ICD-10 Documentation for OB/Gyn
Objectives

At the completion of this lesson the learner will be able to:

• Identify frequently utilized OB/Gyn diagnoses and procedures
• Identify the ICD-10 changes associated with frequently utilized OB/Gyn diagnoses and procedures
• Define documentation recommendations for each diagnosis and procedure
Overview

While the actual number of OB/Gyn diagnoses has increased from ICD-9 to ICD-10, the structure and function of coding has improved to better represent the diagnosis, acuity of patients condition, and the history of the patient.

Standard ICD-10 Documentation Requirements

- Document causal agents as clearly as possible
- Document the condition as acute or chronic
- Document location with as much specificity as possible
- Document the clinical findings/indicators to support the diagnosis documented
- Document related, secondary or causal illness whenever appropriate

*Partner with the Clinical Documentation Improvement Specialist if you have questions, are queried, are documenting an uncommon diagnosis*
Assessment

• **Question:** What resource is available to help ensure proper documentation with complicated, hard to code cases?
Assessment

• **Answer:** Guidance on tips and recommendations for proper documentation from a Clinical Documentation Improvement Specialist is available.
Helpful Hint

To determine how to calculate the new ICD-10 code documentation requirements, think of the acronym “CALCS” (See below). While not all 5 types of documentation will be needed in each case, remembering this acronym will help you to think through the new specifications required and document the case appropriately.

- **C** - Document *causal* agents as clearly as possible
- **A** - Document the condition as *acute* or chronic
- **L** - Document *location* with as much specificity as possible
- **C** - Document the *clinical findings*/indicators to support the diagnosis documented
- **S** - Document related, *secondary* or causal illness whenever appropriate
Assessment

• **Question:** To remember what information is required for proper documentation, recall what the 5 letters in CALCS stand for?
Assessment

- **Answer:** Cause, Acuity, Location, Clinical Findings, Secondary Illnesses
Specifications Unique to OB\Gyn

In some cases, the patient and fetus’ history must also be documented in addition to the CALCS requirement.

**Additional ICD-10 Documentation Requirements**

- **History**: Document the patient’s past pregnancy and related health history
- **Gestation and Trimester**: Document the trimester and gestation period
  - Note: there have been changes in timeframes:
    - Abortion vs. Fetal death (20 weeks)
    - Early vs. Late pregnancy (20 weeks)
- **Delivery specifics**:
  - With or without delivery
  - Preterm or term delivery
  - Trimester of both labor and delivery
  - Identify the fetus with certain complications (malpresentation)
Section 1: ICD-10 Diagnostic Documentation Recommendations

ICD-10 Diagnostic Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
General Pregnancy, Childbirth and the Puerperium- Standard Documentation

Specifications and Examples

- **Acuity:** Document the severity of preeclampsia as
  - *Mild- moderate:* 2 occasions of hypertension at least 6 hours apart without end organ damage in a woman who was normotensive before 20 weeks' gestation
  - *Severe:* One or more of the following symptoms: SBP of 160 mm Hg or higher or DBP of 110 mm Hg or higher on 2 occasions at least 6 hours apart, Proteinuria of more than 5 g in a 24-hour collection or more than 3+ on 2 random urine samples collected at least 4 hours apart, Pulmonary edema or cyanosis, Oliguria (< 400 mL in 24 hours), Persistent headaches, Epigastric pain and/or impaired liver function, Thrombocytopenia, Oligohydramnios, decreased fetal growth, or placental abruption
  - *HELLP syndrome:* can complicate preeclampsia and should be documented
General Pregnancy, Childbirth and the Puerperium - Standard Documentation

**Specifications and Examples**

- **Secondary Illnesses:**
  - Specify any conditions/complications developed during or as a result of pregnancy, document the trimester or weeks of gestation in which the condition(s) occurred.
  - Clarify when the condition being treated is NOT affecting the pregnancy e.g. allergic rash, broken toe, etc.
**Specifications and Examples**

- **History:**
  - Pre-existing conditions, infections, or disorders e.g. HIV, smoking, anemia, maternal congenital anomalies, etc.
  - Any reason for high-risk pregnancy e.g. substance abuse, assisted reproduction, social issues, etc.
  - Social factors that influence pregnancy—(Tobacco use, dependence, past history, or exposure (second hand, occupational, etc.)), BMI, non-compliance with treatment regimen including over/under-dosing, and any corresponding diagnosis
  - First pregnancies and history of Cesarean sections.
  - Any past infertility or poor reproductive history e.g. miscarriage, abortion, pre-term labor, etc.
## OB\Gyn Documentation

- **Gestation**
- **Delivery**

### Specifications and Examples

#### Gestation:
- Document trimesters or weeks of gestation when a disease or condition occurs
  - 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

#### Delivery (See procedure code documentation in Section 2):
- Confirm type of delivery (i.e. vaginal, vaginal assisted with forceps, vacuum, or C-section)
- Clarify approach (i.e. open, via natural opening or external), devices used (i.e. forceps, vacuum, etc.) and reasons for device usage.
- Clarify the qualifier of the C-section (i.e. classical, low cervical, extraperitoneal)
- Clarify estimated blood loss after C-section
General Pregnancy, Childbirth and the Puerperium- Multiple Gestations

• Note for multiple gestations the following documentation is also required:

**Important Note:**

**For twins:**
- Monochorionic/monoamniotic
- Monochorionic/diamniotic
- Dichorionic/diamniotic, or
- Unable to determine number of placenta and number of amniotic sacs

**For triplets, quadruplets and others:**
- With two or more monochorionic fetuses
- With two or more monoamniotic fetuses, or
- Unable to determine number of placenta and number of amniotic sacs
Breast Disorders Associated with Pregnancy

**Documentation**
- Cause
- Acuity
- Location
- Clinical Findings
- Secondary illnesses

**OB\Gyn Documentation**
- History
- Gestation
- Delivery

**Specifications and Examples**

- **Clinical Findings**: Specify the type of disorder e.g. abscess, non-purulent mastitis, infection of the nipple, retracted or cracked nipple, suppressed lactation, galactorrhea, etc.

- **Gestation**: the timing of the occurrence of the condition e.g. the trimester of pregnancy, weeks of gestation, puerperium period, with lactation, etc.
Gestational Diabetes

Specifications and Examples

• **History:**
  • Specify if the diabetes is pre-existing or pregnancy induced.
  • For pre-existing diabetes, document:
    • Type 1 or Type 2
    • LINK diabetes to any manifestations e.g. nephropathy due to diabetes, or diabetic nephropathy.

• **Gestation**
  • For gestational diabetes, document:
    • The trimester or weeks of gestation in which the diabetes occurred
    • Document if it is diet-controlled or insulin-controlled
    • Be specific if the patient has only an abnormal glucose tolerance but no diagnosis of diabetes.
Assessment

**Question:** Gestation needs to be documented for both gestational diabetes and breast disorders. What specifics should be included with this information?
Assessment

• **Answer**: The trimester or weeks of gestation
Gestational Diabetes

Below is an illustration in how gestational diabetes will be coded from ICD-9 to ICD-10. Note the changes from encounter to trimester and how the use of insulin has become a qualifier of the original code and is not an additional code.

**I-9 Gestational Diabetes Prenatal Encounter (18 weeks) for Gestational Diabetes and UTI, Pt. on Insulin**

- 648.83 Gestational Diabetes, Antepartum (episode of care)
- 648.63; 599.0 UTI in Pregnancy, Antepartum
- V58.67 Insulin

**I-10 Gestational Diabetes Prenatal Encounter (18 weeks) for Gestational Diabetes, Pt. on Insulin**

- 024.414 Gestational Diabetes in Pregnancy, Insulin Control (*)
- 023.42 UTI in Pregnancy, 2nd Trimester
Hypertension in Pregnancy

Specifications and Examples

- **Acuity:**
  - Document the severity of pre-eclampsia as mild, moderate, or severe

- **History:**
  - Document if hypertension is pre-existing or pregnancy induced

- **Gestation:**
  - gestational edema and proteinurea either with or without gestational HTN

Documentation
- Cause
- Acuity
- Location
- Clinical Findings
- Secondary illnesses

OB\Gyn Documentation
- History
- Gestation
- Delivery
Genitourinary Tract Infection

Specifications and Examples

- **Cause:**
  - Document the organism, when known e.g. bladder infection due to E. coli

- **Location:**
  - the site e.g. bladder, kidney
Obstructed Labor

Specifications and Examples

• **Cause:**
  - Malposition or malpresentation, such as:
    - Incomplete rotation of head
    - Breech, face, brow, shoulder, or compound presentation
    - Other, such as footling or incomplete breech presentation
  - Maternal pelvic abnormality, such as:
    - Deformed
    - Contraction - generally contracted, pelvic inlet, pelvic outlet, mid-cavity
    - Abnormality of pelvic organ, e.g., congenital malformation of uterus or cervical incompetence
  - Other cause, such as:
    - Shoulder dystocia or unusually large fetus
Underdosing

**Important Note:** Underdosing is a new concept for ICD-10.

### Documentation
- **Cause**
- **Acuity**
- **Location**
- **Clinical Findings**
- **Secondary illnesses**

### OB\Gyn Documentation
- **History**
- **Gestation**
- **Delivery**

### Specifications and Examples

#### Cause:
- Document the cause of underdosing
- Reason code explains why the patient is not taking the medication

#### Clinical Findings:
- Document the outcome of underdosing

#### Secondary Illness:
- The components of underdosing codes include:
  - Medical condition is sequenced first.
  - Under-dosing code is listed as a secondary diagnosis.
  - Reason code explains why the patient is not taking the medication
Underdosing

If a patient presents with a condition that is related to under-dosing, it is important to document the condition and a LINK to the medication:

- **Medical Condition**
  - Examples:
    - Infection
    - Hyperglycemia
    - Hypertension
    - Seizure
    - Mania

- **Identification of Underdosing as Cause**
  - Examples:
    - Antibiotic
    - Antidiabetic
    - Hormonal agents
    - Anti-epileptic
    - Antihypertensive

- **Cause of Underdosing**
  - Includes:
    - Intentional
    - Unintentional
    - Financial Hardship
    - Age-related dementia
Section 2: ICD-10 Procedure Documentation Recommendations

ICD-10 Diagnostic Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
Review of ICD-10 Procedure Code Structure

**ICD-10 Procedure documentation**: More granular and precise

**Focus for Providers**: Understand concepts related to coding capture rather than memorize every detail

- Procedure documentation can be thought of on multiple characters
- Each character captures an increased amount of provider documentation in respect to the service or procedure performed
The majority of procedures that treat reproductive system diseases come under the Medical and Surgical section of ICD-10-PCS in the female reproductive system.

Obstetrics is identified as its own section but the characters hold the same definitions as Med-Surg.
The following root operations of the Medical and Surgical section can be used to report female reproductive system procedures:

<table>
<thead>
<tr>
<th>Root Operation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bypass</td>
<td>Occlusion</td>
</tr>
<tr>
<td>Change</td>
<td>Reattachment</td>
</tr>
<tr>
<td>Destruction</td>
<td>Release</td>
</tr>
<tr>
<td>Dilation</td>
<td>Removal</td>
</tr>
<tr>
<td>Division</td>
<td>Repair</td>
</tr>
<tr>
<td>Drainage</td>
<td>Reposition</td>
</tr>
<tr>
<td>Excision</td>
<td>Resection</td>
</tr>
<tr>
<td>Extirpation</td>
<td>Supplement</td>
</tr>
<tr>
<td>Extraction</td>
<td>Restriction</td>
</tr>
<tr>
<td>Fragmentation</td>
<td>Revision</td>
</tr>
<tr>
<td>Insertion</td>
<td>Transplantation</td>
</tr>
<tr>
<td>Inspection</td>
<td></td>
</tr>
</tbody>
</table>
The following root operations are specific to the Obstetric Section:

<table>
<thead>
<tr>
<th>Root Operation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion (A)</td>
<td>Artificially terminating a pregnancy</td>
</tr>
<tr>
<td>Change (2)</td>
<td>Taking out or off a device from a body part and putting back an identical or similar device in or on the same body part without cutting or puncturing the skin or a mucous membrane</td>
</tr>
<tr>
<td>Delivery (E)</td>
<td>Assisting the passage of the products of conception from the genital canal</td>
</tr>
<tr>
<td>Drainage (9)</td>
<td>Taking or letting out fluids and/or gases from a body part</td>
</tr>
<tr>
<td>Extraction (D)</td>
<td>Pulling or stripping out or off all or a portion of a body part by the use of force</td>
</tr>
<tr>
<td>Insertion (H)</td>
<td>Putting in a non-biological appliance that monitors, assists, performs or prevents a physiological function but does not physically take the place of a body part</td>
</tr>
<tr>
<td>Inspection (J)</td>
<td>Visually and/or manually exploring a body part</td>
</tr>
<tr>
<td>Removal (P)</td>
<td>Taking out or off a device from a body part, region or orifice</td>
</tr>
<tr>
<td>Repair (Q)</td>
<td>Restoring, to the extent possible, a body part to its normal anatomic structure and function</td>
</tr>
<tr>
<td>Reposition (S)</td>
<td>Moving to its normal location, or other suitable location, all or a portion of a body part</td>
</tr>
<tr>
<td>Resection (T)</td>
<td>Cutting out or off, without replacement, all of a body part</td>
</tr>
<tr>
<td>Transplantation (Y)</td>
<td>Putting in or on all or a portion of a living body part taken from another individual or animal to physically take the place and/or function of all or a portion of a similar body part</td>
</tr>
</tbody>
</table>
The only body parts that are unique to the obstetric section include:

- Products of Conception (0)
- Products of Conception, Retained (1)
- Products of Conception, Ectopic (2)
Assessment

- **Question:** What are the body parts unique to obstetrics as listed with ICD-10 coding?
Assessment

• **Answer:**
  - Products of Conception (0)
  - Products of Conception, Retained (1)
  - Products of Conception, Ectopic (2)
Approaches for the female reproductive system recognized under the ICD-10 system

<table>
<thead>
<tr>
<th>Approach</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>External</td>
<td>Definition: Procedures performed directly on the skin or mucous membrane and procedures performed indirectly by the application of external force through the skin or mucous membrane.</td>
</tr>
<tr>
<td>Open</td>
<td>Definition: Cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure.</td>
</tr>
<tr>
<td>Percutaneous</td>
<td>Definition: Entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to reach the site of the procedure.</td>
</tr>
<tr>
<td>Percutaneous Endoscopic</td>
<td>Definition: Entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to reach and visualize the site of the procedure.</td>
</tr>
<tr>
<td>Via Natural or Artificial Opening</td>
<td>Definition: Entry of instrumentation through a natural or artificial external opening to reach the site of the procedure.</td>
</tr>
<tr>
<td>Via Natural or Artificial Opening Endoscopic</td>
<td>Definition: Entry of instrumentation through a natural or artificial external opening to reach and visualize the site of the procedure.</td>
</tr>
<tr>
<td>Via Natural or Artificial Opening With Percutaneous Endoscopic Assistance</td>
<td>Definition: Entry of instrumentation through a natural or artificial external opening and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure.</td>
</tr>
</tbody>
</table>
The seventh character of ICD-10 is the opportunity to capture greater specificity and capture a truer picture of the patient and care delivered. Some 7th character extensions include:

- Multiple Gestations: 0 (unspecified) to 9 (other fetus)
- Specifically identifies Fetus Affected or Causing Condition (i.e. IUGR)
- Episode of Care no longer exists and has been replaced with trimester
Amniocentesis & Perineal Laceration Repair

• Amniocentesis
  – Document whether diagnostic or therapeutic amniocentesis, the substance drained (e.g. amniotic fluid)
  – Document the approach (e.g. Percutaneous)

• Perineal Laceration Repair
  – Document the repair approach
  – Document the type of tear e.g. 1\textsuperscript{st} degree, 2\textsuperscript{nd} degree, etc.
  – Document the anatomical site where the tear is repaired e.g. perineum skin, vulva, vagina, anal sphincter, fourchette, rectovaginal septum, pelvic floor, etc.
Hysterectomy

- **Total Abdominal Hysterectomy (TAH)** - Document the **body parts** involved (e.g. uterus, cervix, etc.), and the **approach**, (e.g. Open).

- **Vaginal Hysterectomy**- Document the **body parts** involved (e.g. uterus, cervix, etc.), and the **approach** (e.g. Via Natural or artificial opening).

- **Laparoscopic-Assisted Vaginal Hysterectomy (LAVH)** - Document the body parts involved (e.g. uterus, cervix, etc.), and the approach (e.g. Via Natural or artificial opening, Via natural or artificial opening with percutaneous endoscopic assistance).

- **Laparoscopic-Assisted Supracervical Hysterectomy (LASH)** - Document the body parts involved (e.g. uterus), and the approach (e.g. percutaneous endoscopic).

- **Pelvic evisceration**- Document the body parts involved (e.g. uterus, cervix, ovaries, etc.) and the approach (e.g. Open).
Curettage, Lysis of adhesions, & Suprapubic sling operation

• **Curettage:** Document the timing of the procedure if performed following delivery, abortion or during times other than the postpartum or post abortion period. Document the **approach**, e.g. via natural or artificial opening, via natural or artificial opening endoscopic.

• **Lysis of adhesions:** Document the **body parts** involved (e.g. uterus, cervix, uterine, ovary, etc.), if the adhesions are in a different anatomic site from the main procedure(s) or multiple sites and the **approach:** e.g. open, percutaneous endoscopic, etc.

• **Suprapubic sling operation:** Document the **approach:** e.g. Open, Percutaneous endoscopic, via natural or artificial opening endoscopic, etc. and the device, i.e. whether a biological or synthetic material was used to reinforce the functioning the body part.
Biopsy & Oophorectomy

• **Biopsy**
  – **Root:** e.g. excision biopsy
  – **Body Part:** e.g. bladder, kidney, ureter, etc.
  – **Approach:** e.g. Open, Percutaneous endoscopic, via natural or artificial opening endoscopic, etc.

• **Oophorectomy**
  – **Body part:** document the laterality and if the fallopian tubes were removed with the ovaries
  – **Approach:** e.g. Open, Percutaneous endoscopic, via natural or artificial opening endoscopic, etc.
Prolapse, Sterilization, & Mastectomy

• **Prolapse:** document the specific repair, the **approach**: e.g. open, Percutaneous endoscopic, via natural or artificial opening endoscopic, etc.) and **insertion site**. Also document any **devices** and if **graft or prosthesis** were used and the type.

• **Sterilization:** document the method or **approach** used (e.g. ligation) and the body part laterality.

• **Mastectomy:** document the **body part laterality**, **specifies about** the lymph nodes, and the laterality of the Pectorals muscle, when involved and if the removal was (complete, partial, etc.)
Vaginal Suspension & Blood Transfusion

• Vaginal suspension
  – **Approach:** e.g. Open, Percutaneous endoscopic, Via Natural or artificial opening endoscopic, etc.
  – **Medical Device:**
    • Specify if Robotic assistance was used (e.g. Da Vinci).
    • Document if graft or prosthesis were used and the type

• Blood Transfusion
  – **Approach:**
    • location or infusion site e.g. peripheral, central venous catheter, etc.
    • route of administration
    • type of cell transfused e.g. RBC, Frozen RBC, etc.

**Important Note:** the receipt of transfusions has to be acknowledged by the provider.
Assessment

• **Question:** Documentation of what aspect of the procedure is most frequently required in the aforementioned examples?
Assessment

• **Answer:** Documentation of the approach used is critical to accurately coding many procedures, including those listed above as examples.
ICD 9 and ICD 10 Coding Comparisons: Complications of Pregnancy

With ICD 9, code 646.83 (Other specified complications of pregnancy; antepartum condition or complication) could be used to identify multiple conditions complicating her pregnancy. With the implementation of ICD-10 many of these conditions now have unique codes to capture a truer picture of the patient condition:

- **O26.11 (Low weight gain in pregnancy, first trimester) or**
  - O26.12 (... second trimester)
  - O26.13 (... third trimester)

- **O26.41 (Herpes gestationis, first trimester) or**
  - O26.42 (... second trimester)
  - O26.43 (... third trimester)

- **O26.811 (Pregnancy related exhaustion and fatigue, first trimester) or**
  - O26.812 (... second trimester)
  - O26.813 (... third trimester)

- **O26.891 (Other specified pregnancy related conditions, first trimester) or**
  - O26.892 (... second trimester)
  - O26.893 (... third trimester)
ICD 9 and ICD 10 Coding Comparisons: Procedure Coding Examples

Procedures performed on the products of conception are included in the obstetrics section. Procedures performed on the pregnant female other than the products of conception are coded to a root operation in the medical and surgical section of ICD-10-PCS.

**Examples of procedures performed on products of conception:**

Manually assisted delivery (10E0XZZ)
Delivery with mid forceps (10D07Z4)
Low cervical cesarean section (10D00Z1).

**Examples of procedures performed on the pregnant female:**

Repair of vaginal laceration (0UQGXZZ)
Episiotomy (0W8NXZZ)
Episiorrhaphy (0WQN0XZZ)
Conclusion

There are several substantial changes in the way that gynecological and obstetric care is coded including:

– Capture of trimester
– Changes in weeks for abortion vs. fetal death and for early/late phases of pregnancy
– Increase in specificity of complications

**Important Note:** Remember the “CALCS” acronym and that history, gestational period, and delivery compose the required documentation to code an OB/GYN case accurately. When coding procedures, remember the 7 character to provide the greatest specificity within your documentation to ensure accurate codes.