Diagnostic Coding in Obstetrics and Gynecology

2018
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Introduction

*International Classification of Diseases*, Tenth Edition, Clinical Modification (ICD-10-CM) implemented October 1, 2015, is the national standard for reporting diagnosis codes in the United States. ICD-10-CM diagnosis codes identify diseases, related health problems, and other reasons for health care encounters. ICD-10-CM codes and their descriptive terminology are developed and maintained by the ICD-10-CM Coordination and Maintenance Committee.

In 2000, the ICD Code Set was designated by the Department of Health and Human Services as the national coding standard for diagnostic codes under the Health Insurance Portability and Accountability Act (HIPAA). All financial and administrative health care transactions sent electronically must use the ICD code set.

**CHANGES IN ICD CODES**

ICD-10 is not a static code set. Revisions, often significant ones, are made to keep pace with clinical changes in medicine and current medical practice. Therefore, it is critical that providers confirm that their EHR has been updated to the latest ICD version and/or purchase a new ICD-10 book each year to ensure that he or she is reporting the most current codes. ICD books may be purchased through ACOG’s Distribution Center (1-800-762-2264) or from ACOG’s website (sales.acog.org) as well as from many commercial vendors.

The process of developing or revising a code reported by obstetrician-gynecologists has five basic steps.

1. **ACOG’s Committee on Health Economics and Coding reviews a request** for a new code or revision of a current code. The request may originate from outside ACOG (e.g., from a related medical specialty society, an individual physician or QHP, or from industry) or be proposed by the Committee itself. If the Coding Committee agrees that a code should be added or revised, an ACOG member develops a proposal, including a detailed description of the service, potential location in the data set and identifies all related clinical articles and documentation to include with the application.

2. **The Committee forwards the proposal and documentation to the ICD-10 Coordination and Maintenance Committee.** The Committee includes representatives from its Co-operating Bodies; the American Hospital Association, the American Health Information Management Association (AHIMA), the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS).

3. **Following submission and presentation of the proposal at the Coordination and Maintenance Committee Meeting**, the proposal is vetted with industry, vendors, and the general public through a 60-day comment period.

4. **At the conclusion of the comment period**, the Committee may accept, reject or request changes in ACOG’s proposal.

5. **If the proposal is accepted, the new or revised code is added to the ICD-10-CM data set, October 1.**
ACOG CODING RESOURCES

Publications
The following coding resources are available from ACOG's distribution center (1-800-762-2264). The resources can also be ordered on ACOG's website bookstore (sales.acog.org).

OB/GYN Coding Manual: Components of Correct Procedural Coding with thumb drive
This 500+ page book and thumb drive provides important information to assist physicians and other Qualified Healthcare Providers (QHPs) in correctly coding for surgical procedures commonly performed by obstetrician-gynecologists. Each code is listed with services that are included/excluded in the procedure's global surgical package. This includes the bundling information for each code, both from Medicare's National Correct Coding Initiative (CCI), and for non-Medicare patients; information from ACOG's clinical vignettes. This allows coders to compare the bundling issues between Medicare and non-Medicare patients. Information about whether Medicare will reimburse for assistants or co-surgeons for the procedure and other Medicare payment indicators is also included. This information may be useful in preparing appeals to third party payers. Also included in the manual are sections on modifiers and a discussion of relative value units. The book and flash drive are revised annually.

ICD-10/CPT Gynecology and Obstetric Quick Reference Coding Guide
Available as laminated sheets, the ICD-10/CPT Quick Reference Coding Guide includes official CPT® and ICD-10-CM codes with abbreviated descriptions for the most commonly reported Obstetrics and Gynecology procedures and diagnoses (one each for Obstetrics and Gynecology codes).

OTHER CODING RESOURCES

ACOG Coding Workshops
ACOG’s enormously popular coding workshops teach Fellows and their staff about appropriate coding and billing practices. These workshops cover the effective use of the International Classification of Diseases, Tenth Clinical Modification (ICD-10-CM) and the Current Procedural Terminology (CPT) coding systems as they pertain to obstetrics and gynecology. If accompanied by the Fellow, office staff and mid-level providers may also attend.

The workshops consist of up to three days of sessions. Fellows may attend one, two, or all three days. Each days' session may last from 4 - 7 hours. The following topics are covered:

<table>
<thead>
<tr>
<th>Day I</th>
<th>E/M Services and Medicare's Documentation Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day II</td>
<td>Procedural Coding</td>
</tr>
<tr>
<td>Day III</td>
<td>Obstetric Coding</td>
</tr>
</tbody>
</table>
ACOG typically hosts between 10-12 Coding Workshops each year. The 2017 Coding Workshops will be held in the following locations:

- February 23-25, 2018  San Antonio, TX
- April 13-15, 2018  San Francisco, CA
- May 18-20, 2018  Atlanta, GA
- June 08-10, 2018  New Orleans, LA
- July 13-15, 2018  Orlando, FL
- August 03-05, 2018  Las Vegas, NV
- August 17-19, 2018  Washington, DC
- September 07-09, 2018  Seattle, WA
- October 12-14, 2018  Chicago, IL

Fellows may register for these workshops online at https://www.acog.org/Education-and-Events. For more information, contact the ACOG Coding Department at 202-863-2498 or HealthEconomics@acog.org.

**ACOG Webcasts**

ACOG presents a series of Webcasts that are offered at 1:00-2:30 pm Eastern Time on the second Tuesday of every other month. Topics include Coding, Practice Management, and Professional Liability. Recordings of past webcasts are also available on a pay per view basis. The following is the schedule of Coding Webinar topics for 2018:

- February 13, 2018  The Dangers of EMRs in Code Selection
- April 10, 2018  E/M Coding for OB/Gyn Services
- June 12, 2018  Clinical Documentation Improvement
- August 14, 2018  Reporting Services for Other Qualified Healthcare Providers
- October 9, 2018  Coding Multiple Services on the Same Day
- December 11, 2018  Preview of New Codes and Medicare Changes 2019

Archived webcasts are also available approximately one week after the live webcast at a minimal cost, but do not provide CME or CEU credits.

We are still offering the following three free ICD-10 archived webcasts. These free webcasts are informational only and do not provide CME or CEUs.

1. ICD-10 Documentation Guidelines
2. ICD-10 Diagnosis Coding for Obstetric Care Complications
3. ICD-10 Diagnosis Coding for Gynecological Conditions

For more information on the live and on-demand webcasts, please visit our webpage at: https://live.blueskybroadcast.com/bsb/client/CL_DEFAULT.asp?Client=490885&title=Home
ACOG’s Listserv
ACOG’s Department of Health Economics offers a free monthly e-mail news service, The Practice Management and Coding Update. The update includes effective coding tips, practice management advice, information about regulatory issues that affect your practice, and the latest news on what ACOG is doing to help address your reimbursement concerns and improve your practice environment. You may subscribe to the newsletter on the ACOG Website on the Practice Management and Managed Care page or by using the following link: http://www.acog.org/About_ACOG/ACOG_Departments/Practice_Management_and_Managed_Care/Practice_Management_Update_Newsletter

ACOG Internet Access
The Coding webpage includes a list of coding resources and timely announcements concerning coding and reimbursement issues. Also posted on this site are the most recent Medicare Relative Value Units charts for codes reported by ob/gyns, the Correct Coding Initiative (CCI) edit charts, Evaluation and Management services documentation templates and an intake history form developed by the ACOG Committee on Health Economics and Coding. ICD-10 general information, updates, and links can also be accessed from the Coding page. The Coding page may be accessed from the ACOG website home page by clicking on the Practice Management tab; https://www.acog.org/Practice-Management or directly from the following URL: https://www.acog.org/About-ACOG/ACOG-Departments/Coding

ACOG Coding Assistance
Fellows and their staff are able to submit specific OB/GYN coding questions to ACOG Coding Assistance by registering for our New Ticket Database at https://acogcoding.freshdesk.com or by fax (202-484-7480). Registration is free, quick, and easy!

Registered database users will have access to a wide variety of features in the ACOG Coding Ticket Database including a Coding Committee knowledge base (FAQ), searchable tickets, Coding Questions of the Month, easier ticket submission and tracking and much, much, more!

When submitting a request, please include your physician name or member number on your request so that the request may be appropriately prioritized. Questions submitted without an ACOG member name or number will be assumed to be from a non-member.

Please do not include any identifiable Protected Health Information in your e-mail or fax.

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CHAPTER 1

Use of ICD-10-CM

The International Statistical Classification of Diseases and Related Health Problems (ICD) is published by the World Health Organization (WHO) and is a classification of diseases, signs and symptoms, abnormal findings and complaints, social circumstances, and external causes of injury or disease. ICD is used for tracking morbidity and mortality statistics and within reimbursement systems. ICD-10 is the 10th revision of this classification system and replaced the ICD-9 classification that was first adopted in 1975. WHO has authorized the development of an adaptation of ICD-10 for use in the United States (ICD-10-CM). All modifications to ICD-10 must conform to WHO conventions for the ICD.

Although ICD was developed for collection of statistical data and disease classification, it is also an important part of reimbursement models. ICD codes are used to facilitate payment of claims, evaluate utilization patterns, and review health care costs. The ability to communicate the justification for clinical services/medical necessity through reporting diagnosis codes is enhanced by the increased specificity of ICD-10-CM. ICD-10-CM is also expected to be an important tool in the move towards value-based purchasing because of its potential to disclose more information about quality of care and improved tracking of outcomes of care. This information can then be used to design more effective algorithms for clinical decision-making and to support clinical research.

ICD-10-CM (International Classification of Diseases, 10th Edition, Clinical Modification) comprises the primary set of diagnosis codes used to describe diseases, related health problems, and other health care encounters in the United States. It is comprised of 3-7 alphanumeric characters organized by organ system or condition. These codes provide the medical necessity for the performance of procedures and other services provided to patients.

ICD-10-CM consists of a tabular section with 21 chapters and an alphabetic index. Each chapter has its own guidelines and conventions. The first section of the ICD-10-CM code set book contains conventions, general coding guidelines and chapter specific guidelines. The guidelines are intended to assist in identifying the diagnoses that may be reported and are applicable to all health care settings unless otherwise indicated. Additional guidelines for specific codes may be found in the tabular section. It is essential that providers and coding staff review and understand these conventions and guidelines in order to correctly code for their services.

ICD-10-CM INDEX TO DISEASES AND INJURIES
The Alphabetic Index to Diseases lists terms and sub-terms that identify diseases, conditions, and symptoms with the corresponding code(s). Terms in the index can be nouns, adjectives, or eponyms. The index consists of the following components: Index of Diseases and Injury, Index of External Causes of Injury, the Table of Neoplasms and the Table of Drugs and Chemicals. The Index does not always provide the complete code. A dash (-) in the Index indicates that additional characters are required for appropriate code selection. The index includes many more diagnostic terms than are found in the Tabular section. For ease of use, many diseases and conditions are listed in multiple locations in the Alphabetic Index.

Sometimes terms listed in the Alphabetic Index will not be included in the Tabular List. However, because the index directs the user to a specific code, that code is the most appropriate code to report.
ICD-10-CM TABULAR LIST OF DISEASES AND INJURIES
The tabular list of diseases and injuries contains more than 91000 ICD-10-CM codes to describe diseases, conditions, illnesses, injuries, signs, and symptoms. The tabular list consists of 21 chapters. Each chapter has a “block” at the beginning that describes the code ranges contained in the chapter. The 21 chapters are as follows:

Chapter 1 (A00–B99): Certain Infectious and Parasitic Diseases
Chapter 2 (C00–D49): Neoplasms
Chapter 3 (D50–D89): Diseases of the Blood and Blood–forming Organs and Certain Disorders Involving the Immune Mechanism
Chapter 4 (E00–E89): Endocrine, Nutritional, and Metabolic Diseases
Chapter 5 (F01–F99): Mental and Behavioral Disorders
Chapter 6 (G00–G99): Diseases of the Nervous System
Chapter 7 (H00–H59): Diseases of the Eye and Adnexa
Chapter 8 (H60–H95): Diseases of the Ear and Mastoid Process
Chapter 9 (I00–I97): Diseases of the Circulatory System
Chapter 10 (J00–J99): Diseases of the Respiratory System
Chapter 11 (K00–K95): Diseases of the Digestive System
Chapter 12 (L00–L99): Diseases of the Skin and Subcutaneous Tissue
Chapter 13 (M00–M99): Diseases of the Musculoskeletal System and Connective Tissue
Chapter 14 (N00–N99): Diseases of the Genitourinary System
Chapter 15 (O00–O9A): Pregnancy, Childbirth, and the Puerperium
Chapter 16 (P00–P96): Certain Conditions Originating in the Perinatal Period
Chapter 17 (Q00–Q99): Congenital Malformations, Deformations, and Chromosomal Abnormalities
Chapter 18 (R00–R99): Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified
Chapter 19 (S00–T88): Injury, Poisoning, and Certain Other Consequences of External Causes
Chapter 20 (V00–Y99): External Causes of Morbidity
Chapter 21 (Z00–Z99): Factors Influencing Health Status and Contact with Health Services

OB/GYN CODING
The following ICD-10-CM chapters contain the codes most commonly reported by Ob/Gyns and are the primary focus of this publication.

Chapter 14 Diseases of the Genitourinary System (N00-N99)
Chapter 15 Pregnancy, Childbirth and the Puerperium (O00-O9A)
Chapter 18 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)
Chapter 19 Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T88)
Chapter 21 Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

GENERAL CODING GUIDELINES
Diagnosis codes submitted to payers should reflect the most accurate code for the service (medical necessity) and follow ICD-10 coding guidelines. Codes may be 3-7 characters long. The 7th character can only be found in the
Tabular List. As a result, it is critical that both the Index and the Tabular List are used to select codes. Codes that have an applicable 7th category are considered invalid without the 7th character. Only complete codes can be used for reporting purposes.

**ICD-10 CONVENTIONS**

Coding conventions, guidelines, and terms in ICD assist in the selection of the most appropriate code(s). The guidelines are a set of rules developed to accompany and complement the conventions and instructions provided within ICD-10-CM. The instructions and conventions of the classification take precedence over the guidelines. The guidelines are intended to assist in identifying the diagnoses and procedures that are to be reported. The guidelines are applicable to all health care settings unless otherwise indicated. The guidelines can be found preceding the alphabetic index in the ICD-10-CM manual.

The guidelines are organized into sections:

- **Section I**: Conventions, General Guidelines, Chapter Specific Guidelines
- **Section II**: Selection of Principle Diagnosis
- **Section III**: Reporting Additional Diagnoses
- **Section IV**: Coding and Reporting for Outpatient Services
- **Section V**: Present on Admission Guidelines and Exempt Codes

This publication will focus on the guidelines in Sections I and IV as these are most important to physician practices. Section I includes the structure and conventions of ICD-10-CM and general guidelines that apply to the entire classification as well as chapter specific guidelines. Section IV includes guidelines for outpatient coding and reporting.

**ABBREVIATIONS AND PUNCTUATION**

Both the Alphabetic Index and the Tabular List use the abbreviations NEC and NOS. NEC stands for “Not elsewhere classified” and represents “other specified”. When no diagnosis code exists to report a specific condition, the Alphabetic Index directs the coder to the “other specified code” in the Tabular List. An NEC entry in the Tabular List is used to identify the “other specified” code.

NOS stands for “Not otherwise specified” and is the equivalent of unspecified. Codes titled “unspecified” are used when the information in the medical record is insufficient to assign a more specific code. Unspecified codes should be avoided when possible.

Brackets [ ] are used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases. In the Alphabetic Index they are used to identify manifestation codes.

**Tabular List Example:**

- N90.0 Mild vulvar dysplasia
  - Vulvar intraepithelial neoplasia [VIN], grade 1

**Alphabetic Index Example**

- Glomerulonephritis due to sepsis A41.9 [N08]
Parentheses ( ) are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the documentation without affecting the code assignment. These terms are referred to as non-essential modifiers.

Tabular List Example:
   N39.3 Stress incontinence (female) (male)

Alphabetic Index Example:
   Anemia (essential) (general) (hemoglobin deficiency) (infantile) (primary) (profound)

As noted earlier, the ICD-10-CM index does not always provide the complete code. A dash (-) in the Index and in this document indicates that additional characters are required for an accurate and complete code.

As stated above, it is essential that both the Alphabetic Index and Tabular List be used when selecting an ICD-10-CM code.

The importance of consistent, complete, and accurate documentation cannot be overemphasized. Without this documentation, the application of coding guidelines will be a difficult, and maybe impossible, task.
ICD-10-CM Coding Principles

DIAGNOSIS CODING
Correct ICD-10-CM coding depends on an understanding of the terminology, characteristics, and conventions used in diagnostic coding. Official coding conventions, general coding guidelines, chapter specific guidelines, and abbreviations can be found in the front of the ICD book along with any additional notations specific to the publisher of the material.

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS) are the government entities charged with the responsibility of maintaining and administering the ICD-10 data set. They have authorized the official coding conventions and guidelines that are to be used in conjunction with ICD-10-CM codes. Adherence to the guidelines is required under the Health Insurance Portability and Accountability Act (HIPAA). These conventions and guidelines assist the user when the ICD manual does not provide specific direction on code selection. This information is continuously reviewed and new conventions and guidelines are developed as required.

The documentation in the medical record should support the ICD code reported to the payer. Under ICD guidelines, the entire record may be used to determine the appropriate ICD code.

BASIC GUIDELINES FOR DIAGNOSIS CODING
• Code to the highest degree of specificity.
• Code to the highest degree of certainty.
• Link the diagnosis code to the procedure code (CPT) on the claim.
• Sequence the diagnoses, reporting the primary diagnosis first, followed by the secondary, etc.
• Code only diagnoses relevant to the current encounter.

MEDICAL NECESSITY
In order to be reimbursed by an insurer, a service must be:
• A covered benefit
• Medically necessary
• Supported by the documentation

The AMA’s Model Managed Care Contract defines medical necessity as health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:
• In accordance with generally accepted standards for medical practice;
• Clinically appropriate in terms of type, frequency, extent, site, and duration; and
• Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.
ICD-10 codes, when appropriately linked to the procedure performed, provide the medical necessity for the performance of specific procedure(s) or service(s).

**SECTION I: CONVENTIONS, GENERAL CODING GUIDELINES AND CHAPTER SPECIFIC GUIDELINES CODING CONVENTIONS FOR ICD-10-CM**

ICD-10-CM is divided into the Alphabetic Index and the Tabular List. It is important that both the Alphabetic Index and Tabular List be used when selecting an ICD-10-CM code. The Alphabetic Index is an alphabetical listing of terms and the corresponding code(s). The index consists of the following: Index of Diseases and Injury, Index of External Causes of Injury, the Table of Neoplasms and the Table of Drugs and Chemicals. The Index does not always provide the complete code. A dash (-) in the Index indicates that additional characters are required for correct code selection.

The Tabular List is a structured chronological list of codes divided into chapters based on body systems or conditions. The Tabular List contains categories, subcategories and codes. All categories are three characters. If a category has no additional subdivisions, then it is equivalent to a code. Subcategories can be either four or five characters. Each level of subdivision after a category is a subcategory. The final level of subdivision is a code.

**CODE STRUCTURE**

ICD-10 contains categories and subcategories of valid codes. ICD-10-CM codes are alphanumeric and can range from three to seven characters in length. The first character is always a letter, the second is always a number with the remaining characters being either letters or numbers. The first three characters of a code identify the category, the next three characters identify the subcategory based on etiology, anatomic site, or severity. The final or 7th character is called an extension.

ICD-10-CM utilizes a dummy placeholder “X” in certain codes to allow for further expansion. The placeholder can also be used when a code requires a 7th character but the code is not six characters in length. The placeholder X is used to fill empty character space(s) since the 7th character must always be present in the 7th character data field for the code to be valid.

**INCLUSION NOTES AND TERMS**

**Includes** notes appear immediately under a three-character code title to further define or give examples of the content of the category. Inclusion terms are included under some codes. These terms are the conditions for which the code is to be used. The terms may be synonyms or a list of various conditions assigned to that code. The inclusion terms are not an exhaustive list. Additional terms found only in the Alphabetic Index may also be assigned to a code.

**EXCLUSION NOTES**

There are two types of excludes notes in ICD-10-CM. Each type has a unique definition.

**Excludes 1** notes are pure excludes notes and mean “NOT CODED HERE”. An Excludes 1 note indicates that the code excluded should never be used at the same time as the code above the note. The National Center for Health Statistics (NCHS) has identified situations where some conditions identified in Excludes 1 notes should be allowed. Until this can be addressed, NCHS has instructed that if the two conditions are not related to one another, it is permissible to report both codes despite the presence of an Excludes 1 note.
Excludes 2 notes represent “NOT INCLUDED HERE”. An Excludes 2 note indicates that the condition excluded is not part of the condition represented by the code. In other words, the patient may have both conditions at the same time. It is acceptable to use both the code and the excluded code together.

**MULTIPLE CODES FOR A SINGLE CONDITION**

Some conditions have both an underlying etiology (cause) and multiple body system manifestations (signs/symptoms) due to the underlying condition. For these conditions, the ICD-10-CM convention requires that the underlying condition be reported first followed by the manifestations. In these instances, there is a “use additional code” note at the etiology code and a “code first” at the manifestation code. Generally, the manifestation code will have “in diseases classified elsewhere” in the code title.

Tabular Example:

N72  Inflammatory disease of the cervix uteri
Use additional code (B95-B97), to identify the infectious agent

There are instances other than the etiology/manifestation convention that require more than one code to describe a single condition. ICD-10-CM uses the same “code first” and “use additional code” instructions for these conditions as for etiology/manifestation codes. Multiple codes may be needed for sequela, complication codes, and obstetric codes to more fully describe a condition.

Tabular Example:

O22.3  Deep phlebothrombosis in pregnancy
Deep vein thrombosis, antepartum
Use additional code to identify the deep vein thrombosis (I82.4-, I82.5-, I82.62-, I82.72-)
Use additional code, if applicable, for associated long-term use of anticoagulants (Z79.01)

**COMBINATION CODES**

Some conditions are described by a single code that includes all the elements of the condition. These are called combination codes and may be used to classify:

- Two diagnoses
- A diagnosis with an associated manifestation
- A diagnosis with an associated complication

When a combination code exists, the single code should be reported rather than reporting multiple codes. If the combination code does not include all the elements of the condition, then additional codes can be reported. Combination codes are identified by referring to the subterm entries in the Index and by reading the inclusion and exclusion notes in the Tabular List.

**ACUTE AND CHRONIC CONDITIONS**

If the same condition is described as both acute (subacute) and chronic, separate ICD-10-CM codes should be reported when available. The acute condition is always reported first.
For example, a patient may have chronic pelvic peritonitis but is treated for an acute exacerbation. This should be coded:

- N73.3 Female acute pelvic peritonitis
- N73.4 Female chronic pelvic peritonitis

**LATERALITY**

Some ICD-10-CM codes specify whether the condition occurs on the right, left or bilateral. If no bilateral code exists and the condition is bilateral, then both the code for the right and left side must be reported. If the side is not identified in the medical record, then the code for unspecified site should be reported. Under the initial, regular ICD-10-CM release (October 1, 2016), there were few codes reported by OB/Gyn physicians that required identification of laterality. For October 1, 2017, however, multiple new codes have been added, to add laterality to some of the ob/gyn related codes. See Chapter 8 for a description of the new codes.

**SELECTING A CODE**

It is important that both the Alphabetic Index and Tabular List be used when selecting an ICD-10-CM code. The changes in terminology and code location in ICD-10, including the addition of 7th character extensions, make it essential that both sections of the manual are used to select the correct code.

The Alphabetic Index does not always provide the full code making it necessary to review the Tabular list for laterality, 7th characters, dummy placeholders and instructional notes. A dash (−) after a code in the Index means that additional characters are required.

**LEVEL OF DETAIL**

Conditions must be coded to the highest level of specificity available. Some codes have only three characters while others may have four, five or six characters. The seventh character and placeholder “X” must be reported when applicable. Failure to report all available characters will result in an invalid code and likely a payment denial for the associated medical service.

**CODING FOR SPECIFICITY**

ICD codes support the medical necessity for a service. Therefore, the physician must clearly indicate the reason(s) for all of the services provided to ensure the selection of the most specific code.

Choosing the most specific code requires selecting:

- The maximum number of digits possible in a category
- The most appropriate descriptor of the patient’s condition

Always report the maximum number of digits available for a specific diagnosis but do not add digits unless instructed to do so by ICD-10-CM guidelines. Most payers, including Medicare, will not pay for services unless the diagnosis has been carried to the highest number of characters.

Some ICD-10 codes include in the descriptor the notation, “other specified” diagnosis. These diagnoses are reported when the physician has a specific diagnosis, but there is no appropriate code for the diagnosis listed in ICD-10-CM. They often contain the abbreviation NEC (not elsewhere classified).
Other ICD-10 codes may indicate an “unspecified” diagnosis. These diagnoses are reported when there is not enough information available to select an appropriate code. They may contain the abbreviation NOS (not otherwise specified). Unspecified diagnoses should be avoided if possible. Unspecified codes often do not support the medical necessity for the services rendered, and therefore may result in either delayed payment or non-payment for the service. The practice’s coding profile may also be adversely impacted by an overabundance of unspecified codes.

However, with the increased specificity found in ICD-10, it may sometimes be necessary to report an unspecified diagnosis until clinical information is available to support a more specific code. Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient’s condition at the time of the particular encounter. It would be inappropriate to select a more specific code that is not supported by the medical record.

For example, an ultrasound may indicate an ovarian cyst but the specific nature of the cyst may not be readily apparent. ICD-10-CM offers specific codes for follicular cysts (N83.0-) and corpus luteum cysts (N83.1-). The codes in this code section now contain laterality. For example, if the documentation indicates the patient has a follicular cyst of the left ovary, code N83.02 would be reported. If the clinical information is not available to accurately select a code from one of these code sections, then the code for an unspecified ovarian cyst (N83.20-) is reported. Codes from code section N83.29- (other ovarian cyst) is not reported since this code means that a specific condition is known but there is not an ICD-10-CM code for the condition.

In some circumstances, ICD-10 provides the opportunity to report greater specificity and therefore helps support the medical necessity of services. Greater specificity may also require changes in documentation to support the appropriate code. Notation of the specific anatomic site or other clinical factors may be required for appropriate coding. Changes in classifications and descriptive language make it important to include this information in the clinical documentation to ensure accurate and specific code selection.

**CODING TO THE HIGHEST DEGREE OF CERTAINTY**

Specific diagnoses should be reported when they are supported by the medical record and clinical knowledge. However, there are instances when the encounter is best coded using a signs/symptoms code or an unspecified code.

Codes should be selected based on what is known clinically and that which accurately reflects the encounter. It is not appropriate to select a specific code that is not supported in the medical record.

There may be times when the clinical information known about the condition is limited and a specific code cannot be reported. In these instances, the appropriate “unspecified” code is reported.

**LINKAGE AND MEDICAL NECESSITY**

Medicare and other health insurance payers commonly use the term “medical necessity”. The term implies the need to “justify” the choice of treatment by linking the service (CPT code) to the appropriate diagnosis, symptom, or complaint (ICD code). Failure to appropriately link the diagnosis to the service is a common reason for insurance denials.
SEQUENCING DIAGNOSES
Often more than one ICD diagnosis code applies to a particular patient. In that case, report the primary diagnosis first, followed by the second most important, etc. The primary diagnosis is the diagnosis chiefly responsible for the services provided.

Up to twelve diagnoses can be submitted on an electronic claim. Some practice management programs may limit the number of diagnoses that can be reported on each claim. Each diagnosis must be linked to the appropriate procedure to establish medical necessity for each service. Some payer software reads only the first diagnosis linked to an individual CPT code when processing the claim. It is therefore important to prioritize and link diagnosis codes accurately.

Conditions that may be classified to a particular code are listed beneath the code description. Note also that in ICD-10, the word “and” should be interpreted to mean either “and” or “or” when it appears in a title. The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a title, the Alphabetic Index, or an instructional note.

RELEVANT DIAGNOSES
Coding guidelines state that only a diagnosis for a current condition(s) should be reported. The diagnosis may indicate:
• The condition(s) that prompted the patient’s visit
• The condition(s) that was treated during the visit
• Co-existing conditions that affect the treatment of the patient

Do not code conditions that either were previously treated or no longer exist. Do not report codes for risk factors (e.g., family history of a disease) if the patient has not been diagnosed with the condition. Instead, report codes for personal or family history as a secondary diagnosis if the history has an impact on the current care or influences treatment. Personal and family history codes in ICD-10 are found in Chapter 21 (Factors Influencing Health Status and Contact With Health Services) and categories Z80- Z87.

When reporting diagnosis codes, care should be taken to distinguish between:
• Conditions presently existing
• Conditions no longer existing
• Certain postoperative conditions that require consideration and management

CODING FOR COMPLICATIONS OF CARE
Codes indicating complications of care should only be reported when the provider’s documentation supports a relationship between the condition and the care or procedure. A complication implies a cause-and-effect relationship between the care and the condition and must be clearly documented in the medical record. Not all conditions that occur during or following medical care or surgery are classified as complications.

Post-operative complications are located in the corresponding disease chapter. Complication codes may also be found elsewhere in ICD-10-CM such as in Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88). The guidelines for reporting complications are the same regardless of the chapter in which they are found.
SECTION IV: DIAGNOSTIC CODING AND REPORTING GUIDELINES FOR OUTPATIENT SERVICES

ICD-10-CM conventions and general guidelines apply to all settings. However, there are differences between inpatient and outpatient ICD-10-CM coding in two main areas:

- The Uniform Hospital Discharge Data Set (UHDDS) definition of principle diagnosis applies only to inpatients in acute, short-term, long-term care, and psychiatric hospitals
- Coding guidelines for inconclusive diagnoses are for inpatient reporting and do not apply to outpatients

The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. The Guidelines for Outpatient Services apply to hospitals and providers when coding and reporting hospital-based outpatient services and provider-based office visits.

SELECTION OF FIRST-LISTED CONDITION

The selection of the first-listed diagnosis (principal diagnosis in the inpatient setting) is based primarily on the general and disease specific guidelines. Since diagnoses may not always be established at the time of the initial encounter, it may take two or more visits before a diagnosis can be confirmed. It is important that both the Alphabetic Index and Tabular List be used to select an ICD-10-CM code.

The code listed first is the ICD-10-CM code supported in the medical record that is chiefly responsible for the encounter. This can be a code for the diagnosis, condition, problem or reasons other than a disease or injury.

When the provider has not established a diagnosis, then codes that describe signs and symptoms should be reported. Sign/Symptom codes are found in both the disease chapters and in Chapter 18: Symptoms, Signs and Abnormal Clinical and Laboratory Findings, NEC (R00-R99).

If the patient is being seen for circumstances other than a disease or injury, then that code is the first-listed diagnosis. This includes encounters for preventive services, screening services or tests, preoperative evaluations and routine prenatal visits.

UNCERTAIN DIAGNOSIS

The guideline for reporting to the highest degree of certainty applies when an uncertain diagnosis is documented. When a diagnosis is documented as probable, suspected, rule out, working diagnosis or other similar term, it is inappropriate to code for that condition. In these instances, the code for the sign, symptom or abnormal test results is reported.

DIAGNOSTIC SERVICES

If the patient is receiving only diagnostic services, the first listed diagnosis is the one chiefly responsible for the service. If a physician has interpreted the test, and a final written report is available, any confirmed or definitive diagnosis can be reported.

If the diagnostic service is for routine laboratory or radiology testing and there are no signs, symptoms, or associated diagnosis, code Z01.89 (Encounter for other specified special examinations) should be reported. The guidelines for reporting screening services will be discussed in the section on Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99).
REPORTING ADDITIONAL DIAGNOSES
Other diagnoses that coexist at the time of the encounter and require or affect treatment or management should also be reported. Chronic conditions can be reported as often as the patient receives treatment and care for the condition.

Conditions that no longer exist should not be coded. In these instances, history codes (Z80-Z87) may be reported if the past condition or family history impacts current care or influences treatment. History codes also will be discussed in the section on Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99).
Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99), ICD-10-CM, Chapter 18

Codes for signs and symptoms are found in ICD-10-CM, Chapter 18, Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified, (R00-R99). These codes can be reported until all the facts are obtained and/or a definitive diagnosis is established. Most payers accept these diagnoses.

Chapter 18 is divided into 14 “blocks” as follows:
- R00-R09 Symptoms and signs involving the circulatory and respiratory systems
- R10-R19 Symptoms and signs involving the digestive system and abdomen
- R20-R23 Symptoms and signs involving the skin and subcutaneous tissue
- R25-R29 Symptoms and signs involving the nervous and musculoskeletal systems
- R30-R39 Symptoms and signs involving the genitourinary system
- R40-R46 Symptoms and signs involving cognition, perception, emotional state and behavior
- R47-R49 Symptoms and signs involving speech and voice
- R50-R69 General symptoms and signs
- R70-R79 Abnormal findings on examination of blood, without diagnosis
- R80-R82 Abnormal findings on examination of urine, without diagnosis
- R83-R89 Abnormal findings on examination of other body fluids, substances and tissues, without diagnosis
- R90-R94 Abnormal findings on diagnostic imaging and in function studies, without diagnosis
- R97 Abnormal tumor markers
- R99 Ill-defined and unknown cause of mortality

Chapter 18 contains codes for which there is no classifiable diagnosis. Codes from this chapter may be reported when a related definitive diagnosis has not been confirmed. The chapter also contains codes for abnormal test findings without a definitive diagnosis. These situations can occur in both gynecologic and obstetrical care.

In ICD-10-CM signs and symptoms that point to a given diagnosis are included in the applicable disease chapter. Therefore, it is important to use both the Alphabetic Index and the Tabular List when selecting a code.

REPORTING CODES FOR SYMPTOMS AND SIGNS

Signs or symptoms that are associated routinely with a disease process should not be reported as additional codes unless instructed by the specific classification. For example, you would not report the code for dysuria (R30.0) if a urinary tract infection (N39.0) has been diagnosed since this commonly occurs with an UTI.
However, you can report signs or symptoms in addition to a definitive diagnosis when the sign/symptom is not routinely associated with that diagnosis. This may often occur with complex syndromes. In this situation the diagnosis code should be reported before the symptom code. For example, some patients with polycystic ovarian syndrome (E28.2) may have thickened or darkened areas on the skin. Since this is not routinely associated with the condition, code R23.4 (changes in skin texture) may be reported as a secondary diagnosis.

ICD-10-CM contains many combination codes that include both the definitive diagnosis and common symptoms of that diagnosis. When the combination code includes the applicable symptoms, an additional code for that symptom should not be reported. For example, you would not report code R20.2 (paresthesia of skin) with the combination code E10.42 (Type I diabetes mellitus with diabetic polyneuropathy) since the combination code includes polyneuropathy and therefore its associated symptoms.
CHAPTER 4

Diseases of the Genitourinary System (N00-N99), ICD-10-CM, Chapter 14

Codes for diseases of the genitourinary system are found in ICD-10-CM, Chapter 14, Diseases of the Genitourinary System (N00-N99).

Chapter 14 is divided into 11 “blocks” as follows:

- N00-N08 Glomerular diseases
- N10-N16 Renal tubulo-interstitial diseases
- N17-N19 Acute kidney failure and chronic kidney disease
- N20-N23 Urolithiasis
- N25-N29 Other disorders of kidney and ureter
- N30-N39 Other disorders of the urinary system
- N40-N53 Diseases of male genital organs
- N60-N65 Disorders of breast
- N70-N77 Inflammatory diseases of female pelvic organs
- N80-N98 Noninflammatory disorders of female genital tract
- N99 Intraoperative and post-procedural complications and disorders of genitourinary system, not elsewhere classified

Certain conditions reportable with Chapter 14 codes require careful documentation in order to facilitate appropriate code selection. For example, codes for vaginitis and vulvitis (N76.-) distinguish between acute and chronic conditions. The codes for salpingitis and oophoritis also distinguish between acute and chronic conditions. Documentation will be a critical factor in selecting the correct code.

ICD-10-CM also distinguishes between primary (N94.4) and secondary dysmenorrhea (N94.5). Secondary dysmenorrhea is a pain that is caused by another disorder in the reproductive system. Endometriosis is a common cause.

ICD-10 has combination codes for cystitis that specify with and without hematuria. The entire medical record can be used to appropriately assign a diagnosis. The ICD-10-CM Coordination and Maintenance Committee recently clarified that the code for “with hematuria” should be used when frank blood is present in the urine. Effective 10-1-2016, new codes were added to ICD-10-CM code section R31.2- to differentiate between asymptomatic and other microscopic hematuria.

In the ICD code book, all of the subcategories for cystitis, including the unspecified code, differentiate between with and without hematuria. In the absence of any indication that hematuria exists, report the code indicating without hematuria.
POSTOPERATIVE COMPLICATIONS
ICD-10 contains codes for postoperative complications in the specific body system chapters. Chapter 14 category N99 (Intraoperative and postprocedural complications and disorders of genitourinary system, not elsewhere classified) has several subcategories for complications. Two subcategories distinguish between intraoperative (N99.6-) and postprocedural (N99.8-) hemorrhage and hematoma of a genitourinary system organ. Subcategory N99.8 further divides the categories into specific subsections for postprocedural hemorrhage, hematoma and seroma. As an example, for a postprocedural hematoma of a genitourinary system organ or structure following a genitourinary system procedure, code N99.840 would be reported. Code N99.841 would be reported for a genitourinary system hematoma following another procedure.

The codes in these subcategories, along with subcategory N99.7 (Accidental puncture and laceration of a genitourinary system organ or structure during a procedure) differentiate between complications that occur during a genitourinary procedure and during “other” procedures.

Codes for prolapse of vaginal vault after hysterectomy (N99.3) and residual ovary syndrome (N99.83) are also included in the N99 category.

Other complications codes can be found in ICD-10-CM, Chapter 19: Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T88). This section includes codes that, on occasion, will be used by gynecologists. Subcategories T80-T88 (Complications of Surgical and Medical Care, Not Elsewhere Classified) specifically relate to complications of surgical and medical care. See Chapter 7 of this booklet for additional information.
Encounters for reasons other than a disease, injury, sign, or symptom are found in ICD-10-CM, Chapter 21, Factors Influencing Health Status and Contact with Health Services (Z00-Z99). A corresponding procedure or service code (CPT or HCPCS) must accompany a Z code on an insurance claim.

Chapter 21 is divided into 15 “blocks” as follows.
- Z00-Z13 Persons encountering health services for examinations
- Z14-Z15 Genetic carrier and genetic susceptibility to disease
- Z16 Resistance to antimicrobial drugs
- Z17 Estrogen receptor status
- Z18 Retained foreign body fragments
- Z19 Hormone sensitivity malignancy status
- Z20-Z29 Persons with potential health hazards related to communicable diseases
- Z30-Z39 Persons encountering health services in circumstances related to reproduction
- Z40-Z53 Encounters for other specific health care
- Z55-Z65 Persons with potential health hazards related to socioeconomic and psychosocial circumstances
- Z66 Do not resuscitate status
- Z67 Blood type
- Z68 Body mass index (BMI)
- Z69-Z76 Persons encountering health services in other circumstances
- Z77-Z99 Persons with potential health hazards related to family and personal history and certain conditions influencing health status

Z codes can be used in any healthcare setting and may be a first-listed diagnosis or a secondary code depending on the circumstances. When a Z code is the most accurate code to describe the reason for an encounter, it must be reported.

OB/Gyn physicians may report codes from several of the many categories of Z codes as listed below.
- Contact/exposure
- Inoculations and vaccinations
- Status
- History of
- Screening
- Observation
- Aftercare
- Follow-up
- Donor
- Counseling
- Encounters for obstetrical and reproductive services
- Newborns and infants
- Routine and administrative examinations
CONTACT AND EXPOSURE CODES

Category Z20 indicates contact with, and exposure to, communicable diseases. They are used for patients who do not show any sign or symptom of a disease but who are suspected to have been exposed by close personal contact with an infected person.

These codes may be first-listed to explain an encounter for testing or as a secondary code to identify a potential risk. For example, Contact with and (suspected) exposure to HIV is reported with code Z20.6.

INOCULATIONS AND VACCINATIONS

Code Z23 is for encounters for prophylactic inoculations and vaccinations. CPT or HCPCS codes are reported for the actual administration of the injection and the type of immunization given. Codes in category Z28 identify reasons inoculations and vaccination were not carried out including contraindications and patient refusal.

STATUS CODES

Status codes indicate a patient is a carrier of a disease or has a sequelae or residual of a past disease or condition. These codes are primarily informative as the status may affect the course of treatment and outcomes of care. These codes are distinct from a history code that indicates the patient no longer has a particular condition.

Codes for genetic carrier (Z14-) and genetic susceptibility (Z15-) are considered status codes. Genetic carrier status means a person carries a gene associated with particular disease that may be passed to an offspring. The person does not have the disease and is not a risk of developing the condition. Code Z14.1, (Cystic fibrosis carrier) is considered a genetic carrier status code. Genetic susceptibility means the person has a gene that increases the risk of disease to that person. These codes should not be used as a first-listed diagnosis. The first-listed should be reason for encounter followed by additional codes for family or personal history as appropriate.

For example, if the purpose of the encounter is for genetic counseling associated with procreative management, then code Z31.5 (Encounter for genetic counseling) is first-listed followed by a code from Category Z15 such as Z15.01 (Genetic susceptibility to malignant neoplasm of the breast).

Other status codes include codes for estrogen receptor status, positive (Z17.0) and negative (Z17.1). ICD-10-CM instructions state to first code malignant neoplasm of the breast (C50-), when applicable.

New code section, Z19 has been added to the October 1, 2016 ICD-10-CM release to identify hormone sensitivity malignancy status. Subcode Z19.1 would be reported for hormone sensitive malignancy status. Subcode Z19.2 would be reported for a hormone resistant malignancy status.

Codes in the Z79 code section that describe long-term (current) drug therapy are also considered status codes. These codes indicate a patient's continuous use of a prescribed drug for long-term treatment or prophylactic use. ICD-10-CM includes a specific code for long-term use of hormonal contraceptives (Z79.3). Other codes such as long term (current) use of agents affecting estrogen receptors and levels (Z79.81-) and hormone replacement therapy, post- menopausal (Z79.890) are included in this category. Note: For the ICD-10-CM October 1, 2017 release, the code description for code Z79.890 has been revised to remove the term (post-menopausal). The new code description on will read simply as: “hormone replacement therapy”.

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HISTORY CODES
There are two types of history Z codes: personal and family. Personal history codes explain a patient's past medical condition that:
- No longer exists
- Is not being treated
- Has the potential for recurrence
- Requires continued monitoring

Family history codes are used when the patient has a family member(s) who has had a particular disease that places the patient at a higher risk for the disease.

Personal and family history codes are acceptable on any medical record regardless of the reason for the visit. A history of an illness or medical treatment may be important information that may alter the care and treatment of the patient. For example, a gynecologist may find it important to note a personal history of contraception (Z92.0) or estrogen therapy (Z92.23) at the time of a particular presenting sign or symptom. Personal history codes can be used with follow-up codes and family history codes can be used with screening codes to explain the need for a test or procedure.

FOLLOW-UP CODES
Follow-up codes are used to explain continuing surveillance after completed treatment of a disease, condition, or injury. Use of these codes implies that the condition has been fully treated and no longer exists.

They can be used in conjunction with history codes to provide the full picture of the healed condition and treatment. In this case, the follow-up code is reported first followed by the history code. If a condition is found to have recurred, the diagnosis code for the condition should be assigned instead of the follow-up code.

There are 3 categories of follow-up codes:
- Z08 Encounter for follow-up examination after completed treatment for malignant neoplasm
- Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
- Z39 Encounter for maternal postpartum care and examination

Codes Z08 and Z09 are used for post-operative visits. They are found in the Index under examination→follow-up→surgery NEC→malignant neoplasm.

Instructions for code Z08 state to report an additional code to identify any acquired absence of organs (Z90.-) as well as a code to identify personal history of malignant neoplasm (Z85.-).

SCREENING CODES
Screening is testing for disease or disease precursors in seemingly well individuals for purposes of early detection and treatment. A screening code can be a first-listed code if the encounter is specifically for the screening exam. Screening codes can also be a secondary code if the screening is done during an encounter for other health problems. A screening code indicates that a screening exam is planned. A CPT or HCPCS code is necessary to confirm that the screening was performed.
If a condition is discovered during a screening, then the code for the condition can be assigned as an additional code. If a test is performed because the patient has a sign or symptom, then a diagnostic examination has been performed. In this instance, the sign or symptom is used to explain the reason for the test.

It is not necessary to report a screening code if the screening is inherent to a routine exam. For example, it is not necessary to indicate a screening Pap test is performed when it is done at the time of a routine gynecologic examination. However, certain screening tests, such as screening for Chlamydia (Z11.8), may be reported at the time of a well-woman examination since it is not indicated for all age groups.

The October 1, 2017 ICD-10-CM code set release includes an expansion of the Z36 (Encounter for antenatal screening of mother) code. This code was expanded to provide more specificity with regards to screening for specific conditions that may impact management of the pregnancy. See Chapter 8 of this booklet for additional details.

**ROUTINE ADMINISTRATIVE CODES**

Categories Z00-Z02 include codes for routine exams (general check-up) or administrative exams (e.g. pre-employment physical). These codes are not used if the visit is for the diagnosis of a suspected condition or for treatment of a problem. For example, pre-procedural exams (Z01.818) and pre-procedural laboratory exams (Z01.812) are used only when the patient is being cleared for surgery and no treatment is given.

If a condition is found during a routine visit, then it is coded as an additional diagnosis. Any pre-existing and chronic conditions and history codes may also be reported as long as the encounter is not for treatment or management of those problems.

**COUNSELING CODES**

ICD-10-CM states that counseling codes are used when a patient or her family member receives assistance in the aftermath of an illness or when support is required in coping with family or social problems. Counseling codes are not used in conjunction with a diagnosis code when counseling is considered integral to standard treatment.

Some of the counseling codes most commonly used by Ob/Gyn practices are:

- Z30.0 Encounter for general counseling and advice on contraception
- Z31.5 Encounter for genetic counseling
- Z31.6 Encounter for general counseling and advice on procreation
- Z32.2 Encounter for childbirth instruction

New counseling codes effective 10-1-2017 include:

- Z71.82 Exercise counseling
- Z71.83 Encounter for nonprocreative genetic counseling

**OBSERVATION CODES**

There are two observation categories in ICD-10-CM:

- Z03 Encounter for medical observation for suspected diseases and conditions ruled out
- Z04 Encounter for examination and observation for other reasons
Observation codes are used *only when the suspected condition is ruled out*. These codes are not used if there is an illness, injury, sign, or symptom related to the suspected condition. In these instances, the diagnosis or sign/symptom code is reported.

Observation codes must be the first-listed diagnosis. Other codes may be reported if they are unrelated to the condition being observed.

Codes found in subcategory Z03.7 (Encounter for suspected maternal and fetal conditions ruled out) are an exception to this guideline. This subcategory of codes may be first-listed or as an additional code depending on the situation. These codes are used in very limited circumstances when an encounter is for a suspected maternal or fetal condition that is ruled out during the encounter. For example, a patient measures small-for-dates at a 26 week prenatal visit. An ultrasound is ordered to rule out a problem with fetal growth. The diagnoses for the ultrasound might include: Z03.74 (Encounter for suspected problem with fetal growth ruled out). Code O26.842 (Uterine size-date discrepancy, second trimester) might also be reported.

Other codes in this sub-category include:
- Z03.71 Encounter for suspected problem with amniotic cavity and membrane ruled out (inclusion terms include suspected oligohydramnios ruled out and suspected polyhydramnios ruled out)
- Z03.72 Encounter for suspected placental problem ruled out
- Z03.73 Encounter for suspected fetal anomaly ruled out
- Z03.74 Encounter for suspected problem with fetal growth ruled out
- Z03.75 Encounter for suspected cervical shortening ruled out
- Z03.79 Encounter for other suspected maternal and fetal conditions ruled out

**ENCOUNTERS FOR OBSTETRICAL AND REPRODUCTIVE SERVICES**

Chapter 21 also contains categories of codes for obstetrical and reproductive services (Z30-Z39). The Z codes for pregnancy are used when there are no complications or problems included in the codes from the Obstetrical Chapter. Routine prenatal and postpartum codes are included in Chapter 21. Routine prenatal codes for high-risk pregnancies are coded from the Obstetrical Chapter.

The following categories and subcategories are of particular interest to Ob/Gyn practices:
- Z30 Contraceptive management
- Z31 Encounter for procreative management
- Z32 Encounter for pregnancy test and childbirth and childcare instructions
- Z33 Pregnant state
- Z34 Supervision of normal pregnancy
- Z36 Encounter for antenatal screening of mother
- Z3A Weeks gestation
- Z37 Outcome of delivery
- Z39 Encounter for maternal postpartum care and examination

**ROUTINE OUTPATIENT PRENATAL VISITS**

Code Z34.0- (Encounter for supervision of normal first pregnancy) or Z34.8- (Encounter for supervision of other normal pregnancy) are reported for routine outpatient prenatal visits. Each subcategory of codes requires the identification of the trimester represented by the 5th character in each code. These codes are used when no complications are present.
They are always listed first and should never be reported with any code from Chapter 15 (Pregnancy, Childbirth, and the Puerperium).

Code Z33.1 (Pregnant state, incidental) is a secondary code that is only used when the pregnancy is in no way complicating the reason for the visit. The primary diagnosis is the condition necessitating the encounter. For example, the patient may see an ED physician for evaluation of acute pharyngitis that is not impacting the pregnancy. Under ICD-10 guidelines, the ED physician would report code J02.9 (acute pharyngitis, unspecified) and Z33.1.

Some payers’ software may bundle any pregnancy related service in the global obstetric package. If the service provided is for treatment of a condition unrelated to pregnancy, it may be necessary to omit code Z33.1 from the claim in order to receive appropriate reimbursement. The trimester of the encounter is incorporated into the code titles. Trimester indications are also included for most of the codes in Chapter 15.

There is an Excludes 1 note for Z34. Any condition listed in the Excludes 1 note should not be reported with a code from Category Z34.

**Excludes 1**
- Any complications of pregnancy (O00-O9A)
- Encounter for pregnancy test (Z32.0-)
- Encounter for supervision of high risk pregnancy (O09-)

Category Z3A includes codes to specify the number of weeks gestation at the time of the encounter. These codes must be reported when codes from Chapter 15, (O00-O9A) are reported. Although it is not required, it is acceptable, to report the number of weeks gestation in conjunction with codes for routine prenatal visits and services.

**PROPHYLACTIC MEASURES**

Code section (Z29) provides coding for encounters for other prophylactic measures. This code section includes diagnosis codes for reporting encounters for prophylactic immunotherapy, Rho(D) and rabies immune globulin administration, fluoride administration, and other and unspecified prophylactic measures.
Chapter 6

Pregnancy, Childbirth and the Puerperium (O00-O9A), ICD-10-CM, Chapter 15

Codes for complications of pregnancy are found in ICD-10-CM, Chapter 15, Pregnancy, Childbirth and the Puerperium (O00-O9A). Codes in this chapter are used on the maternal record to report conditions related to, or aggravated by pregnancy, childbirth, or the puerperium.

Chapter 15 is divided into nine “blocks” as follows:

- O00-O08 Pregnancy with abortive outcome
- O09 Supervision of high risk pregnancy
- O10-O16 Edema, proteinuria and hypertensive disorders in pregnancy, childbirth and the puerperium
- O20-O29 Other maternal disorders predominantly related to pregnancy
- O30-O48 Maternal care related to the fetus and amniotic cavity and possible delivery problems
- O60-O77 Complications of labor and delivery
- O80-O82 Encounter for delivery
- O85-O92 Complications predominantly related to the puerperium
- O94-O9A Other obstetric conditions, not elsewhere classified

COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM

A pregnancy may be considered at-risk if the patient had a problem in a previous pregnancy and/or has a current medical condition that may impact her pregnancy. If no problems develop in this pregnancy, no additional visits are reported, even if the patient is seen for more than 13 visits.

However, medically necessary diagnostic tests such as ultrasounds or laboratory studies are reported separately at the time they were provided.

For routine prenatal visits for a patient with an at-risk pregnancy who has developed complications, a code from category O09 (Supervision of high-risk pregnancy) should be listed first. Other codes from Chapter 15 may be reported in addition to a code from the O09 category, when applicable.

Routine prenatal care, when no complications exist, is reported using a code from code section Z34.- (Encounter for supervision of normal pregnancy). A code from Chapter 15 should never be reported in conjunction with routine prenatal care. Codes from other chapters can be reported as appropriate as additional diagnoses.

When a patient is seen for a complication of pregnancy, the complication chiefly responsible for the encounter should be listed first on the claim. If there are multiple complications, all that are treated or monitored should be reported.
In the event of a delivery, the primary diagnosis is the main circumstance or complication of the delivery. For a cesarean delivery, the primary diagnosis is the condition that was responsible for the patient’s admission. If a particular condition resulted in the admission and the cesarean procedure, that condition should be listed first. If the patient was admitted to the hospital for a condition unrelated to the reason for the cesarean, the reason for the admission should be reported for the E/M service(s) and the reason the cesarean was required should be reported on the day of delivery.

The maternal record should include a code from category Z37 (Outcome of delivery) when a delivery occurs. It should not be reported for subsequent encounters. Prenatal care for an at-risk pregnancy is reported with a code from this chapter (O09.-). Codes from other chapters can be reported in addition to the codes in this chapter, however Chapter 15 codes have sequencing priority over codes from other chapters. In other words, Chapter 15 codes are the first-listed diagnosis.

**TRIMESTER DESIGNATION**
Most codes in Chapter 15 have a final character indicating the trimester of pregnancy. The trimester designation is not present for conditions that occur only in a specific trimester or for which the trimester is not relevant. Some conditions may not have options for all trimesters if the condition exists in some but not all trimesters. Assignment of the final character is based on the provider’s documentation of the trimester or the number of weeks for the current encounter.

An additional code from category Z3A, Weeks of gestation, is reported to identify the specific week of pregnancy. Category Z3A includes codes specifying the number of weeks gestation at the time of the encounter. The codes should be reported in addition to codes from Chapter 15. It is not necessary, but acceptable, to report the number of weeks gestation in conjunction with codes for routine prenatal visits and services.

**7TH CHARACTER EXTENSIONS**
Certain conditions require a 7th character extension to identify the fetus for which the complication applies. A code from O30 (Multiple gestation) should also be reported. If a condition affects more than one fetus, then the code must be assigned for each fetus affected.

Possible 7th character extensions are as follows:
- 0 Not applicable
- 1-5 Fetus number
- 9 Other fetus

The 7th character extension “0” is assigned when:
- There is a single gestation
- The documentation is insufficient to determine the affected fetus and clarification is not possible
- It is not possible to clinically determine which fetus is affected
The following Chapter 15 code categories require a 7th character extension:

- O31 Complications specific to multiple gestations
- O32 Maternal care for malpresentation of fetus
- O33.3-O33.7 Maternal care for disproportion
- O35 Maternal care for known or suspected fetal abnormality and damage
- O36 Maternal care for other fetal problems
- O35.83 Maternal care for abnormalities of the fetal heart rate or rhythm (eff. 10-1-17)
- O40 Polyhydramnios
- O41 Other disorders of amniotic fluid and membranes
- O60.1 Preterm labor with preterm delivery
- O60.2 Term delivery with preterm labor
- O64 Obstructed labor due to malposition and malpresentation of fetus
- O69 Labor and delivery complicated by umbilical cord complication

For example, a twin pregnancy with preterm labor in the second trimester and delivery in the third trimester at 34 weeks would be reported as follows:

- O60.13X1 Preterm labor second trimester with preterm delivery third trimester, fetus 1
- O60.13X2 Preterm labor second trimester with preterm delivery third trimester, fetus 2
- O30.043 Twin pregnancy, dichorionic/diamniotic, third trimester
- Z3A.34 34 weeks gestation

The 6th character “X” is a placeholder and is required for reporting a valid code. Since both babies were delivered, a code for each fetus must be reported. The 7th character extension identifies the fetus. The medical record or the obstetrician’s documentation will need to be reviewed to determine the appropriate trimester for both the labor and delivery. The appropriate code will be based on this documentation.

The guidelines require that a code from category O30 (Multiple gestation) also be reported with codes that require identification of the fetus. Note that the multiple gestation codes include placenta status in the code title.

A code from category Z3A (Weeks gestation) indicating the number of weeks gestation is also required when codes from Chapter 15 are reported.

**PRE-EXISTING CONDITIONS VS. CONDITIONS DUE TO PREGNANCY**

Certain categories in Chapter 15 distinguish between conditions that the mother had prior to pregnancy and those that are a direct result of pregnancy. Proper code selection requires a determination of whether the condition was pre-existing or occurred first during pregnancy.

The classifications for diabetes mellitus and hypertension make this distinction. The documentation in the medical record must clearly indicate the onset of the condition. The thorough history obtained at the initial prenatal visit should indicate all pre-existing conditions.

Categories that do not distinguish between pre-existing and pregnancy related may be used in either situation.
HYPERTENSION CODING

Categories O10-O11 contain codes for pre-existing hypertension and require identification of the trimester. Category O10 also contains codes for hypertensive heart and chronic kidney disease. Most of these codes contain 6 characters. When assigning a code related to these conditions, it is necessary to add a secondary code to specify the type of heart failure or chronic kidney disease. Category O11 is for pre-existing hypertension with pre-eclampsia and requires an additional code from category O10 to identify the type of hypertension.

In addition to essential hypertension, Category O10 includes the following subcategories:

- O10.1 Pre-existing hypertensive heart disease complicating pregnancy
- O10.2 Pre-existing hypertensive chronic kidney disease complicating pregnancy
- O10.3 Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy
- O10.4 Pre-existing secondary hypertension complicating pregnancy
- O10.9 Unspecified pre-existing hypertension complicating pregnancy, childbirth and the puerperium

Each subcategory indicates the condition in Chapter 9: Diseases of the Circulatory System that applies to the specific subcategory. The instructions also state that an additional code from the circulatory chapter should be reported to identify the type of hypertension. It is important to be familiar with the codes that require an additional diagnosis in order to fully describe the patient's condition and circumstances.

Additionally, hypertension has distinct categories, subcategories, and codes to describe pre-existing and pregnancy-related conditions.

GESTATIONAL HYPERTENSION

Category O12 contains codes for gestational edema, gestational proteinuria, and gestational edema with proteinuria without hypertension. Codes from category O12 (Gestational [pregnancy-induced] edema and proteinuria without hypertension) are reported when a patient develops edema and protein in their urine but do not develop hypertension. There are subcategories for edema alone, proteinuria alone and both conditions together. Documentation for these conditions might be found in the examination or laboratory work but it is advisable not to report these codes unless the physician clearly documents one of these conditions.

Category O13 is reported for hypertension without significant proteinuria and can also be used for hypertension, not otherwise specified.

Category O14 is reported for pre-eclampsia and has subcategories to describe the severity of the condition including HELLP syndrome.

Category O15 is reported for eclampsia.

Category O16 is for unspecified maternal hypertension and should be avoided when additional clinical information is known and documented.
Patients who develop edema and protein in their urine, may progress to pre-eclampsia or eclampsia. These conditions are found in categories O14 and O15, respectively, and require designation of the trimester.

Code sections O11-O16 all include codes for hypertension complicating the antepartum, childbirth and the puerperium.

<table>
<thead>
<tr>
<th>PRE-EXISTING (O10.011-O11.9)</th>
<th>PREGNANCY INDUCED (O12.00-O16.9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of hypertension (essential, hypertensive heart, hypertensive chronic kidney disease, secondary, with pre-eclampsia)</td>
<td>Specific condition (edema, proteinuria, pre-eclampsia, eclampsia)</td>
</tr>
<tr>
<td>Trimester</td>
<td>Trimester</td>
</tr>
<tr>
<td>Identification of type of hypertensive heart and/or kidney disease (I11, I12, I13, I15)</td>
<td>Eclampsia-trimester, labor, or puerperium</td>
</tr>
<tr>
<td>Identification of type of hypertensive heart and/or kidney disease (I11, I12, I13, I15)</td>
<td>Severity of pre-eclampsia (O14.-)</td>
</tr>
</tbody>
</table>

**Note:** Pre-eclampsia definitions have been re-defined by a recent ACOG Task Force Report on Hypertension in Pregnancy. ACOG is currently working to update the hypertension in pregnancy diagnosis codes.

**DIABETES CODING**

Since diabetes is a complicating condition in pregnancy, a pregnant woman with diabetes may be seen for additional services. It is important that the ICD code reflect the appropriate condition in order to support these additional services. Pregnant women who are diabetic should be assigned a code from category O24 (Diabetes mellitus in pregnancy, childbirth, and the puerperium).

Subcategories O24.0-, O24.1-, O24.3-, and O24.8- are reported when the pregnant women had pre-existing diabetes. These subcategories distinguish between type 1, type 2, other specified and unspecified diabetes. Each subcategory contains codes to describe services in childbirth and the puerperium as well as the antenatal period. Services provided in the antenatal period require identification of the trimester. ICD also instructs that a code from category E08-E13 be reported to further identify any manifestations.
GESTATIONAL DIABETES

Gestational diabetes occurs in women who develop diabetes in pregnancy but who were not diabetic prior to pregnancy. Gestational Diabetes codes are found in sub-category O24.4-. When a code indicating gestational diabetes is reported, another diabetes code should not be reported.

The 5th character in the O24.4 (gestational diabetes) sub-category specifies whether the encounter occurs:

- In pregnancy
- In childbirth
- In the puerperium

The 6th character indicates the method of diabetes control. There are diagnosis codes for diet, oral hypoglycemic, and insulin control. If a patient is controlled both by diet and insulin, only the code for insulin-controlled is required.

There are no trimester designations in the sub-category for gestational diabetes since the condition only occurs in the second and third trimester.

Abnormal glucose tolerance in pregnancy is assigned a code from the subcategory O99.81 (Abnormal glucose complicating pregnancy, childbirth, and the puerperium).

Subcategory O24.9 (Unspecified diabetes) is reported when the medical record does not indicate the type of diabetes.

A code from the Z3A category should be reported whenever a code from Chapter 15 is reported to identify the week of gestation.

To accurately assign ICD-10 codes for diabetes complicating pregnancy, the following information is needed:

<table>
<thead>
<tr>
<th>PRE-EXISTING</th>
<th>PREGNANCY INDUCED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of diabetes (Type 1, Type 2, other)</td>
<td>Condition (Abnormal glucose O99.81- or Gestational O24.4-)</td>
</tr>
<tr>
<td>Trimester</td>
<td>Maternal episode of care (pregnancy, childbirth, puerperium)</td>
</tr>
<tr>
<td>Any manifestations/complications (E08, E09, E10, E11, E13)</td>
<td>Method of control for gestational (diet, oral glycemic, insulin, unspecified)</td>
</tr>
</tbody>
</table>
PLACEHOLDER AND 7 CHARACTER CODES

Certain categories require a 7th character to identify the fetus for which the complication applies. A 7th character “0” is used for a single gestation, when the documentation does not identify the affected fetus, or when it is not clinically possible to determine which fetus is affected. 7th characters 1-9 are used to identify the specific fetus in the case of a multiple gestation. The appropriate code from category O30 (multiple gestation) must also be assigned when 7th character 1-9 is reported.

The 7th character must always be the 7th character in the data field. If a code that describes a 7th character is not 6 characters, then a placeholder X must be used to fill in the empty character. If the placeholder X is not included, the resulting character set is not a valid code. For example, labor and delivery complicated by prolapse of cord is a 4-character code (O69.0). Since a 7th character is required, a placeholder X must be placed in both the 5th and 6th characters. Therefore, delivery complicated by prolapse of the cord in a single gestation is reported with code O69.0XX0.

As noted earlier in this document, the following code categories require a 7th character:
- O31  Complications specific to multiple gestation
- O32  Maternal care for malpresentation of fetus
- O33.3-O33.6  Maternal care for disproportion
- O35  Maternal care for known or suspected fetal abnormality and damage
- O36  Maternal care for other fetal problems
- O36.83  Maternal care for abnormalities of the fetal heart rate or rhythm (eff. 10-1-17)
- O40  Polyhydramnios
- O41  Other disorders of amniotic fluid and membranes
- O60.1  Preterm labor with preterm delivery
- O60.2  Term delivery with preterm labor
- O64  Obstructed labor due to malposition and malpresentation of fetus
- O69  Labor and delivery complicated by umbilical cord complication

OUTCOME OF DELIVERY

An outcome of delivery code (Z37.-) should be included on all maternal records when a delivery has occurred. These codes would not be reported for encounters subsequent to the delivery. The hospital typically reports these codes on its records. Some payers may also require these codes on the physician claim.

NORMAL DELIVERY VS. OTHER DELIVERY

Code O80 (Normal Delivery) is always a principle diagnosis. It should be reported if there is:
- A full-term uncomplicated delivery
- A single, healthy infant
- The absence of complications during the antepartum, delivery, or postpartum during the delivery episode

Code O80 should not be reported with another code from Chapter 15. Additional codes from other chapters in ICD-10-CM may be reported if they are not related to or are in any way complicating the delivery.
POSTPARTUM CARE

ICD-10-CM defines the postpartum period as beginning immediately after delivery and continuing for six weeks. A postpartum complication is a complication occurring within the six-week period. The peripartum period is defined as the last month of pregnancy to five months postpartum. Chapter 15 codes can be used after the peripartum or postpartum periods if the documentation supports the condition as pregnancy related.

Routine postpartum care is reported using code Z39.2 (Encounter for routine postpartum care). Admissions for routine postpartum care following a delivery outside the hospital is reported using code Z39.0 (Encounter for care and examination of mother immediately after delivery). Care for a postpartum complication is reported using the appropriate code for the complication. Many pregnancy-related complication codes are found in code categories O85-O92, such as code O86.81 (Puerperal septic thrombophlebitis).
Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T88), ICD-10-CM, Chapter 19

Codes for injury, poisoning and other external injury causes are found in ICD-10-CM, Chapter 19: Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T88). This chapter includes codes that, on occasion, will be reported by gynecologists. Subcategories T80-T88 specifically relate to complications of surgical and medical care.

Subcategory T80-T88 is divided into the following 9 code blocks:
- T80 Complications following infusion, transfusion and therapeutic injection
- T81 Complications of procedures, not elsewhere classified
- T82 Complications of cardiac and vascular prosthetic devices, implants and grafts
- T83 Complications of genitourinary prosthetic devices, implants and grafts
- T84 Complications of internal orthopedic prosthetic devices, implants and grafts
- T85 Complications of other internal prosthetic devices, implants and grafts
- T86 Complications of transplanted organs and tissue
- T87 Complications peculiar to reattachment and amputation
- T88 Other complications of surgical and medical care, not elsewhere classified

Most codes in these subcategories require a 7th character. There are three 7th character extensions used with these codes to identify the type of encounter:
- A Initial encounter
- D Subsequent encounter
- S Sequela

While a patient may be seen by a new or different provider over the course of treatment, the assignment of the 7th character is based on whether the patient is receiving active treatment and not whether the provider is seeing the patient for the first time. For example, a patient is seen in the Emergency Department and then presents for the first time with the same condition to the gyn office. Under ICD-10-CM guidelines, the gynecologist reports 7th character “A”.

Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a different provider.

Examples of a subsequent encounter (7th character “D”) are: medication adjustment and follow-up visits following
treatment of the condition. For example, a patient returns for follow-up after removal of a displaced IUD. Under ICD-10-CM guidelines, the gynecologist reports the 7th character “D”. Most codes will require a placeholder X as the 6th character. It is crucial that the Tabular List be consulted to ensure that all required characters are reported. The Alphabetic Index does not always include all characters nor does it necessarily indicate that a 7th character extension is required.

Initial encounter with a patient seen for displacement of an IUD is reported: T83.32XA

\[ \text{T83.32 = Displacement of IUD} \]
\[ \text{X = placeholder} \]
\[ \text{A = initial encounter} \]

The follow-up visit for the same patient is reported as: T83.32XD

\[ \text{D = Subsequent encounter} \]

Surgical treatment for a patient previously seen in the office with exposure of implanted vaginal mesh into the vagina is reported T83.721S.

\[ \text{T83.721 = Exposure of implanted vaginal mesh and other prosthetic materials into vagina} \]
\[ \text{A = Initial encounter} \]

A placeholder X is not required since the code has 6 meaningful characters.

Codes for disruption of a wound are found in the T81.3- subcategory. There are unique codes for disruption of an external surgical wound and an internal surgical wound. All codes require a 6th and 7th character.
ICD-10-CM Changes for 2018

REVISIONS TO ICD-CM
The ICD-CM code set in the United States is maintained by the ICD Coordination and Maintenance Committee. This committee includes representatives from the National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS). This committee reviews all requests for changes or additions to the code set.

ACOG’s Committee on Health Economics and Coding meets regularly with members of the ICD Committee to discuss requests (from ACOG, other groups, or from individuals) for changes in current ob/gyn-related codes or for the creation of new codes. ACOG’s Committee also answers questions from the ICD Committee concerning appropriate terminology and definitions for ob/gyn diagnoses.

The Director of NCHS and the Administrator of CMS make the final coding data set decisions. Changes become effective October 1 of each year. A grace period for implementing new ICD codes is not provided. In preparation for ICD-10-CM implementation, a code freeze was implemented for new ICD-10-CM codes applied for after 2012. As a result, no new ICD-10-CM codes were implemented for the 2016 ICD-10-CM release. However, now that ICD-10 has been implemented, code changes recommended and approved during the code freeze will go into effect as part of the first regular ICD-10-CM update on October 1, 2016.

HIPAA requires insurers to accept new diagnosis codes beginning on October 1st.


The ICD-10 Coordination and Maintenance Committee approved the following changes for 2018.

NEW, REVISED, AND DELETED CODES

N63  Unspecified lump in breast
Code section N63 for an unspecified lump in the breast has been expanded to specify breast laterality and quadrant, in addition to adding codes identifying the axillary tail and subareolar region of the breast.

<table>
<thead>
<tr>
<th>New Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N63.0</td>
<td>Unspecified lump in unspecified breast</td>
</tr>
<tr>
<td>N63.1</td>
<td>Unspecified lump in right breast</td>
</tr>
<tr>
<td>N63.10</td>
<td>Unspecified lump in the right breast, unspecified quadrant</td>
</tr>
<tr>
<td>N63.11</td>
<td>Unspecified lump in the right breast, upper outer quadrant</td>
</tr>
<tr>
<td>N63.12</td>
<td>Unspecified lump in the right breast, upper inner quadrant</td>
</tr>
</tbody>
</table>
### N63.13 Unspecified lump in the right breast, lower outer quadrant
### N63.14 Unspecified lump in the right breast, lower inner quadrant

### N63.2 Unspecified lump in left breast
### N63.20 Unspecified lump in the left breast, unspecified quadrant
### N63.21 Unspecified lump in the left breast, upper outer quadrant
### N63.22 Unspecified lump in the left breast, upper inner quadrant
### N63.23 Unspecified lump in the left breast, lower outer quadrant
### N63.24 Unspecified lump in the left breast, lower inner quadrant

### N63.3 Unspecified lump in axillary tail
### N63.31 Unspecified lump in axillary tail of the right breast
### N63.32 Unspecified lump in axillary tail of the left breast

### N63.4 Unspecified lump in right breast, subareolar
### N63.41 Unspecified lump in right breast, subareolar
### N63.42 Unspecified lump in left breast, subareolar

---

### O00 Ectopic pregnancy

Code section O00 for ectopic pregnancy has been expanded to specify laterality.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O00.1</td>
<td>Tubal pregnancy</td>
</tr>
<tr>
<td>O00.10</td>
<td>Tubal pregnancy without intrauterine pregnancy</td>
</tr>
<tr>
<td><strong>New code(s)</strong></td>
<td><strong>O00.101</strong> Right tubal pregnancy without intrauterine pregnancy</td>
</tr>
<tr>
<td><strong>O00.102</strong></td>
<td>Left tubal pregnancy without intrauterine pregnancy</td>
</tr>
<tr>
<td><strong>O00.109</strong></td>
<td>Unspecified tubal pregnancy without intrauterine pregnancy</td>
</tr>
<tr>
<td>O00.11</td>
<td>Tubal pregnancy with intrauterine pregnancy</td>
</tr>
<tr>
<td><strong>New code(s)</strong></td>
<td><strong>O00.111</strong> Right tubal pregnancy with intrauterine pregnancy</td>
</tr>
<tr>
<td><strong>O00.112</strong></td>
<td>Left tubal pregnancy with intrauterine pregnancy</td>
</tr>
<tr>
<td><strong>O00.119</strong></td>
<td>Unspecified tubal pregnancy with intrauterine pregnancy</td>
</tr>
<tr>
<td>O00.2</td>
<td>Ovarian pregnancy</td>
</tr>
<tr>
<td>O00.20</td>
<td>Ovarian pregnancy without intrauterine pregnancy</td>
</tr>
<tr>
<td><strong>New code(s)</strong></td>
<td><strong>O00.201</strong> Right ovarian pregnancy without intrauterine pregnancy</td>
</tr>
<tr>
<td><strong>O00.202</strong></td>
<td>Left ovarian pregnancy without intrauterine pregnancy</td>
</tr>
<tr>
<td><strong>O00.209</strong></td>
<td>Unspecified ovarian pregnancy without intrauterine pregnancy</td>
</tr>
<tr>
<td>O00.21</td>
<td>Ovarian pregnancy with intrauterine pregnancy</td>
</tr>
<tr>
<td><strong>O00.211</strong></td>
<td>Right ovarian pregnancy with intrauterine pregnancy</td>
</tr>
</tbody>
</table>
O00.212 Left ovarian pregnancy with intrauterine pregnancy
O00.219 Unspecified ovarian pregnancy with intrauterine pregnancy

O36.83 Maternal care for abnormalities of the fetal heart rate or rhythm

Code section O36.8 has been expanded to add new subsection O36.83 (Maternal care for abnormalities of the fetal heart rate or rhythm).

New code sub-subsection O36.831 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester

New code(s) O36.8310 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester, not applicable or unspecified
O36.8311 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester, fetus 1
O36.8312 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester, fetus 2
O36.8313 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester, fetus 3
O36.8314 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester, fetus 4
O36.8315 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester, fetus 5
O36.8319 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester, other fetus

New code sub-subsection O36.832 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester

New code(s) O36.8320 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester, not applicable or unspecified
O36.8321 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester, fetus 1
O36.8322 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester, fetus 2
O36.8323 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester, fetus 3
O36.8324 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester, fetus 4
O36.8325 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester, fetus 5
O36.8329 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester, other fetus
<table>
<thead>
<tr>
<th>New code sub</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>subsection</td>
<td>O36.833</td>
</tr>
<tr>
<td>New code(s)</td>
<td>O36.8330</td>
</tr>
<tr>
<td>O36.8331</td>
<td>Maternal care for abnormalities of the fetal heart rate rhythm, third trimester, fetus 1</td>
</tr>
<tr>
<td>O36.8332</td>
<td>Maternal care for abnormalities of the fetal heart rate or rhythm, third trimester, fetus 2</td>
</tr>
<tr>
<td>O36.8333</td>
<td>Maternal care for abnormalities of the fetal heart rate or rhythm, third trimester, fetus 3</td>
</tr>
<tr>
<td>O36.8334</td>
<td>Maternal care for abnormalities of the fetal heart rate or rhythm, third trimester, fetus 4</td>
</tr>
<tr>
<td>O36.8335</td>
<td>Maternal care for abnormalities of the fetal heart rate or rhythm, third trimester, fetus 5</td>
</tr>
<tr>
<td>O36.8339</td>
<td>Maternal care for abnormalities of the fetal heart rate or rhythm, third trimester, other fetus</td>
</tr>
<tr>
<td>New code sub</td>
<td>O36.839</td>
</tr>
<tr>
<td>subsection</td>
<td>O36.8390</td>
</tr>
<tr>
<td>O36.8391</td>
<td>Maternal care for abnormalities of the fetal heart rate or rhythm, unspecified trimester, fetus 1</td>
</tr>
<tr>
<td>O36.8392</td>
<td>Maternal care for abnormalities of the fetal heart rate or rhythm, unspecified trimester, fetus 2</td>
</tr>
<tr>
<td>O36.8393</td>
<td>Maternal care for abnormalities of the fetal heart rate or rhythm, unspecified trimester, fetus 3</td>
</tr>
<tr>
<td>O36.8394</td>
<td>Maternal care for abnormalities of the fetal heart rate or rhythm, unspecified trimester, fetus 4</td>
</tr>
<tr>
<td>O36.8395</td>
<td>Maternal care for abnormalities of the fetal heart rate or rhythm, unspecified trimester, fetus 5</td>
</tr>
<tr>
<td>O36.8399</td>
<td>Maternal care for abnormalities of the fetal heart rate or rhythm, unspecified trimester, other fetus</td>
</tr>
</tbody>
</table>

The code description for code Z31.5 (Encounter for genetic counseling) has been revised to include the word “procreative.” as follows:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z31.5</td>
<td>Encounter for procreative genetic counseling</td>
</tr>
</tbody>
</table>

**Z36 Encounter for antenatal screening of mother**

Code section Z36 has been expanded to include screening for specific antenatal conditions.

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z36.0</td>
<td>Encounter for antenatal screening for chromosomal anomalies</td>
</tr>
<tr>
<td>Z36.1</td>
<td>Encounter for antenatal screening for raised alphafetoprotein level</td>
</tr>
<tr>
<td>Z36.2</td>
<td>Encounter for other antenatal screening follow-up</td>
</tr>
<tr>
<td>Z36.3</td>
<td>Encounter for antenatal screening for malformation</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Z36.4</td>
<td>Encounter for antenatal screening for fetal growth retardation</td>
</tr>
<tr>
<td>Z36.5</td>
<td>Encounter for antenatal screening for isoimmunization</td>
</tr>
<tr>
<td>Z36.8</td>
<td>Encounter for other antenatal screening</td>
</tr>
<tr>
<td>Z36.81</td>
<td>Encounter for antenatal screening for hydrops fetalis</td>
</tr>
<tr>
<td>Z36.82</td>
<td>Encounter for antenatal screening for nuchal translucency</td>
</tr>
<tr>
<td>Z36.83</td>
<td>Encounter for fetal screening for congenital cardiac abnormalities</td>
</tr>
<tr>
<td>Z36.84</td>
<td>Encounter for antenatal screening for fetal lung maturity</td>
</tr>
<tr>
<td>Z36.85</td>
<td>Encounter for antenatal screening for Streptococcus B</td>
</tr>
<tr>
<td>Z36.86</td>
<td>Encounter for antenatal screening for cervical length</td>
</tr>
<tr>
<td>Z36.87</td>
<td>Encounter for antenatal screening for uncertain dates</td>
</tr>
<tr>
<td>Z36.88</td>
<td>Encounter for antenatal screening for fetal macrosomia</td>
</tr>
<tr>
<td>Z36.89</td>
<td>Encounter for other specified antenatal screening</td>
</tr>
<tr>
<td>Z36.8A</td>
<td>Encounter for antenatal screening for other genetic defects</td>
</tr>
<tr>
<td>Z36.9</td>
<td>Encounter for antenatal screening, unspecified</td>
</tr>
</tbody>
</table>

Code section Z40.0 (Encounter for prophylactic surgery for risk factors related to malignant neoplasms) has been expanded to revise the code description for code Z40.02 (Encounter for prophylactic removal of ovary) to make it single or plural and to add new code Z40.03 for prophylactic removal of the fallopian tube(s).

**Revised code:** Z40.02  
**New code**  Z40.03  
Encounter for prophylactic removal of ovary(s)  
Encounter for prophylactic removal of fallopian tube(s)

New codes have been added to code section Z71.8 (Other specified counseling) to add specific codes for exercise counseling and nonprocreative genetic counseling.

**New code(s)**  
Z71.82  Exercise counseling  
Z71.83  Encounter for nonprocreative genetic counseling

The code description for Code Z79.890 (Hormone replacement therapy (postmenopausal)) has been revised to remove the word “postmenopausal” from the description.

**Revised code:** Z79.890  Hormone replacement therapy
Other Code Changes For 2018

Several new codes have been added to ICD-10-CM Chapter 5, (Mental, Behavioral and Neurodevelopmental Disorders), code block F10-F19, (Mental and behavioral disorders due to psychoactive substance use), to describe substance abuse in remission.

New code(s)  | F10.11       | Alcohol abuse, in remission  
            | F11.11       | Opioid abuse, in remission  
            | F12.11       | Cannabis abuse, in remission  
            | F13.11       | Sedative, hypnotic or anxiolytic abuse, in remission  
            | F14.11       | Cocaine abuse, in remission  
            | F15.11       | Other stimulant abuse, in remission  
            | F16.11       | Hallucinogen abuse, in remission  
            | F18.11       | Inhalant abuse, in remission  
            | F19.11       | Other psychoactive substance abuse, in remission

Code section K56.5 (Intestinal adhesions [bands] with obstruction (postprocedural) (postinfection)) and K56.6 (Other and unspecified intestinal obstruction) have been expanded to add new codes that specify partial and complete obstruction and to remove references to post procedural and other obstructions.

Revised code section: K56.5  
New code(s)  | K56.50       | Intestinal adhesions [bands], unspecified as to partial versus complete obstruction  
            | K56.51       | Intestinal adhesions [bands], with partial obstruction  
            | K56.52       | Intestinal adhesions [bands] with complete obstruction

Code section  | K56.6        | Unspecified intestinal obstruction  
            | K56.60       | Unspecified intestinal obstruction

New code(s)  | K56.600      | Partial intestinal obstruction, unspecified as to cause  
            | K56.601      | Complete intestinal obstruction, unspecified as to cause  
            | K56.609      | Unspecified intestinal obstruction, unspecified as to partial versus complete obstruction  
            | K56.69       | Other intestinal obstruction

New code(s)  | K56.690      | Other partial intestinal obstruction  
            | K56.691      | Other complete intestinal obstruction  
            | K56.699      | Other intestinal obstruction unspecified as to partial versus complete obstruction
Code section K91.3 has been expanded to identify partial and complete postprocedural intestinal obstructions.

<table>
<thead>
<tr>
<th>Code section</th>
<th>K91.3</th>
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<tbody>
<tr>
<td><strong>New code(s)</strong></td>
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<td>K91.30</td>
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<tr>
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<td>K91.31</td>
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<td></td>
<td>K91.32</td>
<td>Postprocedural complete intestinal obstruction</td>
</tr>
</tbody>
</table>

A new code has been added to code section R06.0 (Dyspnea) to identify acute respiratory distress.

| New code | R06.03 | Acute respiratory distress |

The code description for Code Z68.1 (Body mass index (BMI) 19 or less, adult), has been revised to change “19” to “19.9”.

| Revised code: | Z68.1 | Body mass index (BMI) 19.9 or less, adult |