Comparing Data
Improving Quality
Driving Value

Webinar

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Continuing education credit is not available for this activity.
KEY TIPS FOR CODING (AND BILLING) PERINATAL SERVICES

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National Perinatal Information Center/Quality Analytic Services
Webinar
Wednesday, March 25, 2015
Objectives for This Webinar

• At the end of this session, attendees will be able to:
  • Describe common obstetrical and/or perinatal coding issues
  • Recognize the importance of coding accuracy and its relationship to documentation quality
  • Discuss institutional preparations for ICD-10 implementation
  • Identify available resources for obstetrical and/or perinatal coding education
Disclaimer

- ICD-10 codes included in this presentation are not valid prior to the implementation date of October 1, 2015
- ICD-10 codes included in this presentation may be revised prior to implementation
- ICD-9 codes should continue to be used until the transition date of October 1, 2015
THE PURPOSE OF DIAGNOSIS CODES
Diagnosis codes...

- Characterize and communicate the true nature of the patient’s condition
- Support the medical necessity of services that are provided
- Ultimately provide the support for the services that are billed to patients and third party payers
Diagnosis codes...

- If we don’t support our billing with the appropriate diagnosis code(s), then:
  - We mis-state or understate the complexity of the service provided
  - We fail to receive the payment to which we are entitled because we didn’t support our billing
The methodology for generating diagnosis codes

• The diagnosis codes that we assign arrive in two ways...
  • The provider assigns a code based on their knowledge of ICD codes
  • Codes are assigned by coders/billers who abstract the documentation
• There’s two ways in which this can go wrong
  • The provider’s knowledge is incomplete or inaccurate
  • The documentation is incomplete or inaccurate
Documentation

- Medical decision making is the “over-arching” criterion
  - Straightforward/Low
  - Moderate
  - High

- Number and types of problems
- Complexity of establishing a diagnosis
- Management decisions
How do you rate the MDM?

- “Normal postpartum course. No complaints.”
- “Slight redness around wound site. Clear fluid draining. Antibiotic prescribed and dressing changes ordered.”
- “Profound postpartum vaginal bleeding noted. Patient being returned to the OR for a postpartum curettage.”
THE ORGANIZATION OF ICD-9-CM
## ICD-9 Code Organization

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<th>Description</th>
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<tr>
<td>630-633</td>
<td>Ectopic and Molar Pregnancy</td>
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<td>634-639</td>
<td>Other Pregnancy with Abortive Outcome</td>
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<td>650-659</td>
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<tr>
<td>678-679</td>
<td>Other Maternal and Fetal Complications</td>
</tr>
</tbody>
</table>
Key Coding Principles for Obstetrics

• Most ICD-9 codes have a 5th character that indicates the “episode of care”
  • 0 Unspecified, as to episode of care or not applicable
  • 1 Delivered, with or without mention of antepartum condition
  • 2 Delivered, with mention of postpartum complication
  • 3 Antepartum condition or complication
  • 4 Postpartum condition or complication
What do these mean?

• 1 Delivered, with or without mention of antepartum condition

• The patient delivered in this episode of care
  • Typically reported from time of admission to the time of discharge, if delivery occurs during the hospitalization
  • There are no complications that are influencing the postpartum period

642.01
What do these mean?

• 2 Delivered, with mention of postpartum complication

• The patient has a postpartum complication that presented itself...
  • Immediately during or after delivery
  • While the patient was still hospitalized in the postpartum period

642.02
What do these mean?

- **Postpartum condition or complication**
  - The patient has a postpartum complication that presented itself...
    - After the patient was discharged from the hospital
    - Typically, related to outpatient postpartum services
  - 642.04
What do these mean?

- 3 Antepartum condition or complication

- The patient has an antepartum condition
- The patient does not deliver and/or is discharged from the hospital before delivery occurs

642.03
What do these mean?

- 0  Unspecified, as to episode of care or not applicable

- There are few, if any cases, in which the use of this 5th digit is desirable or appropriate

- The most common occurrence is when the documentation does not provide enough information to define where the patient is in their pregnancy
Anne presents to the triage area in Labor and Delivery at 34 weeks 3 days gestation with moderate vaginal bleeding, but no cramping or indication of a rupture of membranes. Dr. Allison takes a history (which revealed that she is a Type 1 diabetic), performs a physical exam, and also orders an ultrasound, which reveals a partial placenta previa.
Anne

• Anne’s bleeding is stabilized and she is discharged home the next day, with instructions.

• The appropriate diagnosis codes
  • 641.13—Hemorrhage from placenta previa, antepartum condition
  • 648.03—Diabetes mellitus in pregnancy, antepartum condition
  • 250.01—Diabetes without mention of complication, type I, not stated as uncontrolled
The worst case scenario for diagnosis coding:
- 641.90—Unspecified antepartum hemorrhage
• At 38 weeks 4 days, Anne presents to Labor and Delivery in active labor, with ruptured membranes. Due to her partial placenta previa, Dr. Allison recommends a cesarean delivery. Anne agrees.
• Dr. Allison delivers a healthy 6 lb. 11 oz. female via cesarean section.
• The correct diagnoses for the delivery:
  • 641.01—Placenta previa, without hemorrhage, delivered
  • 648.01—Diabetes mellitus in pregnancy, delivered
  • 250.01—Diabetes mellitus without complication, type I, not stated as uncontrolled.
  • V27.0—Single liveborn
On the day after the delivery, Dr. Allison rounds on Anne. Anne appears to be doing well, undergoing a normal postpartum course following a cesarean section.

On the next day, Dr. Allison again examines Anne’s surgical wound and finds a 1 cm dehiscence of the wound. The fascia appears to be intact, with drainage of clear fluid. She cleans and packs the wound and provides instructions to the nursing staff regarding wound management.
• Postpartum Day 1
  • V24.2—Routine postpartum follow-up
  • 641.01—Placenta previa, without hemorrhage, delivered
  • 648.01—Diabetes mellitus in pregnancy, delivered
  • 250.01—Diabetes mellitus without complication, type I, not stated as uncontrolled.
Anne

- Postpartum Day 2
  - 674.12—Disruption of cesarean wound
  - 641.01—Placenta previa, without hemorrhage, delivered
  - 648.01—Diabetes mellitus in pregnancy, delivered
  - 250.01—Diabetes mellitus without complication, type I, not stated as uncontrolled.
Every 5\textsuperscript{th} digit isn’t always applicable

- The ICD-9-CM book gives guidance as to what numbers (5\textsuperscript{th} digits) apply to a given code...
  - 643.2X Late vomiting of pregnancy [0,1,3]
  - 646.1X Edema or excessive weight gain in pregnancy, without mention of hypertension [0-4]
  - 670.1X Puerpal endometritis [0,2,4]
ANSWERS TO COMMON QUESTIONS
How do I assign the diagnosis(es) to indicate that an induction has occurred?

• There are two “induction-related” codes
  • 659.01—Failed mechanical induction (surgical or other instrumental methods)
  • 659.11—Failed medical or unspecified induction (medical methods, such as oxytocic drugs)

• Procedure codes
  • 73.01  Induction of labor by artificial rupture of membranes
  • 73.1  Other surgical induction of labor
  • 73.4  Medical induction of labor, excluding medication to augment active labor.
How do I assign the diagnosis(es) to indicate that an induction has occurred?

• There is no diagnosis for “induction,” per se
• Therefore, inductions are indicated by...
  • A clinical statement in the medical record
  • The assignment of a diagnosis code(s) that prompted the induction
    • 645.11—Post term pregnancy
    • 642.41—Mild or unspecified pre-eclampsia
    • 658.11—Premature rupture of membranes
    • 658.21—Delayed delivery after spontaneous or unspecified rupture of membranes
How do I assign the diagnosis(es) to indicate that an augmentation has occurred?

• Similarly, there is no diagnosis for “augmentation,” per se
• Therefore, augmentation is indicated by...
  • A clinical statement in the medical record
  • The assignment of a diagnosis code(s) that prompted the augmentation
    • 661.01—Primary uterine inertia
    • 661.11—Secondary uterine inertia
    • 661.21—Other and unspecified uterine inertia
    • 661.91—Unspecified abnormality of labor
How do I assign the diagnosis(es) to indicate that an augmentation has occurred?

• Similarly, there is no diagnosis for “augmentation,” per se
• Therefore, augmentation is indicated by...
  • A clinical statement in the medical record
  • The assignment of a diagnosis code(s) that prompted the augmentation
    • 662.01—Prolonged first stage
    • 662.11—Prolonged labor, unspecified
    • 662.21—Prolonged second stage
How do I appropriately document and report hemorrhages?

- **Antepartum/Intrapartum**
  - Hemorrhage from placenta previa—641.1X
    - Low-lying placenta NOS or with hemorrhage
    - Placenta previa: incomplete NOS or with hemorrhage
    - Placenta previa: marginal NOS or with hemorrhage
    - Placenta previa: partial NOS or with hemorrhage
    - Placenta previa: total NOS or with hemorrhage
  - Antepartum hemorrhage associated with coagulation defects (641.3X)
    - Afibrogenemia
    - Hyperfibrinolysis
    - Hypofibrinogenemia
How do I appropriately document and report hemorrhages?

• Antepartum/Intrapartum
  • Other antepartum hemorrhage—641.8X
    • Associated with trauma or uterine leiomyoma
  • Unspecified antepartum hemorrhage—641.9X
    • Antepartum hemorrhage, NOS
    • Intrapartum hemorrhage, NOS
    • Hemorrhage of pregnancy, NOS

• These are suboptimal and selected only when no other options are available
How do I appropriately document and report hemorrhages?

- **Postpartum**
  - **Third-stage hemorrhage—666.0X**
    - Hemorrhage associated with retained, trapped, or adherent placenta
    - Retained placenta NOS
  - **Other immediate postpartum hemorrhage—666.1X**
    - Atony of uterus with hemorrhage
    - Hemorrhage within the first 24 hours following delivery of placenta
    - Postpartum atony of uterus with hemorrhage
    - Postpartum hemorrhage (atonic) NOS
How do I appropriately document and report hemorrhages?

- Postpartum
  - Delayed and secondary postpartum hemorrhage—666.2X
    - Hemorrhage after the first 24 hours following delivery
    - Hemorrhage associated with retained portions of placenta or membranes
    - Postpartum hemorrhage specified as delayed or secondary
    - Retained products of conception NOS, following delivery
How do I appropriately document and report hemorrhages?

- Postpartum
  - Postpartum coagulation defects—666.3X
    - Postpartum afibrogenemia
    - Postpartum fibrinolysis

- Related complications
  - Acute posthemorrhagic anemia—285.1
  - Hypovolemia—276.52
How do I report present, suspected, or presumed chorioamnionitis?

• The question is, “What symptoms are presenting that cause chorioamnionitis to be suspected?”
  • Report signs/symptoms until you have a definitive diagnosis
  • When you do have a definitive diagnosis, it will be 658.4X—Infection of amniotic cavity
    • Amnionitis
    • Chorioamnionitis
    • Membranitis
    • Placentitis
How do I report obstetric trauma?

- **Perineal laceration**
  - **First degree—664.01**
    - Perineal laceration, rupture, or tear involving:
      - Fourchette
      - Hymen
      - Labia vulva
      - Skin
      - Vagina
  - **Second degree—664.11**
    - Perineal laceration, rupture, or tear (following episiotomy) involving:
      - Pelvic floor
      - Perineal muscles
      - Vaginal muscles
How do I report obstetric trauma?

- **Perineal laceration**
  - Third degree—664.21
    - Perineal laceration, rupture, or tear (following episiotomy) involving:
      - Anal sphincter
      - Rectovaginal septum
      - Sphincter NOS
  - Fourth degree—664.31
    - Perineal laceration, rupture, or tear as classifiable to 664.2 and involving also:
      - Anal mucosa
      - Rectal mucosa
How do I report obstetric trauma?

- 664.4X—Unspecified perineal laceration
- 664.5X—Vulva and perineal hematoma
- 664.6X—Anal sphincter tear complicating delivery, not associated with third degree perineal laceration
- 664.8X—Other specified trauma to perineum and vulva
- 664.9X—Unspecified trauma to perineum and vulva
How do I report obstetric trauma?

- 665.0X—Rupture of uterus before onset of labor
- 665.1X—Rupture of uterus during labor
- 665.2X—Inversion of uterus
- 665.3X—Laceration of cervix
- 665.4X—High vaginal laceration
  Laceration of vaginal wall or sulcus without mention of perineal laceration
How do I report obstetric trauma?

- 665.5X—Other injury to pelvic organs
  - Injury to bladder or urethra
- 665.6X—Damage to pelvic joints and ligaments
  - Avulsion of inner symphyseal cartilage
  - Damage to coccyx
  - Separation of symphysis (pubis)
- 665.7X—Pelvic hematoma
- 665.8X—Other specified obstetrical trauma
- 665.9X—Unspecified obstetrical trauma
How do I report birth trauma?

- Conditions originating in the perinatal period (760-769)
  - 760—Fetus or newborn affected by maternal conditions which may be unrelated to present pregnancy
  - 761—Fetus or newborn affected by maternal complications of pregnancy
  - 762—Fetus or newborn affected by complication of placenta, cord, and membranes
  - 763—Fetus or newborn affected by other complications of labor and delivery
How do I report birth trauma?

- Conditions originating in the perinatal period (760-769)
  - 764—Slow fetal growth and fetal malnutrition
  - 765—Disorders relating to short gestation and low birthweight
  - 766—Disorders relating to long gestation and high birthweight
  - **767—Birth trauma**
  - 768—Intrauterine hypoxia and birth asphyxia
  - 769—Respiratory distress syndrome
767—Birth Trauma

- 767.0—Subdural and cerebral hemorrhage
- 767.1—Injuries to scalp
  - 767.11—Epicranial subaponeurotic hemorrhage
  - 767.19—Other injuries to scalp
- 767.2—Fracture of clavicle
- 767.3—Other injuries to skeleton
- 767.4— Injury to spine and spinal cord
- 767.5—Facial nerve injury
767—Birth Trauma

- 767.6—Injury to brachial plexus
- 767.7—Other cranial and peripheral nerve injuries
- 767.8—Other specified birth trauma
- 767.9—Birth trauma, unspecified
767—Birth Trauma

- Only report those things that are clinically significant that...
  - That requires evaluation and/or treatment at this time
  - May/will require definitive treatment in the future

- If, following initial evaluation, no further treatment or supervision is required, it does not need to be reported
What diagnoses support cesarean deliveries?

- 656.31—Fetal distress
- 659.71—Abnormality in fetal heart rate or rhythm
- 663.11—Cord around neck, with compression
What diagnoses support cesarean deliveries?

- 661.11—Secondary uterine inertia
- 660.61—Failed trial of labor, unspecified
- 660.71—Failed forceps or vacuum extractor, unspecified
- 659.11—Failed medical or unspecified induction
What diagnoses support cesarean deliveries?

- 660.01—Obstruction caused by malposition of fetus at onset of labor
- 660.41—Shoulder (girdle) dystocia
- 669.71—Cesarean delivery, without mention of indication
- 654.21—Previous cesarean delivery
Codes that don’t work

- 669.71—Cesarean delivery, without mention of indication
- 650—Normal delivery
Tonya

- Tonya is an 18-year-old G₁P₀ who went to her first prenatal visit at 20 weeks and has missed her last two appointments with her obstetrician.
Tonya

- She is admitted to the antepartum floor at 38 weeks after initiation of labor early the same morning. She reports to the nurse that her membranes ruptured at home the day prior, but since she wasn’t having contractions, she decided to wait to come to the hospital.
Dr. Smithson comes in to see her and starts IV Pitocin since her membranes had been ruptured for approximately 24 hours.

Later that same day, she delivers vaginally a healthy male infant. Cultures are taken of mother and baby.
Tonya

• On Day 2, she develops a fever of 102. Additional cultures are taken and IV antibiotics started.

• Cultures are positive for enteric strep and endometritis is diagnosed. She remains on IV antibiotics for the next 3 days (until Day 5).
• On Day 6 she is discharged home on oral antibiotics after being afebrile for 48 hours.
Appropriate diagnoses for Tonya

• **Day of Delivery**
  - 658.21  Delayed delivery after spontaneous or unspecified rupture of membranes
  - V27.0  Single live birth

• **Postpartum Day 1-5**
  - 670.12  Puerpal endometritis
WHAT IS ICD-10 GOING TO LOOK LIKE IN THE PERINATAL SETTING?
Some Common Misconceptions...

- ICD-10-CM is not “a big deal”
- Preparation is not really necessary—EMRs/EHRs and other electronic tools are sufficient to guide physicians, coders, and staff
- “I” don’t need to be involved
Basic Facts About ICD-10

• The ICD-9 code sets (first published in 1975 and implemented in 1979) used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets on October 1, 2015.
  • ICD-10-CM diagnosis coding which is for use in all U.S. health care settings.
Basic Facts About ICD-10

• ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims:
  • Claims for services provided on or after the compliance date should be submitted with ICD-10 diagnosis codes.
  • Claims for services provided prior to the compliance date should be submitted with ICD-9 diagnosis codes.
Code Formatting

• Code Format: XXX.XXX.X
  • XXX = Category
  • XXX = Etiology, anatomic site, severity
  • X = Extension

• Placeholder Character X
  • Used with certain codes for potential future expansion or
  • Used to expand code when 7th digit extension required
An Example

- Labor and delivery complicated by cord around neck, without compression: O69.81X2
  - O69: Labor and delivery complicated by umbilical cord complications
  - 81: Cord around neck, without compression
  - X: Placeholder
  - 2: Fetus 2
## ICD-10-CM Chapters

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<th>Number of Codes</th>
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<td>6</td>
<td>Disease of the Nervous Systems</td>
<td>G00-G99</td>
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## ICD-10-CM Chapters, Con’d

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<th>Equiv. ICD-9 Codes</th>
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<td>18</td>
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<td>R00-R99</td>
<td>639</td>
<td>780-799</td>
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<td>Injury, Poisoning, and Certain Other Consequences of External Causes</td>
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<td>Factors Influencing Health Status and Contact with Health Services</td>
<td>Z00-Z99</td>
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<td>V01-V91</td>
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What is Different with ICD-10?

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<thead>
<tr>
<th></th>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of characters</td>
<td>3–5 characters in length</td>
<td>3–7 characters in length</td>
</tr>
<tr>
<td>Number of codes</td>
<td>Approximately 13,000 codes</td>
<td>Approximately 68,000 available codes</td>
</tr>
<tr>
<td>Types of characters</td>
<td>First digit can be alpha (E or V) or numeric; digits 2–5 are numeric; most codes are all numeric</td>
<td>Digit 1 is alpha; digits 2 and 3 are numeric; digits 4–7 are alpha or numeric</td>
</tr>
<tr>
<td>Code capacity</td>
<td>Limited space for adding new codes</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Specificity</td>
<td>Lacks detail</td>
<td>Very specific</td>
</tr>
<tr>
<td>Laterality designations (right vs. left)</td>
<td>Lacks laterality</td>
<td>Has laterality</td>
</tr>
</tbody>
</table>
There’s not much difference...

<table>
<thead>
<tr>
<th>Convention</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes</td>
<td>Further define terms, clarify information, or list choices for additional digits.</td>
<td>Further define terms, clarify information, or list choices for additional digits. With/without notes are the options for the final character of a set of codes.</td>
</tr>
<tr>
<td>Includes</td>
<td>Notes that further define or provide examples and can apply to a chapter, section, or category.</td>
<td>Same as ICD-9-CM.</td>
</tr>
<tr>
<td>Not otherwise specified</td>
<td>Used when the information at hand does not permit a more specific code assignment.</td>
<td>Same as ICD-9-CM.</td>
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<tr>
<td>Excludes</td>
<td>Notes that indicate terms that are to be coded elsewhere.</td>
<td>Same as ICD-9-CM (compares to Excludes1).</td>
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<tr>
<td>Convention</td>
<td>ICD-9-CM</td>
<td>ICD-10-CM</td>
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<tr>
<td>Code first underlying disease</td>
<td>Used in categories not intended as the primary diagnosis.</td>
<td>Same as ICD-9-CM</td>
</tr>
<tr>
<td>Use additional code</td>
<td>Appears in categories in which further information must be added by using an additional code, to provide a more complete picture.</td>
<td>Same as ICD-9-CM</td>
</tr>
<tr>
<td>Colon</td>
<td>Used after an incomplete term that needs one or more of the modifiers that follows to make it assignable to a category.</td>
<td>Same as ICD-9-CM</td>
</tr>
<tr>
<td>Brackets</td>
<td>Enclose synonyms, alternate wording, or explanatory phrases.</td>
<td>Same as ICD-9-CM</td>
</tr>
<tr>
<td>Convention</td>
<td>ICD-9-CM</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Parentheses</td>
<td>Enclose supplementary words that may be present or absent, without affecting the code number to which it is assigned.</td>
<td>Same as ICD-9-CM.</td>
</tr>
<tr>
<td>Braces</td>
<td>Enclose a series of terms, each of which is modified by the statement appearing at the right.</td>
<td>Not used in ICD-10-CM.</td>
</tr>
<tr>
<td>Excludes1</td>
<td>Not used in ICD-9-CM, although similar to Excludes.</td>
<td>Indicates that the code excluded can never be used at the same time as the code to which the excludes list applies. For example, a congenital and acquired cannot coexist.</td>
</tr>
<tr>
<td>Excludes2</td>
<td>Not used in ICD-9-CM.</td>
<td>Indicates that the condition is not included as part of the code. If the patient has both conditions, a separate code must be used to report it.</td>
</tr>
</tbody>
</table>
Other Changes

• **Incorporation of E and V Codes:** The codes corresponding to ICD-9-CM V codes and E codes are incorporated into the main classification.

• **New Definitions:** In some instances, new code definitions are provided reflecting modern medical practice (e.g., definition of acute myocardial infarction is now 4 weeks rather than 8 weeks, missed abortion is up to 20 weeks, rather than 22 weeks)
Other Changes

- **Restructuring and Reorganization:** Category restructuring and code reorganization have occurred in a number of ICD-10-CM chapters, resulting in the classification of certain diseases and disorders that are different from ICD-9-CM.

- **Reclassification:** Certain diseases have been reclassified to different chapters or sections in order to reflect current medical knowledge.
ICD-10 Coding

• Inclusion of trimesters in many obstetric codes
• Elimination of episodes of care for obstetric codes
• Documentation will need to include trimester or weeks of gestation
• If condition typically occurs in only one trimester, then identification of trimester not required
• Complications of childbirth and puerperium contain information in code descriptor
ICD-10 Coding

• Chapter 15: Pregnancy, childbirth and the puerperium
  • 000-008 Pregnancy with abortive outcome
  • 009-009 Supervision of high risk pregnancy
  • 010-016 Edema, proteinuria and hypertensive disorders in pregnancy, childbirth and the puerperium
  • 020-029 Other maternal disorders predominantly related to pregnancy
ICD-10 Coding

- **030-048** Maternal care related to the fetus and amniotic cavity and possible delivery problems
- **060-077** Complications of labor and delivery
- **080-082** Encounter for delivery
- **085-092** Complications predominantly related to the puerperium
- **094-09A** Other obstetric conditions, not elsewhere classified
## Revisiting the Case of Anne

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>ICD-10-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>641.13</td>
<td>O44.13</td>
<td>Placenta previa with hemorrhage, third trimester</td>
</tr>
<tr>
<td>648.03</td>
<td>O24.013</td>
<td>Pre-existing diabetes mellitus, type 1 in pregnancy, third trimester</td>
</tr>
<tr>
<td>250.01</td>
<td>E10.9</td>
<td>Type 1 diabetes mellitus without complications</td>
</tr>
<tr>
<td></td>
<td>Z3A.34</td>
<td>34 weeks gestation</td>
</tr>
</tbody>
</table>

### Code to Avoid

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>ICD-10-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>641.90</td>
<td>O46.90</td>
<td>Antepartum hemorrhage, unspecified, unspecified trimester</td>
</tr>
</tbody>
</table>
## Revisiting the Case of Anne

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>ICD-10-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>641.01</td>
<td>O44.00</td>
<td>Placenta previa specified as without hemorrhage, unspecified trimester</td>
</tr>
<tr>
<td>648.01</td>
<td>O24.02</td>
<td>Pre-existing diabetes mellitus, type 1 in childbirth</td>
</tr>
<tr>
<td>250.01</td>
<td>E10.9</td>
<td>Type 1 diabetes mellitus without complications</td>
</tr>
<tr>
<td>V27.0</td>
<td>Z37.0</td>
<td>Single liveborn</td>
</tr>
<tr>
<td>V27.0</td>
<td>Z3A.38</td>
<td>38 weeks gestation</td>
</tr>
</tbody>
</table>
# Revisiting the Case of Anne

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>ICD-10-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum Day 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V24.2</td>
<td>Z39.2</td>
<td>Encounter for routine postpartum follow up</td>
</tr>
<tr>
<td>641.01</td>
<td>O44.00</td>
<td>Placenta previa specified as without hemorrhage, unspecified trimester</td>
</tr>
<tr>
<td>648.01</td>
<td>O24.03</td>
<td>Pre-existing diabetes mellitus, type 1 in the puerperium</td>
</tr>
<tr>
<td>250.01</td>
<td>E10.9</td>
<td>Type 1 diabetes mellitus without complications</td>
</tr>
</tbody>
</table>
Revisiting the Case of Anne

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>ICD-10-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum Day 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>674.12</td>
<td>O90.0</td>
<td>Disruption of cesarean delivery wound</td>
</tr>
<tr>
<td>641.01</td>
<td>O44.00</td>
<td>Placenta previa specified as without hemorrhage, unspecified trimester</td>
</tr>
<tr>
<td>648.01</td>
<td>O24.03</td>
<td>Pre-existing diabetes mellitus, type 1 in the puerperium</td>
</tr>
<tr>
<td>250.01</td>
<td>E10.9</td>
<td>Type 1 diabetes mellitus without complications</td>
</tr>
</tbody>
</table>
Revisiting the Case of Tonya

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>ICD-10-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>658.21</td>
<td>O42.12</td>
<td>Full-term premature rupture of membranes, onset of labor more than 24 hours following rupture</td>
</tr>
<tr>
<td>V27.0</td>
<td>Z37.0</td>
<td>Single liveborn</td>
</tr>
<tr>
<td></td>
<td>Z3A.38</td>
<td>38 weeks gestation</td>
</tr>
<tr>
<td>Postpartum Day 1-5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>670.12</td>
<td>O86.12</td>
<td>Endometritis following delivery</td>
</tr>
</tbody>
</table>
Resources

- CMS: http://www.cms.gov/ICD10
- www.roadto10.org
- NCHS (CDC):
  http://www.cdc.gov/nchs/icd/icd10.htm
- AHIMA: http://www.ahima.org/icd10/
- AAPC: http://www.aapc.com/icd-10/
- ACOG: http://www.acog.org/About_ACOG/ACOG_Departments/Coding/ICD_10
MAKING IT WORK
Coding Principles

- Physicians and institutions do better financially if they:
  - Select their own codes
  - Understand the coding process
  - Involve themselves in the reimbursement cycle
- Physicians and staff teamwork is critical!
Coding Principles

• Physicians and staff must stay current and involved
• Physicians are responsible for the coding information on claims!
Models for process management

• Trends are toward centralization—moving away from physician/coder interaction
• It can’t be successful if the process centralization destroys the communication
• Why?
  • The doctor is in the room/the coder is not
  • The coder has the expertise in coding rules/the physician generally doesn’t
Models for process management

- The coder needs information to be accurate
- The physician/institution needs accurate claims to make money
- The coder is more efficient if they don’t have to correct the same issue over and over
QUESTIONS?
Brad Hart, MBA, MS, CMPE, CPC, CPMA, COBGC
bhart@rmaci.com
(862) 438-1678