Dear Colleagues,

I hope this finds you well and off to a great start in the New Year. As for SOGH, we are positioning the organization for an exciting and successful 2018.

We recently transitioned to a new management team and I invite you to join me in welcoming Sue O’Sullivan, SOGH Managing Director, and Donna Kelly, Co-Director and Head of Industry Relations. Together Sue and Donna have over 30 years of experience in non-profit medical association management and will oversee the society’s administrative and programmatic operations with their support staff. I am confident that SOGH will thrive under this new partnership and am looking forward to a long and productive relationship.

I am also excited to share an update regarding the Core Competencies initiative. As many of you know, SOGH has committed to developing core competencies to characterize and define the role of hospitalists in Obstetrics and Gynecology. We are tracking on schedule in this three year project with the recent completion of phase one - defining the purpose and guiding principles for the core competencies and developing a list of content areas or “chapters”, if you will. My sincere thanks to the dynamic and collaborative task force of 15 hospitalists who accomplished this work through a series of robust, monthly discussions. They have done a fantastic job of setting the foundation for the work that is yet to come on the core competencies and their efforts are greatly appreciated.

With phase one accomplished, we will move to phase two - content development. We are seeking hospitalists to author or co-author one or more chapters in this phase. More information will be forthcoming with details of how to apply. In the meantime, I wanted to plant the seed and encourage you to get involved. Authors will be provided with ample guidance and support throughout the writing phase. As hospitalists, we have an important responsibility to define our role and a significant opportunity to shape the field of Obstetrics and Gynecology. Please consider participating in this important SOGH initiative and watch for e-blasts and website updates for more information.

Sincerely,

Tanner Colegrove, MD
SOGH President
Greetings from the 2018 annual clinical meeting (ACM) planning committee. We are hard at work constructing this year’s meeting. Please make note of our change in date, now scheduled for September 27-30, 2018. Our meeting will be held in the resurgent city on America’s north coast, Cleveland, Ohio. We are planning a great line up of speakers, focused on topics vital to the OB/GYN hospitalist, such as maternal mortality and OB infectious disease. You will have the chance to get practical, hands-on experience in workshops targeted to your needs. Some are back by wildly popular demand, such as high fidelity OB/GYN emergency simulations and others are making their first, innovative appearance. Learn with others on the front lines of making healthcare safer for women.

Vanessa E. Torbenson, MD | Kim Puterbaugh, MD  
SOGH ACM Co-Chairs
IN THE NEWS

FEATURED SOGH FACULTY PRESENTATIONS at the 2018 ACOG ANNUAL CLINICAL & SCIENTIFIC MEETING
Austin Convention Center | April 27-30, 2018 | Austin, Texas

THE OBSTETRICAL EMERGENCY DEPARTMENT: IMPROVED SAFETY, PATIENT SATISFACTION AND REIMBURSEMENT
► Friday April 27th | 1:00 PM | Room 18AB

BRIGID MCCUE, MD | Lead OB/GYN Hospitalist at Ochsner Baptist Hospital
Will be reviewing licensing strategy, clinical experience and billing data. Come and listen to Dr. McCue discuss how to restructure the OB Triage in order to generate new revenue and fund an OB/GYN Hospitalist program.

THE EDUCATIONAL IMPACT OF OB-GYN HOSPITALISTS
A JOINT ACOG/SOGH SESSION
► Sunday, April 29th | 2:00 PM | Room 16A

JENNIFER BUTLER, MD | SOGH Board Member and OB Hospitalist Fellowship Director, University of California Irvine, Irvine, CA
Will discuss the importance of OB/GYN hospitalist fellowships and impart practical knowledge and skills for starting one. She will then further explore the curriculum of fellowships and the development of core competencies.

NGOZI WEXLER, MD | SOGH Board Member and OB Hospitalist Chair, OB/GYN Department, Medstar Montgomery Medical Center, Olney, MD
Will discuss the nuts and bolts of starting and implementing a hospitalist program in a community hospital setting. Will further explore the challenges hospitalists face and best practices for managing those challenges in the community hospital setting.

CATHERINE STIKA, MD | SOGH Vice President & President Elect and OB Hospitalist, Clinical Professor of Obstetrics and Gynecology Northwestern Medicine, Feinberg School of Medicine, Chicago, IL
Will present evidence supporting the impact of protocol use on improvement of obstetrical care. In addition, will be reviewing management recommendations for two common OB Triage presentations: Mild - Moderate Trauma and Shortness of Breath.
CLINICAL SCENARIO

34 yo G5P2113 morbidly obese patient at 37 1/7 weeks by 10 week sonogram presents to labor and delivery in active labor and was found to be 7 cm dilated on cervical exam. Cervical exam revealed that the fetus was in breech presentation. The patient is from out of town and is currently visiting family. She reports that her water broke early in the morning and she began contracting. The patient disclosed that she has had three prior cesarean sections and mentions that her last cesarean section took a long time, was “difficult” and the surgery ended with her having to have a blood transfusion. The patient was admitted with plans for an urgent repeat cesarean section. The anesthesia team was notified. The patient was taken to the OR, was prepped and draped and placed under general anesthesia. The OB/GYN hospitalist encountered severe adhesive disease and spent 50 minutes performing adhesiolysis in order to safely gain entry into the peritoneum. Another 30 minutes was spent dissecting and protecting the bladder which was severely adhered to the uterus. The remainder of the surgery was uncomplicated. Blood loss was 1500ml and total operating time was two hours. The patient received a second dose of Ancef at the end of the surgery. The patient was transferred to the Mother/Baby Unit for postoperative recovery.

As the OB hospitalist, how would your services be coded?

ANSWER

ICD 10 DIAGNOSIS CODING CONSIDERATIONS INCLUDE

ICD10-CM   O42.02 PROM, Full-term premature rupture of membranes, onset of labor within 24 hours of rupture
ICD10-CM   O82 Delivery: Encounter for Cesarean Delivery
ICD10-CM   O34.219 maternal care for unspecified type scar from previous C/S
ICD10-CM   O32.1XX1 Breech, Maternal Care for breech presentation
Z38.01 Liveborn Infant, Singleton, delivered by Cesarean
Z3A.37 37 weeks gestation of pregnancy

EVALUATION AND MANAGEMENT CODES (E&M)

99223 Initial Hospital Care, Comprehensive, Hugh

CPT CODES

59514-22 Cesarean Delivery Only, Unusual Procedural Services (Modifier 22)
IN THE SPOTLIGHT: MODIFIER 22 USAGE  continued

Currently, the usage of Modifier 22 has been in the spotlight because carriers have not been reimbursing the physicians based upon the additional work provided. This dilemma has been noted by numerous hospitalist providers, that even though the Modifier 22 was appended to a claim, the reimbursement was paid at the same rate as if the service was provided under “normal” circumstances.

The definition of Modifier 22 is, as explained in CPT® Appendix A: “When the work required to provide a service is substantially greater than typically required, it may be identified by adding Modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (e.g. increased intensity, time, technical difficulty of procedure, severity of patient’s condition, physical and mental effort required).”

Neither CPT, CMS, ACOG or even the AMA guidelines precisely define the term “substantially greater than typically required.” Nor does CPT address the issue that Modifier 22 allows a physician to receive a larger reimbursement (usually an extra 20-25%) for an especially difficult or time-consuming procedure. Unfortunately, third-party payers won’t automatically increase reimbursement for a Modifier 22 claim. It is common for physicians to increase their fee by 20-25% when submitting a claim with the Modifier 22 attached to compensate the provider for the “over and above” work that was performed on the case. CPT does not specify “financial compensation” in the Modifier definition.

However, in getting Modifier 22 claims paid, overall the case will require more than just extra work in the operating room. It also means clear and concise clinical documentation to support the “additional work performed” to be noted by the provider.

Modifier 22 usage with global maternity care, or maternal services may be appropriate if:

- Management of pregnancy related complications (in-patient antepartum oversight for diagnoses such as pre-eclampsia, preterm labor, bleeding, etc.)
- For cesarean delivery of multiple gestations.
- The cesarean delivery requires substantial additional work.

However, with usage in obstetric services, third-party payers may have restrictions or specified criteria to be followed when submitting obstetric service claims with a Modifier 22. CMS/Medicare/Medicaid have not specifically addressed usage of this modifier with claims. ACOG has also noted that Modifier 22 can be used for third and fourth degree lacerations that occur at the time of delivery, or you can use the integumentary codes.
A clear and concise description of the unusual circumstance(s) that outline why this particular encounter required greater effort than the normal services should be well documented by the provider. Avoid using a generalized statement(s) such as “patient was obese”, “surgery took longer than usual” or “multiple adhesions” that lack specificity. Instead, use comparative verbiage to show how the procedure was significantly different from the typical and/or average procedure. For instance, a statement such as “The patient lost 850 cc’s of blood during the delivery with extensive clotting, hemorrhage and uterine atony. Normal blood loss is approximately 200 cc’s”, is a good comparative statement.

When using time as a Modifier 22 criteria, comparative verbiage is also helpful, such as stating “I spent 2two hours of abdominal adhesiolysis due to the patient’s morbid obesity before gaining access to the operative field. Normal time for adhesiolysis for this surgery is usually 20-30 minutes.”

With regards to clinical documentation for a twin delivery via cesarean section, you may append the Modifier 22, only if the delivery is significantly more difficult compared to a singleton delivery. ACOG states you can add Modifier 22 if delivery is significantly more difficult as compared to a single gestation pregnancy. Be sure to document specifically “why” it was more difficult. (e.g. transverse lie, Fetal distress, placental abruption, etc.).

LORI-LYNNE A. WEBB, CPC, CCS-P, CCP, CHDA, COBGC and ICD10 CM/PCS Ambassador/Trainer is an E&M, and Procedure based Coding, Compliance, Data Charge entry and HIPAA Privacy specialist, with over 20 years of experience. Lori-Lynne’s coding specialty is OB/GYN office & Hospitalist Services, Maternal Fetal Medicine, OB/GYN Oncology, Urology, and general surgical coding. She can be reached via e-mail at webbservices.lori@gmail.com or you can also find current coding information on her blog site: http://lori-lynnescodingcoachblog.blogspot.com/.

RENEE ALLEN, MD, MHSc., FACOG served as co-author of this column. She is Chair of the SOGH Coding Committee and is the SOGH Liaison to the ACOG Committee on Health Economics and Coding. She currently works as an OB/GYN Hospitalist with Mednax/Obstetrix at Eastside Medical Center in Snellville, Georgia.
Over the past few months I have had eye-opening conversations with Elliott Main, a key leader in the Alliance for Innovation on Maternal Health (AIM) project, and Lisa Hollier, incoming president of ACOG and keynote speaker at our SOGH ACM in Cleveland this fall. Both emphatically stated something we all know - that OBGYN hospitalists are the perfect providers to champion implementation of culture changing bundles aimed at improving patient safety at our individual institutions.

Here at The Children’s Hospital of San Antonio, we are in the process of building a new safety initiative program. Last week during my shift I received a call from the MFM clinic. They were sending a patient with BPs in the 170/90s. Upon arrival, her first BP was 230/130. I learned a lot about the readiness of my unit over the next few minutes. The nurses did a great job getting an IV started. I ordered hydralazine and magnesium and was shocked to find out that these medicines could not be pulled because the patient was not yet registered and there was no way to override these medicines. We creatively worked around the system and after administering 25 mg of hydralazine her BPs were 140/90s. Ironically, we were scheduled to have an in-situ simulation on severe hypertension the following month.

With this in mind, I’d like to focus this second Sim Corner of 2018 on the AIM Severe Hypertension Safety Bundle and the power of in-situ simulation. Simulations can be high or low fidelity and can take place in a simulation center but just as easily on our own units. When simulation is done on the unit we can see how our systems function with the teams we work with. Real life situations often bring us face-to-face with clinical scenarios that demonstrate our inadequacies.

Below are the guidelines set forth in the AIM Hypertension Safety Bundle which I have slightly rearranged to fit the mantra of “Every Unit, Every Patient, Every Time”. The shaded area is information taken directly from the AIM bundle.
SIM CORNER continued

► EVERY UNIT

- Standards for early warning signs, diagnostic criteria, monitoring and treatment of severe preeclampsia/eclampsia (include order sets and algorithms)
- Unit education on protocols, unit-based drills (with post-drill debriefs)
- Process for timely triage and evaluation of pregnant and postpartum women with hypertension including ED and outpatient areas
- Rapid access to medications used for severe hypertension/eclampsia: Medications should be stocked and immediately available on L&D and in other areas where patients may be treated. Include brief guide for administration and dosage.
- System plan for escalation, obtaining appropriate consultation, and maternal transport, as needed
- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of all severe hypertension/eclampsia cases admitted to ICU for systems issues
- Monitor outcomes and process metrics

► EQUIPMENT

- Hypertension Kit allowing immediate access to labetalol, hydralazine, nifedipine, and magnesium; involve pharmacy. Periodic re-evaluation of medications to reflect current guidelines and recommendation.
- Establish OB Emergency Response Team: OB/GYN hospitalist, specific nursing staff, rapid response teams, anesthesiologist, MFM, intensivist.

► EVERY PATIENT

- Standard protocol for measurement and assessment of BP and urine protein for all pregnant and postpartum women
- Standard response to maternal early warning signs including listening to and investigating patient symptoms and assessment of labs (e.g. CBC with platelets, AST and ALT)
- Facility-wide standards for educating prenatal and postpartum women on signs and symptoms of hypertension and preeclampsia
EVERY CASE OF SEVERE HYPERTENSION/PREECLAMPSCIA

Facility-wide standard protocols with checklists and escalation policies for management and treatment of:

- Severe hypertension
- Eclampsia, seizure prophylaxis, and magnesium over-dosage
- Postpartum presentation of severe hypertension/preeclampsia

Minimum requirements for protocol:

- Notification of physician or primary care provider if systolic BP =/> 160 or diastolic BP =/> 110 for two measurements within 15 minutes
- After the second elevated reading, treatment should be initiated ASAP (preferably within 60 minutes of verification)
- Includes onset and duration of magnesium sulfate therapy
- Includes escalation measures for those unresponsive to standard treatment
- Describes manner and verification of follow-up within 7 to 14 days postpartum
- Describe postpartum patient education for women with preeclampsia
- Support plan for patients, families, and staff for ICU admissions and serious complications of severe hypertension

SIMULATION

**Length:** 10-30 minutes depending on end point chosen by user.

**Physical Space:** Labor room.

**Primary Issue being assessed:**

**Staff knowledge and treatment of hypertensive crisis.**

**Drill may be modified to assess:**

- Effective communication in emergencies
- Patient flow in a physical space
- Unit’s preparedness with necessary tools and materials to meet staff’s needs in an emergency

SCENARIO

- Mrs. Hydra Lazine is a 41-year-old, G1P0 at 29 2/7 weeks whose pregnancy is a result of IVF. She has gestational diabetes (poorly controlled) and chronic hypertension but not requiring medications during this pregnancy. She was noted to have an increase in BP from her baseline 140/80s to 155/95 in clinic today and sent to L&D for further evaluation.

- VS on arrival: blood pressure 230/130, Pulse 110, Temp 98.8, RR 14.

- Pt is conscious and alert but reports a worsening headache that was mild in clinic.

- Scene opens with triage nurse calling MD about concern for elevated BP.
ADDITIONAL INFORMATION

**Weight:** 260 lb

**PMH:** Gestational diabetes A1, chronic hypertension, infertility.

**PSH:** Cholecystectomy, Tonsillectomy.

NKDA

Meds: PNV

**SH:** denies alcohol, tobacco or illicit drugs

FH of diabetes and hypertension in many family members

**LABS:** None yet.

**PARTICIPANTS** (will vary depending on direction scenario is taken):

1. Primary obstetrician
2. Triage nurse
3. Patient’s partner
4. Anesthesiologist
5. Support nurse
6. Support physician (if needed)
7. Simulation observer assessing whether objectives and goals are met.

**OBJECTIVES**

1. Recognition of dx
2. Effective communication
3. Prompt treatment
4. Illicit staff support
5. Assemble team, assign roles with clear communication and/or task assignment.
6. Patient and family are kept informed and included in the debrief.
7. Debrief the event

**GOALS OF THE SIMULATION**

**RN:**

- Start fetal monitoring immediately.
- Notify MD of patient using SBAR communication
- Relay her concern for dx of pre-eclampsia
- Request prompt bedside evaluation and/or orders for labs and meds.
- Ensure both bedrails are raised
- Inform charge nurse of patient
- Inform NICU of patient
RN Challenges/Confederates you may include:
• MD disregards RN’s concerns.
• Understaffed unit with high patient volume.
• Fatigued or distracted RN (i.e RN was asked to stay beyond her regular shift or reluctantly came in on her day off).
• Very concerned/anxious (i.e difficult) family member
• Difficulty gaining IV access.
• Patient with large body habitus making it difficult for fetal assessment and determining accuracy of BP values.

MD:
• Prompt recognition of hypertensive crisis in pregnancy (severe hypertension, pre-eclampsia or eclampsia).
• Appropriate antihypertensive medications according to ACOG protocol (IV labetalol, IV hydralazine or oral nifedipine).
• Prompt recognition of clinical dx of pre-eclampsia.
• Magnesium sulfate for seizure prophylaxis- IM or IV
  In this case magnesium sulfate would also serve as fetal neuro-protection.
• Use of antenatal corticosteroids.
• Timely bedside evaluation of the patient.
• MFM consulted
• Identify and notify surgical assistant in case they are needed.

MD Challenges/Confederates you may include:
MD is in the OR and is unable to make a bedside evaluation immediately. 
Fatigued or distracted MD
Very concerned/anxious (i.e difficult) family member.
Patient with large body habitus making it difficult for fetal assessment and determining accuracy of BP values.

Simulation end options. Simulation drill ends with:
a) Correct administration of appropriate medications and achievement of appropriate blood pressures.
b) Eclamptic seizure which is appropriately managed with or without delivery.
c) Patient is transferred to an ICU setting if blood pressure is not controlled with recommended measures.
Debrief:
1. What went well?
2. What were some obstacles?
3. What are areas for improvement?

Simulation Pearl:
Often, we are eager to teach the full scope of a subject through a single drill. This is unrealistic. Participants are more apt to learn from simple drills where one or two salient points are the main focus. This is especially true in drills designed to change a current practice pattern.

The drill should still be carried through in its entirety, but the main teaching point should be limited in scope. i.e getting participants familiar with or comfortable using the IM regimens in patients w/o IV access or performing a procedure in a unfamiliar physical space are but two examples. Design your drill in detail, keep your goals simple. Participants are less likely to be overwhelmed and are more likely to retain your take home message this way.

I hope you will join us in reducing maternal morbidity and mortality in your facility through implementation of both the AIM Patient Safety Bundles of Obstetric Hemorrhage and Hypertension by the end of 2018. May we all succeed as we take on this mission. Mothers and their families everywhere are depending on us.

REFERENCES AND RESOURCES:
3. ACOG Committee Opinion Number 692, April 2017

BROOK THOMSON, MD, FACOG | SOGH Simulation Co-Chair
Dr. Thomson is the OB Hospitalist Division Director at Baylor College of Medicine, The Children’s Hospital of San Antonio.
DECREASING CESAREANS: VBAC AND PATIENT EMPOWERMENT
Jane van Dis, MD, FACOG, Medical Director for Business Development

Jane van Dis, MD, an OB Hospitalist with OB Hospitalist Group in Bakersfield and Burbank California, and Chair of her Department, highlights key components of ACOG’s revised Practice Bulletin addressing VBAC. Dr. van Dis serves on the Board of SOGH and the article highlights the role that OB Hospitalists can play in decreasing the Cesarean Section rate.

► COLUMN: Decreasing cesareans: VBAC and patient empowerment

do you have FEEDBACK? email us newsletter@societyofobgynhospitalists.org