FOR FISCAL 2012

Change has come again to ICD-9 diagnostic codes

New codes were unveiled on October 1 to report elective cesarean delivery, ART pregnancy, and vaginal mesh complications, to name a few

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Did you know? When October 1 rolled around a short time ago, so did new codes for you to learn in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

If you consider that unpleasant news for your billing efforts, I also have what I consider good news: **The 2012 fiscal year is the final year for changes to ICD-9-CM codes: On October 1, 2013, the nation switches to 10th Revision (that is, ICD-10-CM) codes.** The National Center for Health Statistics has indicated that the only changes to ICD-9 codes permitted from now on are ones describing **new diseases** that require immediate reporting during this transition/freeze period.

This last set of changes isn't as massive as what we saw in previous years. Nevertheless, the changes certainly enhance the ability of ObGyn practices to report the reasons for patient encounters.

The major gyn change this year involves reporting **vaginal mesh complications.** There are several new obstetric codes, too, to enhance reporting of **cesarean delivery and management of high-risk OB conditions.**

The new codes were added to the national code set on October 1. As in prior years, there is no grace period.

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Additional detail is available

Download a free copy of the complete addenda of ICD-9-CM code changes that have been made for fiscal year 2012 at: www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

Changes to obstetric codes

ANTIPHOSPHOLIPID ANTIBODY

Antiphospholipid syndrome and lupus anticoagulant are associated with complications of pregnancy that include fetal loss, fetal growth restriction, preeclampsia, thrombosis, and autoimmune thrombocytopenia. Until now, the obstetrician reporting **649.3x** (*Coagulation defects complicating pregnancy, childbirth, or the puerperium*), had only two secondary code options to further describe the patient's condition: **795.79**, used to report a finding of antiphospholipid antibody in a blood specimen, and **289.81**, antiphospholipid antibody with hypercoagulable state.

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A new code, **286.53** (*Antiphospholipid antibody with hemorrhagic disorder*), provides a third option when reporting 649.3x.

CHEMICAL PREGNANCY AND BLIGHTED OVUM

Fertility clinics and physicians who specialize in the use of assisted reproductive technology requested a code to identify patients who have what is referred to (imprecisely) as a "false-positive pregnancy," "chemical pregnancy," or "biochemical pregnancy." These terms do not, however, accurately describe a pregnancy achieved using hormone stimulation or other such "chemical" methods.

In some cases, of course, a woman's pregnancy test comes back positive, indicating a serum human chorionic gonadotropin (hCG) level, but, when she is followed with ultrasonography, no fetus is present—in effect, she has had an early miscarriage. But there has been no ICD-9 code to use at this stage that discriminates between confirmed ectopic pregnancy and confirmed miscarriage—only a code for a laboratory finding.

To improve the specificity of coding, therefore, and to track such pregnancies, existing code **631** (*Other abnormal product of conception*) has been expanded and divided in two:

631.0 Inappropriate rise (decline) of quantitative hCG in early pregnancy

631.8 Other abnormal products of conception

Documentation by the physician that signals that 631.0 should be reported might include a reference to biochemical pregnancy, chemical pregnancy, or an inappropriate level of quantitative hCG for gestational age in early pregnancy. For 631.8 to be reported, documentation might mention such findings as a "blighted ovum" or "fleshy mole."

Note: Because of this code expansion, the three-digit code 631 will no longer be a valid code for billing purposes.

ELECTIVE CESAREAN DELIVERY BEFORE 39 WEEKS' GESTATION

ACOG requested new codes for elective cesarean delivery before 39 weeks' gestation—a scenario that is one of the new markers of quality of care. Whereas ICD-9 has two diagnosis codes that mention cesarean delivery (**654.2x**, [*Previous cesarean delivery not otherwise specified*] and **669.71** [*Cesarean delivery, without mention of indication*]), neither code captures a case in which a woman presents in labor at 37 to 38 weeks' gestation and the physician determines that it is best to deliver at that time rather than try to take measures that will forestall delivery until the 39th week.

Although ICD-9 already also has a code for early onset of delivery (**644.21**), it applies only to pregnancies before 37 completed weeks.

The new codes are:

649.81 Onset (spontaneous) of labor after 37 completed weeks of gestation but before 39 completed weeks' gestation, with delivery by (planned) cesarean section, delivered, with or without mention of antepartum condition

649.82 Onset (spontaneous) of labor after 37 completed weeks of gestation but before 39 completed weeks' gestation, with delivery by (planned) cesarean section, delivered, with mention of postpartum complication

Note: The new code has two options for a fifth digit:

- Reporting a fifth digit **1** indicates that the patient may, or may not, have had a complication in the antepartum period that is related to early onset of labor.
- Reporting a fifth digit **2** indicates that the patient developed a complication after delivery (but before discharge) that is related to the delivery.

For any hospitalization that results in a delivery, you must select a fifth digit 1 *or* 2; the choice depends on the overriding complication. You may *not* list code 649.8 twice—i.e., once with a fifth digit 1 and once with a fifth digit 2.

If the patient had a condition that was documented to be why cesarean delivery was medically indicated, list that as a secondary

FAST TRACK

Two new codes have been created to report early onset of labor between 37 and 39 weeks' gestation, with delivery by elective cesarean

diagnosis—for example, cephalopelvic disproportion (**653.4x**) or prior cesarean delivery (**654.2x**).

SUPERVISION OF HIGH-RISK PREGNANCY

Code subcategory **V23.4** (*Pregnancy with other poor obstetric history*) had only two coding options before October 1, 2011: **V23.41** (*Pregnancy with history of pre-term labor*) and **V23.49** (*Pregnancy with other poor obstetric history*).

Ectopic pregnancy. ACOG considers that it is important to track patients who had a prior ectopic pregnancy because such a history gives rise to an increased risk of ectopic pregnancy during the current pregnancy. Therefore, a new code for this status was requested by ACOG, and provided.

Note: Use the new history code only until the patient is confirmed *not* to have an ectopic pregnancy, if that is the outcome. Once you've confirmed that she has only a normal, intrauterine pregnancy, the risk posed by her history no longer has an impact on the current pregnancy. (ICD-9 rules direct you to report conditions that require active intervention or a change in routine care of the pregnancy—not conditions that merely exist without the need for intervention or additional monitoring.)

The new code is:

V23.42 Pregnancy with history of ectopic pregnancy

Fetal viability. There was also no specific code before October 1 to report the need for a sonogram to check fetal viability, especially when a previously confirmed pregnancy comes into question because of the apparent absence of a fetal heartbeat on examination of the mother. In such a case, an additional sonogram might be required beyond the initial scan to confirm fetal demise or a continuing viable pregnancy. Until now, either of these findings could have been reported only with codes that do not accurately describe the situation, such as **659.7** (*Abnormality in fetal heart rate or rhythm*); **V28.89** (*Other specified antenatal screening*); and **V23.89** (*Other high-risk pregnancy*).

The new code is:

V23.87 Pregnancy with inconclusive fetal viability

FAST TRACK

ACOG requested, and was granted, a new code for pregnancy in a woman who has a history of ectopic pregnancy (Code V23.42)

Changes to gyn codes

COMPLICATIONS OF VAGINAL MESH

An effective surgical treatment for vaginal vault prolapse is sacrocolpopexy that uses a graft to suspend the upper vagina to the anterior longitudinal ligament of the sacrum. But, regrettably, synthetic graft material has also been associated with erosion of the mesh and subsequent pelvic infection (by erosion into surrounding organs or tissue). Exposure of the mesh in the vagina can also occur (see "Take this simplified approach to correcting exposure of vaginal mesh" in the July 2011 issue, available at obgmanagement.com).

Before October 1, erosion or exposure of mesh (without infection) would have been reported with code **996.39** (*Mechanical complication of a genitourinary device, implant and graft*) or **996.76** (*Other complications due to genitourinary device, implant, and graft*). With creation of a new subcategory code, **629.3** (*Complication of implanted vaginal mesh and other prosthetic materials*), however, these specific complications can be reported and tracked. The new codes also give you a specific linking diagnosis for revision of the mesh.

The two new codes are:

629.31 Erosion of implanted vaginal mesh and other prosthetic materials to surrounding organ or tissue (e.g., into pelvic floor muscles)

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629.32 Exposure of implanted vaginal mesh and other prosthetic materials into vagina (e.g., through the vaginal wall)

Note: If the patient's graft material has caused fibrosis, hemorrhage, occlusion, or pain, continue to report **996.76.** And, of course, any infection or inflammatory reaction caused by mesh is reported with existing code **996.65**.

Because erosion and exposure can occur at the same time, it is proper to report both new codes, if that is the case.

HISTORY OF GESTATIONAL DIABETES

Code **V12.2** (*Personal history of endocrine, metabolic, and immunity disorders*) has been expanded and divided into two five-digit codes:

V12.21 Gestational diabetes

V12.29 Other endocrine, metabolic, and immunity disorders

With this change, four-digit code V12.2 became an invalid diagnosis code; your claim will be denied if you report it as the reason for an encounter.

Note: Code V12.21 may *not* be reported as a primary diagnosis for an obstetrical patient. Instead, a personal history that may be having an impact on the current pregnancy should be reported with a **V23.xx** code (*Supervision of high risk pregnancy*), until (and if) the patient develops a condition.

For example: If a patient had gestational diabetes during a prior pregnancy, she risks developing it again in the current pregnancy. In that case, report **V23.49** (*Pregnancy with other poor obstetric history*) as the primary code and assign **V12.21** as the secondary code.

LONG-TERM USE OF BISPHOSPHONATES

In a woman being treated to prevent loss of bone mass, the side-effect profile of the medication and the need to measure its effectiveness require regular follow-up visits. Effective October 1, code **V58.68** (*Long-term [current] use of bisphosphonates*) should be reported for these follow-up visits. The code can be also used to support ordering follow-up bone densitometry.

Medications that might be applicable here are alendronate (Fosamax), ibandronate (Boniva), risedronate (Actonel), and zoledronic acid (Reclast).

FAST TRACK

Code V58.68 should be reported for follow-up care of long-term bisphosphonate users, including the ordering of follow-up bone densitometry