Comparing Data
Improving Quality
Driving Value

Webinar
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Continuing education credit is not available for this activity.
ICD-10 Obstetrical and Perinatal Data
Improved Data Collection
It’s About Time

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Objectives

- Describe clinical scenarios that create common coding problems
- Examine problem solving strategies when coding criteria is unclear
- Discuss the importance of clear documentation by providers and coders for clinical practice and reimbursement
Objective 1

• Describe clinical scenarios that create common coding problems
PROVIDERS – A OR B; CODERS – C OR D;
ALL OTHERS: E

PROVIDER:
A. A hospital coder taught me the specifics on hospital documentation and how it is different from outpatient documentation
B. I learned hospital documentation from someone other than a hospital coder, or from responding to queries

CODER:
C. Yes, we try to help all new providers with hospital documentation and known problem areas so there won’t be the rework of ‘queries’ later.
D. Providers learn how to document from other providers or based on our queries.

ALL OTHERS:
E. Not a provider or coder
Why is coded data important to providers?

• Do you know your post partum hemorrhage rate?
Principal Diagnosis Documentation

• Make sure documentation permits determination of:

• “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”
Reporting Additional Diagnoses

• For reporting purposes the definition of “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:
  – clinical evaluation; or
  – therapeutic treatment; or
  – diagnostic procedures; or
  – extended length of hospital stay; or
  – increased nursing care and/or monitoring.

• Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.
Reporting Additional Diagnoses

• **Previous conditions**

• If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. **Such conditions are not to be reported** and are coded only if required by hospital policy.
Reporting Additional Diagnoses

- **Abnormal findings** (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.
Reporting Additional Diagnoses

• Previous conditions

• However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

• For instance: Z83.3 Family history of diabetes mellitus
Reporting Additional Diagnoses

• Uncertain Diagnosis

• If the diagnosis documented at the time of discharge is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out” or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.
“Rule Out”

• “Rule Out” does not belong on a discharge note
• Options:
  – Found it – list as diagnosis
  – Looked but it wasn’t there - state “not found”
  – Professional opinion is that it exists but no definitive result yet – “probable” or “likely”
  – Don’t think it was – “ruled out”
Documentation: Not specific as to gestational

- Be sure to document if it is gestational - chronic hypertension is not coded the same way as gestational hypertension
  - O10.01 Pre-existing essential hypertension complicating pregnancy
  - O10.11 Pre-existing hypertensive heart disease complicating pregnancy
  - O10.21 Pre-existing hypertensive chronic kidney disease complicating pregnancy
  - O12.0 Gestational edema
  - O12.1 Gestational proteinuria
  - O13 Gestational [pregnancy-induced] hypertension without significant proteinuria
  - O24.4 Gestational diabetes mellitus
General Rules for Obstetric Cases

• Codes from chapter 15 and sequencing priority
• ... It is the provider’s responsibility to state that the condition being treated is not affecting the pregnancy.
Describe clinical scenarios that create common coding problems

• Unable to tell if documented condition/disorder/symptom caused
  – clinical evaluation; or
  – therapeutic treatment; or
  – diagnostic procedures; or
  – extended length of hospital stay; or
  – increased nursing care and/or monitoring; or
  – has implications for future health care needs
Goal

• Documentation that supports all diagnoses
• All diagnoses that impacted the hospitalization are coded
• Uniformly coded data which can be
  – compared,
  – used to improve patient outcomes, and
  – used to appropriately allocate resources
Guidelines for Coding and REPORTING

• “A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses and procedures that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized.”
Objective 2

• Examine problem solving strategies when coding criteria is unclear
Development of a Hospital Coder

• In general, coders new to hospital coding begin with Obstetrics and Newborns
  – Limited number of procedures
  • In ICD-10-PCS –
    – Obstetrics - 3 pages of procedures
    – Cardiac –
      » Medical/Surgical Heart and Great Vessels – 9 pages
      » Measurement and Monitoring – 1 page
      » Extracorporeal Assistance and Performance – 1 page
    – Osteopathic – 0.25 page
Inexperienced Coders

• Mentoring by other coders
• Able to ask questions of/be mentored by experience OB nurse
• Providers - review attestation sheets, query coders as to why a diagnosis was or was not assigned
• Training
  – Attend continuing education for providers at the hospital
Production Coders

• Some coders are paid by the number of records they code

• Querying a provider frequently involves starting over when the reply is received
  – For most production coders, there is no additional payment for the extra time spent; “It is built into the contract…”

• Mentoring inexperienced coders is usually not included in the contract
Examine problem solving strategies when coding criteria is unclear

• What does “complicating” mean?

• For coders, it means:
  • O99- Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium
  • Includes: conditions which complicate the pregnant state, are aggravated by the pregnancy or are a main reason for obstetric care
  • Use additional code to identify specific condition
Examine problem solving strategies when coding criteria is unclear

• “depression complicating pregnancy” What should the coder do?

• If during the 2nd trimester, the lady had an issue with depression. But it resolved prior to the delivery episode. Provider documents “depression complicating pregnancy” in the delivery hospitalization record. Nothing in record about depression during childbirth or mental health consultation, therapy, extended length of stay, extra nursing...

• O99.340 Other mental disorders complicating pregnancy, unspecified trimester

• O99.344 Other mental disorders complicating childbirth
Examine problem solving strategies when coding criteria is unclear

- **Blood loss**

- **Index:** Loss (of) blood – see Hemorrhage

- The coder will not code ‘hemorrhage’ based on cc of blood loss, decrease in hematocrit, “uterine atony”...

- The provider must document the diagnosis in the medical record
Examine problem solving strategies when coding criteria is unclear

• **Retained placenta**

• **Index: Retention**
  – Placenta (total) (with hemorrhage) O72.0
  – without hemorrhage O73.0
  – portions or fragments (with hemorrhage) O72.0
  – without hemorrhage O73.1
O72 Postpartum hemorrhage

Includes: hemorrhage after delivery of fetus or infant

- **O72.0 Third-stage hemorrhage**
  - Hemorrhage associated with retained, trapped or adherent placenta
    - **Retained placenta NOS**
      - Code also: type of adherent placenta (O43.2-)

- **O72.1 Other immediate postpartum hemorrhage**
  - Hemorrhage following delivery of placenta
  - Postpartum hemorrhage (atonic) NOS
  - Uterine atony with hemorrhage
  - **Excludes1:**
    - uterine atony NOS (O62.2)
    - uterine atony without hemorrhage (O62.2)
    - partum atony of uterus without hemorrhage (O75.89)

- **O72.2 Delayed and secondary postpartum hemorrhage**
  - Hemorrhage associated with retained portions of placenta or membranes after the first 24 hours following delivery of placenta
    - **Retained products of conception NOS, following delivery**

- **O72.3 Postpartum coagulation defects**
  - Postpartum afibrinogenemia - Postpartum fibrinolysis
Examine problem solving strategies when coding criteria is unclear

• **Shoulder dystocia**

• O66.0 Obstructed labor due to shoulder dystocia
  – Impacted shoulders

• ‘McRoberts maneuver’ does not mean there was shoulder dystocia, nor does ‘Woods-screw,’ ‘Rubin’ or ‘Gaskin’

• The provider must document the diagnosis “shoulder dystocia” in the medical record
Examine problem solving strategies when coding criteria is unclear

- **Meconium** – please specify “not complicating” or “complicating”
- O77.0 Labor and delivery complicated by meconium in amniotic fluid
- **P03.8 Newborn (suspected to be) affected by other specified complications of labor and delivery**
  - P03.82 Meconium passage during delivery
- **P24.00 Meconium aspiration without respiratory symptoms**
  - Meconium aspiration NOS
- **P24.01 Meconium aspiration with respiratory symptoms**
  - Meconium aspiration pneumonia
  - Meconium aspiration pneumonitis
- **P76 Other intestinal obstruction of newborn**
  - P76.0 Meconium plug syndrome
    - Meconium ileus NOS
- **P96.83 Meconium staining**
  - Excludes1:
    - meconium aspiration (P24.00, P24.01)
    - meconium passage during delivery (P03.82)
Examine problem solving strategies when coding criteria is unclear

- **Trauma, birth – see “Birth Injury”**

- **P12 Birth injury to scalp**
  - **P12.0** Cephalhematoma due to birth injury
  - **P12.1** Chignon (from vacuum extraction) due to birth injury
  - **P12.2** Epicranial subaponeurotic hemorrhage due to birth injury
    - Subgaleal hemorrhage
  - **P12.3** Bruising of scalp due to birth injury
    *The provider must document it is a birth injury or birth trauma with the diagnosis in the medical record*
  - **P12.4** Injury of scalp of newborn due to monitoring equipment
    - Sampling incision of scalp of newborn
    - Scalp clip (electrode) injury of newborn
  - **P12.8** Other birth injuries to scalp
    - **P12.81** Caput succedaneum
      - **P12.89** Other birth injuries to scalp
    - **P12.9** Birth injury to scalp, unspecified

- **P12.9** Birth injury to scalp, unspecified

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What can be done to avoid the issues so far?

When the provider lists discharge conditions:

– **Current conditions affecting this episode of care/childbirth** (e.g., shoulder dystocia, postpartum hemorrhage)

– **Current conditions not affecting the pregnancy but using significant resources of this hospitalization**

– **Conditions RULED OUT**

– List separately, if you must:

  • Conditions that affected/complicated the pregnancy but not the hospitalization (e.g., genital herpes outbreak 2\textsuperscript{nd} trimester)

  • Current conditions not affecting the pregnancy and not using significant resources during this hospitalization
Objective 3

• Discuss the importance of clear documentation by providers and coders for clinical practice and reimbursement
Discuss the importance of clear documentation

- 7th character indicates which fetus (new in ICD-10-CM)
  - 0 - not applicable or unspecified
  - 1 - fetus 1
  - 2 - fetus 2
  - 3 - fetus 3
  - 4 - fetus 4
  - 5 - fetus 5
  - 9 - other fetus
Documentation and MS-DRGs

• Documentation supports coding complications and co-morbidity

• If there are complications/co-morbidities (CC) or major complications/co-morbidities (MCC) the MS-DRG changes
Uncomplicated Deliveries ICD-10

• **O80 Encounter for full-term uncomplicated delivery**
  – Delivery requiring minimal or no assistance, with or without episiotomy, without fetal manipulation [e.g., rotation version] or instrumentation [forceps] of a spontaneous, cephalic, vaginal, full-term, single, live-born infant. This code is for use as a single diagnosis code and is not to be used with any other code from chapter 15.
  – Use additional code to indicate outcome of delivery (Z37.0)

  – For Coders: With ICD-10-CM, this code must be accompanied by a delivery code from the appropriate ICD-10-PCS procedure classification.
Uncomplicated Deliveries ICD-10

• O82  Encounter for cesarean delivery without indication
  – Use additional code to indicate outcome of delivery (Z37.0)
  – For providers – this may not be reimbursed as it does not indicate medical necessity; if this is the case, the patient may need to understand in advance that the patient will be responsible for payment
  – For Coders: With ICD-10-CM, this code must be accompanied by a delivery code from the appropriate ICD-10-PCS procedure classification.
General Rules for **ICD-10-CM**

- **Trimesters**
  - 1\textsuperscript{st} trimester – less than 14 weeks 0 days
  - 2\textsuperscript{nd} trimester – 14 weeks 0 days to less than 28 weeks 0 days
  - 3\textsuperscript{rd} trimester – 28 weeks 0 days until delivery
General Rules for **ICD-10-CM**

- Use additional code from category Z3A, Weeks of gestation, to identify the specific week of pregnancy

- Z3A.00  Weeks of gestation of pregnancy not specified
- Z3A.01  Less than 8 weeks gestation of pregnancy
- Z3A.08  8 weeks gestation of pregnancy
- Z3A.09  9 weeks gestation of pregnancy...
- Z3A.40  40 weeks gestation of pregnancy
- Z3A.41  41 weeks gestation of pregnancy
- Z3A.42  42 weeks gestation of pregnancy
- Z3A.43  Greater than 42 weeks gestation of pregnancy
General Rules for ICD-10-CM

• Reason for admission
  • O48.0 Post-term pregnancy
    – Pregnancy over 40 completed weeks to 42 completed weeks of gestation
  • O48.1 Prolonged pregnancy
    – Pregnancy which as advanced beyond 42 completed weeks gestation

• For each encounter
  • Z3A.40 40 weeks gestation of pregnancy
  • Z3A.41 41 weeks gestation of pregnancy
  • Z3A.42 42 weeks gestation of pregnancy
  • Z3A.43 Greater than 42 weeks gestation of pregnancy
General Rules for ICD-10-CM

• High Risk Pregnancy
  • No longer factors influencing health (old V-Codes)
  • Are in the O09 category
  • Cannot be used as a principal diagnosis in hospital coding
Discuss the importance of clear documentation - ICD-10-PCS Deliveries

- 10D00Z0 – Classical C-Section
- 10D00Z1 – Low cervical C-Section
- 10D07Z3 – Vaginal delivery using low forceps...
ICD-10-PCS Deliveries – Does your current documentation support code selection?

- 10E0XZZZ - Normal spontaneous vaginal delivery
ICD-10-PCS Deliveries – Does your current documentation support code selection?

- 10H073Z Insert fetal monitoring electrode
- 10P073Z Remove fetal monitoring electrode
ICD-10-PCS Deliveries – Does your current documentation support code selection?

- Monitoring not using electrode
- 4A0HXCZ Externally monitoring the cardiac rate of the fetus

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<th>Approach</th>
<th>Function / Device</th>
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ICD-10-PCS Deliveries – Does your current documentation support code selection?

- 0W8NXZZ - Episiotomy

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ICD-10-PCS Deliveries – Does your current documentation support code selection?

- 0WQNXZZ – repair perineal laceration

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ICD-10-PCS Deliveries – Does your current documentation support code selection?

- **0U7C7ZZ** Induction by cervical dilation (devices are things left intentionally)

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ICD-10-PCS Deliveries – Does your current documentation support code selection?

• In general, for inpatient surgical procedures, the documentation must state:

• **Body Part**
  – Ovary
  – Uterine supporting structure
  – Fallopian tube
  – Cervix
  – Cul-de-sac
  – Uterus
  – Vagina
  – Products of conception
ICD-10-PCS Deliveries – Does your current documentation support code selection?

• In general, for inpatient surgical procedures, the documentation must state:
  • **Procedure (root operation):** not an eponym, a term or many words to describe the procedure
    – **Excision** – cutting of PART of a body part
    – **Resection** – cutting of ALL of a body part
    – **Dilation** – expanding an orifice or lumen of a tubular body part
    – **Restriction** – partially closing an orifice or lumen of a tubular body part
    – **Occlusion** – completely closing an orifice or lumen of a tubular body part
ICD-10-PCS Deliveries – Does your current documentation support code selection?

• In general, for inpatient surgical procedures, the documentation must state:

• **Root operation**
  – **Extraction** – pull or stripping out or off all or a portion of a body part using force
  – **Delivery** – assisting the passage of products of conception from the genital canal
ICD-10-PCS Deliveries – Does your current documentation support code selection?

• In general, for inpatient surgical procedures, the documentation must state:

• **Approach**
  – Open
  – Percutaneous
  – Percutaneous Endoscopic
  – Via Natural or Artificial Opening
  – Via Natural or Artificial Opening Endoscopic
  – Via Natural or Artificial Opening with Percutaneous Endoscopic Assistance
  – External
ICD-10-PCS Deliveries – Does your current documentation support code selection?

• In general, for inpatient surgical procedures, the documentation must state:

• **Device** – devices intentionally remain after the procedure is completed, include things like
  – Fetal Monitoring Electrodes
  – Grafts and Prostheses
  – Implants
  – Simple or Mechanical Appliances
  – Electronic Appliances
ICD-10-PCS Deliveries – Does your current documentation support code selection?

• In general, for inpatient surgical procedures, the documentation must state:

• **Qualifier**
  – X = diagnostic (e.g., biopsies which are excisions)
  – Classical/low cervical/extraperitoneal
  – Low/mid/high forceps, vacuum, internal version
  – For ‘bypass’ the termination location (e.g., fallopian tubes)
  – For ‘transplant’ allogenic, syngenec, zooplastic (e.g., ovary)
ICD-10-PCS Deliveries – Does your current documentation support code selection?

• In general, for obstetrical procedures, it is expected that current procedure documentation will be sufficient

• For GYN procedures, there may be a need for additional documentation
  – Documentation of “approach”
  – There may be some issue with coders knowing a procedure term, but not knowing the exact method
Discuss the importance of clear documentation

- Ruled out = Observation for condition not found
- Incident to = impacts the pregnancy, look to the chapter 15 “O” codes
- Complicating childbirth is current episode
- Uterine atony, decreased hematocrit, “1,000 cc blood loss” is not hemorrhage unless specifically documented “hemorrhage”
- “Shoulder dystocia” only if specifically documented
- “Birth trauma” only if specifically documented
- Meconium passage during delivery “affecting the newborn” or “complicating labor and delivery”
Review Objectives

• Describe clinical scenarios that create common coding problems
• Examine problem solving strategies when coding criteria is unclear
• Discuss the importance of clear documentation by providers and coders for clinical practice and reimbursement
Questions?
Questions

• Question: Will home care codes change?
• Response: No, these are CPT/HCPCS and they do not change.
General Comments:
CPT and HCPCS are NOT changing

• CPT/HCPCS do NOT change with transition to ICD-10-CM and ICD-10-PCS
  – These are the outpatient and the professional services codes, like home health, observation, routine OB care
• Professional (privileged provider) procedure coding will NOT change
General comments: Perinatal Care Measures


• There is no ICD-10-CM code for exclusive breast milk feeding

• When there are codes (ICD-10-CM and ICD-10-PCS), they are listed
General comments:
Perinatal Care Measures - Diagnosis

General comments: Perinatal Care – Induction Procedures

• [link](https://manual.jointcommission.org/releases/TJC2015A1/AppendixPTJC.html#Table_11.05_Medical_Induction_of_Labor)
Questions

• Question: Conflicting notes on augmentation vs induction.

• Response: The National Center for Health Statistics, part of the CDC has a downloadable PDF of ICD-10-CM and ICD-10-PCS. [http://www.cdc.gov/nchs/icd/icd10cm.htm](http://www.cdc.gov/nchs/icd/icd10cm.htm)

• Easy to search. The only time ‘augmentation’ is used in ICD-10-CM is in reference to breast augmentation.
Questions

• Question: Outpatient triage, capture for outpatient placement of insitu foley balloon for cervical ripening and sent home to readmit for L&D IOL

• Question: Outpatient clinical setting, mainly Medicaid coverage

• Response: These are outpatient services which would be captured with CPT/HCPCS
Questions

• Question: Are there different codes for artificial rupture of membranes and AROM for induction of labor?

• Response: ICD-10-PCS does not indicate why something is done – it just describes what is done. To explain why, you use a diagnosis.
Question: Does POA (Present on Admission) change with I-10? No.

• Obstetrical conditions
  – Whether or not the patient delivers during the current hospitalization does not affect assignment of the POA indicator. The determining factor for POA assignment is whether the pregnancy complication or obstetrical condition described by the code was present at the time of admission or not.
  – If the pregnancy complication or obstetrical condition was present on admission (e.g., patient admitted in preterm labor), assign “Y”.
Question: Does POA (Present on Admission) change with I-10? No.

- Obstetrical conditions
  - If the pregnancy complication or obstetrical condition was not present on admission (e.g., 2nd degree laceration during delivery, postpartum hemorrhage that occurred during current hospitalization, fetal distress develops after admission), assign “N”.
  - If the obstetrical code includes more than one diagnosis and any of the diagnoses identified by the code were not present on admission assign “N”.
    - (e.g., Category O11, Pre-existing hypertension with pre-eclampsia)