Peer Reviewed

The Delivery Room

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" Within the delivery room, differences exist between the CPT® code sets, 99464 (attendance at delivery) and 99465 (the code for delivery or birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output)."

A 2020 article titled "The Bundled Neonate" reviewed the concept of "bundled" procedures within the global daily codes and highlighted the differences within the Current Procedural Terminology (CPT®) codes for delivery room management. Within the delivery room, differences exist between the CPT® code sets, 99464 (attendance at delivery) and 99465 (the code for delivery or birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output). Ultimately, reimbursement requires proper documentation supporting the CPT® code and International Classification of Disease, Tenth Revision, and Clinical Modification (ICD-10) diagnosis codes.

Proper documentation found in a delivery room note should include the following:

- Request for attendance at delivery
- Known maternal-fetal conditions impacting the delivery
- Attendance at delivery and/or resuscitation
- Focused physical examination
- Disposition of the patient

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The encounter should be initiated by the delivery physician's request for attendance at delivery. A hospital policy that requires a neonatologist to attend select deliveries (ex. - all cesarean sections) will not suffice for reimbursement purposes as a medical indication for attending the delivery. Preferably, the documentation should note the name of the delivery physician who requested the care provider to attend the delivery.

The neonatologist and/or advanced practice provider (APP) should be aware of known maternal-fetal conditions impacting the delivery. Note that maternal diagnosis found within the "O" Chapter, Pregnancy, Childbirth, and the Puerperium (O00 – O9A) is for use only on the maternal record! Further, the ICD-10 codes found within Z37 (Outcome of delivery) are used exclusively on the maternal record.

As noted above, there is a difference between CPT® codes 99464 (attendance at delivery) and 99465 (the code for delivery or birthing room resuscitation, positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output). It is important to note that the application of continuous positive airway pressure (CPAP) is not considered resuscitation.

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If the infant requires additional resuscitative efforts, including intubation, surfactant administration, thoracentesis, paracentesis, and umbilical artery and/or vein catheterization, they should be reported separately. However, the procedure must be an essential component of resuscitation. Examples of CPT® procedure codes include emergency endotracheal intubation (31500), catheterization of the umbilical vein (36510), catheterization of the umbilical artery (36660), and surfactant administration (34610). Documentation of the procedure(s) should be included as part of the delivery room note.

The care provider should perform a focused physical examination of the infant prior to disposition. Note that this examination should not be construed as the initial examination upon admission to the newborn nursery or NICU, which represent separate encounters. Once disposition has been determined, the parent should be up-

dated as to the condition and ongoing care of the infant.

Question

Dr. Smith asked you to attend an emergency cesarean delivery of a 28-week estimated gestational age neonate. The mother presents with chronic hypertension and a placenta previa with bleeding. Upon reviewing her prenatal labs, she is noted to have had a Group B Strep UTI during the pregnancy. The neonate is born limp, with poor respiratory effort, low heart rate, and cyanosis. Following NRP guidelines, you provide bag-mask ventilation. Subsequently, the neonate requires intubation and positive-pressure ventilation. The heart rate was initially less than 60 beats per minute and accelerated once the airway was secured. The physical examination demonstrates respiratory distress, with findings consistent with 28 weeks gestation and birthweight of 720 g. You discuss the findings with the parents and obstetrician and note the need for ongoing care. The infant is moved to the NICU. CXR confirms RDS. The infant is placed on assisted ventilation, an umbilical arterial catheter is placed, and surfactant is given. What is the correct CPT® code(s) for the delivery room?

A. 99465

B. 99465, 31500

C. 99465, 31500, 36660

The correct answer is B.

99465 represents the code for delivery or birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output.

31500 represents the code for endotracheal intubation, an emergency procedure.

36660 represents the code for catheterization of the umbilical artery for diagnosis or therapy in the newborn. As this procedure was performed in the NICU, this procedure is not billable as part of the resuscitation nor as part of the initial day of critical care.

Question

Correct ICD-10 Codes include all the following except:

A. Z38.01 Single liveborn infant, delivered by cesarean

B. P07.31 Preterm newborn, gestational age 28 completed weeks

C. P05.13 Disorders of newborn related to slow fetal growth and fetal malnutrition, small for gestational age, 500-749 g

D. P00.0 Newborn affected by maternal hypertensive disorders

E. O69.4 Labor and delivery complicated by vasa previa

F. P00.82 Newborn affected by maternal group B Streptococcus (GBS) colonization

G. P22.0 Respiratory distress syndrome of the newborn

The correct answer is **E**. Codes from the "O" chapter are exclusive to the maternal chart. The correct code for placenta previa affecting the newborn is P02.0.

Proper documentation may be similar to the following:

Dr. Smith asked me to attend a cesarean section for an EGA 28-week infant. The maternal history is significant for chronic hypertension and a GBS UTI during the pregnancy. She presents with placenta previa and vaginal bleeding. The infant was delivered by emergency cesarean section, which produced a live/viable female infant. Delayed cord clamping was not performed as the infant was limp with no respiratory effort. The infant was dried, the OP was suctioned, and the infant was stimulated. HR was approximately 60 bpm. PPV was applied via bag and mask. The infant was subsequently intubated with a 2.5 ETT via direct laryngoscopy with a 00 Miller blade and demonstrated increased HR, respiratory effort, and tone. PE was consistent with a symmetrically SGA 28-week infant. There continue to be significant intercostal and subcostal retractions and an increase in WOB with bilateral rales. HR is regular w/o murmur. The abdomen reveals a 3-vessel umbilical cord. There is no HSM Normal preterm female genitalia. The anus is patent. The infant is to be transferred to the NICU. The parents were updated following the delivery. Dr. Smith is aware and updated.

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