time alone. The Current Procedural Terminology states: “When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time may be considered the key or controlling factor to qualify for a particular level of E/M service. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (e.g., foster parents…). The extent of counseling and/or coordination of care must be documented in the medical record.”

Definition of Counseling
Counseling as used in the aforementioned definition is a discussion with a patient, or her family, or both, about the following
• Diagnostic results, impressions, or recommended studies, or a combination of these
• Prognosis
• Risks and benefits of management (treatment) options
• Instructions for management (treatment) or follow-up
• Importance of compliance with chosen management (treatment) options
• Risk factor reduction
• Patient and family education

Documenting Time
When time is the determining factor for the selection of the level of service, documentation should include the following:
• The total length of time spent by the physician with the patient
• The time spent in counseling or coordination of care activities
• A description of the content of the counseling or coordination of care activities

Measuring Time
The average times listed for the E/M services represent the “intraservice” time associated with providing the service. Only the time spent providing the time-based code can be used in the selection of the code. Time spent in other concurrent activities, such as procedures, should not be considered in the selection of the time-based code. Time for E/M services is measured as follows:

• **Face-to-Face Time (office and other outpatient E/M codes and office consultations):**
  Physician time spent face-to-face with the patient, or family, or both. This includes the time in which the physician obtains a history, performs a physical examination, and counsels the patient.

• **Unit or floor Time (hospital observation, inpatient hospital care, inpatient consultations):**
  Physician time spent with the patient and on the patient’s unit. This includes the time during which the physician establishes or reviews the patient’s chart, or both; examines the patient; writes notes; and communicates with other professionals and the patient’s family. A unit of time is met when the midpoint is passed (e.g., an hour is attained when 31 minutes has passed). Time that falls between two times for codes ranked in sequential typical times, such as some E/M service codes, is reported using the code with the closest actual time. Note that Medicare carriers may require that the time be equal to or greater than the typical time for the reported E/M code.
  Time for services measured in units other than days are considered continuous times even if the service extends into another calendar date. An example is critical care services that begin before midnight and extend into the next calendar date. The date of service on which the service began should be reported as the date of service.
Chronic Diseases Involving the Cardiovascular and Renal Systems

Cardiovascular System
Valvular heart disease
Atherosclerosis and ischemic heart disease
Cardiomyopathy
Atrial fibrillation
In the case of preexisting heart disease complicating puerperium, code 099.43, Diseases of the circulatory system complicating the puerperium should be used. An additional code is used to identify the specific disease of the circulatory system. Codes from the following categories should be applied:
- Q24.8 Other specified congenital malformations of heart
- I38 Endocarditis, valve unspecified
- I70 Atherosclerosis
- I20–I25 Ischemic heart diseases (use additional code to identify presence of hypertension [I10–I16])
- I48 Atrial fibrillation
- I42 Cardiomyopathy

Renal System
Nephrotic or nephritic syndrome
Renal insufficiency
Renal transport
Preexisting hypertensive chronic kidney disease
Preexisting hypertensive heart and chronic kidney disease
For chronic kidney disease with preexisting hypertension complicating the puerperium, codes from category O10, Pre-existing hypertension complicating pregnancy, childbirth and the puerperium, should be applied, as follows:
- O10.23 Pre-existing hypertensive chronic kidney disease complicating the puerperium
- O10.33 Pre-existing hypertensive heart and chronic kidney disease complicating the puerperium
When assigning one of the O10 codes that include hypertensive heart disease or hypertensive chronic kidney disease, a secondary code from the appropriate hypertension category must be added to specify the type of hypertensive chronic kidney disease (category I12) or hypertensive heart and chronic kidney disease (category I13).
In the case of preexisting renal system disease complicating pregnancy and puerperium, codes from subcategory O99.88, Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium, should be used. An additional code from categories N00–N99 is used to identify the specific condition. Possible codes to use are the following:
- N00–N05 Nephritic syndrome/nephrotic syndrome
- N18 Chronic kidney disease
- N10–N16 Renal tubule-interstitial diseases
Immunization

According to the Current Procedural Terminology (CPT), report vaccine immunization administration codes 90460, 90461, and 90471–90474 in addition to the vaccine and toxoid code(s) 90476–90749.

Administration

- 90460 Immunization administration through 18 years of age by any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
- 90461 Immunization administration through 18 years of age by any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)
- 90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine or toxoid)
- 90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine or toxoid) (List separately in addition to code for primary procedure)
- 90473 Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine or toxoid)
- 90474 Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine or toxoid) (List separately in addition to code for primary procedure)

Vaccine Codes

Human Papillomavirus

- 90649 Human papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3-dose schedule, for intramuscular use
- 90650 Human papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3-dose schedule, for intramuscular use
- 90651 Human papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2- or 3-dose schedule, for intramuscular use

Influenza

For the influenza virus vaccine, the following CPT codes are reported: 90630, 90653–90658 HCPCS codes Q2034–Q2039 are used to report influenza virus vaccine:

- 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 (FLULAVEL)
- 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)

For Medicare beneficiaries, the seasonal influenza vaccine is usually administered once a year during the fall or winter months. Additional influenza vaccines (ie, the number of doses of a vaccine 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

Tdap Vaccination
• 90715 Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine, when administered to individuals 7 years or older, for intramuscular use

MMR
• 90707 Measles–mumps–rubella (MMR) virus vaccine, live, for subcutaneous use

Varicella
• 90716 Varicella (VAR) virus vaccine, live, for subcutaneous use

There is also combination MMR and varicella vaccine code:
• 90710 Measles–mumps–rubella–varicella (MMRV) vaccine, live, for subcutaneous use

Diagnosis Codes
*International Classification of Diseases, 10th Edition, Clinical Modification, diagnosis code Z23 (Encounter for immunization) is appropriate when reporting these services.*
Intimate Partner Violence

Counseling

Current Procedural Terminology Codes

According to the Current Procedural Terminology (CPT), codes 99384–99397 include age-appropriate counseling, anticipatory guidance, and risk factor reduction interventions provided at the time of the initial or periodic comprehensive preventive medicine examinations.

If the encounter was for screening for a patient without symptoms, report a preventive medicine code. These codes are selected according to the time spent in face-to-face counseling with the patient. Use codes 99401, 99402, 99403, 99404 for individual counseling, and codes 99411 and 99412 for group counseling as appropriate:

- 99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
- 99402 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
- 99403 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
- 99404 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
- 99411 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
- 99412 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

Diagnosis Codes

- O9A.4 Sexual abuse complicating pregnancy, childbirth, and the puerperium
  - O9A.41 Sexual abuse complicating pregnancy
  - O9A.411 Sexual abuse complicating pregnancy, first trimester
  - O9A.412 Sexual abuse complicating pregnancy, second trimester
  - O9A.413 Sexual abuse complicating pregnancy, third trimester
  - O9A.42 Sexual abuse complicating childbirth
  - O9A.43 Sexual abuse complicating the puerperium

There is no specific ICD-10 or CPT code for domestic, sexual, and interpersonal violence screening, but code Z13.89, Encounter for screening for other disorder, could possibly be reported. In addition to abuse diagnosis codes, codes from category Y07, Perpetrator of assault, maltreatment and neglect, may be reported. Codes from this category may be used only in cases of confirmed abuse (T74.-) (T74–T74.92XS).

Medicare does not reimburse for consultation codes. Physicians 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.
Long-Term Follow-up from Pregnancy Complications

Diabetes Coding
Because diabetes is a complicating condition in pregnancy, a pregnant woman with diabetes may be seen for additional services. It is important that the International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) code reflects the appropriate condition in order to support these additional services. Pregnant women who are diabetic should be assigned a code from category O24 (Diabetes mellitus in pregnancy, childbirth, and the puerperium). Subcategories O24.0-, O24.1-, O24.3-, and O24.8- are reported when a pregnant woman has preexisting diabetes. These subcategories distinguish between type 1, type 2, other specified, and unspecified diabetes. Each subcategory contains codes to describe services in childbirth and the puerperium as well as the antenatal period. Services provided in the antenatal period require identification of the trimester. The ICD-10-CM also instructs that a code from category E08–E13 be reported to further identify any manifestations.

Gestational Diabetes
Gestational diabetes occurs in women who develop diabetes in pregnancy but who were not diabetic before pregnancy. Gestational diabetes codes are found in subcategory O24.4-. When a code indicating gestational diabetes is reported, another diabetes code should not be reported. The 5th character in the O24.4 (gestational diabetes) subcategory specifies whether the encounter occurs
- in pregnancy
- in childbirth
- in the puerperium
The 6th character indicates the method of diabetes control. There are diagnosis codes for diet, oral hypoglycemic, and insulin control. If a patient is controlled by diet and insulin, only the code for insulin-controlled is required. There are no trimester designations in the subcategory for gestational diabetes because the condition occurs only in the second and third trimesters.
Abnormal glucose tolerance in pregnancy is assigned a code from the subcategory O99.81 (Abnormal glucose complicating pregnancy, childbirth, and the puerperium). Subcategory O24.9 (Unspecified diabetes) is reported when the medical record does not indicate the type of diabetes.

A code from the Z3A category should be reported whenever a code from Chapter 15 is reported to identify the week of gestation.
To accurately assign ICD-10-CM codes for diabetes complicating pregnancy, the following information is needed:
Hypertension Coding
Categories O10–O11 contain codes for preexisting hypertension and require identification of the trimester. Category O10 also contains codes for hypertensive heart and chronic kidney disease. Most of these codes contain six characters. When assigning a code related to these conditions, it is necessary to add a secondary code to specify the type of heart failure or chronic kidney disease. Category O11 is for preexisting hypertension with preeclampsia and requires an additional code from category O10 to identify the type of hypertension.

In addition to essential hypertension, Category O10 includes the following subcategories:
- O10.1 Pre-existing hypertensive heart disease complicating pregnancy
- O10.2 Pre-existing hypertensive chronic kidney disease complicating pregnancy
- O10.3 Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy
- O10.4 Pre-existing secondary hypertension complicating pregnancy
- O10.9 Unspecified pre-existing hypertension complicating pregnancy, childbirth, and the puerperium

Each subcategory indicates the condition in Chapter 9, Diseases of the Circulatory System, that applies to the specific subcategory. The instructions also state that an additional code from the circulatory chapter should be reported to identify the type of hypertension. It is important to be familiar with the codes that require an additional diagnosis in order to fully describe the patient’s condition and circumstances.

Additionally, hypertension has distinct categories, subcategories, and codes to describe preexisting and pregnancy-related conditions.

Gestational Hypertension
Category O12 contains codes for gestational edema, gestational proteinuria, and gestational edema with proteinuria without hypertension. Codes from category O12 (Gestational [pregnancyinduced] edema and proteinuria without hypertension) are reported when patients develop edema and protein in their urine but do not develop hypertension. There are subcategories for edema alone, proteinuria alone, and both conditions together. Documentation for these conditions might be found in the examination or laboratory work, but it is advisable not to report these codes unless the physician clearly documents one of these conditions.

Category O13 is reported for hypertension without significant proteinuria and also can be used for hypertension not otherwise specified.

Preeclampsia
Category O14 is reported for preeclampsia without any preexisting hypertension and has subcategories to describe the severity of the condition, including hemolysis, elevated liver enzymes, and low platelet count (HELLP) syndrome. Category O15 is reported for eclampsia.

Counseling
Per CPT, codes 99384–99397 include age-appropriate counseling, anticipatory guidance, and risk factor reduction interventions provided at the time of the initial or periodic comprehensive preventive medicine examinations.
If the encounter was for screening for a patient without symptoms, report a preventive medicine code. These codes are selected according to the time spent in face-to-face counseling with the patient. Use codes 99401, 99402, 99403, 99404 for individual counseling, and codes 99411 and 99412 for group counseling as appropriate:
• 99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
• 99402 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
• 99403 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
• 99404 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
• 99411 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes

Coding for Long-term Follow-up From Pregnancy Complications 3
• 99412 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes
These 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 is reported. For counseling groups of patients with symptoms or established illness, see code 99078.
Newborn Care

Counseling
Services bundled as a part of the routine obstetrics care visits should not be billed separately. Those services include education on breastfeeding and lactation. Postpartum care includes inpatient and outpatient services. The typical inpatient stay is 2 days for a vaginal delivery and 3 days after a cesarean delivery. Outpatient services include one visit for a vaginal delivery and two visits for a cesarean delivery.

Current Procedural Terminology (CPT) includes the following services in the postpartum package:

- Routine outpatient visit(s) after delivery
- Routine inpatient visit(s) after delivery

Note that routine inpatient visit(s) immediately after delivery are considered part of the delivery and not reported separately.

The CPT global package does not include inpatient or outpatient Evaluation and Management (E/M) services or procedures performed to treat complications, illness, or disease unrelated to routine postpartum care.

Consultations on breastfeeding, lactation, and basic newborn care are considered a part of the global package and not billed separately. Only codes for complications, illness, or disease could be excluded from the routine postpartum care and billed separately.

Examples of complications that might require services in addition to the global obstetric code are:

- Infection of nipple associated with the puerperium (O91.02)
- Infection of nipple associated with lactation (O91.03)
- Abscess of breast associated with the puerperium (O91.12)
- Abscess of breast associated with lactation (O91.13)
- Nonpurulent mastitis associated with the puerperium (O91.22)
- Nonpurulent mastitis associated with lactation (O91.23)
- Retracted nipple associated with the puerperium (O92.02)
- Retracted nipple associated with lactation (O92.03)
- Cracked nipple associated with the puerperium (O92.12)
- Cracked nipple associated with lactation (O92.13)
- Unspecified disorder of breast associated with pregnancy and the puerperium (O92.20)
- Other disorders of breast associated with pregnancy and puerperium (O92.29)
- Agalactia (O92.3)
- Hypogalactia (O92.4)
- Suppressed lactation (O92.5)
- Galactorrhea (O92.6)
- Unspecified disorders of lactation (O92.70)
- Other disorders of lactation (O92.79)

For some high-risk pregnancies, a neonatal consultation during the antepartum period may be helpful in obstetric management and can assist the parents in understanding what to expect for their newborn. This is of particular importance when fetal anomalies are significant or the delivery of a very preterm infant is expected.
Current Procedural Terminology Codes
According to the CPT, codes 99384–99397 include age-appropriate counseling, anticipatory guidance, or risk factor reduction interventions provided at the time of the initial or periodic comprehensive preventive medicine examinations. For counseling provided at a separate time from the preventive medicine examination encounter, codes 99401, 99402, 99403, 99404, 99411, and 99412 could be used:
• 99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
• 99402 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
• 99403 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
• 99404 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
• 99411 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
• 99412 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

Diagnosis Codes
• Z32.3 Encounter for child care instruction
Postpartum Depression

Prevalence
• According to the Centers for Disease Control and Prevention, 11–20% of women in the postpartum period have some form of depression

Major Risk Factors
• Depression during pregnancy
• Anxiety during pregnancy
• Experiencing stressful life events during pregnancy or the early postpartum period
• Preterm birth or infant admission to neonatal intensive care
• Low levels of social support
• Previous history of depression
• Breastfeeding problems

Presenting Symptoms and Signs
• Feeling sad, hopeless, empty, or overwhelmed
• Crying more often than usual for no apparent reason
• Worrying or feeling overly anxious
• Feeling moody, irritable, or restless
• Oversleeping or being unable to sleep even when the infant is asleep
• Having trouble concentrating, remembering details, and making decisions
• Experiencing anger or rage
• Losing interest in activities that are usually enjoyable
• Suffering from physical aches and pains, including frequent headaches, stomach problems, and muscle pains
• Eating too little or too much
• Withdrawing from or avoiding friends and family
• Having trouble bonding or forming an emotional attachment with her infant
• Persistently doubting her ability to care for her infant
• Thinking about harming herself or her infant

Screening and Diagnosis
The following are validated screening instruments:
• Edinburgh Postnatal Depression Scale
• Postpartum Depression Screening Scale
• Patient Health Questionnaire 9
• Beck Depression Inventory
• Beck Depression Inventory II
• Center for Epidemiologic Studies Depression Scale
• Zung Self-Rating Depression Scale
• Tests to evaluate for anemia and thyroid dysfunction

Treatment
• Peer counseling
• Cognitive behavioral therapy
• Antidepressants

Anticipatory Guidance and Follow-up
• Expected response to treatment—improvement in screening scale on repetitive testing
• “You are not alone. You are not to blame. With help, you will get better.”
• Referral to behavioral health care provider for suicidal ideation, severe symptoms, bipolar disorder
• Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated; clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both.

Resources
American College of Obstetricians and Gynecologists Clinical Guidance

Patient Resources
❖ Postpartum Support International. http://www.postpartum.net Information for families and professionals and a directory of peer and professional support providers.

Resources on Depression and Postpartum Depression

Coding
A list of ICD-10 codes for perinatal depression.
Returning to Work and Paid Leave

Current Procedural Terminology Codes
Counseling regarding paid leave or returning to work could be billed with preventive services codes. Per Current Procedural Terminology (CPT), Evaluation and Management (E/M) preventive services codes 99384–99397 include age appropriate counseling, anticipatory guidance, and risk factor reduction interventions provided at the time of the initial or periodic comprehensive preventive medicine examinations. Preventive medicine services are reported for comprehensive E/M services provided to patients without current symptoms or diagnosed illness. Preventive codes are used to report annual well woman examinations and include the following:

- Counseling, anticipatory guidance, and 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 gynecologic examination, breast examination, and collection of a Pap test specimen
- Discussions about the status of previously diagnosed stable conditions
- Ordering of appropriate laboratory or diagnostic procedures and immunizations
- Discussions about tissues related to the patient’s age or lifestyle

For counseling provided at an encounter separate from the preventive medicine examination encounter, codes 99401, 99402, 99403, 99404, 99411, and 99412 could be used:

- 99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
- 99402 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
- 99403 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
- 99404 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
- 99411 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
- 99412 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

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Diagnosis Codes
Categories Z00–Z02 include codes for routine examinations (general check-up) or administrative examinations (e.g., preemployment physical). These codes are not used if the visit is for the diagnosis of a suspected condition or for treatment of a problem.

If a condition is found during a routine visit, then it is coded as an additional diagnosis. Any preexisting and chronic conditions and history codes may also be reported as long as the encounter
is not for treatment or management of those problems. The *International Classification of Diseases, 10th Edition*, Clinical Modification (ICD-10-CM) states that the counseling codes are used when a patient or her family member receives assistance in the aftermath of an illness or when support is required in coping with family or social problems. *Counseling codes are not used in conjunction with a diagnosis code when counseling is considered integral to standard treatment.* Possible ICD-10-CM codes to use are the following:

- Z02.1 Encounter for preemployment examination
- Z00.0 Encounter for general adult medical examination
- Z39.2 Encounter for routine postpartum follow-up
- Z71.89 Other specified counseling

**Online Communications and Consultations**

Discussions to return to work activities can be provided online in the form of email and *only to established patients*. This type of service can be billed only when personally made by the following:

- Attending health care provider
- Consultant
- Psychologist
- Physical or occupational therapist

**Current Procedural Terminology Codes**

If services were provided by the physician, then E/M code 99444 from the Non-Face-to-Face Services section should be applied:

- 99444 Online evaluation and management service provided by a physician or other qualified health care professional who may report E/M services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic network

For services provided by nonphysician, apply CPT code 98969 from Medicine/Non-Face-to-Face Services section:

- 98969 Online assessment and management service provided by a qualified nonphysician health care professional to an established patient or guardian, not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network

**Coding for Returning to Work and Paid Leave 2**

Documentation for electronic communications must include the date, the participants and their titles, the nature of the communication, and all decisions made.

**Billing for Telephone Services**

According to the CPT, telephone services are non-face-to-face E/M services provided to a patient using the telephone by a physician or other qualified health care professional, who may report E/M services.

- 99441 Telephone evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion
- 99442 11–20 minutes of medical discussion
- 99443 21–30 minutes of medical discussion

For services provided by nonphysicians, apply CPT codes 98966–98968 from the Medicine/Non-
Face-to-Face Services section:
• 98966 Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian, not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion
• 98967 11–20 minutes of medical discussion
• 98968 21–30 minutes of medical discussion

Back-to-Work Physical
For job-related physical examinations, preventive service codes should be used from the series (99381–99387 or 99391–99397). These codes should be used with a well-visit diagnosis code (Z00.00, Encounter for general adult medical examination without abnormal findings).
Substance Use: Opioid Use, Alcohol Use, Tobacco Use

Tobacco Use

Prevention of Fetal Alcohol Spectrum Disorder Basics:


Tobacco Use and Smoking Cessation:

Opioid Use

For any case of pregnancy in which a woman uses opioids during the pregnancy or postpartum period, codes from subcategory O99.32, *Drug use complicating pregnancy, childbirth, and the puerperium*, should be assigned. A secondary code from category F11, *Opioid-related disorders*, should also be assigned to identify manifestation of the opioid use.

Possible ICD-10-CM codes:

- O99.320 Drug use complicating pregnancy, unspecified trimester
- O99.321 Drug use complicating pregnancy, first trimester
- O99.322 Drug use complicating pregnancy, second trimester
- O99.323 Drug use complicating pregnancy, third trimester
- O99.324 Drug use complicating childbirth
- O99.325 Drug use complicating puerperium
- F11.10 Opioid abuse, uncomplicated
- F11.11 Opioid abuse, in remission
- F11.12- Opioid abuse with intoxication
- F11.14 Opioid abuse with opioid-induced mood disorder
- F11.15- Opioid abuse with opioid-induced psychotic disorder
- F11.18- Opioid abuse with other opioid-induced disorder
- F11.19 Opioid abuse with unspecified opioid-induced disorder
- F11.2- Opioid dependence
- F11.9- Opioid use, unspecified
Counseling

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 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 tobacco cessation counseling. These services are reported as follows:

**Code Description Code**

- Preventive medicine, Smoking/tobacco use cessation counseling visit; 99406 intermediate, greater than 3 minutes up to 10 minutes
- Preventive medicine, Smoking/tobacco use cessation counseling visit; 99407 intensive, greater than 10 minutes

For counseling groups of patients with symptoms or established illness, use CPT code 99078.

If the encounter was for other treatment for a patient with a diagnosis of tobacco use or nicotine 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 of the encounter or more than 50% of total time was spent counseling the patient. The patient record also must provide details on the topics discussed.
Support Teams for New Mothers

Counseling


According to the CPT, codes 99384–99397 include age appropriate counseling, anticipatory guidance, and risk factor reduction interventions provided at the time of the initial or periodic comprehensive preventive medicine examinations.

For counseling provided at an encounter separate from the preventive medicine examination encounter, codes 99401, 99402, 99403, 99404, 99411, and 99412 could be used. Codes 99411 and 99412 are used for counseling provided in group sessions:

- 99411 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
- 99412 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

Diagnosis Codes

- Z32.3 Encounter for child care instruction

It may be possible to bill for the counseling and education sessions for these patients, but you should contact your specific payers for guidance.

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