# VARYING CHANGES BY CLINICAL AREAS

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ICD-10 STRUCTURE & CONTENT

Category: O3 6.0 1 2
Anatomic Site, Etiology, Severity
Extension: 2

Maternal care for other fetal problems
Anti-D (RH) antibodies, second trimester
Fetus 2

O36.0122 - Maternal care for anti-D [Rh] antibodies, second trimester, fetus 2
CLINICAL IMPACTS
ICD-10 CLINICAL DOCUMENTATION IMPACTS

- Timing of care
- Combination codes with symptoms and/or manifestations
- Anatomical site specificity
- Complications
- Laterality
- Status codes, personal and family history codes
- Disease acuity
- General – BMI, tobacco use/smoking exposure, health status
WITH ICD-10, APPROPRIATE CLINICAL DOCUMENTATION CAN

• Enhance communication and collaboration among providers and between physician and patient by filling in the gaps in treatment and care.

• Provide an accurate representation of the severity and complexity of a patient's illness.

• Improve the quality of patient care, the patient care experience and strengthen the doctor-patient relationship.

• Connect the pieces of the medical record together for problems, assessments, procedures and treatments.

• Support and supplement provider documentation.

• Help substantiate the level of specificity required within ICD-10.

• Ensure we are paid for the services we provide.
ICD-10-CM EXAMPLES OF DOCUMENTATION SPECIFICITY

- New codes identifying abnormal findings separating routine preventative exams from exams that were clinically necessary for further investigation and assessment:

  Z00.01 - Encounter for general adult medical examination with abnormal findings
  Z00.121 - Encounter for routine child health examination with abnormal findings

- Document specific abnormal findings in a routine examination.

- Chronic conditions (i.e. asthma, bronchitis, COPD, etc.) requires that any related tobacco use, abuse, dependence, past history or smoke exposure (e.g., second hand) be reported.

- More specific documentation regarding laterality and anatomical location is required to identify site for medicated dressings, splints, etc.
ICD-10-CM EXAMPLE OF REVISED CLASSIFICATION

- Hypertension is no longer classified by type- benign, malignant or unspecified.

- ICD-10 classifies hypertension as Essential (primary).

- The following are the available categories for hypertensive conditions in ICD-10-CM. In some cases you may need to note if heart failure is present (e.g., I11) and the type of heart failure.
  - I10, Essential (primary) hypertension
  - I11, Hypertensive heart disease
  - I12, Hypertensive chronic kidney disease
  - I13, Hypertensive heart and chronic kidney disease
  - I15, Secondary hypertension

- I10 is used when hypertension is not further specified/associated with/ caused by another disease process such as chronic kidney disease.

- Gestational hypertension is assigned OB chapter codes O13.- or O14.-
DOCUMENTATION REQUIREMENTS
DOCUMENTING PREGNANCY

For pregnancy, the following documentation should be included:

- In ICD-10-CM, antepartum encounters are classified by the trimester of the pregnancy at the time of the encounter.

- Document weeks of gestation.

- The definition of a complication remains the same as under ICD-9-CM. Examples include asthma, smoking, obesity, gestational diabetes, pre-existing hypertension, etc…

- It is important to note if an obstetric complication is associated with delivery as an “in childbirth” option may exist and should be assigned.
OBSTETRIC COMPLICATIONS- DIABETES

- When diabetes complicates pregnancy it can be further classified as:
  - Pre-existing (type 1 or 2) and by the trimester in which the encounter occurred
  - Gestational in pregnancy, childbirth or puerperium and how it is controlled

O24.011 - Pre-existing diabetes mellitus, type 1, in pregnancy, first trimester
O24.02 - Pre-existing diabetes mellitus, type 1, in childbirth
O24.13 - Pre-existing diabetes mellitus, type 1, in the puerperium
O24.410 - Gestational diabetes mellitus in pregnancy, diet controlled
O24.424 - Gestational diabetes mellitus in childbirth, insulin controlled
O24.439 - Gestational diabetes mellitus in the puerperium, unspecified control
OBSTETRIC COMPLICATIONS NOT PREVIOUSLY SPECIFIED

• Added specification for certain complications in pregnancy, childbirth and the puerperium
  - Document if the following complications are present in pregnancy: low birth weight, retained intrauterine contraceptive device or herpes gestationis.

• Complications associated with anesthesia during pregnancy should be documented and are classified as: pulmonary, cardiac, central nervous system, toxic reaction and spinal and epidural anesthesia induced headache.
OBSTETRIC – ABNORMAL FINDINGS

- Abnormal findings during antenatal screening of the mother should be specified as:
  - Hematological
  - Biochemical
  - Cytological
  - Ultrasonic
  - Radiological
  - Chromosomal and genetic

O28.0 - Abnormal hematological finding on antenatal screening of mother
O28.1 - Abnormal biochemical finding on antenatal screening of mother
O28.2 - Abnormal cytological finding on antenatal screening of mother
O28.3 - Abnormal ultrasonic finding on antenatal screening of mother
O28.4 - Abnormal radiological finding on antenatal screening of mother
O28.5 - Abnormal chromosomal and genetic finding on antenatal screening of mother
OBSTETRIC COMPLICATIONS – ANTEPARTUM HEMORRHAGE

- Identify the specific type of antepartum hemorrhage with coagulation defect as:
  - Afibrinogenemia
  - Hypofibrinogenemia
  - Disseminated intravascular

- O46.013 - Antepartum hemorrhage with afibrinogenemia, third trimester
- O46.021 - Antepartum hemorrhage with disseminated intravascular coagulation, first trimester
- O46.092 - Antepartum hemorrhage with other coagulation defect, second trimester
OBSTETRIC COMPLICATIONS – FALSE LABOR

- Specify if labor prior to or at 37 weeks is false labor

O47.02 - False labor before 37 completed weeks gestation, second trimester
O47.03 - False labor before 37 completed weeks of gestation, third trimester
O47.1 - False labor at or after 37 completed weeks of gestation
7TH CHARACTER FOR FETUS IDENTIFICATION WHEN DOCUMENTING A COMPLICATION

• When documenting a complication, the fetus for which the complication is relevant should be identified if possible

• A seventh character will be assigned if relevant for specific codes

• If it is a single gestation, or when it is not possible to clinically determine which fetus is affected, your coder would assign a seventh character of “0”

O32.1XX0 - Maternal care for breech presentation, not applicable or unspecified
O32.1XX1 - Maternal care for breech presentation, fetus 1
O32.1XX2 - Maternal care for breech presentation, fetus 2
O32.1XX3 - Maternal care for breech presentation, fetus 3
O32.1XX4 - Maternal care for breech presentation, fetus 4
O32.1XX5 - Maternal care for breech presentation, fetus 5
O32.1XX9 - Maternal care for breech presentation, other fetus
DOCUMENTATION REQUIREMENTS

DOCUMENTATION FOR GYNECOLOGICAL CONDITIONS

- Documentation for gynecological conditions is relatively unchanged

- Vaginitis is further classified as either vaginitis or vulvitis and includes the specification of acute or subacute and chronic

- Delineation of a high risk screening mammogram is not available
DOCUMENTATION CHANGES & NEW CONCEPTS
NEW PREGNANCY CONCEPTS

- Trimester
- Hypertension with proteinuria
- Weeks of gestation
- HELLP – Pre-eclampsia with hemolysis, elevated liver enzymes and low platelet count
- Retained intrauterine contraceptive device in pregnancy
- Herpes gestationis
- Multiple concepts for pregnancy related complications
- Addition of seventh character for sequence of multiple births
- Placental conditions
  o Malformation
  o Infarction
  o Accreta
  o Increta
  o Percreta
TIMEFRAMES AND RULES FOR OBSTETRIC CASES

• The majority of codes in that are applicable to pregnancy, childbirth and the puerperium have a final character indicating the trimester of pregnancy.

• If trimester is not a component of a code it is because the condition always occurs in a specific trimester, or the concept of trimester of pregnancy is not applicable.

• Certain codes have characters for only certain trimesters because the condition does not occur in all trimesters, but it may occur in more than just one.

• With ICD-10, trimesters are counted from the first day of the last menstrual period. They are defined as follows:
  - First trimester – less than 14 weeks 0 days
  - Second trimester – 14 weeks 0 days to less than 28 weeks 0 days
  - Third trimester – 28 weeks 0 days until delivery

• An additional code from category Z38 should be used to define specific weeks of gestation.
TIMEFRAMES AND RULES FOR OBSTETRIC CASES (cont.)

- Codes are available for each week of gestation from eight weeks to 42 weeks. For example:
  - Z3A.11 - 11 weeks gestation of pregnancy
  - Z3A.22 - 22 weeks gestation of pregnancy
  - Z3A.37 - 37 weeks gestation of pregnancy

- Gestation weeks should only be used on the maternal record and in addition to the maternal condition or complication.
REMOVED CONCEPTS

- Illegitimacy/illegal
- Abortion (now “termination of pregnancy”) other than spontaneous or threatened abortion
- Antepartum
- Postpartum
- Delivered
- Various disorders complicating pregnancy:
  - Thyroid dysfunction of mother antepartum
  - Malaria in the mother
  - Rubella in the mother
  - Congenital cardiovascular disorders of the mother
  - Cerebrovascular disorders in the puerperium
  - Epilepsy complicating pregnancy
UNDERDOSING

- The concept of underdosing has been added to the poisoning and adverse effect classification
  - Includes the ability to report why the underdosing is occurring

T38.3X6A-Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs, initial encounter
T38.3X6D-Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs, subsequent encounter
T38.3X6S-Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs, sequelae

Z91.120-Patient’s intentional underdosing of medication regimen due to financial hardship
Z91.128-Patient’s intentional underdosing of medication regimen for other reason
Z91.130-Patient’s unintentional underdosing of medication regimen due to age-related debility
Z91.138-Patient’s unintentional underdosing of medication regimen for other reason
CODING SUPPORTS THE PATIENT STORY

- The primary code is the main reason for the visit
  - Ensure that the primary code is an appropriate primary code as defined in the guidelines.

- Additional codes should be reported where required by coding conventions (“code also”, “use additional code”).

- Avoid “over-coding” – if it isn't relative to the visit, don’t code it.
USE OF “UNSPECIFIED”
CMS GUIDANCE

- Unspecified codes have acceptable, even necessary uses.

- Specific diagnosis codes should be reported when supported by medical record documentation and clinical knowledge of the patient's condition.

- When sufficient clinical information about a patient's condition is not known, an unspecified code is the appropriate option.
When should an unspecified code be used?

O42.00 - Premature rupture of membranes, onset of labor within 24 hours of rupture, unspecified weeks of gestation

O42.019 - Preterm, premature rupture of membranes, onset of labor with 24 hours of rupture, unspecified trimester

O42.92 - Full term premature rupture of membranes, unspecified as to length of time between rupture and onset of labor

O46.001 - Antepartum hemorrhage with coagulation defect, unspecified, first trimester

O61.9 - Failed induction of labor, unspecified
TRAINING SOURCES

This presentation along with the coding scenarios can be seen in its entirety on the CMS Road to 10 website

http://www.roadto10.org
MVP CONTACTS

If you have any questions or concerns about the information presented here, please contact Mary Ellen Reardon or Shannon Chase and we will be glad to assist you.

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