March 2015

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ICD-10 for OB/GYN

UConn Health

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Introductions

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Agenda

- After attending this session, participants will be able to:
  - Describe the challenges associated with ICD-10 implementation
  - Identify documentation standards necessary for complete and accurate code assignment
  - Identify the importance of physician documentation and coding
  - Discuss the importance behind the query writing process and Physician response.

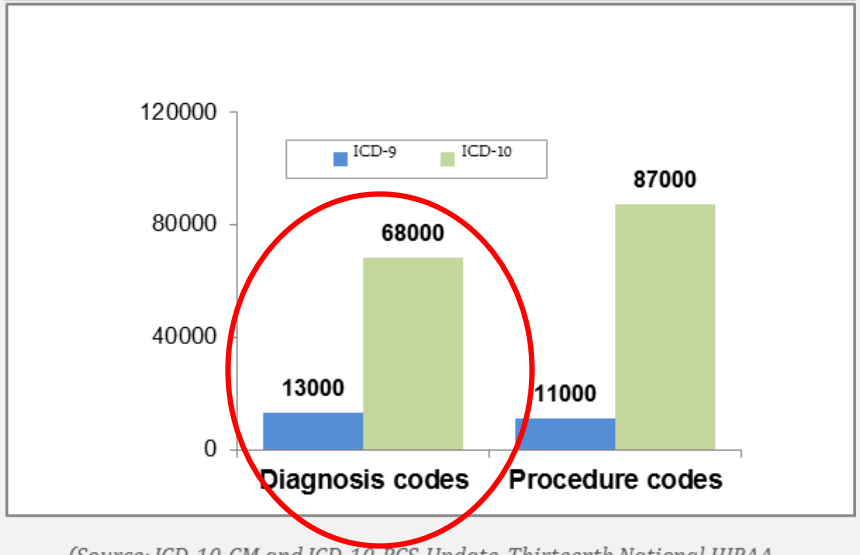
Changes to Diagnosis Codes

The most significant difference between ICD 9 and ICD 10 is the size and composition of the new codes

- ICD 9 is five digits where ICD 10 is 7 alphanumeric characters
- Re-structured classification
- Specificity and detail have been expanded

ICD 10 better describes acuity, complexity and laterality of the patients under your care

Number of ICD 9 and ICD 10 codes for diagnoses and procedures



(Source: ICD-10-CM and ICD-10-PCS Update, Thirteenth National HIPAA Summit, 9/26/2006; Rand Study, March 2004)

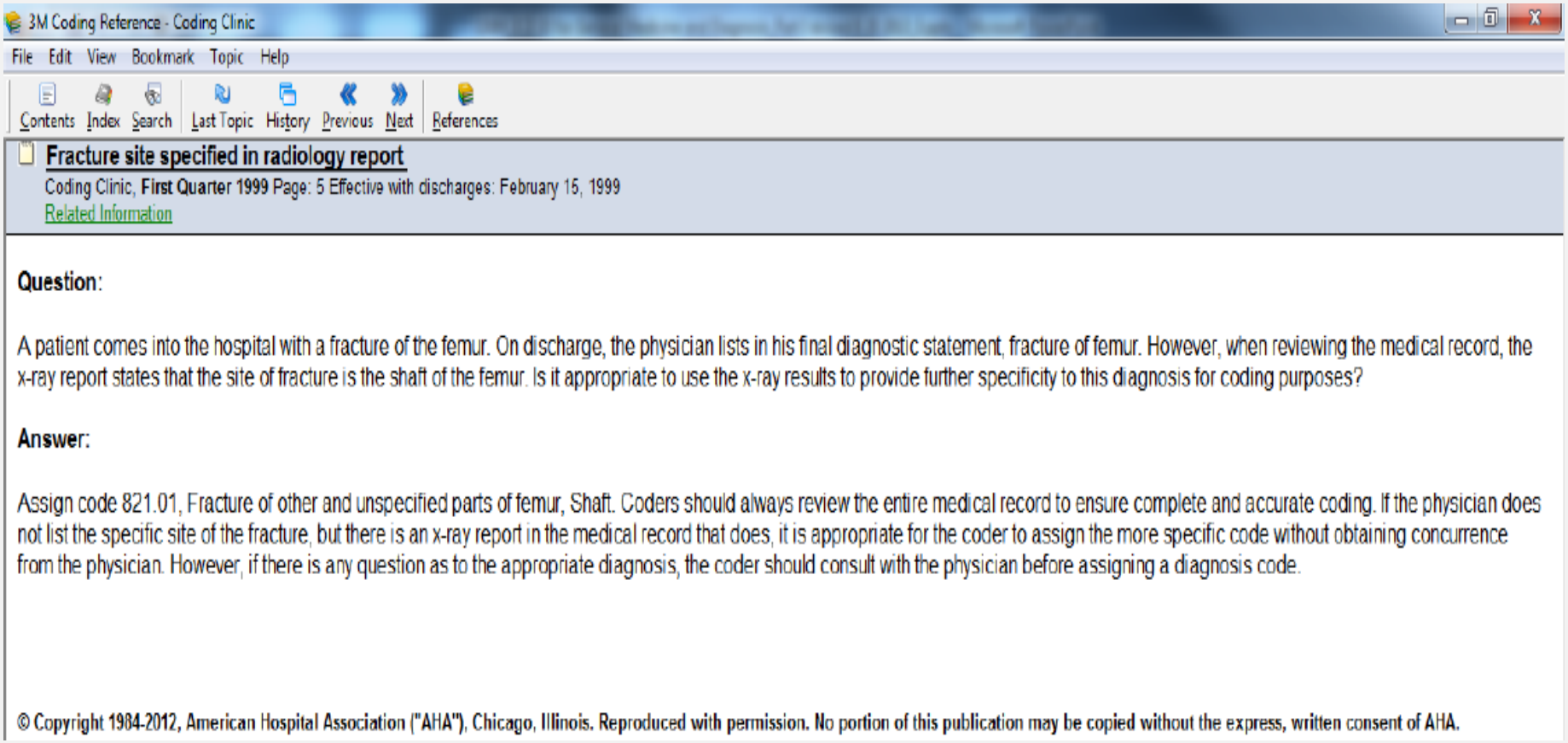
Considerations

- ICD-10 requires collaboration, collaboration and more collaboration between all members of the clinical and non-clinical healthcare team:
  - Education of CDI/coder staff
  - Template revisions
  - Query revisions

Challenges

- ICD-10 is a classification system, not a clinical language system:
  - Physician documentation - primarily directed for communication between clinicians
  - Bridging gaps between coder classification language and physician clinical documentation

Challenges: Coding Specificity



3M Coding Reference - Coding Clinic

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Fracture site specified in radiology report

Coding Clinic, **First Quarter 1999** Page: 5 Effective with discharges: February 15, 1999

Related Information

Question:

A patient comes into the hospital with a fracture of the femur. On discharge, the physician lists in his final diagnostic statement, fracture of femur. However, when reviewing the medical record, the x-ray report states that the site of fracture is the shaft of the femur. Is it appropriate to use the x-ray results to provide further specificity to this diagnosis for coding purposes?

Answer:

Assign code 821.01, Fracture of other and unspecified parts of femur, Shaft. Coders should always review the entire medical record to ensure complete and accurate coding. If the physician does not list the specific site of the fracture, but there is an x-ray report in the medical record that does, it is appropriate for the coder to assign the more specific code without obtaining concurrence from the physician. However, if there is any question as to the appropriate diagnosis, the coder should consult with the physician before assigning a diagnosis code.

Challenges

- Documentation by the physician of specific components of a particular classification (diagnosis code) is required:
  - Test results, labs, x-rays, EKGs, echo reports, path reports, studies performed for diagnosis are not sufficient documentation for classifying (coding) a disease/injury
  - Coders are only allowed to use physician documentation to classify a disease/injury or procedure

Documentation for Diagnosis

Requirements for Detailed Documentation for Diagnoses	
Acuity	Acute, chronic or both
Specific site	Femur trochanteric – apophyseal, greater trochanter, intertrochanteric, lesser trochanter
Laterality	Right, left, bilateral
Specific type of fractures	Displaced/non-displaced fractures, transverse, oblique, spiral, comminuted, segmental
Etiology of diagnosis	Fracture/dislocation due to – pathological, recurrent, fatigue, age-related, osteoporosis
Link must be established between manifestations and underlying diseases	Osteomalacia – puerperal, senile, due to malabsorption or malnutrition, aluminum bone disease, drug induced
Non-pressure skin ulcers	Site, laterality and depth of tissue involvement

Documentation for Diagnosis (cont.)

Requirements for Detailed Documentation for Diagnoses	
Complications of care	Intraoperative, postoperative, mechanical malfunctions, Infections (device vs. wound)
Injury details	Place of occurrence, activity causing the injury; accident details
Episode of care	Initial treatment, subsequent treatment (for routine or delayed healing), sequela
Drug reactions/interactions/adverse reactions	Poisoning (accidental/intentional/assault/undetermined), adverse effect, underdosing (due to financial hardship, age-related)
Degree of severity	Mild, moderate, severe, e.g., Malnutrition: mild, moderate, severe

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OB/GYN Diagnoses Documentation Examples

Top Diagnosis Codes

OB/GYN Diagnosis
V72.31 - ROUTINE GYNECOLOGICAL EXAMINATION
V22.1 - SUPERVIS OTH NORMAL PREG
V25.9 - CONTRACEPTIVE MANGMT NOS
V22.0 - SUPERVIS NORMAL 1ST PREG
625.9 - FEM GENITAL SYMPTOMS NOS
626.2 - EXCESSIVE MENSTRUATION
112.1 - CANDIDAL VULVOVAGINITIS
616.10 - VAGINITIS NOS
623.5 - NONINFECT VAG LEUKORRHEA
V24.2 - ROUT POSTPART FOLLOW-UP
V04.81 - NEED FOR PROPHYLACTIC VACCINATION AND INOCULATION, INFLUENZA
V06.1 - VACCIN FOR DTP
V25.11 - ENCOUNTER FOR INSERTION OF INTRAUTERINE CONTRACEPTIVE DEVICE
V72.42 - PREGNANCY EXAMINATION OR TEST, POSITIVE RESULT
626.8 - MENSTRUAL DISORDER NEC
V74.5 - SCREEN FOR VENERAL DIS
626.1 - SCANTY MENSTRUATION
V76.2 - SCREEN MAL NEOP-CERVIX
218.9 - UTERINE LEIOMYOMA NOS
698.1 - PRURITUS OF GENITALIA
648.83 - ABN GLUCOSE-ANTEPARTUM
V25.42 - IUD SURVEILLANCE
627.1 - POSTMENOPAUSAL BLEEDING
V72.41 - PREGNANCY EXAMINATION OR TEST, NEGATIVE RESULT
788.41 - URINARY FREQUENCY

Documentation Requirements

- An *assumption of relationship cannot be made without documentation*, and a ***query to the attending physician would be required***
- Coders/CDI staff are ***not permitted*** to classify diseases from laboratory or vascular study results alone
- For inpatients: possible, probable and suspected conditions are coded as though they exist
- ***For outpatients: code only to the highest level of certainty***

Pregnancy, childbirth, and puerperium

- Code range O00-O9A, Includes ectopic, abortion, pregnancy, childbirth and postpartum conditions
- Assign up to seven characters when applicable
- Sequencing priority: Exception pregnancy incidental to reason for encounter
  - Use additional codes from other chapters to explain condition(s)
- Supervision of care for high-risk pregnancy, alcohol, tobacco, adverse effects, underdosing

Clinical Example: Documentation Improvement

Below is an example of the classification differences between ICD-9-CM and ICD-10-CM for a pregnancy complication.

- ICD-9-CM

  648.03 –Diabetes Mellitus in mother complicating pregnancy, antepartum
- ICD-10-CM

  O24912 – Unspecified diabetes mellitus in pregnancy, second trimester
- The *trimester, or number of weeks in which the condition occurred should be coded from physician documentation*.
- It's also *important to know whether the condition is pre-existing or not.*

Trimesters

- Knowledge of trimester is a required secondary code
  - Trimester timeframes found at beginning of chapter
  - Trimester conditions are specific to trimester characters
  - Base trimester character on provider documentation or number of weeks documented in health record
  - Inpatient - Choose trimester when complication developed
  - Outpatient – choose trimester patient is currently seeking care
- Trimester axis of classification rather than episode of care
  - Not all conditions include codes for all three trimesters or is N/A
  - Counted from first day of last menstrual period

Trimesters	
1st	Less than 14 weeks 0 days
2nd	14 weeks 0 days to less than 28 weeks 0 days
3rd	28 weeks 0 days until delivery

Pregnancy

- ICD-9-CM Diagnosis
  - 648.03 –Diabetes Mellitus in mother complicating pregnancy, antepartum.
- ICD-10-CM
  - O24.912 – Unspecified diabetes mellitus in pregnancy, second trimester.
- **The trimester or number of weeks in which the condition occurred should be coded from physician documentation.**
- It is also important to know whether the condition is pre-existing or not.

Clinical Example: Documentation Improvement

Complications of labor and delivery

To properly classify complications of **multiple pregnancy** labor and delivery in ICD-10-CM, *physicians must specify which fetus is affected for appropriate classification.*

- 7th character extensions of 0 through 9
  - 0 - not applicable or unspecified
  - 1 - fetus 1
  - 2 - fetus 2
  - 3 - fetus 3
  - 4 - fetus 4
  - 5 - fetus 5
  - 9 - other fetus

In pre-term deliveries, the specific trimester is also classified.

Z code usage in Maternal codes

- Z33.1 Pregnant state, incidental – used instead of chapter 15 pregnancy codes
- Z33.2 Encounter for elective TOP
- Z34 Encounter for Supervision of normal pregnancy – used on outpatient prenatal visits with no complications
  - If patient has complication – used chapter 15 codes
- Z37 Outcome of delivery is used only on Mothers record that has delivery
- Z39.0 Encounter for care and examination of mother immediately after delivery

Normal Delivery

- Code O80 used if no known antepartum or postpartum complications are affecting Mother at time of delivery and encounter.

Postpartum

- Begins at the time of delivery and extends to six-weeks following any type of delivery
- Chapter 15 codes can be used beyond six-week period if documentation states pregnancy-related
- O85-O92 Postpartum conditions from time of delivery through six-weeks
- Infant born outside of hospital Z39.0

Other Obstetrical Conditions

- Category requires additional code
- O94 Sequelae or late effect
  - Code first the condition
- O98.xxx Infectious and Parasitic diseases
- O99.82x Streptococcus B Carrier State
- 099.84x Bariatric Surgery
- O9A.x xx Malignant neoplasm, Injury Poisoning, Physical, Sexual, Psychological Abuse

Clinical Example: Documentation Improvement

Genitourinary tract infections in Pregnancy

In ICD-9-CM, two codes were required to classify genitourinary tract infections: one for pregnancy with urinary tract infection and one to specify the type of infection. ***In ICD-10-CM, classification provides for site specificity***. If a pregnant patient has a genitourinary infection ***the specified site must be documented***. Otherwise, it defaults to "unspecified."

- **For example:**
  - Kidney
  - Bladder
  - Urethra
  - Other parts of urinary tract
  - Unspecified infections of urinary tract
  - Infections of the genital tract
  - Cervix Salpingo-oophoritis
  - Other parts of genital tract
  - Unspecified genitourinary tract infection

Clinical Example: Documentation Improvement

Obstructed labor and delivery

To properly classify complications of an obstructed labor and delivery in ICD-10-CM, physicians must be specific as to cause.

- For example:
  - Incomplete rotation of fetal head
  - Presentation: breech, face, brow, or shoulder
  - Other/unspecified malposition
  - Deformed pelvis
  - Generally contracted pelvis
  - Pelvic inlet contraction
  - Pelvic outlet and mid-cavity contraction
  - Fetopelvic disproportion, unspecified
  - Abnormality of maternal pelvic organs
  - Shoulder dystocia

Clinical Example: Documentation Improvement

Noninflammatory disorders of female genital tract

To properly classify for noninflammatory disorders of female genital tract in ICD-10-CM, physicians must specify by condition.

- **Fistulae involving female genital tract**
  - Vesicovaginal
  - Other urinary-genital tract fistulae
  - Vagina to small intestine
  - Vagina to large intestine
  - Other intestinal-genital fistulae
  - Genital tract-skin fistulae
  - Other/unspecified

Clinical Example: Documentation Improvement

- ***ICD-10-CM relies more heavily on categorizing the episodes of care*** for injuries and illnesses.

- A - Initial encounter is defined as the period when the patient is receiving active treatment
- D - Subsequent encounter is defined as the period after the active phase of treatment and when the patient is receiving routine care for the injury during the period of healing or recovery.
- S – Sequela is assigned for complications or conditions that arise as a direct result of an injury.

Clinical Example: Documentation Improvement

- **Absent, scanty, and rare menstruation**
  - Primary amenorrhea
  - Secondary amenorrhea
  - Amenorrhea, unspecified
  - Primary oligomenorrhea
  - Secondary oligomenorrhea
  - Oligomenorrhea, unspecified
- **Excessive, frequent, and irregular menstruation**
  - Excessive and frequent menstruation with regular cycle
  - Excessive and frequent menstruation with irregular cycle
  - Excessive menstruation at puberty

ICD10 requires Physicians to documents with much more specificity!

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Clinical Example: Documentation Improvement

Abortions

A spontaneous abortion that results in delivery of a fetus is classified as a delivery, rather than as an abortion. Because the objective of an abortion is to therapeutically terminate a pregnancy, a spontaneous abortion—or miscarriage—that results in some manual assistance is coded as a delivery rather than an abortion. ***The spontaneous abortion is captured via the diagnosis code requiring Physicians to document***:

- Type – complete, spontaneous, incomplete
- Complications
- Outcome – success of failed
- Habitual or recurrent
- Induced

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Additional Diagnosis and Documentation Requirements

Clinical Example: Documentation Improvement

Underdosing – new concept in ICD-10

- Taking less of a medication than prescribed by physician or manufacturer's instruction
  - Noncompliance
  - Complication of care

Underdosing – ***Documentation Needed***:

- If a patient is purposely stopping or altering their medication regimen this needs to be documented to provided accurate coding

Clinical Example: Documentation Improvement

Alcohol Abuse/Use

- ***Classifications include***
  - ***Uncomplicated***
  - ***Complications***
    - With intoxication
    - Delirium
    - Delusions
    - Hallucinations
    - Anxiety disorder
    - Sexual dysfunction
    - Sleep disorder
    - unspecified

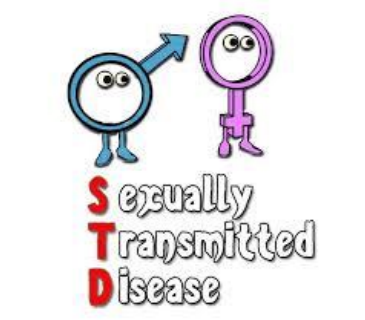
Clinical Example: Documentation Improvement

- Documentation Requirements
  - Physician (provider) ***must document whether the complication is associated with/due to the alcohol abuse.***
  - Alcohol abuse uncomplicated is how disease is classified without further documentation of relationship between specified complication and the alcohol abuse
    - F10.10 – Alcohol abuse, uncomplicated

Clinical Example: Documentation Improvement

ICD-10-CM has created a range of codes to identify infections with a predominantly Sexual mode of transmission (A50-A64).

- Physician (provider) must document the type of STD and infection.
- It is important to note that human immunodeficiency ***virus (HIV) disease is excluded from this range of codes***.
  - A56.11 Disease, diseased, sexually transmitted, chlamydial



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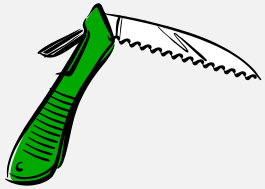
Clinical Example: Documentation Improvement

Domestic Violence Coding

- ICD-10-CM has *multiple codes each describing type of assault instrument as well as type of encounter such as:*
  - ICD-9 : Example: ICD-9-CM E code=E966=Assault by cutting and piercing instrument
  - X99.0xxA = Assault by sharp glass, initial encounter;
  - X99.0xxD = Assault by sharp glass, subsequent encounter;
  - X99.1xxA = Assault by knife, initial encounter;
  - X99.1xxD = Assault by knife, subsequent encounter



Clinical Example: Documentation Improvement

Domestic Violence Coding

- ICD-10-CM *includes whether the maltreatment was suspected or confirmed and also details if the encounter was initial or subsequent*
- *I10 also includes the terminology of "abandonment"*
  - T74.91xA Unspecified adult maltreatment, confirmed, initial encounter;
  - T74.91xD Unspecified adult maltreatment, confirmed, subsequent encounter
  - T76.91xA Unspecified adult maltreatment, suspected, initial encounter
  - T76.91xD Unspecified adult maltreatment, suspected, subsequent encounter

Genital Tract Fistula

Example of Female Genital Tract Fistula

Clinical (pathology) findings reported by anyone other than a physician directly caring for the patient does not suffice as documentation of disease (disorder) processes **without provider documentation of specific condition**.

Vaginal fistula

Code N82.9 Female genital tract fistula, unspecified is how disease would be classified without further documentation

Code N82.2 Fistula of vagina to small intestine is classification with documentation of specific site involvement

Site specificity must be documented by attending and/or consulting physician for reflection of appropriate patient acuity and quality of healthcare data. Without further specification of pathology findings, a query to the attending physician would be required for further specificity.

Pain

- ICD-9-CM Admit Diagnosis
  - 625.9 Unspecified symptom associated with female genital organs
- ICD-10-CM Translation Options
  - N9489 Other specified conditions associated with female genital organs and menstrual cycle
  - R102 Pelvic and perineal pain

Diabetes Mellitus ICD-9

- 250 Diabetes mellitus
  - 250.0 Diabetes mellitus without mention of complication
    - 250.00 type II or unspecified type, not stated as uncontrolled
    - 250.01 type I, not stated as uncontrolled
    - 250.02 type II or unspecified type, uncontrolled
    - 250.03 type I, uncontrolled
  - 250.1 Diabetes with ketoacidosis
  - 250.2 Diabetes with hyperosmolarity
  - 250.3 Diabetes with other coma
  - 250.4 Diabetes with renal manifestations
  - 250.5 Diabetes with ophthalmic manifestations
  - 250.6 Diabetes with neurological manifestations
  - 250.7 Diabetes with peripheral circulatory disorders
  - 250.8 Diabetes with other specified manifestations
  - 250.9 Diabetes with unspecified complication

Diabetes Mellitus ICD-10

- E11 Type II diabetes mellitus, includes diabetes NOS
  - E11.0 with hyperosmolarity
  - E11.2 with kidney complications
  - E11.3 with ophthalmic complications
  - E11.4 with neurological complications
  - E11.5 with circulatory complications
  - E11.6 with other specified complications
  - E11.8 with unspecified complications
  - E11.9 without complications

ICD-10-CM Changes for Diabetes

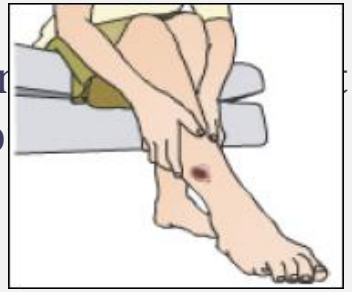
Condition	New in ICD-10-CM	Description of Change
Diabetes Mellitus (DM)	Poorly controlled, out of control, inadequately controlled and controlled are no longer used in ICD-10-CM	Diabetes must be described by type with hyperglycemia
Gestational Diabetes	Classified to insulin controlled, diet controlled, or puerperal in the OB chapter	If described as puerperal, the diet controlled or insulin controlled component must be described as well
Other specified complications of Diabetes	Expanded to include with neuropathic arthropathy, dermatitis and oral complication including periodontal disease	Documentation of complication relationships to diabetes continues to be an opportunity for improvement
Secondary Diabetes	Specify if due to underlying condition or drug or chemical induced	Documentation must reflect the underlying cause of the DM

Clinical Examples – Documentation Improvement

Scenario

A patient is admitted with a chronic non-pressure ulcer of the leg

- In ICD-9-CM, seven (7) codes specify the site of the lower limb
- In ICD-10-CM, more than 100 codes are used to delineate:
  - Site of the chronic non-pressure ulcer
  - Laterality
  - Depth of ulcer of the lower limb (e.g., limited to breakdown layer exposed, with necrosis of muscle, with necrosis of bo unspecified severity)



Clinical Examples – Documentation Improvement

Documentation Requirements (cont'd)

- Relationship of conditions to diabetes must be documented if known by the attending physician
- An assumption of relationship cannot be made without documentation, and a query to the attending physician would be required
- Coders/CDI staff are not permitted to classify diseases from laboratory or vascular study results alone
- For inpatients: possible, probable and suspected conditions are coded as though they exist
- For outpatients: code only to the highest level of certainty

Anemia ICD-9

- 285 Other and unspecified anemias
  - 285.0 Sideroblastic anemia
  - 285.1 Acute posthemorrhagic anemia
  - 285.2 Anemia of chronic disease
  - 285.3 Antineoplastic chemotherapy induced anemia
  - 285.8 Other specified anemias
  - 285.9 Anemia, unspecified

Anemia ICD-10

- D62 Acute posthemorrhagic anemia

- D64 Other anemias
  - D64.0 Hereditary sideroblastic anemia
  - D64.1 Secondary sideroblastic anemia due to disease
  - D64.2 Secondary sideroblastic anemia due to drugs and toxins
  - D64.3 Other sideroblastic anemias
  - D64.4 Congenital dyserythropoietic anemia
  - D64.8 Other specified anemias
  - D64.9 Anemia, unspecified

Acquired Hypothyroidism ICD-10

- E03 Other hypothyroidism
  - E03.0 Congenital hypothyroidism with diffuse goiter
  - E03.1 Congenital hypothyroidism w/o diffuse goiter
  - E03.2 Hypothyroidism due to medicaments and other exogenous substances
  - E03.3 Postinfectious hypothyroidism
  - E03.4 Atrophy of thyroid (acquired)
  - E03.5 Myxedema coma
  - E03.8 Other specified hypothyroidism
  - E03.9 Hypothyroidism, unspecified
    - Myxedema NOS

Urinary Tract Infection ICD-9

- 599 Other disorders of urethra and urinary tract
  - 599.0 Urinary tract infection, site not specified
    - Use additional code to identify organism, such as E. coli

Urinary Tract Infection ICD-10

Other diseases of the urinary system (N30-N39)

- N30 Cystitis
  - N30.0 Acute cystitis
  - N30.1 Interstitial cystitis (chronic)
  - N30.2 Other chronic cystitis
  - N30.3 Trigonitis
  - N30.4 Irradiation cystitis
  - N30.8 Other cystitis
  - N30.9 Cystitis, unspecified
    - N30.90 without hematuria
    - N30.91 with hematuria
- N39 Other disorders of urinary system
  - N39.0 Urinary tract infection, site not specified
    - Use additional codes (B95-B97), to identify infectious agent

Hypertension ICD-9

- 401 Essential hypertension
  - 401.0 Malignant
  - 401.1 Benign
  - 401.9 Unspecified

Hypertension ICD-10

- I10 Essential (primary) hypertension
  - Includes high blood pressure, hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)
  - Excludes hypertension complicating pregnancy and associated with end organ disease

Hypertension

- There is only one code for hypertension without manifestations (benign, malignant, essential, etc…) in ICD-10.
  - The code is I10
- Documentation is required for any relationship between hypertension and other diseases.
  - Hypertensive heart disease- I11
  - Hypertensive chronic kidney disease- I12

Abdominal Pain ICD-9

- 789.0 Abdominal pain
  - 789.00 unspecified site
  - 789.01 RUQ
  - 789.02 LUQ
  - 789.03 RLQ
  - 789.04 LLQ
  - 789.05 periumbilic
  - 789.06 epigastric
  - 789.07 generalized
  - 789.09 other specific site
    - includes multiple sites

Abdominal Pain ICD-10

- R10 Abdominal and pelvic pain
  - R10.0 Acute abdomen
  - R10.1 Pain localized to upper abdomen
  - R10.2 Pelvic and perineal pain
  - R10.3 Pain localized to other parts of lower abdomen
  - R10.8 Other abdominal pain
  - R10.9 Unspecified abdominal pain

Abdominal Pain ICD-10

- R10 Abdominal and pelvic pain
  - R10.8 Other abdominal pain
    - R10.81 Abdominal tenderness
      - R10.811 RUQ
      - R10.812 LUQ
      - R10.813 RLQ
      - R10.814 LLQ
      - R10.815 Periumbilic
      - R10.816 Epigastric
      - R10.817 Generalized
      - R10.819 Unspecified site
    - R10.81 Rebound abdominal tenderness
      - R10.821 RUQ
      - R10.822 LUQ
      - R10.823 RLQ
      - R10.824 LLQ
      - R10.825 Periumbilic
      - R10.826 Epigastric
      - R10.827 Generalized
      - R10.829 Unspecified site
    - R10.83 Colic
    - R10.84 Generalized abdominal pain
  - R10.9 Unspecified abdominal pain

Long-term Use of Medications ICD-9

- V58.6 Long-term (current) drug use
  - V58.61 anticoagulants
  - V58.62 antibiotics
  - V58.63 antiplatelets/antithrombotics
  - V58.64 NSAID
  - V58.65 steroids
  - V58.66 aspirin
  - V58.67 insulin
  - V58.69 other medications

Routine General Medical Exam ICD-9

- V70 General medical examination
  - V70.0 General medical examination at a health care facility, excludes
    - Health checkup of infant/child >28 d/o (V20.2)
    - Health supervision of newborn 8-28 d/o (V20.32)
    - Health supervision of newborn under 8 d/o (V20.31)
    - Preprocedural general physical exam (V72.83)

Routine General Medical Exam ICD-10

- Z00 Encounter for general exam w/o complaint, suspected or reported diagnosis
  - Z00.0 General adult medical exam
    - Z00.00 without abnormal findings
    - Z00.01 with abnormal findings
      - Use additional code to identify abnormal findings
  - Z00.1 Newborn, infant and child health exams
  - Z00.2 Period of rapid growth in childhood
  - Z00.3 Adolescent development state
  - Z00.5 Potential donor of organ and tissue
  - Z00.6 Normal comparison and control in clinical research program
  - Z00.7 Delayed growth in childhood
  - Z00.8 Other general examination

Colonoscopy/Breast Screening ICD-9

- V76 Special screening for malignant neoplasms
  - V76.0 Respiratory organs
  - V76.1 Breast
  - V76.8 Other neoplasm
  - V76.9 Unspecified

Colonoscopy/Breast Screening ICD-10

- Z12 Encounter for screening for malignant neoplasms
  - Z12.0 Stomach
  - Z12.2 Respiratory organs
  - Z12.3 Breast

Routine General Medical Exam ICD-9

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Pain

- ICD-9-CM Admit Diagnosis
  - 625.9 Unspecified symptom associated with female genital organs
- ICD-10-CM Translation Options
  - N9489 Other specified conditions associated with female genital organs and menstrual cycle
  - R102 Pelvic and perineal pain

Influenza Vaccine ICD-9

- V04 Need for prophylactic vaccination and innoculation against certain diseases (also separate procedure code)
  - V04.0 Poliomyelitis
  - V04.1 Smallpox
  - V04.2 Measles alone
  - V04.3 Rubella alone
  - V04.4 Yellow fever
  - V04.5 Rabies
  - V04.6 Mumps alone
  - V04.7 Common cold
  - V04.8 Other viral diseases
    - V04.81 Influenza
    - V04.82 RSV
    - V04.89 Other viral diseases

Influenza Vaccine

- Z23 Encounter for immunization
  - Code 1st any routine childhood examination
  - NOTE – Procedure codes are required to identify the types of immunizations given

Colonoscopy ICD-9

- V76 Special screening for malignant neoplasms
  - V76.0 Respiratory organs
  - V76.1 Breast
  - V76.2 Cervix
  - V76.3 Bladder
  - V76.4 Other sites
  - V76.5 Intestine
    - V76.50 Intestine, unspecified
    - V76.51 Colon
    - V76.52 Small intestine
  - V76.8 Other neoplasm
  - V76.9 Unspecified

Colonoscopy ICD-10

- Z12 Encounter for screening for malignant neoplasms
  - Z12.0 stomach
  - Z12.1 intestinal tract
    - Z12.10 unspecified
    - Z12.11 colon
    - Z12.12 rectum
    - Z12.13 small intestine
  - Z12.2 respiratory organs
  - Z12.3 breast
  - Z12.4 cervix
  - Z12.5 prostate
  - Z12.6 bladder
  - Z12.7 other GU organ
  - Z12.8 other sites
  - Z12.9 site unspecified

Dysuria ICD-9

- 788 Symptoms involving urinary system
  - 788.0 Renal colic
  - 788.1 Dysuria
  - 788.2 Retention of urine
  - 788.3 Urinary incontinence
  - 788.4 Frequency of urination and polyuria
  - 788.5 Oliguria and anuria
  - 788.6 Other abnormality of urination
  - 788.7 Urethral discharge
  - 788.8 Extravasation or urine
  - 788.9 Other symptoms involving urinary system

Dysuria ICD-10

- R30 Pain associated with micturition
  - R30.0 Dysuria
  - R30.1 Vesical tenesmus (feeling of incomplete emptying after unination)
  - R30.2 Painful micturition, unspecified

- **[Painful micturition (dysuria, oliguria)].**
- [Article in German]
- Hochreiter W.
- **Source**
- Urologische Universitätsklinik, Inselspital, Bern.
- **Abstract**
- Painful micturition is one of the most common symptoms of urological diseases. The term "dysuria" is descriptive for micturition which the patient perceives as unpleasant.

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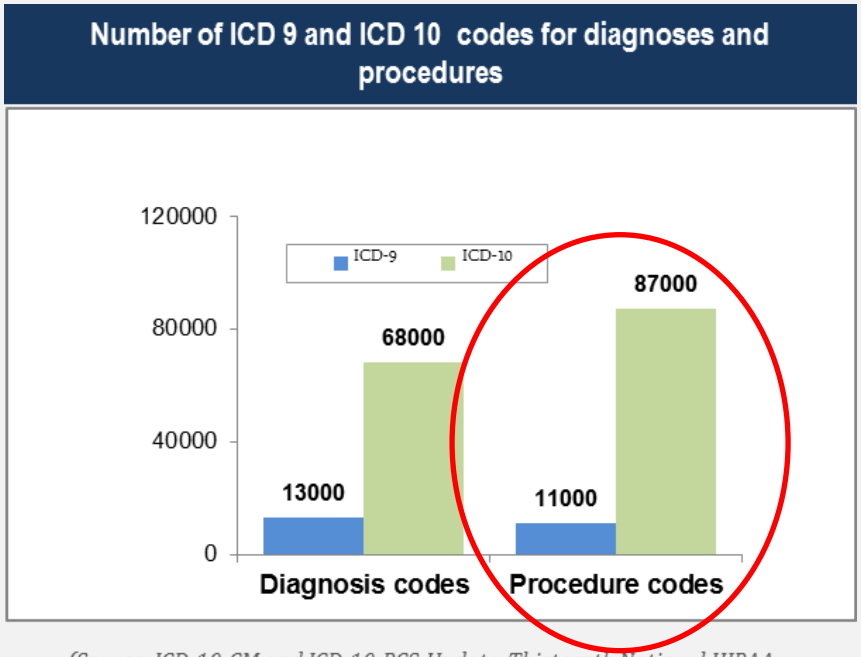
OB/GYN Procedure Documentation Examples

Overview of ICD-10-PCS

- Basic principles used when developing the system were that **no diagnostic information is included** in the procedure description (i.e., no codes for procedures exclusive to aneurysms, cleft lip, strictures or neoplasms, etc.).
- This procedure classification system is only utilized in the **inpatient hospital setting.**

ICD-10-PCS



(Source: ICD-10-CM and ICD-10-PCS Update, Thirteenth National HIPAA Summit, 9/26/2006; Rand Study, March 2004)

ICD-10 procedure codes will require additional and significant detail in surgical reporting

- Key ICD-10 characteristics
  - ICD-10 is a "dramatic departure" from current practice
  - Surgical codes lack decimals
  - The new code set will allow for incorporation of new procedures and technologies
  - Terminology is precisely defined and used consistently across all codes

ICD-10-PCS Delivery

1st	2nd	3rd	4th	5th	6th	7th
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
1	0	D	0	7	Z	3

The ICD-10-PCS code structure tells a story

Assisted Deliveries

- ***Procedures require documentation of:***
  - ***Type of assistance***
    - 3 Low forceps
    - 4 Mid forceps
    - 5 High forceps
    - 6 Vacuum
    - 7 Internal version
    - 8 Other

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Normal Vaginal Delivery Example

Section	**1**	Obstetrics
Body System	**0**	Pregnancy
Operation	**E**	Delivery: Assisting the passage of the products of conception from the genital canal

Body Part	*Approach*	*Device*	*Qualifier*
0 Products of Conception	**X** External	**Z** No Device	**Z** No Qualifier

Laceration Repair Example

Section	**0**	Medical and Surgical
Body System	**W**	Anatomical Regions, General
Operation	**Q**	Repair: Restoring, to the extent possible, a body part to its normal anatomic structure and function

Body Part	*Approach*	*Device*	*Qualifier*
0 Head **2** Face **4** Upper Jaw **5** Lower Jaw **8** Chest Wall **K** Upper Back **L** Lower Back **M** Perineum, Male **N** Perineum, Female	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **X** External	**Z** No Device	**Z** No Qualifier

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Cesarean Section/Forceps Deliveries

- C-section and forceps deliveries are classified to “extraction” pulling/stripping out/off a portion of body part by use of force.
- The Low Cervical C-section is classified to code 10D00Z1 and all c-sections are considered to have an open approach.
- Forceps deliveries are only differentiated by type of device (forceps/vacuum).
- Conflicting documentation on nursing delivery records and physician delivery notes sometimes require queries from CDI/coding professionals to determine which forceps (or vacuum) is utilized for delivery.
- High forceps delivery is classified to code 10D07Z5 as the approach is always considered via natural or artificial opening.
- NOTE: A D&C after an incomplete abortion is classified here as well. It is classified as an extraction of retained products of conception – code 10D17ZZ

ICD-10-PCS Table

Sect…	1	Obstetrics
…ody System	0	Pregnancy
Op…tion	D	Extraction: Pulling or stripping out or off all or a portion of a body part by th… use of force

Body Part	*Approach*	*Device*	*Qualifier*
0 Products of Conception	**0** Open	**Z** No Device	**0** Classical **1** Low Cervical **2** Extraperitoneal
0 Products of Conception	**7** Via Natural or Artificial Opening	**Z** No Device	**3** Low Forceps **4** Mid Forceps **5** High Forceps **6** Vacuum **7** Internal Version **8** Other
1 Products of Conception, Retained **2** Products of Conception, Ectopic	**7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**Z** No Device	**Z** No Qualifier

Episiotomy Example

Section	**0**	Medical and Surgical
Body System	**W**	Anatomical Regions, General
Operation	**8**	Division: Cutting into a body part, without draining fluids and/or gases from the body part, in order to separate or transect a body part

Body Part	*Approach*	*Device*	*Qualifier*
N Perineum, Female	**X** External	**Z** No Device	**Z** No Qualifier

- In ICD-10-PCS, episiotomy is classified to division – cutting of a body part.
- The classification requires no further specificity in the documentation and is classified to 0W8NXZZ.

Hysterectomy

- ***Procedures require documentation of:***
  - ***Full extent of hysterectomy***
    - Supracervical or subtotal
    - Total
    - Radical
  - ***Any lymph node or ovary removal*** (chain, single, sampling)
  - ***Any other tissue removal***
  - ***Path reports cannot be used to determine entirety of the procedure*** – *physicians (surgeons) must document every aspect of procedures performed*

ICD-10-PCS Resection

Patient presents for hysterectomy

ICD-10-PCS

0UT9FZZ

- Resection of Uterus, Via Natural or Artificial Opening With Percutaneous Endoscopic Assistance

ICD-10-PCS Table

Section	**0**	Medical and Surgical
Body System	**U**	Female Reproductive System
Operation	**T**	Resection: Cutting out or off, without replacement, all of a body part

Body Part	*Approach*	*Device*	*Qualifier*
0 Ovary, Right **1** Ovary, Left **2** Ovaries, Bilateral **5** Fallopian Tube, Right **6** Fallopian Tube, Left **7** Fallopian Tubes, Bilateral **9** Uterus	**0** Open **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic **F** Via Natural or Artificial Opening With Percutaneous Endoscopic Assistance	**Z** No Device	**Z** No Qualifier
4 Uterine Supporting Structure **C** Cervix **F** Cul-de-sac **G** Vagina	**0** Open **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**Z** No Device	**Z** No Qualifier
J Clitoris **L** Vestibular Gland **M** Vulva	**0** Open **X** External	**Z** No Device	**Z** No Qualifier
K Hymen	**0** Open **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic **X** External	**Z** No Device	**Z** No Qualifier

ICD-10-PCS Resection

1st	2nd	3rd	4th	5th	6th	7th
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
0	U	T	9	F	Z	Z

The ICD-10-PCS code structure tells a story

ICD-10-PCS Excisional biopsy

Patient presents for excisional biopsy left ovary

ICD-10-PCS
10D07Z3

- Excision of Left Ovary, Percutaneous Endoscopic Approach, Diagnostic

ICD-10-PCS Table

Section	**0**	Medical and Surgical
Body System	**U**	Female Reproductive System
Operation	**B**	Excision: Cutting out or off, without replacement, a portion of a body part

Body Part	*Approach*	*Device*	*Qualifier*
0 Ovary, Right **1** Ovary, Left **2** Ovaries, Bilateral **4** Uterine Supporting Structure **5** Fallopian Tube, Right **6** Fallopian Tube, Left **7** Fallopian Tubes, Bilateral **9** Uterus **C** Cervix **F** Cul-de-sac	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**Z** No Device	**X** Diagnostic **Z** No Qualifier
G Vagina **K** Hymen	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic **X** External	**Z** No Device	**X** Diagnostic **Z** No Qualifier
J Clitoris **L** Vestibular Gland **M** Vulva	**0** Open **X** External	**Z** No Device	**X** Diagnostic **Z** No Qualifier

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ICD-10-PCS Excisional biopsy

1st	2nd	3rd	4th	5th	6th	7th
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
0	U	T	1	4	Z	X

The ICD-10-PCS code structure tells a story

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Physician Queries

Query…why?

A query is a communication tool used to clarify documentation in the health record for accurate code assignment.

The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment.

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

Query…when?

A query is written when the Health record Documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear for present on admission indicator assignment

"A proper query process ensures that appropriate documentation appears in the health record"

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

Query…when?

"A proper query process ensures that appropriate documentation appears in the health record"

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

Query… answer?

- Coding data is incorporated into the information used by insurance companies to determine which physicians they are going to contract.

- ***Coded information is made available to consumers on various platforms, such as HealthGrades, which uses coding data as well as other information to 'rate' facility and provider service***

Query… answer how?

Queries are generated to elicit more information from the Provider.

- A response is ***necessary*** from the provider to fulfill this process.

- A. ***signature alone on a generated query does not fulfill this requirement***

Query… answer how?

Queries are generated in various formats depending on the information being requested:

- *Written response* format
  - Requesting provider to freehand a response
- *Multiple Choice* format
  - Requesting provider select one of the offered responses

Please sign, date and time Queries!

Query… answer how?

A Physician response, ***'see notes'*** does not fulfill the request generated by the query.

- The coder has already reviewed the notes and Medical Record Documentation
- ***Although the response may seem 'obvious' coders are only 'reporters'*** of the medical record and ***cannot code a diagnosis*** that is ***not documented by the Provider.***

Questions?