Alert! The 2011 ICD-9 code set is already in force

Among the changes that have arrived are codes to improve the specificity of what you provide to payers—including characterizations of multiple gestations and distinctions in uterine, vaginal, and cervical anomalies

This year, ObGyn-related additions and revisions to the International Classification of Diseases, Clinical Modification (ICD-9-CM), involve tinkering with existing codes and adding some new code categories. The latter development means that more information will be required of you to code to the highest level of specificity.

On the **obstetrics** side, there are now specific codes for placental status for multiple gestations and some revised terminology.

In **gynecology,** changes include new codes for congenital anomalies of the cervix, vagina, and uterus; reporting an expanded list of a history of dysplasia; and reporting the insertion and removal of an intrauterine device for contraception.

In addition, new codes have been established for fecal incontinence and for reporting a body mass index >40.

Last, changes to the alphabetical index of codes have been put in place that will help you select the most appropriate code.

The new and revised ICD-9-CM codes were added to the national code set on October 1, 2010. As in previous years, there is no grace period for failing to use the new code set!

IN THIS ARTICLE

Changes to obstetric codes

PLACENTAL/AMNIOTIC SAC SPECIFICATION FOR MULTIPLE-GESTATION PREGNANCY

Multiple-gestation pregnancies are classified as monochorionic/monoamniotic, monochorionic/diamniotic, and dichorionic/diamniotic. Until now, however, you've had no way to report this additional information to a payer.

For fiscal year 2011, you are able to be more specific, which can increase your ability to report medical support care for a higher-risk pregnancy or an expanded treatment plan.

Because the current category of multiple-gestation codes **(651)** did not allow for expansion to include this information, a new code category, **V91** (*multiple gestation placenta status*), was created for that purpose. The **V91** category has distinct codes for twin gestation, triplet gestation, quadruplet gestation, and other "unspecified" gestations to denote placental/amniotic sac status.

Be aware that use of the **V91** codes is *optional*, and that they can be reported only as a secondary diagnosis, with a category **651.xx**

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(*multiple gestation,* etc.) code as primary. As I noted, however, the new codes may provide better information to the payer—and that might result in additional reimbursement for your care of such pregnancies.

The new codes for a **twin pregnancy** are:

V91.00 Twin gestation, unspecified number of placentae, unspecified number of amniotic sacs

V91.01 Twin gestation, monochorionic/monoamniotic (one placenta, one amniotic sac)

V91.02 Twin gestation, monochorionic/diamniotic (one placenta, two amniotic sacs)

V91.03 Twin gestation, dichorionic/diamniotic (two placentae, two amniotic sacs)

V91.09 Twin gestation, unable to determine number of placentae and number of amniotic sacs

There are similar V codes for **triplet gestations (V91.10–V91.19), quadruplet gestations (V91.20–V91.29),** and other unspecified **multiple gestations (V91.91–V91.99)**.

RECURRENT PREGNANCY LOSS

The term "habitual aborter" has been replaced for 2011 with the more clinically accurate term "recurrent pregnancy loss." This change is noted in both the ICD-9 alphabetical index and in the code definitions in the tabular section. The codes affected by this terminology change are:

629.81 Recurrent pregnancy loss without current pregnancy

646.3x Recurrent pregnancy loss (affecting the current pregnancy)

INDEX AND INSTRUCTIONAL CHANGES

These OB changes took effect on October 1, 2010:

- Periurethral trauma should be reported using **664.8x** (*other specified trauma to perineum and vulva*), not **665.5x** (*other injury to pelvic organs*).
- If you report puerperal sepsis (**670.2x**), you must report an additional code to identify severe sepsis (**995.92**) and any associated acute organ dysfunction, if applicable.
- If your diagnosis is superficial thrombosis (**671.2x**), an additional code—either **453.6**, **453.71**, or **453.81**—should be reported to further explain the type of thrombophlebitis.
- If your patient has either asymptomatic, inactive, or a history of genital herpes that is complicating her current pregnancy, report **647.6x** (*other viral diseases*).
- If you report pneumonia as complicating pregnancy, assign code **648.9x** (*other current conditions classifiable elsewhere*).

FAST TRACK

A higher level of specificity in coding can make all the difference in receiving adequate reimbursement and preventing denials

Changes to gyn codes

CONGENITAL ANOMALIES OF THE UTERUS, CERVIX, AND VAGINA

Before October 1, 2010, of the seven distinct types of uterine anomalies, only a didelphus uterus (**752.2**, *doubling of the uterus*) and a diethylstilbestrol-related anomaly (**760.76** [*noxious influences affecting fetus or newborn via placenta or breast milk; diethylstilbestrol (DES)*]) had specific codes. All other uterine anomalies were coded to "other" or "unspecified" codes that could include many different conditions.

Although vaginal and cervical anomalies may be less common, the only codes available before October 1, 2010, were ones that described an unspecified anomaly (**753.40**), imperforate hymen (**752.42**), or an embryonic cyst (**752.41**).

A higher level of specificity in coding, however, can make all the difference in receiving adequate reimbursement and preventing denials. For example, if you perform a Pap smear on a patient who has two cervices, a code that specifies a duplicate cervix

can clearly tell the payer that billing for both is not a duplicate service or billing error.

Changes to codes in this area of care take the form of expanding existing codes. Code **752.3** (*other anomalies of uterus*) has been expanded to seven distinct five-digit codes to capture the seven anomalies of the uterus:

752.31 Agenesis of uterus
752.32 Hypoplasia of uterus
752.33 Unicornuate uterus (This code would be reported if the unicornuate uterus did or did not have a separate uterine horn, or if the uterus had only one functioning horn.)
752.34 Bicornuate uterus
752.35 Septate uterus (This code would be reported whether the septate was complete or partial.)
752.36 Arcuate uterus
752.39 Other anomalies of uterus (This code category includes aplasia or any other Müllerian anomaly of the uterus that is not otherwise or elsewhere classified.)

New codes have been added to the **752.4** code category (*anomalies of cervix, vagina, and external female genitalia*) to expand the options. Before October 1, 2010, any of these conditions would have been coded as **752.49**, an "other" category.

752.43 Cervical agenesis
752.44 Cervical duplication
752.45 Vaginal agenesis (This code can also be reported for vaginal hypoplasia.)
752.46 Transverse vaginal septum
752.47 Longitudinal vaginal septum

For a patient who has a history of one of these anomalies, you would report new code **V13.62**, (*personal history of other [corrected] congenital malformations of genitourinary system*) if this history was a factor in her current care.

IUD INSERTION AND REMOVAL

Inserting and removing an IUD are integral services that most ObGyn practices provide, so it is imperative that your encounter forms reflect two new codes, to avoid denials for an invalid diagnosis code.

A reminder: Code **V45.51** (*intrauterine contraceptive device*) is a status code. It indicates that a patient has an IUD in place but you should *never* use it as a diagnosis code when the purpose of the visit is for you to check on the device and assess how it is working.

Changes in this area are:

Before October 1, 2010:

V25.1 Insertion
V25.42 Checking, reinsertion and/or removal

After October 1, 2010:

V25.11 Encounter for insertion of intrauterine contraceptive device
V25.12 Encounter for removal of intrauterine contraceptive device
V25.13 Encounter for removal and reinsertion of intrauterine contraceptive device
V25.42 Encounter for routine checking of intrauterine contraceptive device

FAST TRACK

Code V45.51 is intended to reflect the IUD status of a patient, not to serve as a diagnosis code when the purpose of the visit is to check on the device and assess how it is working

BODY MASS INDEX

Regrettably, the number of patients who have a very high body mass index (BMI) is increasing. When surgery is planned, reporting this information in your coding can help establish **1)** the medical need for significant additional work during the procedure or **2)** health risks in support of therapy.

Code **V85.4** (*Body mass index 40 and over, adult*) has been expanded to five new codes. They should be reported secondary to the type of obesity (i.e., codes **278.0x** [*overweight and obesity*]).

V85.41 Body Mass Index 40.0–44.9, adult
V85.42 Body Mass Index 45.0–49.9, adult
V85.43 Body Mass Index 50.0–59.9, adult
V85.44 Body Mass Index 60.0–69.9, adult
V85.45 Body Mass Index 70 and over, adult

FECAL INCONTINENCE

Fecal incontinence can present as problematic symptoms—fecal smearing, fecal urgency, incomplete defecation—but, until now, you only had one code to report any of these problems.

For that reason, **787.6** (*incontinence of feces*) has been expanded into four new five-digit codes. In addition, a new code has been added to report fecal impaction, which, in

CONTINUED ON PAGE 68

the past, was reported as **560.39**, an "other" category code that was not specific to this problem.

New codes are:

560.32 Fecal impaction
787.60 Full incontinence of feces
787.61 Incomplete defecation
787.62 Fecal smearing
787.63 Fecal urgency

PERSONAL HISTORY OF DYSPLASIA

New codes have been added to complete the personal history codes for dysplasia. In addition to the existing code for cervical dysplasia history (**V13.22**), you can now report:

V13.23 Personal history of vaginal dysplasia
V13.34 Personal history of vulvar dysplasia

INDEX AND INSTRUCTIONAL CHANGES

These changes take effect October 1, 2010:

- Clarification that an abnormal Pap result indicated non-atypical endometrial cells should be reported using **795.09**.
- Clearly indicate whether a fistula between the uterus and another organ is congenital (**752.39**) or noncongenital (**619.0-619.9**).
- Precocious menstruation should be coded as **259.1**, not as a menstrual disorder.
- The terminology in the index and tabular sections has been revised to more clearly differentiate long-term from prophylactic use of medications. This change affects only code category titles and look-up terms, not existing code numbers.

Instant Quiz Answer

Approximately 25 mm Hg

The $Pa0_2$ in the umbilical artery of the normal term fetus is very similar to that of an adult breathing ambient air at the top of Mount Everest. In the fetus and newborn, however, fetal hemoglobin permits greater delivery of oxygen to tissues than adult hemoglobin does.

Also, in the fetus and newborn, fully oxygenated blood is carried in the umbilical vein, where the partial pressure of oxygen is approximately 40 mm Hg. This pressure is similar to the $Pa0_2$ observed in adults breathing air at about 21,000 feet above sea level—an altitude at which pulmonary and cerebral dysfunction are less common.[1–3]

References

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See page 13 for the quiz.