ICD-10-CM documentation and coding for obstetric procedures

⮧ With the new system set to take effect in less than a month, here's what you need to know about key changes to obstetric coding

Melanie Witt, RN, CPC, COBGC, MA

The countdown is on for the big coding switch. Last month I wrote about changes in *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM) codes that will occur in relation to gynecologic services, but now it's time to tackle obstetric services. For obstetricians, the changes will be all about definitions. And documentation of obstetric conditions will be more complicated due to several factors, including the need to report trimester information and gestational age, use of a placeholder code, more complex guidelines for certain conditions, chorionicity for multiple gestations, and use of a 7th digit to identify the fetus with a problem.

No one is expecting clinicians to instantly be fluent in code-speak, but in order for the most specific diagnoses to be reported, the clinical documentation must be spot on. Think of it this way: ICD-10-CM is not requiring you to document *more*, it's requiring you to document more *precisely*.

Ms. Witt is an independent coding and documentation consultant and former program manager, department of coding and nomenclature, American Congress of Obstetricians and Gynecologists.

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How to get started

Figuring out where you are now goes a long way toward knowing where you need to be when the calendar changes to October 1—and the best way to do it is to perform a gap analysis. This analysis can be carried out by the clinician or a qualified practice staff person.

To begin, run a report of the distinct obstetric codes you have billed in 2015 by frequency. Then sort them in numeric order so that each individual code category is captured for all of the 5th digits (and the code then will be counted as a single code). Finally, review 5 medical records for each of the top 10 reported diagnosis categories and determine whether you could have reported a more specific ICD-10-CM code.

The information you gain will go a long way toward identifying potential weaknesses in the documentation, or, if you are currently using an electronic health record (EHR) to look up a code, it will point up any weak points in searching for the right code, based on your specific documentation at the encounter. Remember, practice makes perfect...eventually.

Well-trained staff can help

Not only must you, the clinician, learn about the part your clinical documentation will play in providing the most specific information that will lead to a very specific code, but your

coding and billing staff will need training as well. They are the ones who should be checking your claims for accuracy from October 1 forward, as they will know the basic rules about which codes can be billed together, code order, place codes, and so on. In other words, while you as a clinician should be responsible for picking the more specific code in ICD-10-CM, your staff is your backup when you don't.

Feedback from your staff on how the claims are being processed and, perhaps, the overuse of unspecified codes will keep you moving toward the goal of complete and precise clinical documentation and the reporting of diagnoses at the highest level possible given the documentation.

Highlights of ICD-10-CM obstetric coding

Given the complexity of obstetric coding, this article deals only with the most important changes. It will be up to each clinician to learn the rules that surround the diagnostic codes that you report most frequently. Here again, a trained staff can help by preparing specific coding tools for the most frequently used diagnoses, including notes about what must be in the record to report the most specific code.

Trimester, gestational age, and timing definitions

The majority of obstetric complication codes (these are the codes that start with the letter "O") and the "Z" codes for supervision of a normal pregnancy require trimester information to be valid. In the outpatient setting, the trimester will be based on the gestational age at the date of the encounter. For inpatient admissions, the trimester will be based on the age at the time of admission; if the patient is hospitalized over more than one trimester, it is the admission trimester that continues to be recorded, not the discharge trimester.

Although there are codes that indicate an unspecified trimester, they should be reported rarely if this information is, in fact, available. Trimesters are defined as:
- first: less than 14 weeks, 0 days

- second: 14 weeks, 0 days to less than 28 weeks, 0 days
- third: 28 weeks, 0 days until delivery.
  Examples of trimester codes include:
- **O25.11** *Malnutrition in pregnancy, first trimester*
- **O14.02** *Mild to moderate preeclampsia, second trimester*
- **O24.013** *Preexisting diabetes mellitus, type 1, in pregnancy, third trimester.*

However, definitions in ICD-10-CM go beyond this, and these definitions will have to be taken into account to provide sufficient documentation to report the condition. In ICD-9-CM, a missed abortion and early hemorrhage in pregnancy occurred prior to 22 completed weeks, but in ICD-10-CM that definition changes to prior to 20 completed weeks.

Additional definitions that may impact coding:
- **preterm labor or delivery:** 20 completed weeks to less than 37 completed weeks
- **full-term labor or delivery:** 37 completed weeks to 40 completed weeks
- **postterm pregnancy:** more than 40 completed weeks to 42 completed weeks
- **prolonged pregnancy:** more than 42 completed weeks.

You also will be required to include a code for gestational age any time you report an obstetric complication. This and the trimester information will change as the pregnancy advances, so always be sure that the code selected matches the gestational age on the flow sheet at the time of the encounter. The gestational age code is **Z3A.__**, with the final 2 digits representing the weeks of gestation (for instance, from 27 weeks, 0 days to 27 weeks, 6 days, the final 2 digits will be "27").

ICD-10-CM also has different conventions when it comes to timing as it relates to conditions that are present during the episode in which the patient delivers. When this is the case, an "in childbirth" code must be selected instead of assigning the diagnosis by trimester, if one is available. There also are codes that are specific to "in the puerperium," and these generally will be reported after the patient has been discharged after

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For inpatient admissions, the trimester will be based on the gestational age at the time of admission, even if the patient is hospitalized over more than one trimester

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Most docs still not ready for ICD-10 switch

A majority of physician practices will not be ready when the ICD-10 compliance date rolls around on October 1, according to a recent survey by the Workgroup for Electronic Data Interchange (WEDI).

Less than half of physician practices reported that they were ready or would be ready to implement ICD-10 by the compliance date. Nearly one-quarter of practices indicated they would not be ready, with the balance identifying their readiness status as "unknown."

The WEDI survey was conducted in June, prior to the Centers for Medicare and Medicaid Services' announcing a 1-year transition period during which Medicare will not deny claims based solely on the specificity of diagnosis codes, provided they are in the appropriate family of ICD-10 codes.

Physician practices "may now be working more quickly toward compliance, since the potential for further delay has been removed," WEDI wrote in a letter to Health and Human Services Secretary Sylvia Burwell.

WEDI, formed in 1991 by the HHS and named as an advisory organization to the agency under HIPAA, warned that if physician practices in particular "do not make a dedicated and aggressive effort to complete their implementation activities in the time remaining, there is likely to be disruption to industry claims processing on Oct. 1, 2015."

Physician practices may have a lot of catching up to do in a short amount of time because of inaction taken with each delayed implementation date. Many organizations "did not take full advantage of this additional time and as indicated in prior surveys, many organizations stopped or slowed down efforts when a delay was announced," WEDI noted.

In a separate letter, WEDI called for more transparency regarding the readiness of state Medicaid agencies to convert to ICD-10, and urged the HHS to appoint an ombudsman for ICD-10 as soon as possible.

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For multiple gestations, several code categories require a 7th numeric character of 0 or 1 through 9

delivery but also would be reported if there is no "in childbirth" code available at the time of delivery. The code categories to which this concept will apply are:
- preexisting hypertension
- diabetes mellitus
- malnutrition
- liver and biliary tract disorders
- subluxation of symphysis (pubis)
- obstetric embolism
- maternal infectious and parasitic diseases classifiable elsewhere
- other maternal diseases classifiable elsewhere
- maternal malignant neoplasms, traumatic injuries, and abuse classifiable elsewhere.

Taking time to read a code description from a search program or drop-down menu also will be important because some codes refer to "of the puerperium" versus "complicating the puerperium" or "in the puerperium." The first reference means that the condition develops after delivery, while the second and third terms mean that it developed prior to delivery. For example, code **O90.81**, *Anemia of the puerperium,* refers to anemia that develops following delivery, while code **O99.03** *Anemia complicating the puerperium,* denotes preexisting anemia that is still present in the postpartum period.

Multiple gestation coding and the 7th digit

The first thing you will notice here is that several code categories require a 7th numeric character of 0 or 1 through 9. This rule will apply to the following categories:
- complications specific to multiple gestation
- maternal care for malpresentation of fetus
- maternal care for disproportion
- maternal care for known or suspected fetal abnormality and damage
- maternal care for other fetal problems
- polyhydramnios
- other disorders of amniotic fluid and membranes

CMS takes steps to ease transition to ICD-10-CM

To help health care providers get "up to speed" on the *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM), which takes effect October 1, 2015, the Centers for Medicare and Medicaid Services (CMS) has launched a new series for specialists. A guide tailored to ObGyns is available at http://roadto10.org/example-practice-obgyn. The guide includes:
- common codes for the specialty, such as excessive, frequent, and irregular menstruation; disorders of the breast; and inflammation of the vagina and vulva, with corresponding ICD-9-CM codes
- a primer on changes in clinical documentation that involve new definitions and terminology and a need for greater specificity
- clinical scenarios to demonstrate key ICD-10-CM concepts, such as a patient with a breast lump at her annual well-woman exam
- links to other resources, including Webcasts on various topics.

The guide is geared to small ObGyn practices making the switch to the new system.

- preterm labor with preterm delivery
- term delivery with preterm labor
- obstructed labor due to malposition and malpresentation of fetus
- labor and delivery with umbilical cord complications.

A 7th character of 0 will be reported if this is a singleton pregnancy, and the numbers 1 through 5 and 9 refer to which fetus of the multiple gestation has the problem. The number 9 would indicate any fetus that was not labeled as 1 to 5.

The trick in documentation will be identifying the fetus with the problem consistently while still recognizing that, in some cases, such as fetal position, twins may switch places. On the other hand, if one fetus is small for dates, chances are good that this fetus will remain so during pregnancy when twins are present.

A code will be denied as invalid without this 7th digit, so it will be good practice for the clinician to document this information at each visit.

Additional information in regard to multiple gestations will be the chorionicity of the pregnancy, if known, but there will also be an "unable to determine" and an "unspecified" code available if that better fits the documentation for the visit. Note, however, that there is no code for a trichorionic/triamniotic pregnancy; therefore, only the unspecified code would be reported in that case. In addition, if there is a continuing pregnancy after fetal loss, the cause must be identified within the code (that is, fetal reduction, fetal demise [and retained], or spontaneous abortion).

Documentation requirements for certain conditions

If you plan on reporting any complication of pregnancy at the time of the encounter, information about that condition needs to be part of the antepartum flow sheet comments. If, at the time of the encounter, a condition the patient has is not addressed and the entire visit involves only routine care, you would report the code for routine supervision of pregnancy rather than the complication code. If the complication is again addressed at a later visit, the complication code would be reported again for that visit. The routine supervision code and the complication code cannot be reported on the record for the same encounter under ICD-10-CM rules.

Hypertension. Documentation needs to state whether the hypertension is preexisting or gestational. If it is preexisting, it needs to be identified as essential or secondary. If the patient also has hypertensive heart disease or chronic kidney disease, this information should be included, as different codes must be selected.

Diabetes. The documentation needs to state whether it is preexisting or gestational. If preexisting, you must document whether it is type 1 or type 2. If it is type 2, you must report an additional code for long-term insulin use, if applicable. The assumption for a woman with type 1 diabetes is that she is always insulin-dependent, so long-term use is not reported separately. Note, however, that neither metformin nor glyburide is considered insulin and there is no mechanism for reporting control with these medications.

If diabetes is gestational, you must indicate whether the patient's blood glucose level is controlled by diet or insulin. If both, report only the insulin. There is no code for the use of other medications for the control of gestational diabetes, so you would have to report an unspecified code in that case.

Also note that ICD-10-CM differentiates between an abnormal 1-hour glucose tolerance test (GTT) and gestational diabetes. Unless a 3-specimen or 4-specimen GTT has been performed and results are abnormal, a diagnosis of gestational diabetes should not be reported.

An additional code outside of the obstetric complication chapter is required to denote any manifestations of diabetes. If there are none, then a diabetes uncomplicated manifestation code must be reported.

Preterm labor and delivery. Your documentation must clearly indicate whether the patient has preterm labor with preterm delivery or whether the delivery is term in addition to the trimester. For instance, if you document that Mary presents with preterm labor at 27 weeks, 2 days and delivers a girl at 28 weeks, 6 days, your code will describe *Preterm labor second trimester with preterm delivery third trimester*. However, if Susan presents with preterm labor at 30 weeks, 2 days and is managed until 37 weeks, 1 day, when she delivers a baby boy, your code would describe *Term delivery with preterm labor, third trimester*.

New coding options

Among the new coding options under ICD-10-CM:

- Abnormal findings on antenatal screening. These would be reported when the antenatal test is abnormal but you have not yet determined a definitive diagnosis.
- Alcohol, drug, and tobacco use during pregnancy. If you report any of these codes, you must also report a manifestation code for the patient's condition. If the use is uncomplicated, you would report that code instead.
- Abuse of the pregnant patient. You can report sexual, physical, or psychological abuse, but you also must report a code for any applicable injury to the patient and identify the abuser, if known.
- Pruritic urticarial papules and plaques of pregnancy
- Retained intrauterine contraceptive device in pregnancy
- Maternal care due to uterine scar from other previous surgery. This would mean a surgery other than a previous cesarean delivery.
- Maternal care for (suspected) damage to the fetus by other medical procedures
- Maternal care for hydrops fetalis
- Maternal care for viable fetus in abdominal pregnancy
- Malignant neoplasm complicating pregnancy
- Failed attempt at vaginal birth after previous cesarean delivery
- Supervision of high-risk pregnancy due to social problems (for instance, a homeless patient)
- Rh incompatibility status (when you lack confirmation of serum antibodies and are giving prophylactic Rho[D] immune globulin).

Parting words

ICD-10-CM may seem like the end of the world, but its difficulty is exaggerated. If you fail to prepare, you will fail, and money coming in the door may be affected. If you prepare with training and practice, you will have a short learning curve. I wish you all the best. If you have specific questions about your practice, don't hesitate to let us know so they can be addressed early. ⊘