ICD-10-CM Coding Workshop (Chapters 14-17)

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Basic Coding Tips

• Start looking up the codes from the top down.
• Looking up codes from the middle of the page will lead you to the WRONG way!
• Use colored tabs to mark the alphabet and the sections.
• ALWAYS confirm your code in the Tabular.

Chapter 14

Diseases of the Genitourinary System

National Cancer Institute Alan Hoofring
DISEASES OF THE GENITOURINARY SYSTEM

- N00-N99
- Laterality in relation to: Kidneys/Ovaries
- Urosepsis is no longer classified in ICD-10-CM
- Five stages of Chronic kidney disease:
  - Stage 1 - Slight kidney disease with normal filtration
  - Stage 2 - Mild decrease in kidney function
  - Stage 3 - Moderate decrease in kidney function
  - Stage 4 - Severe decrease in kidney function
  - Stage 5 - End stage/Kidney Failure

Additional Codes Required

- Code also underlying condition
  - N17 Acute Kidney Failure
  - N18 Chronic Kidney Disease
  - N30 Cystitis
  - N31 Neurovascular dysfunction of bladder
  - N40.1 Enlarged prostate with LUTS

- Code first etiology
  - N18 Chronic Kidney Disease
  - N30 Cystitis

- Additional code infectious agent
  - N30 Cystitis

- Additional code urinary incontinence
  - N30 Cystitis

- Additional code underlying disease
  - N30 Cystitis

- Additional code for associated symptoms
  - N40.1 Enlarged prostate with LUTS

CASE 14.1

Assign the code(s) for the following diagnosis: Premenopausal menorrhagia.

N92.4 Menorrhagia (primary), preclimacteric or premenopausal
CASE 14.2
Hypertension in a patient with end stage renal disease, both as a result of long-term stimulant abuse.

Assign the appropriate diagnosis code(s):
I12.0 Hypertension, hypertensive, (accelerated) (benign) (essential) (idiopathic) (malignant) (systemic), with, kidney involvement—see hypertension, kidney, with, stage 5 chronic kidney disease (CKD) or end stage renal disease (ESRD)
N18.6 Disease, diseased, renal (functional) (pelvis), end-stage (failure)
F15.10 Abuse, drug, stimulant, NEC

CASE 14.3
This 30-year-old female was seen with frequent urination with pain. Diagnosis: Acute suppurative cystitis, with hematuria due to E. Coli. What diagnosis codes are assigned?

N30.01 Cystitis (exudative) (hemorrhagic) (septic) (suppurative), acute, with hematuria
B96.20 Escherichia (E.) coli, as cause of disease classified elsewhere

CASE 14.4
Code for the following diagnosis:
Acute vaginitis, unknown agent

N76.0 Vaginitis (acute) (circumscribed) (diffuse) (empysematous) (non-venereal) (ulcerative)
ICD-10-CM

PREGNANCY, CHILDBIRTH AND THE PUEPERIUM

Chapter 15

Codes from this chapter are for use only on Maternal Records, never on Newborn Records.

For use for conditions related to or aggravated by the pregnancy, childbirth, or the puerperium (maternal causes or obstetric causes).

Have sequencing priority.

Exception: Pregnancy incidental to reason for encounter (Z33.1)

Category Z3A - Weeks of Gestation, added to identify specific week of pregnancy.

TRIMESTERS

• Trimester is the Axis of Classification - Documentation Required
• Counted from the first day of the last menstrual period
• Inpatient - Choose trimester when complication developed
• Outpatient - Choose trimester patient is currently seeking care
• Not all conditions include codes for Trimester identification

1st
Less than 14 weeks 0 days

2nd
14 weeks 0 days to less than 28 weeks 0 days

3rd
28 weeks 0 days until delivery
New 7th Character for Fetus Identification

• When applicable, a 7th character is to be assigned for certain categories to identify the fetus for which the complication code applies.

• Assign 7th character “0”:
  - For single gestations
  - When the documentation is insufficient to determine the fetus affected and it is not possible to obtain clarification
  - When it is not possible to clinically determine which fetus is affected

NORMAL DELIVERY

• Code O80 is used if no known antepartum or postpartum complications are affecting Mother at time of delivery and encounter.

• Normal Delivery includes spontaneous, cephalic, vaginal, episiotomy. Vacuum extractions are not included.

• No other Chapter 15 codes may be used

• Can only reflect Outcome of delivery Z37.0 – for a Single live birth
CESAREAN SECTION DELIVERY

• Principal diagnosis should reflect reason for Cesarean Section unless patient is admitted for unrelated reason to the performance of the C-section.

• O82 is used when there is no documented indication for cesarean section.

POSTPARTUM

• Codes O85-O92

• Begins at the time of delivery and extends to six-weeks following any type of delivery.

• Chapter 15 codes can be used beyond six-week period if documentation states condition is pregnancy-related.

SCENARIO 15.1

This 34-year-old woman, who is G4, P3, 28 weeks, is seen today for continued follow-up of her gestational diabetes. Her diabetes has been well controlled on oral medications. What is the correct diagnosis code?

O24.419 Pregnancy (single) (uterine), complicated by (care of) (management affected by), diabetes (mellitus), gestational (pregnancy induced) see Diabetes, gestational (in pregnancy)

Z3A.28 Pregnancy (single) (uterine), weeks of gestation, 28 weeks
SCENARIO 15.2

During a routine maternal health clinic visit, a 23-year-old female, in her 2nd trimester and who has already been diagnosed with gestational diabetes, is also diagnosed with eclampsia. Assign the appropriate diagnosis code(s).

O15.02 Eclampsia in pregnancy, second trimester
O24.419 Gestational diabetes mellitus in pregnancy, unspecified control

SCENARIO 15.3

This 24-year-old woman is 3 weeks postpartum and seen today for breast pain. Final diagnosis documented as nonpurulent postpartum mastitis. What is the correct code?

O91.22 Mastitis (acute) (diffuse) (nonpuerperal) (subacute), obstetric (interstitial) (nonpurulent), associated with, puerperium

SCENARIO 15.4

Code the following diagnosis code(s): 20 week pregnancy with low weight gain and pre-existing essential hypertension complicating the pregnancy.

O26.12 Pregnancy (single) (uterine), complicated by (care of) (management affected by), insufficient, weight gain.
O10.012 Pregnancy (single) (uterine), complicated by (care of) (management affected by), hypertension, see Hypertension, complicating, pregnancy, pre-existing, essential.
Z3A.20 Pregnancy (single) (uterine), weeks of gestation, 20 weeks
This 36-year-old G2 P1 woman is 26-weeks pregnant and being seen for gestational hypertension. At this time, she is not having any other problems. What is the correct diagnosis code(s)?

- O13.2 Pregnancy (single) (uterine), complicated by (care of) (management affected by), hypertension – see Hypertension, complicating, pregnancy, gestational (pregnancy induced) (transient) (without proteinuria)
- O09.522 Pregnancy (single) (uterine), complicated by (care of) (management affected by), elderly, multigravida
- Z3A.26 Pregnancy (single) (uterine), weeks of gestation, 26 weeks
INTRODUCTORY NOTES

• Codes from this chapter are for use on newborn records only, never on maternal records.
• Includes conditions that have their origin in the fetal or perinatal period (before birth through the first 28 days after birth) even if morbidity occurs later.


BLOCK P00-P04

• For use when the listed maternal conditions are specified as the cause of confirmed morbidity or potential morbidity that have their origin in the perinatal period.
• For use for newborns who are suspected of having an abnormal condition resulting from exposure from the mother or the birth process, but without signs or symptoms, and which after examination and observation is found not to exist.
• May be used even if treatment is begun for a suspected condition that is ruled out.

Newborn affected by maternal factors and complications of pregnancy, labor, and delivery.

CATEGORIES P07 AND P08

• Note: When both birth weight and gestational age of the newborn are available, both should be coded, with birth weight sequenced before gestational age.

Disorders related to short gestation/low birth weight and long gestation/high birth weight.
Classifies Liveborn Infants by:

- Place of birth
- Type of delivery
- Initial record of a newborn baby
- Mother record

PERINATAL Z CODES

- Z00.1xx Health examination, under 29 days old (age specific)
- Z13. XXX Encounter for screenings
- Z28.xx Immunizations not carried out
- Z38 Birth episode code for newborn (assigned only once)
- Z38 is not to be used by the transfer facility when newborn is transferred to that facility (only used by birth facility)

SCENARIO 16.1

Assign the code(s) for the following diagnosis: 20-day-old infant was admitted with Staphylococcus aureus sepsis.

P36.2 Newborn, (infant) (liveborn) (singleton), sepsis (congenital), due to Staphylococcus aureus
SCENARIO 16.2

This full-term newborn was delivered four days ago and she was discharged with no problems. After going home she was noticed to be somewhat jaundiced, and her mother brought her to the pediatrician’s office. She was diagnosed with hyperbilirubinemia and will have phototherapy provided at home. What diagnosis codes are assigned?

P59.9 Newborn (infant) (liveborn) (singleton), hyperbilirubinemia

SCENARIO 16.3

This full-term female infant was born in this hospital by vaginal delivery. Her mother has been an alcoholic for many years and would not stop drinking during her pregnancy. The baby was born with fetal alcohol syndrome and was placed in the NICU. What diagnosis codes are assigned?

Z38.00 Newborn (infant) (liveborn) (singleton), born in hospital
Q86.0 Syndrome, fetal, alcohol (dysmorphic)

SCENARIO 16.4

Mother brings in her 27 day old newborn in for routine first month newborn appointment and HepB immunization. The mother also noted that the baby had not had a wet diaper in the last 24-hours and was diagnosed with dehydration. Assign the appropriate diagnosis code(s):

Z00.111 Newborn health examination
Z23 Encounter for immunizations
P74.1 Dehydration of newborn
Chapter 17

ICD-10-CM

CONGENITAL MALFORMATIONS, DEFORMATIONS AND CHROMOSOMAL ABNORMALITIES

These codes are assigned when a malformation or deformation or chromosomal abnormality is documented. Code may be principal or first listed diagnosis or secondary diagnosis.

When no unique code is available, assign additional code(s) for any manifestations. When the code assignment specifically identifies the malformation, deformation, or chromosomal abnormality, manifestations that are an inherent component of the anomaly should not be coded separately. Additional codes should be assigned for manifestations that are not an inherent component.
CONGENITAL MALFORMATION

- Chapter 17 codes may be used throughout the life of the patient
- If congenital malformation has been corrected, a personal history code should be used
- Although present at birth, abnormality may not be identified until later in life, and if diagnosed by physician, assign a code from codes Q00-Q99

For birth admission:
- The appropriate code from category Z38, Liveborn infants, according to place of birth and type of delivery, should be sequenced as the principal diagnosis
  - Followed by any congenital anomaly codes, Q00-Q89

SCENARIO 17.1
Assign the code for the following diagnosis: Frontal encephalocele with hydroencephalocele.

Q01.0 Encephalocele, frontal
SCENARIO 17.2
Assign the code(s) for the following diagnosis: Cleft palate involving both the soft and hard palate, with bilateral cleft lip.

Q37.4 Cleft, (congenital) lip (unilateral), bilateral, with cleft palate, hard with soft

SCENARIO 17.3
Assign the code(s) for the following diagnosis: Penoscrotal hypospadias.

Q54.2 Hypospadias, penoscrotal

SUMMARY
- There are many new changes in ICD-10-CM and learning the new guidelines will be imperative!
- Focus on Specific Guidelines that you will use frequently.
- Training is Critical to Practice!
ICD-10-CM SUMMARY & TIPS

1. Productivity Impact to Coding Process
2. Translation Needs to Support ICD-10 Coding
3. Specificity and Physician Documentation
4. Education needs for Staff and Physicians
5. Process Changes in Functional Areas
6. System Readiness

NEXT STEPS

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PCPW5