**Clinical Chats Official Podcast Transcript**

**Title:** Coding with Ann Episode 23: Billing and Coding for Early Pregnancy Loss

**Speaker:** Ann Finn and Michael Policar, MD

**Duration:** 00:18:57

**Katherine Atcheson** ([00:05](https://www.rev.com/transcript-editor/shared/6wSsLSzXj5nUK5XV-Osj3QcWu76t0co6fQKNfTHTt7RkWKxVPdGtcUBIFRkx_mKjneb8xfgSZ4c545dM80dvKk9Mlcc?loadFrom=DocumentDeeplink&ts=5.13)):

Hello and welcome to Clinical Chats: A Podcast for Sexual and Reproductive Health Professionals, formerly known as The Family Planning Files. Clinical Chats is a product from the National Clinical Training Center for Sexual and Reproductive Health, or CTC-SRH, formerly known as the National Clinical Training Center for Family Planning, or NCTCFP, and is funded by the Office of Population Affairs in order to enhance the knowledge of Title X clinicians and other staff. I'm your host, Katherine Atcheson.

**Katherine Atcheson** ([00:38](https://www.rev.com/transcript-editor/shared/6K50-x68TS-iMhNFxRShIj4sbIsp6EGIvmLzenucEEpUqAHgumv_D7g69pwMeUw9lcJ7BHD_1iSsJAiK36jttxU8O1k?loadFrom=DocumentDeeplink&ts=38.73)):

In our podcast today, part of our ongoing series Coding with Ann, we'll be discussing billing and coding for early pregnancy loss in the family planning setting. Our speaker, Ann Finn, is a healthcare reimbursement consultant and a national trainer with many reproductive healthcare organizations. Ann heads her own company Ann Finn Consulting, LLC. Today, we also have Dr. Michael Policar, a special guest and friend joining us. Dr. Policar is professor emeritus of OB-GYN and reproductive sciences at the University of California San Francisco School of Medicine, a senior medical advisor to the California State Office of Family Planning, and the senior clinical fellow for the National Family Planning and Reproductive Health Association. Welcome back to the podcast, Ann, and hello to Dr. Policar.

**Ann Finn** ([01:32](https://www.rev.com/transcript-editor/shared/qSW5jt8OoVgEA-2VG5MqgJQCE-j1z5YwQn1mSBXra3n7HLjijb2dpgZcOngop49dwBGVwqVab2z6n_NnYcJ8hRerEGs?loadFrom=DocumentDeeplink&ts=92.37)):

Hi, Katherine. I'm looking forward to our discussion today and excited to have Dr. Policar joining us to share his clinical expertise. We're very excited to be able to offer these focus coding sessions to provide you with some tips and guidance on coding and billing to enable you to get paid appropriately for all your services. Today's talk will focus on coding for early pregnancy loss in the family planning visit setting, and what codes we would typically use to code and bill for this complication.

**Katherine Atcheson** ([02:05](https://www.rev.com/transcript-editor/shared/jCBbHiyUUxoIvlewMyuQ8Wx5Dr5AjrrLgFDDbQXv77_NmD330W8ynkIYG7J-hYjKFABgvkeLMUExD2T7H6beH0LqXfo?loadFrom=DocumentDeeplink&ts=125.46)):

Pregnancy loss can be a very tough topic to discuss, but so important for clinicians and other family planning staff to understand. So, I think our conversation today will be very informative for our listeners.

**Ann Finn** ([02:18](https://www.rev.com/transcript-editor/shared/oxEAQt1uekUfcdkLSEn-zymoZlvMjwLN15VU7_Gp5Uj09XhZa3jttmIMrD7NMt903fsTeXcvGU9h1i_qTRrBdSjofSU?loadFrom=DocumentDeeplink&ts=138.12)):

I agree. So, let's jump right in. Welcome, Dr. Policar. We're very excited to have you join us. Let's start with defining what early pregnancy loss means, and then we'll talk about some of the codes that might help you.

**Dr. Policar** ([02:31](https://www.rev.com/transcript-editor/shared/mQoZKpP2OoIkUojVMnXbxu9wEeHaLQC3rmzZB_b9ldax7RiwYFb-L-sL35cgftmj-w3OLoYw_99l9vfXTkdXGk3RSro?loadFrom=DocumentDeeplink&ts=151.98)):

Thank you for including me today. Early pregnancy loss is most commonly defined as the loss of pregnancy before 13 weeks gestation. Other terms include miscarriage, early pregnancy failure, and spontaneous abortion. The terms early pregnancy loss or miscarriage have actually be preferred by patients because of the negative connotations associated with the word failure and confusing regarding elective versus spontaneous abortion.

**Dr. Policar** ([03:02](https://www.rev.com/transcript-editor/shared/Zc_H2Pc9VIiyXAdWv3nVYlLvR5Sjol__G1Sap1_9V0gPSsBdrzBdgO5kQDNUD8suc5rEniB0huI-lbO344VKl3lMJFY?loadFrom=DocumentDeeplink&ts=182.1)):

In the past, the management of early pregnancy loss occurred in the hospital setting, mainly in the emergency department. It's now shifted to the outpatient setting, allowing women to remain under the care of clinicians in the clinic or office, where they received their other reproductive healthcare services. Up to 18% of recognized pregnancies end up in miscarriage, and as many as 80% of miscarriages occur in the first trimester with chromosomal abnormalities being the leading cause of pregnancy loss.

**Dr. Policar** ([03:33](https://www.rev.com/transcript-editor/shared/v8U8aJ50ddH-fPN86Ow7OEqa9yWchdRPJZwNBN8apSmzoDncy_PpGHD1vUPXYm73zs9GSIPLejRZSyJARAOaZ_rddWk?loadFrom=DocumentDeeplink&ts=213.72)):

Consequently, no interventions have been proven to prevent early pregnancy loss and patient care is based on making a diagnosis of the subtype of early pregnancy loss, and a shared decision-making process, which centers on the management options available to the patient. Most common risk factors identified among women who have experienced early pregnancy loss are advanced maternal age and a prior early pregnancy loss. The frequency of clinically recognized early pregnancy loss for women aged between 20 and 30 years of age is somewhere between 9 and 17%, and this increases sharply from 20%, at age 35, to 40% at age 40 years, and all the way up to 85% of miscarriage rates at age 45 or older.

**Katherine Atcheson** ([04:24](https://www.rev.com/transcript-editor/shared/gJo2NGDep7LwXGHJ0jajbptZlEAmNJuYAGPZQjbATCgWO7tUFBJZbY5cWEhTKiPZMW21hhs7xbtIVtL6j_gujCQjD60?loadFrom=DocumentDeeplink&ts=264.66)):

So, what sort of clinical findings can be used to confirm a diagnosis of early pregnancy loss?

**Dr. Policar** ([04:32](https://www.rev.com/transcript-editor/shared/9psplYA__o0Fa1nC3xL2qVf0iIzorv86YoqIR4Qyn_GlI6F2PRdr5ZXxnA0AkMgMpDANEBYdk8aM7nfjumR86cEPRAo?loadFrom=DocumentDeeplink&ts=272.19)):

Katherine, unless products of conception are seen or reported by the patient, the diagnosis of early pregnancy loss ideally is made with pelvic ultrasonography and the trending of beta HCG levels, or both in combination. In fact, most commonly the two are used together. Management options for early pregnancy loss include expected management, waiting for the patient to miscarry on her own, medication management, which will hasten the process, and uterine aspiration.

**Ann Finn** ([05:03](https://www.rev.com/transcript-editor/shared/zujyuyqZNAuF3edlNVFuwiuSfNWSPbY8cDOe1CRmCqsC58i01zoNlBPgy-3NlrschVwUl-Jq_y-ZSA4bi6CO_xGPI88?loadFrom=DocumentDeeplink&ts=303.18)):

Thank you. We've put together some great tools including reference sheets with common codes and some scenarios of common visits that you'll be able to download with this podcast. Let's start with going over a few scenarios. Our first scenario is Susan, she's a 29-year-old established patient whose last vaginal delivery was 18 months ago. Believe she's about seven weeks pregnant due to symptoms, amenorrhea over one month, bilateral breast tenderness, morning nausea, and no vomiting. Three days ago, Susan noted pink vaginal spotting. She presents today with painless dark red vaginal spotting. She has mild dysuria and denies itching, burning and discharge. Can you take us through her exam and what tests would typically be done?

**Dr. Policar** ([05:51](https://www.rev.com/transcript-editor/shared/mCed4zVsnUiwZ9FM_1lhEg8PBIPI_1C2HRu3r1vv1566mbdiOdrg8LQOq0KVsSWVaKAtLSxwmu_eOmrxG4USkhMk1CI?loadFrom=DocumentDeeplink&ts=351.66)):

Sure, Ann. Today, Susan's vitals are a blood pressure of 124 over 74, a pulse of 80, and a normal temperature of 98.6 degrees Fahrenheit. Pelvic exam revealed the following, her vagina was pink with a moderate amount of maroon-colored vaginal discharge. On having a look at her cervix, the external os was closed. There was no exudate or cervical lesion seen. The sample for gonorrhea and chlamydia nucleic acid application tests were obtained and sent to the lab.

**Dr. Policar** ([06:21](https://www.rev.com/transcript-editor/shared/Ewn9BWcq3MhC5u3Q4CTX44eJMbvXD8dYApCdlBIFYtnOcXiifLKzeUDvjQiOzyMZElf-0KRGInGlZ2V-Tyi2Rp4LZEA?loadFrom=DocumentDeeplink&ts=381.66)):

By manual, her uterus was anteverted, non-tender, and about a six-to-seven-week gestational size. There was no cervical motion tenderness. However, her left adnexa is slightly tender to palpation, and her right adnexa is non-tender. Susan was given two point-of-care tests, a urine pregnancy test, which has a positive result, and a dipstick urinalysis, which was negative. The clinician also performed a transvaginal ultrasound which showed a thickened endometrial stripe and a slightly enlarged uterus. No gestational sac was seen.

**Dr. Policar** ([06:58](https://www.rev.com/transcript-editor/shared/PE2ge3-k1kdwjesJ36SP5-RKdoBRLAxDXcvYqD-qK5Hwai0PEUbjJOd4IKWO_oQZalS8OKl0h-UsRH-YEJL4meqMSo8?loadFrom=DocumentDeeplink&ts=418.5)):

The left adnexa had increased vascularity adjacent to the left ovary, and the right ovary was entirely normal. Because an unruptured tubal ectopic pregnancy was suspected, an emergency department physician was contacted in a direct conversation to arrange transfer. This is a critically important clinical point. This type of transfer is referred to as a warm handoff. When immediately life-threatening condition is suspected, the patient should never be left on her own to find follow-up care. Instead, the clinician has the responsibility to contact a clinician or institution to whom the patient is being referred in order to provide a history, presumed diagnosis, and mode of transportation. That is to say personal car, non-emergency transport, or an ambulance, and what the timeframe of the transfer will be. Now, for this visit, the total time was 35 minutes, not including the time for the performance of the ultrasound.

**Ann Finn** ([07:57](https://www.rev.com/transcript-editor/shared/2zxynJmUZm735m3LNXysleNK7ETmhC680Vxp3Na-VhBgbGMc-0Wpkt1w2fv5r2C7pYWueN60LlQ03uq4o_VF6gliv2Q?loadFrom=DocumentDeeplink&ts=477.9)):

Thanks, Dr. Policar. Now, let's review what codes we would need for the visit. Let's start with the office visit. Remember using the new E&M Coding Guidelines that were updated back in 2021, we can select the code using either total time on the date of the encounter or medical decision-making, using the method that results in the highest-level visit code.

**Ann Finn** ([08:22](https://www.rev.com/transcript-editor/shared/Nern5U3rqZWn7pp58BLoJG74-L7PnOIz3UbTsWw2bLCoJ7mbhtNWHgXo4gMwGFxGt8DAvfO4AQX_JplDvPq0uam67ms?loadFrom=DocumentDeeplink&ts=502.59)):

Susan is an established patient in the practice. If we use total time, we can select 99214 for an established patient visit, which is 30 to 39 minutes, based on the 35 minutes on the date of the encounter that Mike described. Remember to count all of your time spent on this encounter, including before, during, and after the visit, not just the face-to-face time. That's a really important point for clinicians to take note of.

**Ann Finn** ([08:58](https://www.rev.com/transcript-editor/shared/FOvWDv6-V3Y-VR29Lj5ugX6CXJFyPqasRDXMGlD3SaUN36kan0TI_PPzIGqUieqYhsd4h1fpDsrXoOrs3-AY4oH8t5Q?loadFrom=DocumentDeeplink&ts=538.17)):

If we use medical decision-making, we would select a 99215 based on, first, the problems, it would be considered a high level or one acute or chronic illness that poses a threat of life or bodily function. The next element is data, and we would be considered extensive, since we have four tests ordered and a discussion of management or test interpretation with an external physician. And then risk, we are low risk of morbidity for additional diagnostic testing or treatment. In this case, we would choose the 99215 based on medical decision-making versus total time to ensure we bill the highest-level E&M code, which typically raises the reimbursement rate. Dr. Policar, what primary diagnosis code would you use to support the E&M code for this visit?

**Dr. Policar** ([09:48](https://www.rev.com/transcript-editor/shared/xlf8iAfL_rrM2l1NlJe9dmZiloeuzS4UckZ8LJ6l3glxPRTTwa1LuC1-ceKAiWwQfJpWtawOoWu9tm9zoFXK4Wa7IzE?loadFrom=DocumentDeeplink&ts=588.12)):

Ann, for this case, I would use ICD O20.0, which is defined as threatened abortion as the primary diagnosis. Remember, when one or more conditions are suspected but not confirmed, in other words, rule-out diagnoses, we do not use the ICD-10 codes for that rule-out diagnosis as they may prove to be incorrect. Instead, the code for the most important symptom, sign, or provisional diagnosis should be used. In this case, it's threatened abortion. We would also use CPT code 76817 for the transvaginal pelvic ultrasound in a pregnant patient, as the CPT code is different for non-pregnant patients, and the two point-of-care test, the urine pregnancy test and the dipstick urinalysis to evaluate her dysuria.

**Ann Finn** ([10:38](https://www.rev.com/transcript-editor/shared/l9SuHaPCnajASQe8Y8xq0NbOotMh3R0MZwYBGch4pC2qg49ea5_Mi4u8AmYXq0gRtaz2PPD5JTL6cO1LDlhNiHoqiDM?loadFrom=DocumentDeeplink&ts=638.37)):

Great, thank you. Now, let's take a look at our second scenario. Amy is a 24-year-old G1P0 and is a new patient at seven weeks gestation according to her last menstrual period. She's complaining of bright red vaginal bleeding for about four hours, lighter than a menstrual period, but requiring sanitary pad protection and intermittent uterine cramping. Amy denies lightheadedness, dizziness, nausea, vomiting, or focal pain. She reports bilateral breast tenderness, which started about two weeks ago, and she also denies trauma, recent intercourse, or changes in vaginal discharge preceding the onset of this bleeding. Back to you, Dr. Policar.

**Dr. Policar** ([11:23](https://www.rev.com/transcript-editor/shared/RsnK2PfzX2fkGfjI36_9Z6NlhxUd8E9GEMIZwJTHgyzahMdIeyZdlZq2srWKZqceu0P3yr_bZSPpFyNSnx9FetBitUE?loadFrom=DocumentDeeplink&ts=683.28)):

Amy's vitals are recorded as a blood pressure of 116 over 66, a pulse of 78, and a temperature of 98.4 Fahrenheit. Her exam includes the following, on speculum exam, her external cervical os was closed. A small amount of dark blood is noted coming from the cervical os. On my manual, she has a six-to-seven-week size uterus, which is anteverted, and soft, and minimally tender to palpation. There are no adnexal masses or tenderness. An office pregnancy test is positive and microscopy of a sample of vaginal fluid is negative for trichomoniasis. Samples are sent out to the outside lab for other tests, including a quantitative beta HCV, chlamydia and gonorrhea nucleic acid application tests, as well as an HIV test, and a syphilis RPR. There is no office imaging available at the clinic, and referral to an imaging center is not considered to be necessary at this time. The total time of Amy's encounter, including pre- and post-clinician time is 25 minutes.

**Ann Finn** ([12:33](https://www.rev.com/transcript-editor/shared/m0cHMmoGQHu9Qy_BUGf3AriH0nUbw9MgyXsGHQOuGjYxPmspYhHzoeeelfXatw114rB35ZkTksFZTpQQ6osVMt1G-Rs?loadFrom=DocumentDeeplink&ts=753.39)):

Okay, let's first determine the E&M office visit code for Amy. Remember, Amy is a new patient, or someone who has not been seen by the practice in over three years. If we use the 25 minutes noted as the total time on the date of the encounter, we would select 99202 for a new patient visit, which is between 15 and 29 minutes total.

**Ann Finn** ([12:58](https://www.rev.com/transcript-editor/shared/bQF6MriknCewlj2sASLFgawiqyJ5iOHydG_x-OVFvHmrQeKuLz15VDXHqqZ8UygRR2DqgGggAxGnSwNAxVI1cXgE704?loadFrom=DocumentDeeplink&ts=778.92)):

If we use medical decision-making, let's look at the three elements. The first being the problem, so we have one acute or chronic illness or injury, which we'd consider a low level. We have the data element, and we have six tests that were ordered, so we can count a moderate level of data using all of the tests. And then we have the risk, and this is a low-risk morbidity from additional diagnostic testing or treatment. So, we have a low, a moderate, and a low. So, the E&M code would be 99203. So, the E&M code, remember, can be based on either total time or MDM, and since the MDM results in a higher code, we would bill the 99203. If we look at the primary diagnosis for this visit, it would be O20.0 for threatened abortion.

**Katherine Atcheson** ([13:53](https://www.rev.com/transcript-editor/shared/z_Q09OzxsL-hRI97_07QGCb2q34S2d-zWM0NVY1iLdcafogqtqgr0Hs6_-7XFGz46CDMZ1OwFgrp9MNeB9IYddnsxhA?loadFrom=DocumentDeeplink&ts=833.46)):

Thanks, Ann and Dr. Policar. These scenarios have been really helpful, but are there other common diagnoses codes that providers might use on these types of visits?

**Dr. Policar** ([14:04](https://www.rev.com/transcript-editor/shared/23x0XVni4nl5LA6PRv5us4SgEhMzDqa9nJZTg62Mr9-29rR1SfOzAI3ieJNiNEuJeQXReSn4vBxQGXzTH81QGhpyNmQ?loadFrom=DocumentDeeplink&ts=844.86)):

Yes, that's a great question. A few examples of the codes we see used include the following, O02.1, which is missed abortion, and that includes any of the terms, empty gestational sac on ultrasound, and embryonic pregnancy, and embryo without cardiac activity. Next is O03.0 pelvic infection following an incomplete spontaneous abortion. Next is O03.1, delayed or excessive hemorrhage following an incomplete spontaneous abortion. O03.39, which is an incomplete spontaneous abortion with other complications. O03.4, an incomplete spontaneous abortion without complications. O03.9, complete or unspecified spontaneous abortion without complication. O21, and this series is used to describe excessive vomiting in pregnancy, what you may know as hyperemesis gravidarum. And then O23.11, which is a lower urinary tract infection, that is to say, acute cystitis in the first trimester.

**Ann Finn** ([15:22](https://www.rev.com/transcript-editor/shared/OAbDHpH4xflNaWab0QvBlJ6bzfNkvQyy11hkRL6jvPOI4a5qtB-e-HHdR5yqNJE8Z2kxKCBH6zln0dBCg5ySES2nGWQ?loadFrom=DocumentDeeplink&ts=922.41)):

Great. Thanks for all of those codes. Let's recap what we talked about today. In the past, while an occasional patient has been seen at a family planning clinic for early pregnancy symptoms, this may become a more common reason for clinic visits. Clinicians must be familiar with the correct terms and definitions used to describe the subcategories of early pregnancy loss, the cause of vaginal bleeding in early pregnancy is determined on the basis of the speculum and bimanual exam, quantitative serum beta HCG, pelvic ultrasound, or all three used in concert.

**Ann Finn** ([16:02](https://www.rev.com/transcript-editor/shared/5zLyCYlGpCFPYRWKucmQyFtr50_lpU3uTl4PGzGYQZ2QZL0YqxHHJUa1aKkebNbibjq7o3coKyVJrT4vbGinbOhfV8A?loadFrom=DocumentDeeplink&ts=962.07)):

Next code only for provisional or definite diagnosis. Remember not to use rule-out diagnoses. When choosing an E&M code level, use the higher of total time or medical decision-making, make sure that the actual total time figure is included in your note in the medical record, and it includes all the time on the date of the encounter. We know that this is a lot of information to remember, so the CTC-SRH, along with myself and Dr. Policar have put together a bundle of three job aids on billing and coding around early pregnancy loss, and all of these can be found on the CTC-SRH website resource library. We hope that this podcast has been helpful to you and thank you for listening.

**Katherine Atcheson** ([16:48](https://www.rev.com/transcript-editor/shared/9-7v_w14m84SQ_HSTrfbr_RcPyl_HTgULPe0QjFdA6nLFSwmT2zAvR7xWeaYwCxmMR2p-RUf0L6hKQZR0CoGPlOsj_c?loadFrom=DocumentDeeplink&ts=1008.36)):

And thank you so much for joining us today, Ann and Dr. Policar, and for sharing your time and expertise. For more content, including previous podcast episodes, search for Clinical Chats or subscribe to our show on iTunes, Google Podcasts, Spotify, Stitcher, or wherever you listen to podcasts. For a transcript of this podcast, as well as other online learning activities, and continuing education opportunities, please visit our website at www.ctcsrh.org. While you're there, you can sign up to receive our newsletter, Clinical Connections, at the top of the page.

**Katherine Atcheson** ([17:25](https://www.rev.com/transcript-editor/shared/mU4Bhtzzpmhr6OoUMAnqoXB9ojQlong0pfNDLKDACk3VLs88owEI099a_sWck_3wkqgmu0VEtooekrDGkhJuGZpgEbo?loadFrom=DocumentDeeplink&ts=1045.59)):

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**Katherine Atcheson** ([17:56](https://www.rev.com/transcript-editor/shared/iPPlXa6_Zd5ndaheFchxdgvoBs_icGVjxYCYdrfFEsxHxYj8q9pFuX7c2XS9PPDJDn_F798AQcdYjGNn1ieh_wMW5uo?loadFrom=DocumentDeeplink&ts=1076.67)):

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**Katherine Atcheson** ([18:29](https://www.rev.com/transcript-editor/shared/48aiTKT-7_hg2sr7sRSOXNuK6U7vuNfGZcmGyp-in6h-m64xHyq23xGANmtZlbCojirS46cnxK-QIURe3kdwd2_NKgs?loadFrom=DocumentDeeplink&ts=1109.37)):

Theme music written by Dan Jones and performed by Dan Jones and The Squids. Other production support provided by the Collaborative to Advance Health Services at the University of Missouri-Kansas City School of Nursing and Health Studies. Finally, thank you to our listeners for tuning in today. We hope that you'll join us next time for another episode of Clinical Chats.