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Obstetric and Gynecologic Ultrasound: Coding and Legal Issues

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ABSTRACT

The topics of ultrasound practice-related coding and liability are not frequently covered in ultrasound treatises. The paper covers these crucial subjects, starting with the proper Current Procedural Terminology (CPT) and International Classification of Diseases, 10th edition (ICD-10) coding in ultrasound procedures when assessing early pregnancy and gynecologic problems. The second section of the article highlights common mistakes that might result in liability in obstetric and gynecologic ultrasonography practise. To explain the concepts, concrete examples and situations are used to illustrate the discussion.

Keywords: Gynecologic problems; Ultrasound; Coading

INTRODUCTION

The ICD-10 and American Medical Association CPT manuals set the standards for coding. More than 141,000 codes in the ICD-10 book define diseases that support the use of an ultrasonography. The ultrasound procedure(s) that were carried out are described by the CPT code. The most precise ICD-10 code or codes that are confirmed or the conclusive diagnosis stated in the ultrasonography interpretation should be used when classifying an encounter. If a conclusive diagnosis cannot be made, the condition, issue, or symptom that prompted the ultrasound scan is coded in decreasing order of preference.

DESCRIPTION

Ultrasound coding

The professional component and the technical component are the two main parts of a CPT code. The physician or provider is paid through the professional component (indicated by the modifier -26) for supervising the test, interpreting the results, and writing a report. The costs connected with the sonographer's pay and benefits, the ultrasound machine, and any necessary supplies are covered by the technical component (denoted with the modifier -TC). There is a relative value unit assigned to each component that has been modified for regional cost variations. The Centers for Medicare & Medicaid Services devised a conversion factor that is multiplied by the relative value unit for each CPT code to arrive at the compensation for each CPT code. In order to determine the reimbursement for each procedural code, this element frequently has a percentage modification, for instance, Medicare plus 10%. Hospital-based clinics and provider-based (physician-owned) clinics use different CPT codes. A doctor-owned practise invoices a fully integrated nonfacility charge without any additional modifiers.

The level of monitoring necessary for certain ultrasound treatments is likewise determined by the Centers for Medicare & Medicaid Services. The majority of gynecologic and obstetric ultrasonography treatments only need general supervision. When a physician's presence is not necessary while the procedure is being performed, general supervision mandates that the procedure be provided under the doctor's overall guidance and control. The doctor is in charge of teaching the non-medical staff members who carry out the diagnostic procedure and maintain the equipment, though. Specific obstetric and gynecologic ultrasonography treatments call for personal supervision. The doctor must be present in the room during the process under their personal supervision. Amniocentesis, chorionic villus sampling, and percutaneous umbilical cord blood sampling are obstetric procedures that call for personal supervision. Sonohysterography and sonosalpingography, often

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known as hysterocontrast-sonography, are two gynecologic ultrasound procedures that need personal supervision.

Coding for early pregnancy

Following confirmation of pregnancy, there are various codes for ultrasound scans. According to CPT (1), the first trimester of pregnancy begins before 14 weeks and 0 days of gestation. There are no additional codes to apply for the evaluation of the uterus and adnexa because the first trimester sonography code, 76801, comprises evaluation of the foetus, uterus, and ovaries. Measurements of the foetus, if present, should be supplied together with a description of the gestational sac's location. The crown-rump length is the ideal ultrasonography measurement for determining gestational age (CRL). Although the CRL can be measured, the mean diameter of the sac should not be used because it is more variable.

Hysterosonography, also known as sonohysterography, calls for the use of two CPT codes. The ultrasonography portion of the investigation is covered by CPT 76831. The study's execution, interpretation, and documentation are all included. It should be noted that the code contains colour flow Doppler in addition to all the components of a vaginal ultrasound study. As a result, billing for a vaginal ultrasound or a Doppler examination in addition to hysterosonography is not appropriate. The procedure code for injecting saline or a contrast agent into the uterus is CPT 58340. For sonohysterography, one commonly submits CPT 76831 and CPT 58340. The office-based process of sonosalpingography, also known as hystero-contrast-sonohysterography, is used to assess tubal patency. It is uncommon to guide various aspiration or injection methods with ultrasound. For example, ilioinguinal nerve block, which involves the monitoring and analysis of the study, uses CPT 76942 for ultrasonography guidance for needle insertion. For procedures like follicular aspiration, embryo transfer, or insemination, CPT 76998 is used for intraoperative ultrasonography guidance. Additionally, this code is ideal for intrauterine device insertion and retrieval as well as hysteroscopy under ultrasound supervision [1-3].

A perception error occurs when an irregularity is missed at the original interpretation but is later noticed. Was the doctor's failure to notice the aberration below the level of care? is the constant question. An evident prenatal abnormality that was missed during the initial evaluation might serve as an example. As 80% of cases that proceed to a jury trial are lost, it is evident that these cases are challenging to defend. A finding is identified, but when it is interpreted, it is done so incorrectly. The biggest risk with this kind of liability is when a malignant lesion is misdiagnosed as benign. However, benign lesions that are misdiagnosed as malignant may also give rise to culpability claims, especially if the ensuing operation results in serious problems.

This argument becomes even more crucial when the data are unclear or do not match the clinical presentation. Examples include recommending additional imaging when an ectopic pregnancy is suspected and there are no particular or obvious ultrasound findings, or when a 4-chamber foetal heart image is not visible. The sonologist's failure to effectively explain important findings constitutes the fourth significant area of culpability. Critical findings, such as a ruptured ectopic pregnancy or a foetal defect not communicated to the referring practitioner, may necessitate personal notification with adequate documentation of such notification. This section examines the liability issues specific to gynecologic and obstetric ultrasonography practise.

OBGYN ultrasound procedure

Prenatal ultrasound examination is the main imaging technique employed. Although there is a wide range in the quantity of prenatal ultrasound exams, most American women get at least two done while they are pregnant. At 10 to 13 weeks gestation, the first ultrasound exam is often done to assess the nuchal translucency. The anatomical evaluation of foetal structures is done during the second ultrasound examination, which takes place between weeks 18 and 22 of gestation. A practitioner with specific training in obstetric ultrasonography examinations conducts obstetric ultrasound exams. The most frequent problems in obstetric ultrasonography practise are the absence of a diagnosis, a wrong diagnosis, or improper therapy of an abnormal foetal condition. Among the many immune-mediated or non-immune-mediated conditions that can cause abnormalities are anatomical malformations (such as congenital cardiac defects, intracranial lesions), genetic disorders (such as Down syndrome, trisomy 18), infectious aetiologies (such as Parvovirus, Zika, and TORCH), foetal growth disturbances (such as foetal growth restriction or acceleration), amniotic fluid imbalances such as oligohydramnio [4-7].

CONCLUSION

A genuine knowledge or skill gap may be the cause of certain malpractice situations. When a doctor neglects to order the necessary ultrasound examination or fails to recommend a patient for it because they lack the necessary knowledge of the hazards associated with foetal malformations, this knowledge gap may exist. A physician has a technical competence deficit when this leads to misreadable images or erroneous measurements. For instance, if a foetal echocardiography was not performed, a doctor may be held accountable for a patient's undiscovered heart abnormality if type I diabetes is not properly managed.

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