Practice Matters

by REBECCA DUNSMOOR- SU, MD MSCE FACOG
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After many years in a traditional university based academic practice I transitioned to a full time obstetric hospitalist practice in 2012. I am employed by Obstetrix Medical Group as part of a larger organization that includes perinatologists, obstetric hospitalists, and advanced registered nurse practitioners. Our hospital, Swedish Medical Center (SMC), First Hill Campus, in Seattle, WA does over 7000 deliveries a year. A large proportion of these patients are cared for by community based family practitioners.

Seattle is a large urban center with extensive tertiary medical services. It serves as a referral center for a large 5 state region (including Washington, Alaska, Wyoming, Idaho and Montana). In these outlying rural areas, a high proportion of the obstetric care is provided by family medicine physicians. Seattle also has a very active Certified Nurse Midwife community who provide obstetric care in free standing birthing centers and attend home births.

SMC is a community teaching hospital with medical students, family practice residents, a rotating ob-gyn resident, and family practice fellows. Interestingly, SMC offers a one year family medicine fellowship program to interested family medicine physicians in cesarean delivery and more intensive obstetrics.

Prior to the establishment of our obstetric hospitalist model, the family practice physicians at SMC were backed up by a perinatologist and private ob-gyns. Teaching and care for all unassigned patients and home birth transfers were the responsibility of the perinatologists. As SMC’s delivery volume grew, this work load was not sustainable. SMC responded by developing
the current obstetric hospitalist model. There are now four other hospitals in the SMC system utilizing the obstetric hospitalist services provided through Obstetrix. While my hospital provides 24/7 in-hospital coverage, coverage schemes vary based on hospital volume. In total, there are 18 full and part time obstetric hospitalist on this large team. Each individual obstetric hospitalist has a primary practice location, but all are cross-credentialed to practice in all four locations and cover scheduling gaps.

My specific practice is a group of four full time obstetric hospitalists who provide coverage in 24 hour shifts. Our schedule allows each of us to pursue professional interests and personal commitments outside of work. We participate in activities such as quality assurance, research, administration, and teaching. We work between 6 and 9 shifts per month, and receive hourly compensation and a yearly bonus as part of the larger group of physicians.

Our primary responsibility as obstetric hospitalists is to Labor and Delivery, where we function as a safety net for all of the varied practitioners and practice types. We are present as backup for all delivering physicians, but are primarily focused on support of the family medicine groups. We provide consultations, perform cesarean deliveries, and assume care for patients whose clinical situations have evolved beyond the scope of a family medicine practitioner. We also care for all unassigned patients, accept planned out of hospital birth transfers, and provide first assistant surgical services to any provider who requests them. We work collaboratively with physicians and nurses to ensure protocols are understood and followed; and that high standards of patient safety and quality of care are maintained.

Each day, the obstetric hospitalist on deck perform rounds with a team that includes the perinatologist, third year ob-gyn resident, family practice fellow, and two family practice residents. We are
A 38 yo G1P0 presented to the emergency department with complaints of vaginal spotting. She strongly desired pregnancy. She was certain of her last menstrual period dating, placing her pregnancy at 4 weeks 5 days gestation. Her initial hCG was 2,406 mIU/mL. Her ultrasound showed no evidence of intrauterine or extrauterine pregnancy. She was stable, had no pain, and was advised to return in 48 hours for repeat evaluation. On her subsequent visit to the ED, her hCG rose to 3669 mIU/mL. Her repeat ultrasound revealed a gestational sac and yolk sac within the cervix. There was a questionable fetal pole, but no cardiac activity. At this time, the obstetric hospitalist was consulted.

She had no significant past medical or surgical history. Her gynecological history was significant for a remote history of abnormal pap smear and newly diagnosed uterine myomas.

The patient was counseled extensively on cervical ectopic pregnancy and treatment options. The decision was made to proceed with the two-dose methotrexate regimen as outlined in the ACOG Practice Bulletin Number 94. She received her first dose of methotrexate at this visit. She returned on day 4 and her hCG had increased to 5574 mIU/mL. As per the two-dose regimen protocol, she was given a second dose of methotrexate. On day 7, her hCG decreased by only 14% (target was 15% decline) and, following protocol, she received a third dose of methotrexate. Again, on day 11, her hCG decreased by 14%. The decision was made to delay a fourth dose of methotrexate and repeat hCG on day 15. At this time, her hCG dropped to 2034 mIU/mL, reflecting a 51% decrease. The patient continued to have weekly monitoring of her hCG level. After seven weeks, her hCG normalized to a pre-pregnancy range of <2.4 mIU/mL. The patient tolerated the methotrexate regimen well and had no immediate complications.
Initially, this scenario posed the dilemma of pregnancy of unknown location. This predicament occurs in 8 to 31% of patients with early pregnancy who undergo ultrasound [1]. It can be a perplexing and complicated situation for both patient and physician. The possibility of viable IUP, failing IUP, or ectopic pregnancy exists. As stated, the pregnancy in this case was highly desired. Her initial hCG of 2,406 mIU/mL was above the commonly employed "discriminatory zone" of 1500-2000 mIU/mL. However, many variables, including multiple gestation and adequacy of ultrasound, make the use of the "discriminatory zone" an imperfect tool for definitive diagnosis of ectopic pregnancy. The International Society of Ultrasound in Obstetrics and Gynecology consensus statement for Pregnancies of Unknown Location supports a vigilant, multi-visit approach and discourages the practice of making treatment decisions based on a single hCG level and patient encounter in clinically stable patients [1]. On this patient’s follow up visit, 65 hours after initial presentation, her hCG failed to increase by 53% in 48 hours; indicating she did not have a normally developing intrauterine pregnancy.

Fifteen to twenty-six percent of women with ectopic pregnancy will have no evidence of extrauterine pregnancy on initial ultrasound [2]. It was not until she had a second ultrasound, that this patient’s cervical ectopic pregnancy became apparent. Cervical pregnancies are rare, representing 1 in 1,000 to 1 in 18,000 pregnancies, and account for less than 1% of all ectopic pregnancies [3]. Implantation occurs in the endocervical canal. Patients typically present with painless vaginal bleeding. On examination, the cervix may feel soft and ballooned. However, bimanual examination in patients with cervical pregnancy can lead to vaginal hemorrhage and should be deferred if possible.
Ultrasound is key in the diagnosis of cervical ectopic pregnancy and is accurate in 87.5% of cases. Sonographic criteria for the diagnosis of a cervical ectopic pregnancy include, gestational sac or placenta in the cervix, a normal appearing endometrial stripe and an enlarged endocervical canal [4]. As there is significant potential for hemorrhage leading to hysterectomy with surgical treatment of cervical pregnancy, medical treatment is preferable in hemodynamically stable patients. Because cervical ectopic pregnancy is uncommon, guidelines for treatments have not been firmly established. Differing approaches, including systemic methotrexate, injection of intra-gestational sac methotrexate alone, or in conjunction with potassium chloride (KCl) have all been used as therapy and provided resolution of cervical ectopic pregnancy in 80-90% of cases [4]. In this instance, the absence of fetal cardiac activity and the lack of readily available personnel experienced in intra gestational sac methotrexate or KCl injection favored the choice of systemic medical therapy.

In the hemodynamically unstable patient, surgical evacuation will likely be necessary. In that case, the surgeon should expect and be prepared to handle a potential hemorrhage. A variety of methods have been employed to decrease bleeding, including uterine artery embolization, ligation of the cervical branches of the uterine arteries, and cervical tamponade after evacuation [4].

Systemic methotrexate therapy is implemented in the medical treatment of ectopic pregnancies. The two-dose regimen has been shown to have an 87% success rate in resolution of ectopic pregnancies with minimal side effects [5]. It involves administering methotrexate 50mg/m^2 IM on day 0, and again on day 4. If hCG levels decline by at least 15% between days 4 to 7, weekly surveillance is begun. As this patient's hCG failed to achieve the 15% decline threshold, a third dose was given on day 7.

While the ACOG Practice Bulletin was used as a guide in management, the protocol was not strictly followed. If the patient fails to shows a 15% drop in hCG between days 4 and 7, ACOG calls for repeat methotrexate dosing on both days 7 and 11. In this case the methotrexate was repeated only on day 7 and not on day 11. The fourth dose of methotrexate was held at the request of the patient, who was concerned that mounting doses increased her risk of experiencing potential side effects. Surgical management should also be considered in cases where hCG fails to decrease appropriately. This was considered in this case, however, given the risk of hemorrhage in this
nulliparous patient, it was decided that all attempts would be made for medical management. Fortunately, she responded appropriately and medical management was ultimately successful.

References:


2 Mehta, TS. Ultrasonography in Pregnancy of Unknown Location. In: UpToDate, Falk SJ MD (Ed), UpToDate, Waltham, MA. (Accessed on January 30, 2016).

3 De La Vega, GA MD; Avery, C MD; Nemiroff, R MD; Marchiano, D MD. Treatment of Early Cervical Pregnancy With Cerclage, Carboprost, Curettage, and Balloon Tamponade. Obstetrics and Gynecology 2007; 109: 505-507.


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Submit your cases to newsletter@societyofobgynhospitalists.org for consideration.
kept abreast of the complicated antepartum patients, and occasionally assist on complex surgical cases, or provide other back up to the perinatologist. Finally, we provide phone consultation to our emergency department for all unassigned patients. We do not perform formal evaluations in the emergency department or do floor consults. Our work as obstetric hospitalist has improved safety and satisfaction and freed our perinatologists to focus on education and high risk obstetric care.

For a recovering academic like myself, this obstetric hospitalist model offers a blend of clinical service, teaching, and collaboration that keeps me engaged and active in my specialty. It also allows me, as a mother of two teens and wife of a physician, the flexibility to be a full time physician and still be involved in family life. I find that the stress of practicing medicine no longer creeps home with me at the end of a shift and, as an obstetric hospitalist, I am welcome and respected at work.
A 31yo G1P0 at 40+1 wks presents for scheduled induction of labor. The indication for induction is gestational diabetes, controlled with glyburide. In addition to GDM, this pregnancy is also complicated by diastasis recti which occurred 3 weeks ago. Dr. Zeback is the patient’s primary OB/GYN but you, the OB hospitalist, are covering for Dr. Zeback per prior arrangement. You perform a full history and physical, review the prenatal records, evaluate the fetal heart tracing, and complete an NST report.

Fetal heart tones are category 1 (reactive) and mild contractions are noted every 6 minutes. Her cervix is dilated at 1 cm. Cervical ripening using misoprostol is started per protocol. If not delivered, you plan to turn care back over to Dr. Zeback at shift change in the morning.

How would your OB Hospitalist services be coded?

**ANSWER:**

The “Code This!” column from the August eNewsletter discusses coverage arrangements OB Hospitalists may have with the private OB/GYN’s. These coverage agreements enable the primary OB to bill the global fee and separately reimburse the OB Hospitalist group for their specific services (example e.g., $250-400 to cover labor and $250-400 to cover delivery. Dollar amounts vary depending on contractual agreements).

If an agreement is in place, billing for the OB hospitalist’s services is done according to the terms of the agreement. If no agreement exists, billing for the OB hospitalist’s services goes to the patient’s insurance as follows:

**Diagnosis Codes (ICD-10):**

- 024.419 Gestational diabetes mellitus in pregnancy, unspecified control
- 099.89 Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium
- 048.0 Post Term Pregnancy (40-42 weeks)
- M62.08 Separation of muscle (nontraumatic), other site
- Z3A.40 40 weeks gestation of pregnancy

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<td>99223-25</td>
<td>Admission H&amp;P</td>
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<td>59025-26</td>
<td>Fetal NST</td>
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Under ICD-10, any pregnancy complication diagnosis code must be accompanied by a code in the Z3A family to specify gestational age. Furthermore, complications, such as diastasis recti, don’t have a specific “Condition X in Pregnancy” diagnosis code. Those problems are
coded using the O99.89 (other specified conditions complicating pregnancy) code AND the diagnosis code used for the condition (irrelevant of pregnancy).

In the specific case of gestational diabetes, it is important to know whether the patient is controlled by diet, insulin, or other means. At this time, there is no specific diagnosis code for gestational diabetes controlled using glyburide so the recommendation from the ACOG Committee on Health Economics and Coding is to use the “Unspecified Control” diagnosis code until further notice.

Once the diagnosis codes have been chosen, the appropriate level E&M should be chosen for the history and physical and the CPT code for reading the NST should also be added. If the patient is subsequently delivered by the OB Hospitalist, then CPT code for vaginal delivery only (59409) or Cesarean delivery only (59514) should be added. Some insurance carriers may deny payment for a history and physical when the delivery happens that day or the next day, considering that an H&P is included with the payment for delivery. However, in this scenario, the patient has several diagnosis complicating the pregnancy. Global CPT codes specify that they cover “routine” obstetric care and “uncomplicated” labor. It would be worth considering having the biller submit an appeal for payment of the 99223 if denied.

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