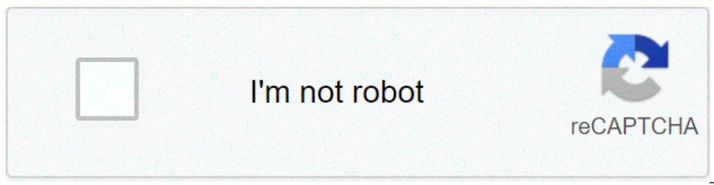

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Ultrasound guided dilation and evacuation cpt code

Hello coding community! We have a different opinion on how to encode the case below: Cpt and Dx. We would like to hear your rational. Thank you very much for your help. We both agree that with 76998 Us and -22 for extra work, we disagree on Px and Dx. Option 1: 59841-22 D&; E, 76998 with dx O03.4-SAB 24 weeks Option 2: 59821-22, 76998 with O36.4xx0 24 weeks, 59821- Treatment of missed abortion, surgically terminated; Second Trimester O03.4 Incomplete spontaneous abortion without complication O36.4xx0- Prenatal care for intrauterine death, not applicable or unspecified PROCEDURE: Standard dilation and evacuation/D and E CLINICAL indications: . G2P0010 at 24+0d with fetal death She was spotted yesterday at L&; D there .. She had cervical preparation with cervical osmotic dilators overnight.. Procedure:... Dilation was assessed and found to be somewhat inadequate. Dilation performed with Pratt dilators to 45 Fr. A 14 mm suction needle was advanced and the amniotic fluid removed. Bierer cocks were used to transect the umbilical cord and to evacuate fragmented fetal parts and placenta. Sharp curettage was used to confirm an empty uterine cavity and suction aspiration was repeated. Throughout the procedure, we were careful to pass the instruments gently into the uterine cavity due to significant distortion from a posterior lower uterine fibroid segment. Hemostas was not satisfactory at the time the procedure was terminated. Methergine and then TXA were given. An ultrasound revealed a thin uterine stripe. The posterior cervix was raw and did not become hemostatic after pressure and application of Monsel's solution. The cervix was whip-stitched from 6:00 am to 9:00 pm with running locked 0-Vicryl. Further Monsels and pressure were applied and then hemostasis was satisfactory. All instruments were removed from the vagina and the patient was taken to the post-anesthesia recovery room awake and in stable condition. Products of conception were examined and noted to be complete. INTRAOPERATIVE SONO: Indication for intraoperative sono: D&; E executed with dice. SPECIMEN: products of conception were sent fresh, permanent to pathology. Small portion of the fetus and placenta was sent for microarray (SNP) Thank you, Sharon! I'm stuck on the dx. My gut tells me it's a missed abortion and that's why I went to 59821 for the second trimester. But what puzzled me is Dx MD put-O364xx0-fetal dödise not O02.1. In ob/gyn comprehensive guide book 2020' 59821 and 59841 have both dx for fetal death but in a different format. 59821 has only one Dx-Missed AB along with definition –retention dead fetuswhere foetal death occurred before 20 w (ME: however 59821 second trimester is up to 27 w) Our fetus is 24w. 59841 has been listing O36.4xx0- intrauterine death and that is what MD indicated. There is no Missed AB for 59841. So, both CPT's for fetal death, they both have no Heart Beat. Our case can fall into both CPT since PT is 24w and evacuation of the dead fetus was done. We know that a not ' happen and now we will make elective, induced, surgical expulsion of the dead fetus. The question is which code to choose? If MD had added Missed Abortion dx that would help the encoder to go straight into 59821 but MD stated fetal doom. I'm puzzled. The Encoder has Exclude 1 during O36.4- Missed Abortion (O02.1) (O02.1) Should I assign Missed AB O02.1 and go with 59821? I never, ever, ever count on my MD to know what the nuances of coding diagnoses are. For him, missed abortion and fetal death would be the same thing. Heck, mine makes things up all the time. He will say lower back pain, severe and when I try to tell him that there is no severe (or other intensity), he says, of course there is. I say: not in state 10, there isn't. (ICD10 State) Thank you, Sharon! I'm stuck on the dx. My gut tells me it's a missed abortion and that's why I went to 59821 for the second trimester. But what puzzled me is Dx MD put-O364xx0-fetal dödise not O02.1. In ob/gyn comprehensive guide book 2020' 59821 and 59841 have both dx for fetal death but in a different format. 59821 has only one Dx-Missed AB along with definition –retention dead fetuswhere foetal death occurred before 20 w (ME: however 59821 second trimester is up to 27 w) Our fetus is 24w. 59841 has been listing O36.4xx0- intrauterine death and that is what MD indicated. There is no Missed AB for 59841. So, both CPT's for fetal death, they both have no Heart Beat. Our case can fall into both CPT since PT is 24w and evacuation of the dead fetus was done. We know that a natural abortion did not happen and now we will make elective, induced, surgical expulsion of the dead fetus. The question is which code to choose? If MD had added Missed Abortion dx that would help the encoder to go straight into 59821 but MD stated fetal doom. I'm puzzled. The Encoder has Exclude 1 during O36.4- Missed Abortion (O02.1) (O02.1) Should I assign Missed AB O02.1 and go with 59821? I understand what you're saying, and I'm not sure why 59841 has that DX and a few others listed – as I've always been told to use induced abortion codes when it's a termination. For dx, it is the weeks of pregnancy that are the difference and are listed in ICD 10 : Missed abortion up to 20 weeks and O36 .4 for after 20 weeks. I would use O36.4 with 59821 Abortion considers the most common cause of fetal doom worldwide. The majority of cases occur during the first trimester. The termination of abortion can be through medical or surgical methods, however; the surgical methods represent most of the termination. Therefore, the safety of this procedure is a worldwide public health problem. Many clinical studies have reported the safety of surgical evacuation in the first trimester. Suction-aspiration or vacuum aspiration are the most common surgical methods of induced abortion. This consists of removing the foetus, embryo, and membranes by sucking using a manual syringe or electric pump. However; However; technique always needs cervical dilation before aspiration. Menstrual cravings do not require cervical dilation and can be used in very early pregnancy. The surgical evacuation is generally considered safe, however; Short-term complications are reported due to the need for dilatation of the cervix and incomplete evacuation because the surgeon is the only one who can determine the end of the operation depending on his subjective meaning. However; With continuous ultrasound guidance, the process could be almost complete because the ultrasound can accurately identify the direction and size of the uterus, the position of the pregnancy sac, observe the introduction of surgical instruments and the advancement of the operation especially when the configuration of the uterus is distorted. At present; ultrasonography is not considered an essential condition for abortion in all cases so our study aims to discover whether complete evacuation can be achieved by ultrasonographic assistance or not. We also tried in this study to compare the operative time, amount of blood loss and the presence of accidental uterine perforation during the procedure with and without the use of ultrasound. Condition or Disease Intervention/Treatment Phase Abortion Procedure: Blind Evacuation Procedure: Evacuation under ultrasound guidance phase 2 Arm Intervention/Treatment Active Comparator: Blinded Evacuation Ring evacuation was performed conventionally without the use of ultrasound followed by sharp mild curettage until complete evacuation Procedure: Blinded evacuation Ring evacuation was performed in conventional manner without the use of ultrasound followed by sharp gentle curettage until complete evacuation. Active Comparator: Evacuation under ultrasound guidance Ring evacuation was performed under ultrasonic guidance followed by sharp gentle curettage until complete evacuation. The operation was considered complete when the endometrial cavity appeared as a common echogenic line. Procedure: Evacuation under ultrasound guidance Ring evacuation was performed under ultrasonic guidance followed by sharp mild curettage until complete evacuation. The operation was considered complete when the endometrial cavity appeared as a common echogenic line. Primary Outcome Dimensions : Measurement of endometrial thickness by ultrasound (mm) [Time picture: 1 year] Secondary outcome Dimensions : Measurement of blood loss (mL) [Time picture: 1 year] measurement of operative time (minutes) [Time picture: 1 year] measurement of hemoglobin level(g/g/g/ml) [Time frame: 1 year] Inclusion Criteria: women with non-viable first trimester intrauterine pregnancy no contrainment to surgical evacuation under general anesthesia Exclusion criteria: gestational age more than 13 weeks hemodynamically unstable suspicion of an ectopic pregnancy