Agenda

• Pregnancy, childbirth and the puerperium
• Trimesters and OB code extensions
• Code sequencing for OB cases
• Diabetes and other conditions complicating pregnancy
• Newborns and perinatal conditions
• ICD-10-CM Implementation
Remember!

- Understanding the coding guidelines for each section is as important as identifying the codes!!
• Chapter 15: *Pregnancy, childbirth and the puerperium*

• Episode of care is no longer a secondary axis of classification
  - No antepartum, postpartum, etc.
  - ICD-10-CM defines by trimester in the code description if relevant
Pregnancy...

- Chapter notes apply to the entire chapter
- Codes from this chapter are for use only on maternal records – never on newborn records.
- Codes from this chapter are for use for conditions related to or aggravated by the pregnancy, childbirth, or by the puerperium (maternal causes or obstetric causes)
Trimesters

- Trimesters are counted from the first day of the last menstrual period:
  - 1st trimester – less than 14 weeks, 0 days
  - 2nd trimester – 14 weeks 0 days to less than 28 weeks 0 days
  - 3rd trimester – 28 weeks 0 days until delivery

- If trimester is not documented, base # of weeks on estimated gestational age and not from last menstrual period
Example

• A pregnant patient has pre-existing essential hypertension.
  – 010.011 Pre-existing essential hypertension complicating pregnancy, first trimester
  – 010.012 ... second trimester
  – 010.013 ... third trimester
  – 010.019 ... unspecified trimester
Selecting the Trimester

- Select the code for the trimester of the current admission or encounter
  - For example, if patient developed gestational hypertension during the 2\textsuperscript{nd} trimester and is now being seen during the 3\textsuperscript{rd} trimester, choose the code for 3\textsuperscript{rd} trimester

- Codes for “unspecified trimester” should rarely if ever be used
Code titles have been revised in a number of places in Chapter 15.

ICD-10-CM terminology is more descriptive of what the code represents.

Codes have been moved from other chapters in ICD-9-CM to Chapter 15 in ICD-10-CM.

- Example – Encounter for supervision of high risk pregnancy
Obstructed Labor

• In ICD-10-CM the codes for obstructed labor incorporate the reason for the obstruction into the code so only one code is needed instead of two as in ICD-9-CM.
  
  – 064.1xx- Obstructed labor due to breech presentation
Abortion

- In ICD-9-CM the codes for elective abortions are with the abortion codes.
- In ICD-10-CM the elective abortion code (without complication) has been moved to Z33.2, Encounter for elective termination of pregnancy.
• Seventh Characters
  – Provide further specificity about the characteristics of the encounter being coded
  – The 7th character identifies the fetus to which certain complication codes apply
## Extensions: Fetus

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>not applicable or unspecified</td>
</tr>
<tr>
<td>1</td>
<td>fetus 1</td>
</tr>
<tr>
<td>2</td>
<td>fetus 2</td>
</tr>
<tr>
<td>3</td>
<td>fetus 3</td>
</tr>
<tr>
<td>4</td>
<td>fetus 4</td>
</tr>
<tr>
<td>5</td>
<td>fetus 5</td>
</tr>
<tr>
<td>9</td>
<td>other fetus</td>
</tr>
</tbody>
</table>
Gestations

- The “0” is for single gestations and for multiple gestations where the affected fetus is unspecified.
- 7\textsuperscript{th} characters 1-9 are for cases of multiple gestation to identify the fetus to which the code applies.
- A code from category O30, Multiple gestation must also be assigned when assigning these codes.
Placeholders

• Many OB codes require placeholder ("x") between the last digit of the code and the 7\textsuperscript{th} digit extension

• Example:
  – 069.1\textcolor{red}{xx}0 Labor and delivery complicated by cord around neck, with compression, not applicable or unspecified
  – Use extension “0” for singleton pregnancy
  – The code is invalid without the placeholders
Sequencing

• Chapter 15 codes have sequencing priority over codes from other chapters.
• Additional codes from other chapter may be used in conjunction with Chapter 15 codes to further specify conditions.
• If the pregnancy is incidental to the patient encounter, then code Z33.1, Pregnant state, incidental, should be used in place of any chapter 15 codes.

• It is the provider’s responsibility to state that the condition being treated is not affecting the pregnancy.
Incidental Pregnancy

- Patient is seen in ED due to a right thumb laceration. The ED physician documents a secondary diagnosis of incidental pregnancy, 8 weeks.
  - S61.001A Unspecified open wound of right thumb without damage to nail, initial encounter
  - Z33.1 Pregnant state, incidental
Selection of OB Principal or First-Listed Diagnosis

- For routine outpatient prenatal visits when no complication are present, a code from category Z34, Encounter for supervision of normal pregnancy, should be used as the first-listed diagnosis.
- These codes should not be used in conjunction with chapter 15 codes.
Selection of OB Principal or First-listed Diagnosis

- For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category O09, Supervision of high-risk pregnancy should be used as the first-listed diagnosis.

- Secondary chapter 15 codes may be used in conjunction with these codes if appropriate.
Selection of OB Principal or First-listed Diagnosis

- In episodes when no delivery occurs, the principal diagnosis should correspond to the principal complication of the pregnancy which necessitated the encounter. Should more than one complication exist, all of which are treated or monitored, any of the complications codes may be sequenced first.
Selection of OB Principal or First-listed Diagnosis

- When a delivery occurs, the principal diagnosis should correspond to the main circumstances or complication of the delivery. In cases of cesarean delivery, the selection of the principal diagnosis should be condition established after study that was responsible for the patient’s admission.

- If the patient was admitted with a condition that resulted in the performance of a cesarean procedure, that condition should be selected as the principal diagnosis.
Selection of OB Principal or First-listed Diagnosis

- *If* the reason for the admission/encounter was unrelated to the condition resulting in the cesarean delivery, *the condition related to the reason for the admission/encounter should be selected as the principal diagnosis, even if a cesarean was performed.*
Selection of OB Principal or First-listed Diagnosis

- A code from category Z37, Outcome of delivery, should be included on every maternal record when a delivery has occurred.
- These codes are not to be used on a subsequent records or on the newborn record.
Selection of OB Principal or First-listed Diagnosis

• Certain categories in Chapter 15 distinguish between conditions of the mother that existed prior to pregnancy (pre-existing) and those that are a direct result of pregnancy.

• When assigning codes from Chapter 15, it is important to assess if a condition was pre-existing prior to pregnancy or developed during or due to the pregnancy in order to assign the correct code.
Selection of OB Principal or First-listed Diagnosis

- Categories that do not distinguish between pre-existing and pregnancy-related conditions may be used for either. It is acceptable to use codes specifically for the puerperium with codes complicating pregnancy and childbirth if a condition arises postpartum during the delivery encounter.
Fetal Conditions Affecting the Management of the Mother

- Codes from categories O35, Maternal care for known or suspected fetal abnormality and damage, and O36, Maternal care for other fetal problems, are assigned only when the fetal condition is actually responsible for modifying the management of the mother, i.e., by requiring diagnostic studies, additional observation, special care, or termination of pregnancy.

- The fact that the fetal condition exists does not justify assigning a code from this series to the mother’s record.
• Patient is referred during third trimester for an umbilical artery Doppler exam due to suspected placental insufficiency.
  – 036.5130 Maternal care for known or suspected placental insufficiency, third trimester, not applicable or unspecified
During pregnancy, childbirth or the puerperium, a patient admitted because of an HIV-related illness should receive a principal diagnosis from subcategory 098.7-, Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium followed by the code(s) for the HIV-related illness(es).
Patients with asymptomatic HIV infection status admitted during pregnancy, childbirth, or the puerperium should receive codes of O98.7 – and Z21, Asymptomatic human immunodeficiency virus [HIV] infection status.
Diabetes mellitus in pregnancy

- Diabetes mellitus is a significant complicating factor in pregnancy.
- Be sure to distinguish between pregnant women with pre-existing diabetes and women with gestational diabetes (pregnancy-related).
Pre-Existing Diabetes

- For pre-existing diabetes:
  - Assign first a code from category O24, Diabetes mellitus in pregnancy, childbirth, and the puerperium
  - Assign a code for diabetes mellitus (E08-E13) as a secondary diagnosis.
Long term use of insulin

- Code Z79.4, Long-term (current) use of insulin, should also be assigned if the diabetes mellitus is being treated with insulin.
• A patient with type 2 diabetes mellitus, controlled on diet and oral medications, is in her second trimester of pregnancy.
  – 024.112 Pre-existing diabetes mellitus, type 2, in pregnancy, second trimester
  – E11.9 Type 2 diabetes mellitus without complications
Gestational (pregnancy induced) Diabetes

- Gestational (pregnancy induced) diabetes can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy.
- Gestational diabetes can cause pregnancy complications similar to those of pre-existing diabetes mellitus.
- Also puts the woman at risk of developing diabetes mellitus after the pregnancy.
• The codes under subcategory O24.4 include diet controlled and insulin controlled.
• If a patient with gestational diabetes is treated with both diet and insulin, only the code for insulin-controlled is required.
• Code Z79.4, Long-term (current) use of insulin, should not be assigned with codes from subcategory O24.4.
• No other code from category O24, Diabetes mellitus in pregnancy, childbirth, and the puerperium, should be used with a code from O24.4.
Example

- A 38-year-old woman develops gestational diabetes in her second trimester. It is controlled by diet.
  - 024.410 Gestational diabetes mellitus in pregnancy, diet-controlled
An abnormal glucose tolerance in pregnancy is assigned a code from subcategory O99.81, Abnormal glucose complicating pregnancy, childbirth, and the puerperium.
When assigning a chapter 15 code for sepsis complicating abortion, pregnancy, childbirth, and the puerperium, a code for the specific type of infection should be assigned as an additional diagnosis.

If severe sepsis is present, a code from subcategory R65.2, Severe sepsis, and code(s) for associated organ dysfunction (s) should also be assigned as additional diagnoses.
Normal Delivery, Code O80

- Code O80 should be assigned when a woman is admitted for a full-term normal delivery and delivers a single, healthy infant without any complication antepartum, during the delivery, or postpartum during the delivery episode.
- Code O80 is always a principal diagnosis.
- It is not to be used to describe a current complication of the antenatal, delivery or perinatal period.
- Z37.0, single live birth, is the only outcome of delivery code appropriate for use with O80.
• Chapter 16: *Certain conditions originating in the perinatal period (P00-P96)*

• Several new subchapters have been added to Chapter 16 for certain conditions originating in the perinatal period.

• Codes in this chapter are never used on the maternal record.
Perinatal Period

• Also contains several terminology updates
• Terms *fetus* and *newborn* utilized in many ICD-9-CM titles have been removed
• Newborns affected by maternal factors and by complications of pregnancy, labor and delivery, the phrase “suspected to be” is included in the code title as a nonessential modifier to indicate that the codes are for use when the listed maternal condition is specified as the cause of confirmed or suspected newborn morbidity or potential morbidity.
Example

• P03.0 Newborn (suspected to be) affected by breech delivery and extraction
  – This code should not be assigned simply because the infant was delivered in breech position
  – However, it should be used if the infant suffered complications of the breech delivery
Birth Episode

- When coding the birth episode in a newborn record, assign a code from category Z38, liveborn according to place of birth and type of delivery, as the principal diagnosis.
- A code from Z38 is assigned only once, to a newborn at the time of birth.
- If a newborn is transferred to another institution, a code from category Z38 should not be used at the receiving hospital.
Perinatal Period

• Codes from other chapters may be used with codes from Chapter 16 if the codes from the other chapters provide more specific detail.

• Codes for signs and symptoms may be assigned when a definitive diagnosis has not been established.

• If the reason for the encounter is a perinatal condition, the code from Chapter 16 should be sequenced first.
• Should a condition originate in the perinatal period and continue throughout the life of the patient, the perinatal code should continue to be used regardless of the patient’s age.

• Example: An adolescent patient suffers from bronchopulmonary dysplasia that was present at birth. Assign the following code:
  - P27.1 Bronchopulmonary dysplasia originating in the perinatal period
Community Acquired Conditions

- If a newborn has a condition that may be either due to the birth process or community acquired and the documentation does not indicate which it is, the default is due to the birth process and the code from Chapter 16 should be used.

- If definitely community acquired do not use a code from Chapter 16.
Perinatal Period

- All clinically significant conditions noted on routine newborn examination should be coded.
  - Clinical evaluation
  - Therapeutic treatment
  - Diagnostic procedures
  - Extended length of hospital stay
  - Increase nursing care and/or monitoring
  - Has implications for future health care needs
Prematurity

- A code for prematurity should not be assigned unless the condition is documented.
Remember!

• Don’t forget that it is very important to review the coding guidelines and instructions when assigning codes from any section in ICD-10-CM.
Prepare Now!

• Begin early
• Allow plenty of time
• Develop a clear plan
• Follow logical implementation
According to Canadian and Australian participants in the change to ICD-10, the single most important factor of the conversion process was clear, concise and complete communication across the organization.
Who Needs Training?

- Coding staff
- Billing and/or finance
- Compliance staff
- Clinicians (Clients)
- Management
- Information technology
- Information systems
- AND MANY MANY MORE!
And don’t forget the Physicians

Educate your physicians or other healthcare providers on the additional detail required to be documented in the medical record in order to assign ICD-10-CM codes.
Step 1: Organize Implementation Effort

• Look at all areas that will impact your organization and identify each one that will be affected:
  – Billing System
  – Other financial systems
  – Super bills?
Step 2: Establish Your Communication Plan

- Internal plan
  - Communication methods for your staff
    - Meetings
    - Email
    - Intranet?
    - Other?
Step 3: Conduct Impact Analysis

• What resources do you require for implementation?
• What will be the potential costs be?
• System inventory
  – Your control
  – Vendor control
• Time to implement new systems?
  – EMR
  – New billing system?
Step 4: Contact System Vendors

- Are they prepared for the move to ICD-10?
- Will they be ready for 5010 on 1/1/12?
- What costs will be involved with the transition?
- What are their implementation plans?
- Will we need new or enhanced software/hardware?
MGMA estimates that the average cost of moving to ICD-10 for a three-physician practice will be $84,000.
## Cost Breakdown - EXAMPLE

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>$2,500</td>
</tr>
<tr>
<td>Process Analysis</td>
<td>$7,000</td>
</tr>
<tr>
<td>Changes to Superbills</td>
<td>$3,000</td>
</tr>
<tr>
<td>IT Costs</td>
<td>$7,500</td>
</tr>
<tr>
<td>Increased Documentation</td>
<td>$44,000</td>
</tr>
<tr>
<td>Cash Flow Disruption</td>
<td>$20,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$84,000</strong></td>
</tr>
</tbody>
</table>

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Step 6: Implementation Planning

- Introduce the ICD-10-CM concept
- Select a champion to:
  - Lead cross-functional team
  - Monitor updates
  - Coordinate education
  - Troubleshoot implementation
- Allocate budget
- Review current coding processes
- Revise paper documents
- Work with software vendors
Information Systems Changes

- Billing
- Coding edits
- Clearinghouses
- Interfaces
- Utilization & Reporting
- Claims submission
- Groupers & Coding Edits
- Clinical systems
- Hardware changes
- Software applications
- Data conversion
Step 7: Develop Training Plan

- Who specifically needs training?
  - Physicians
  - Coders
  - Billing staff
  - Administrative Staff
  - Clinical Staff

- How many hours should be allocated for each position type?

- What resources are available, needed, etc.?
Step 7: Develop Training Plan

- Set timeframes for training
- Will you need to utilize temps, outsourcing and/or overtime during the training period?
- What about ongoing support/training after implementation?
Step 8: Analyze Business Processes

- How and where is ICD-9-CM utilized in your organization now?
- Review of their medical policies and contracts
  - Identify changes that will need to occur prior to implementation
Step 9: Policy Change Development

- As soon as available:
  - Review new medical necessity policies
  - Identify opportunities to improve internal processes
  - Identify opportunities to improve client issues
    - Documentation problems
    - Data capture concerns
    - Etc.
Now – Don’t wait!!

- Download and read AHIMA’s “ICD-10 Preparation Checklist”
  (www.ahima.org/ICD10)
- Identify and appoint an internal champion
  - Process issues (Operations/IT)
- Identify and appoint an external champion (if needed)
  - Physician relations (might be same person)
Now – Don’t wait!!

- Identify and appoint an ICD-9-CM/ICD-10-CM content expert
  - Training/implementation

- Identify and appoint a project leader

- Establish an interdisciplinary steering committee
Thank you for listening to this course in the ICD-10-CM coding series.