PREPARING FOR ICD-10-CM

OB/ GYN SPECIALTY TRAINING

PART 2

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REPORTING COMPLICATIONS IN ICD-10-CM

Introduction/Overview
In ICD-9-CM, the opportunity to report complications is both limited and generic. In ICD-10-CM, the reporting of complications is very different because:

• They are far more detailed—ICD-10-CM has multiple options that are rolled into a single code in ICD-9-CM.
• There are multiple sections—usually divided by organ system-specific complications.
• They are organized in a far more logical fashion

In ICD-9-CM, codes are scattered throughout the book, but are not always identified as complications. There is only section in ICD-9-CM that is uniquely associated with “complications.” The categories are as follows:

• 996-Complications peculiar to certain specified procedures
• 997-Complications affecting specified body systems, not elsewhere classified
• 998-Other complications of procedures, NEC
• 999-Complications of medical care, not elsewhere classified

In ICD-10-CM, there are “complications” sections in multiple organ system chapters. Those chapters that report conditions that may be treated via a procedure or operation give the user the opportunity to report whether it is a postprocedural complication, and intraoperative complication, or a postoperative complication.

The sections that have these types of categories are as follows:

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Category</th>
<th>Description</th>
<th>Chapter</th>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>E89</td>
<td>Postprocedural endocrine and metabolic complications and disorders, not elsewhere classified</td>
<td>10</td>
<td>J95</td>
<td>Intraoperative and postprocedural complications and disorders of respiratory system, not elsewhere classified</td>
</tr>
<tr>
<td>Chapter</td>
<td>Section</td>
<td>Description</td>
<td>Chapter</td>
<td>Section</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
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<td>-------------</td>
</tr>
<tr>
<td>6</td>
<td>G97</td>
<td>Intraoperative and postprocedural complications and disorders of nervous system, not elsewhere classified</td>
<td>11</td>
<td>K91</td>
<td>Intraoperative and postprocedural complications and disorders of digestive system, not elsewhere classified</td>
</tr>
<tr>
<td>7</td>
<td>H59</td>
<td>Intraoperative and postprocedural complications and disorders of eye and adnexa, not elsewhere classified</td>
<td>13</td>
<td>M96</td>
<td>Intraoperative and postprocedural complications and disorders of musculoskeletal system, not elsewhere classified</td>
</tr>
<tr>
<td>8</td>
<td>H95</td>
<td>Intraoperative and postprocedural complications and disorders of ear and mastoid process, not elsewhere classified</td>
<td>14</td>
<td>N99</td>
<td>Intraoperative and postprocedural complications and disorders of genitourinary system, not elsewhere classified</td>
</tr>
<tr>
<td>9</td>
<td>I97</td>
<td>Intraoperative and postprocedural complications and disorders of circulatory system, not elsewhere classified</td>
<td>15</td>
<td>O99</td>
<td>Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth, and the puerperium</td>
</tr>
</tbody>
</table>
There is another specific block of codes in Chapter 19 (T80-T88-Complications of surgical and medical care, not elsewhere specified). This block is used when the patient has an issue that is directly related to medical services, but don’t necessarily fit within the context of the organ system-specific complication sections. The instructions at the beginning of this code block indicate that these codes are to be used as secondary diagnoses if there is an organ system-specific section that is applicable. If not, then these codes are used as primary diagnoses. T80-T88 is used for all kinds of medical/surgical complications. Therefore, for the purpose of this training, we will only look at those codes that are applicable to OB/GYN providers.

These codes (T80-T88) are unique because all of them require a 7th character. The 7th character will be either:
- A = Initial encounter
- D = Subsequent encounter
- S = Sequela

**N99-Introperative and postprocedural complications and disorders of genitourinary system, not elsewhere classified**

<table>
<thead>
<tr>
<th>Sub-category</th>
<th>Description</th>
<th>Sub-category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N99.0</td>
<td>Postprocedural (acute) (chronic) kidney failure</td>
<td>N99.5-</td>
<td>Complications of stoma of urinary tract</td>
</tr>
<tr>
<td>N99.1-</td>
<td>Postprocedural urethral stricture</td>
<td>N99.6-</td>
<td>Intraoperative hemorrhage and hematoma of a genitourinary system organ or structure complicating a procedure</td>
</tr>
<tr>
<td>N99.2</td>
<td>Postprocedural adhesions of vagina</td>
<td>N99.7-</td>
<td>Accidental puncture and laceration of a genitourinary system organ or structure during a procedure</td>
</tr>
<tr>
<td>N99.3</td>
<td>Prolapse of vaginal vault after hysterectomy</td>
<td>N99.8-</td>
<td>Other intraoperative and postprocedural complications and disorders of genitourinary system</td>
</tr>
</tbody>
</table>
This category encompasses complications of both the urinary and genital systems. The first sub-category that we will consider is **N99.2-Postprocedural adhesions of vagina.** This is a fairly rare condition following surgical or procedural services. It is different than pre-pubescent vaginal adhesions, which are more common. That condition is reported using ICD-10-CM code Q52.5-Fusion of labia or Q52.4-Other congenital malformations of vagina.

The presence of **N99.3-Prolapse of vaginal vault after hysterectomy** reveals a weakness in the design of ICD-10-CM. Prolapse of the pelvic organs is not uncommon following a hysterectomy. Sometimes it occurs shortly after the procedure and on other occasions it happens years after the hysterectomy. When it happens long after the procedure, it really should not be considered a “complication” of the procedure.

Unfortunately, for now, this code is to be used any time the patient has a prolapse after they have had a hysterectomy, regardless of the exact timing of the procedure relative to the prolapse.

**N99.4-Postprocedural pelvic peritoneal adhesions** is used to report a common complication that occurs following abdominal procedures. Adhesions can occur in three circumstances:

- Post-procedural
- Post-infection
- No particular etiology
There is a single code (N73.6) to report when the patient’s adhesions are unexplained or are due to a known pelvic/abdominal infection. Ultimately, it is the provider’s responsibility to determine code assignment in this area because only they are going to have the clinical knowledge of the patient necessary to make the decision. Therefore, the correct code(s) and the possible scenarios are:

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adhesion without a procedure or known infection</td>
<td>N73.6</td>
</tr>
<tr>
<td>Adhesions due to a known infection</td>
<td>N73.6</td>
</tr>
<tr>
<td>Adhesions due to a previous procedure</td>
<td>N99.4</td>
</tr>
<tr>
<td>Adhesions due to both an infection and a procedure</td>
<td>N73.6 &amp; N99.4</td>
</tr>
</tbody>
</table>

There are three broad categories of procedure-related complications. They are:
- N99.6 Intraoperative hemorrhage and hematoma of genitourinary system organ or structure complicating a procedure
- N99.7 Accidental puncture and laceration of a genitourinary system organ or structure during a procedure
- N99.8 Other intraoperative and postprocedural complications and disorders of genitourinary system

The type and timing of the complication will help determine which specific code is selected. Another factor is the type of procedure that is being performed:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Puncture/ laceration</th>
<th>Intraoperative</th>
<th>Postprocedural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genitourinary Procedure</td>
<td>N99.71</td>
<td>N99.61</td>
<td>N99.820</td>
</tr>
<tr>
<td>Other Procedure</td>
<td>N99.72</td>
<td>N99.62</td>
<td>N99.821</td>
</tr>
</tbody>
</table>

Imagine if a general surgeon is performing a cholecystectomy and, in the process, accidentally nicks the patient’s fallopian tube. A gynecologist is called in to repair the laceration. The primary diagnosis for the gynecologist would be **S37.531A- Laceration of fallopian tube, unilateral, initial encounter**, but the secondary diagnosis would be **N99.72—Accidental puncture and laceration of a genitourinary system organ or structure during other procedure**. This code would be used because the original procedure was not genitourinary in its original purpose.
The reason for the distinctions is to clearly define responsibility for surgery or procedure-related problems.

There are three other codes that can be used to describe genitourinary system complications. They are:

- N99.81 Other intraoperative complications of genitourinary system
- N99.83 Residual ovary syndrome
- N99.89 Other postprocedural complications and disorders of genitourinary system

Codes N99.81 and N99.89 should be used as a last resort because most complications can be successfully reported with one of the other, more specific codes.

**Call for Documentation Specificity**

- If adhesions exist, is there a known cause? If so, what is it?
  - Unknown?
  - Infection?
  - Procedural?
- If a complication occurs related to a surgical procedure, is it:
  - Intraoperative?
  - Postoperative?
  - A puncture or laceration?
  - Was it associated with a genitourinary system procedure, or some other procedure?

**T80-T88 Complications of surgical and medical care, not elsewhere classified**

As mentioned previously, all codes in this code block require a 7th character. However, in many cases, the individual codes do not have six characters in them. Some of them have as few as 4 or 5 characters. When that happens, it is necessary to add “placeholders” to facilitate a 7th character. For example:

- T83.6XXA Infection and inflammatory reaction due to prosthetic device, implant and graft in genital tract, initial encounter
- T83.39XA Other mechanical complication of intrauterine contraceptive device, initial encounter
- T83.418A Breakdown (mechanical) of other prosthetic devices, implants and grafts of genital tract, initial encounter.

Placeholders ("X") are necessary only when the base code has less than 6 characters.
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T80</td>
<td>Complications following infusion, transfusion, and therapeutic injections</td>
<td>T85</td>
<td>Complications of other internal prosthetic devices, implants, and grafts</td>
</tr>
<tr>
<td>T81</td>
<td>Complications of procedures, not elsewhere classified</td>
<td>T86</td>
<td>Complications of transplanted organs and tissue</td>
</tr>
<tr>
<td>T82</td>
<td>Complications of cardiac and vascular prosthetic devices, implants and grafts</td>
<td>T87</td>
<td>Complications peculiar to reattachment and amputation</td>
</tr>
<tr>
<td>T83</td>
<td>Complications of genitourinary prosthetic devices, implants, and grafts</td>
<td>T88</td>
<td>Other complications of surgical and medical care, not elsewhere classified</td>
</tr>
<tr>
<td>T84</td>
<td>Complications of internal orthopedic prosthetic devices, implants and grafts</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The possible 7th characters for this code block are:
- **A** Initial encounter. This means “active treatment”—surgical treatment, emergency department, evaluation and treatment by new physician.
- **D** Subsequent encounter. This means “after care”—cast change, medication adjustment, follow up visits, etc.
- **S** Sequela. This means “complications or conditions that are a direct result of a condition.” The most common sequela are the motor-neurological defects that result from a stroke, often long after the stroke event is over. Perhaps the best example of a sequela in the field of gynecology would be a patient who has continued fecal incontinence years after a 4th degree laceration during a delivery occurred.

This seventh character is important in order to capture the nature of the encounters and to have a better understanding of how many follow up visits are necessary to address the specific conditions.

After reviewing the categories in this block, it is obvious that not every block would be used in the practice of gynecology. In fact, a fairly limited number of codes will be used by gynecologists. Let’s review those specific codes.
• T80.4--- Rh incompatibility reaction due to transfusion of blood or blood products
• T81.31X- Disruption of external operation (surgical) wound, not elsewhere classified
• T81.32X- Disruption of internal operation (surgical) wound, not elsewhere classified
• T81.4XX- Infection following a procedure
• T81.5-0- Complications of foreign body accidentally left in body following procedure

The instructions for code T81.4XX- indicate that an additional code is to be supplied as a secondary diagnosis to indicate the particular cause of the infection. Additionally, if the patient has severe sepsis (R65.2-), that diagnosis should also be reported. This code should not be used if any of the following circumstances are present.
• Obstetric wound (O86.0)
• Postprocedural fever (R50.82)
• Postprocedural retroperitoneal abscess (K68.11)

For the code beginning with T81.5, the 5th character will vary to indicate the particular complication that is resulting from the foreign body.

| 0 | Unspecified |
| 1 | Adhesions |
| 2 | Obstruction |
| 3 | Perforation |
| 9 | Other specified |

<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>Description</th>
<th>Sub-Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T83.0-</td>
<td>Mechanical complication of urinary (indwelling) catheter</td>
<td>T83.5-</td>
<td>Infection and inflammatory reaction due to indwelling urinary catheter</td>
</tr>
<tr>
<td>T83.1-</td>
<td>Mechanical complication of other urinary devices and implants</td>
<td>T83.6-</td>
<td>Infection and inflammatory reaction due to prosthetic device, implant, and graft in genital tract</td>
</tr>
<tr>
<td>T83.2-</td>
<td>Mechanical complication of graft of urinary organ</td>
<td>T83.7-</td>
<td>Complications due to implanted mesh and other prosthetic materials</td>
</tr>
</tbody>
</table>

Billing and Coding Experts for OB/GYN Specialists
<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>Description</th>
<th>Sub-Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T83.3-</td>
<td>Mechanical complication of intrauterine contraceptive device</td>
<td>T83.8-</td>
<td>Other specified complications of genitourinary prosthetic devices, implants, and grafts</td>
</tr>
<tr>
<td>T83.4-</td>
<td>Mechanical complication of other prosthetic devices, implants and grafts of genital tract</td>
<td>T83.9</td>
<td>Unspecified complication of genitourinary prosthetic device, implant and graft</td>
</tr>
</tbody>
</table>

Gynecologists will use two portions of category T83—T83.3- and T83.71-.

The services described in subcategory T83.3- are all related to complications of an intrauterine device (IUD). There are three categories:

- T83.31 Breakdown (mechanical) of intrauterine contraceptive device
- T83.32 Displacement of intrauterine contraceptive device
- T83.39 Other mechanical complication of intrauterine contraceptive device

The inclusion terms associated with T83.39 are “obstruction,” “perforation,” and “protrusion.” This code should be used if any of these conditions are present, related to the IUD.

T83.4- is not used by gynecologists as it is unique to the male reproductive system.

The table below illustrates the usage of the codes connected with T83.71-. The primary difference between codes is whether or not the mesh has eroded or is exposed and where the mesh has moved to—to surrounding organs or tissues or into the vagina.

<table>
<thead>
<tr>
<th></th>
<th>To surrounding organ or tissue</th>
<th>Into vagina</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erosion</td>
<td>T83.711-</td>
<td>T83.721-</td>
</tr>
<tr>
<td>Exposure</td>
<td>T83.718-</td>
<td>T83.728-</td>
</tr>
</tbody>
</table>
Call for Documentation Specificity

- If a postprocedural infection occurs, what is the cause of the infection?
- If there is a postprocedural encounter for a complication, what type of encounter is it?
  - Initial?
  - Subsequent?
  - Sequela?
- If a foreign body is left behind following a procedure, what are the precise complications caused by it?
- If there is a problem with an IUD, what is the specific complication?
- If there is a problem with mesh, is it:
  - Eroded?
  - Exposed?
    - Into the vagina?
    - Into other tissues/organs?

CHAPTER 21: FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVICES (Z00-Z99)

Introduction/Overview

Not every encounter with a health care provider occurs because an illness, injury, or disease is present or because the patient is having some sort of signs or symptoms that need further investigation. The purpose of Chapter 21 codes (Z00-Z99) are to give the opportunity to explain why the patient is presenting for service and/or to give context to the patient’s condition and the possible reasons the patient is receiving care.

These codes are the equivalent of the “V” codes in ICD-9-CM. They can be used in any health care setting and they can be either a primary or a secondary diagnosis code. It is important to bear in mind that these are not procedure codes. In order to be used properly, these codes have to be associated with the appropriate CPT or HCPCS code(s).

In instructions preceding Chapter 21, the codes are sorted into a number of categories, based on their purpose.
The individual categories will be addressed as each block is reviewed. In this particular phase of the training, codes related to reproduction will be discussed to the degree that they are used by gynecologists. Codes that are explicitly related to pregnancy and obstetric care (including the relevant codes in Chapter 21) will be discussed in the next phase of this training.
<table>
<thead>
<tr>
<th>Blocks</th>
<th>Description</th>
<th>Blocks</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z00-Z13</td>
<td>Persons encountering health services for examinations</td>
<td>Z40-Z53</td>
<td>Encounters for other specific health care</td>
</tr>
<tr>
<td>Z14-Z15</td>
<td>Genetic carrier and genetic susceptibility to disease</td>
<td>Z55-Z65</td>
<td>Persons with potential health hazards related to socioeconomic and psychosocial circumstances</td>
</tr>
<tr>
<td>Z16</td>
<td>Resistance to antimicrobial drugs</td>
<td>Z66</td>
<td>Do not resuscitate status</td>
</tr>
<tr>
<td>Z17</td>
<td>Estrogen receptor status</td>
<td>Z67</td>
<td>Blood type</td>
</tr>
<tr>
<td>Z18</td>
<td>Retained foreign body fragments</td>
<td>Z68</td>
<td>Body mass index (BMI)</td>
</tr>
<tr>
<td>Z20-Z28</td>
<td>Persons with potential health hazards related to communicable diseases</td>
<td>Z69-Z76</td>
<td>Persons encountering health services in other circumstances</td>
</tr>
<tr>
<td>Z30-Z39</td>
<td>Persons encountering health services in circumstances related to reproduction</td>
<td>Z77-Z99</td>
<td>Persons with potential health hazards related to family and personal history and certain conditions influencing health status</td>
</tr>
</tbody>
</table>

### Z00-Z13-Persons encountering health services for examinations

One of the most significant changes between ICD-9-CM and ICD-10-CM is the fact that gynecologists (and providers in other specialties) can make the distinction between a “normal” administrative exam and a “normal” administrative exam with “abnormal” findings. In ICD-9-CM, it was not possible to clearly indicate that preventive medicine or administrative service occurred with a concurrent problem.

The last character defines whether the patient had the service with or without abnormal findings. Unfortunately, the patterns are not consistent throughout ICD-10. There are two distinct code patterns:

- **Z00 and Z01 (Adult medical examinations/Other special examinations)**
  - XXX.X0 = without abnormal findings
  - XXX.X1 = with abnormal findings
- **Z00.12- and Z01.41- (Routine child health exams/Routine gynecological exams)**
  - XXX.XX1 = with abnormal findings
  - XXX.XX9 = without abnormal findings
The routine child health exams and routine gynecological exams have their own patterns, while other administrative exams follow the first pattern.

The most common services that will be used by gynecologists are:

- Z01.411—Encounter for gynecological exam (general) (routine) with abnormal findings
- Z01.419—Encounter for gynecological exam (general) (routine) without abnormal findings

According to the guidelines, it is not necessary to report component parts of procedures that typically occur during a service. That means that it is not necessary to use a pap smear diagnosis (V12.4-cervical smear or V12.72-vaginal smear) code when a Z01.41-code is reported. However, given the changing nature of clinical pap smear guidelines, it may be advantageous to do so because more and more preventive medicine services don’t have a pap smear included. The use of the pap smear codes would easily indicate which encounters had pap smears and which ones did not.

Other administrative codes that will be commonly used by gynecologists include:

Preoperative services
- Z01.812—Encounter for preprocedural laboratory examination
- Z01.818—Encounter for other preprocedural examination

Screening services (infectious and parasitic disease)
- Z11.3—Encounter for screening for infections with a predominantly sexual mode of transmission
- Z11.4—Encounter for screening for HIV (not included in Z11.3)
- Z11.51—Encounter for screening for HPV
- Z11.59—Encounter for screening for other viral diseases

Screening services (malignant neoplasms)
- Z12.31—Encounter for screening mammogram for malignant neoplasm of breast
- Z12.39—Encounter for other screening for malignant neoplasm of breast
- Z12.4—Encounter for screening for malignant neoplasm of cervix
- Z12.72—Encounter for screening for malignant neoplasm of vagina
- Z12.73—Encounter for screening for malignant neoplasm of ovary
- Z12.79—Encounter for screening for malignant neoplasm of other sites

Z14-Z15-Genetic carrier and genetic susceptibility to disease
The codes in this particular category are almost always used as a secondary diagnosis to provide an explanation as to why a particular service may be provided, which typically would not be provided.

A genetic carrier is a person who does not have a particular disease. However, if they are a carrier of the disease, if they procreate with another carrier of the disease, there
is a high probability that their child would have the disease. In most cases, these diseases are quite serious, if not life-threatening. There are three categories for genetic carrier status:

- **Z14.0** Hemophilia A carrier
  - **Z14.01** Asymptomatic hemophilia A carrier
  - **Z14.02** Symptomatic hemophilia A carrier
- **Z14.1** Cystic fibrosis carrier
- **Z14.8** Genetic carrier of other disease

The category for **Z15-Genetic susceptibility to disease** will be used more and more as understanding and insurance coverage related to the nature of genetic disease increases. The guidelines for this category have four very specific instructions:

1. A code from this section should not be used if the patient has a known chromosomal abnormality
2. If the patient has a family history of the disease, it should be reported appropriately.
3. If the patient has a current neoplasm, that should be the primary diagnosis.
4. If the patient has a personal history of a malignant neoplasm, that should be reported, in addition to the genetic susceptibility.

There are two categories of genetic susceptibility—susceptibility to malignant neoplasms and susceptibility to other diseases.

- **Z15.0** Genetic susceptibility to malignant neoplasm
  - **Z15.01** Breast
  - **Z15.02** Ovary
  - **Z15.03** Prostate
  - **Z15.04** Endometrium
  - **Z15.09** Other malignant neoplasm
- **Z15.8** Genetic susceptibility to other disease
  - **Z15.81** Multiple endocrine neoplasia (MEN)
  - **Z15.89** Other disease

**Z17-Estrogen receptor status**

This category is very limited in both the number of codes and its scope of use. The rules concerning this category are:

1. These diagnoses can only be used as a secondary diagnosis
2. The primary diagnosis can only be a malignant neoplasm of the breast (C50.-)

The two codes in this category are:

- **Z17.0** Estrogen receptor positive status
- **Z17.1** Estrogen receptor negative status
Z20-Z28-Persons with potential health hazards related to communicable diseases

The ICD-10-CM codes in this code block are used when a patient does not present with any particular signs or symptoms, but they believe there is a possibility that they have been exposed to a communicable disease, either by being:

- In close personal contact with an infected individual (or someone who may be infected)
- Located in an area where the disease is epidemic

When choosing whether to use a code from this category or a screening code (such as Z11.3), the appropriate code from this category should be used if there is a particular incident or person with whom/which the risk is associated. If the testing is being done because of general risk factors, then the screening code should be used.

There are five broad categories that will be used by OB/GYN providers. They are:

- Z20 Contact with and (suspected) exposure to communicable diseases
- Z21 Asymptomatic HIV infection status
- Z22 Carrier of infectious disease
- Z23 Encounter for immunization
- Z28 Immunization not carried out and underimmunization status

Category Z20 has seven codes that will be used frequently by providers in women’s health when the patient has been potentially exposed to a communicable disease. They are:

- Z20.2 Infections with a predominantly sexual mode of transmission
- Z20.4 Rubella
- Z20.5 Viral hepatitis
- Z20.6 HIV
- Z20.818 Other bacterial communicable diseases
- Z20.820 Varicella
- Z20.828 Other viral communicable diseases

Z21 is used to report circumstances in which the patient has a known HIV infection, but is currently asymptomatic. Ultimately, the provider determines whether the patient’s condition is reported with diagnosis code B20 (active/current HIV) or Z21.

In ICD-9-CM, there were four different categories and multiple diagnosis codes to be used in conjunction with vaccinations and other inoculations. The ICD-9-CM categories are:

- Need for prophylactic vaccination and inoculation against
  - V03 Bacterial diseases
  - V04 Certain diseases
  - V05 Single diseases
  - V06 Combinations of diseases
In ICD-10-CM, a single code is used for any immunization services—**Z23—Encounter for immunization**. In reality, all of the individual diagnosis codes were unnecessary because the specific disease(s) for which immunizations were being provided are communicated through the CPT or HCPCS code. Reporting it through the diagnosis code was redundant.

The next category immediately following Z23 is **Z28-Immunization not carried out and underimmunization status**. This supplies the provider with a means by which to explain why immunizations typically done were not done. The general sub-categories within this category are:

- **Z28.0-** Contraindication
- **Z28.1** Reasons of belief or group pressure
- **Z28.2-** Other and unspecified reason
- **Z28.3** Underimmunization status
- **Z28.8-** Other reasons
  - **Z28.81** Patient had disease
  - **Z28.82** Caregiver refusal (Excludes1 for Z28.1)
  - **Z28.89** Other reasons

**Z30-Z39-Persons encountering health services in circumstances related to reproduction**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z30</td>
<td>Encounter for contraception management</td>
<td>Z36</td>
<td>Encounter for antenatal screening of mother</td>
</tr>
<tr>
<td>Z31</td>
<td>Encounter for procreative management</td>
<td>Z37</td>
<td>Outcome of delivery</td>
</tr>
<tr>
<td>Z32</td>
<td>Encounter for pregnancy test and childbirth and childcare instruction</td>
<td>Z38</td>
<td>Liveborn infants according to place of birth and type of delivery</td>
</tr>
<tr>
<td>Z33</td>
<td>Pregnant state</td>
<td>Z39</td>
<td>Encounter for maternal postpartum care and examination</td>
</tr>
<tr>
<td>Z34</td>
<td>Encounter for supervision of normal pregnancy</td>
<td>Z3A</td>
<td>Weeks of gestation</td>
</tr>
</tbody>
</table>

Obviously, the codes in this section are largely associated with obstetric care. However, the codes for contraception and infertility diagnosis/treatment are found here as well.
In this portion of the training, the focus will be on these services, as well as the diagnosis of pregnancy.

The organization of **Z30-Encounter for contraception management** is largely parallel to the organization of the comparable diagnoses in ICD-9-CM.

<table>
<thead>
<tr>
<th>Mode of Contraception</th>
<th>Initial Prescription</th>
<th>Surveillance of Contraceptives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive Pills</td>
<td>Z30.011</td>
<td>Z30.41</td>
</tr>
<tr>
<td>Injectable Contraceptive</td>
<td>Z30.013</td>
<td>Z30.42</td>
</tr>
<tr>
<td>Intrauterine Contraceptive Device (IUD)</td>
<td>Z30.014</td>
<td>Z30.43</td>
</tr>
<tr>
<td>Other Contraceptives</td>
<td>Z30.018</td>
<td>Z30.49</td>
</tr>
<tr>
<td>Unspecified Contraceptives</td>
<td>Z30.019</td>
<td>Z30.49</td>
</tr>
</tbody>
</table>

The three primary categories for contraception mode are contraceptive pills, injectable contraceptives, and IUDs. For other specific types of contraception (subcutaneous implants, vaginal inserts, etc.), diagnosis codes Z30.018 and Z30.49 should be used. The codes for unspecified contraceptives (Z30.019 and Z30.49) should be avoided because it is highly unlikely that a provider would not know what kind of contraceptive they prescribed or were surveilling.

There are other codes that will be used for contraception management:

- **Z30.02** Counseling and instruction in natural family planning to avoid pregnancy
- **Z30.09** Encounter for other general counseling and advice on contraception
- **Z30.2** Encounter for sterilization
- **Z30.8** Encounter for other contraceptive management
- **Z30.9** Encounter for contraceptive management, unspecified

Z30.09 should be used to report circumstances in which a discussion regarding contraception occurs, but no contraception is prescribed or surveilled. There is no compelling reason to use diagnosis code Z30.9 and the use of Z30.8 should be exceptionally rare.

**Z31-Encounter for procreative management** is used for three categories of service:

- Fertility reversal services
- Fertility testing (and related genetic testing services)
- Genetic counseling
• Fertility treatment

<table>
<thead>
<tr>
<th>Encounter for</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reversal of previous sterilization</td>
<td>Z31.0</td>
<td>Z31.0</td>
</tr>
<tr>
<td>Fertility testing</td>
<td>Z31.41</td>
<td>Z31.41</td>
</tr>
<tr>
<td>Aftercare following sterilization reversal</td>
<td>Z31.42</td>
<td>Z31.42</td>
</tr>
<tr>
<td>Genetic disease carrier status for procreative management</td>
<td>Z31.440</td>
<td>Z31.430</td>
</tr>
<tr>
<td>Genetic testing of male partner of patient with recurrent pregnancy loss</td>
<td>Z31.441</td>
<td>N/A</td>
</tr>
<tr>
<td>Other genetic testing for procreative management</td>
<td>Z31.448</td>
<td>Z31.438</td>
</tr>
</tbody>
</table>

The procreative management counseling services are reported as follows:

• Z31.5  Encounter for genetic counseling
• Z31.61 Procreative counseling and advice using natural family planning
• Z31.62 Encounter for fertility preservation counseling
• Z31.69 Encounter for other general counseling and advice on procreation

Codes to report fertility treatment are found in subcategory Z31.8-. They are:

• Z31.81 Encounter for male factor infertility in female patient
• Z31.82 Encounter for Rh incompatibility status
• Z31.83 Encounter for assisted reproductive fertility procedure cycle
• Z31.84 Encounter for fertility preservation procedure

Z31.81 is a code that does not have a comparable code in ICD-9-CM. For the first time, providers can specifically indicate that a female patient is being seen because of male factor infertility. If a patient is being treated for infertility (in a treatment cycle), ICD-10-CM code Z31.83 should be reported as the primary diagnosis and the type of infertility (N97.-) is the secondary diagnosis code. If the patient is undergoing pre-cycle diagnosis and testing, Z31.83 should not be used. In that case, the reason for that encounter should be used (e.g. Z31.41, Z31.43-, or Z31.44-).

The category for **Z32-Encounter for pregnancy test** is used when the patient presents with signs or symptoms of a pregnancy, but it has not yet been confirmed by a medical professional.

• Z32.0 Pregnancy test, result unknown
• Z32.1 Pregnancy test, result positive
• Z32.2 Pregnancy test, result negative
It is not appropriate to use the amenorrhea codes if there is known or suspected pregnancy because the codes for amenorrhea are in a block for “Noninflammatory disorders of the female genital tract.” If a patient is pregnant and not having a period, it is not a disorder—it is completely normal and to be expected. In addition, the clinical definition of amenorrhea is a patient who has missed three consecutive periods. It is improbable that a patient that is pregnant has not had a period in three or more months.

When reporting codes from the Z32.- series, the service should be separately payable by most insurers and not included as part of the global obstetric package. Z32 codes should not be used if supervision of the pregnancy takes place during the encounter. There is an Excludes1 note that precludes this because it is not possible to both diagnose and supervise a pregnancy during the same encounter.

**Z67-Blood type**

This code block may not be used frequently, but it is important in certain circumstances. All blood type codes are reported with the patient’s Rh status. The code pattern is:

- Z67.X0 = Rh positive
- Z67.X1 = Rh negative

The specific types are:

- Z67.1- Type A blood
- Z67.2- Type B blood
- Z67.3- Type AB blood
- Z67.4- Type O blood
- Z67.9- Unspecified blood type

**Z68-Body mass index (BMI)**

As the national BMI continues to increase, its effect on patient health is unquestionable. BMI becomes an important component of health care reporting, especially when the BMI adversely influences the patient’s condition.

BMI is sorted into two broad categories—pediatric (age 21 and under) and adult. For adults, the categories are sorted as follows:

- Z68.1 BMI, 19 or less, adult
- Z68.2 BMI, 20-29, adult
- Z68.3 BMI, 30-39, adult
- Z68.4 BMI, 40 or greater, adult
  - Z68.41 BMI 40.0-44.9, adult
  - Z68.42 BMI 45.0-49.9, adult
  - Z68.43 BMI 50.0-59.9, adult
• Z68.44    BMI 60.0-69.9, adult
• Z68.45    BMI 70 or greater, adult

For a patient with a BMI between 20 and 39 (Z68.2- and Z68.3-), the fifth character reflects the exact BMI level. For example, a patient with a BMI of 24.0 through 24.9 is reported with a diagnosis of Z68.24. A patient with a BMI of 37.8 would be reported with a diagnosis of Z68.37.

BMI will always be reported as a secondary diagnosis. If the patient has a high BMI, the primary diagnosis would be from Chapter 4 to report “overweight” or “obesity.”

**Z77-Z99-Persons with potential health hazards related to family and personal history and certain conditions influencing health status**

The block of codes represented by Z77-Z99 will be used by every specialty, including OB/GYN. Although there are a significant number of categories that will be used, there are generally just a handful of codes in each category that will be applicable.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z77</td>
<td>Other contact with and (suspected) exposures hazardous to health</td>
<td>Z85</td>
<td>Personal history of malignant neoplasm</td>
</tr>
<tr>
<td>Z78</td>
<td>Other specified health status</td>
<td>Z86</td>
<td>Personal history of certain other diseases</td>
</tr>
<tr>
<td>Z79</td>
<td>Long term (current) drug therapy</td>
<td>Z87</td>
<td>Personal history of other diseases and conditions</td>
</tr>
<tr>
<td>Z80</td>
<td>Family history of primary malignant neoplasm</td>
<td>Z88</td>
<td>Allergy status to drugs, medicaments and biological substances</td>
</tr>
<tr>
<td>Z81</td>
<td>Family history of mental and behavioral disorders</td>
<td>Z89</td>
<td>Acquired absence of limb</td>
</tr>
<tr>
<td>Z82</td>
<td>Family history of certain disabilities and chronic diseases (leading to disablement)</td>
<td>Z90</td>
<td>Acquired absence of organs, not elsewhere classified</td>
</tr>
<tr>
<td>Z83</td>
<td>Family history of other specific disorders</td>
<td>Z91</td>
<td>Personal risk factors, not elsewhere classified</td>
</tr>
<tr>
<td>Z84</td>
<td>Family history of other conditions</td>
<td>Z92</td>
<td>Personal history of medical treatment</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Category</td>
<td>Description</td>
</tr>
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</tr>
<tr>
<td>Z93</td>
<td>Artificial opening status</td>
<td>Z97</td>
<td>Presence of other devices</td>
</tr>
<tr>
<td>Z94</td>
<td>Transplanted organ and tissue status</td>
<td>Z98</td>
<td>Other postprocedural states</td>
</tr>
<tr>
<td>Z95</td>
<td>Presence of cardiac and vascular implants and grafts</td>
<td>Z99</td>
<td>Dependence on enabling machines and devices, not elsewhere classified</td>
</tr>
<tr>
<td>Z96</td>
<td>Presence of other functional implants</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The only code that will be used regularly in the Z78 category will be Z78.0-Asymptomatic menopausal state, to report the fact that the patient is menopausal, but is having no symptoms or other complications. A number of codes in the Z79 category will be used. In most cases, these “status” codes will indicate the patient’s use of certain medications that will influence the provider’s thinking about the patient’s particular health care needs and future medication options. The most common codes that will be used by gynecologists are:

- Z79.3 Long term (current) use of hormonal contraceptives
- Z79.4 Long term (current) use of insulin
- Z79.810 Long term (current) use of selective estrogen receptor modulators (SERMs)
- Z79.811 Long term (current) use of aromatase inhibitors
- Z79.818 Long term (current) use of other agents affecting estrogen receptors and estrogen levels
- Z79.890 Hormone replacement therapy (postmenopausal)

Family history categories are used to indicate that the patient is at increased risk for certain conditions because other family members have the condition. This may modify the way in which the patient’s care is managed.

- Z80 Family history of primary malignant neoplasm
  - Z80.3 Breast (C50.-)
  - Z80.41 Ovary (C56.-)
- Z82 Family history of certain disabilities and chronic disease
  - Z82.61 Family history of arthritis
  - Z82.62 Family history of osteoporosis
- Z83 Family history of other specific disorders
  - Z83.3 Diabetes
- Z84 Family history of other conditions
  - Z84.81 Family history of carrier of genetic disease
• Z84.89  Family history of other specified conditions

Personal history codes are used to report that the patient has had a condition in the past and that they do not have it at present. However, the patient does need supervision concerning that condition because it has the potential for returning. Typically, this will require more intensive supervision than would be expected for the typical patient.

• Z85  Personal history of malignant neoplasm
  • Z85.3  Breast
  • Z85.41  Cervix
  • Z85.42  Uterus
  • Z85.43  Ovary
  • Z85.44  Other female genital organs

• Z86  Personal history of certain other diseases
  • Z86.000  In-situ neoplasm of breast
  • Z86.001  In-situ neoplasm of cervix
  • Z86.008  In-situ neoplasm of other site
  • Z86.32  Personal history of gestational diabetes

• Z87  Personal history of other diseases and conditions
  • Z87.410  Cervical dysplasia
  • Z87.411  Vaginal dysplasia
  • Z87.412  Vulvar dysplasia
  • Z87.42  Other diseases of female genital tract
  • Z87.5-  Complications of pregnancy, childbirth, and the puerperium
  • Z87.718  Other specified (corrected) congenital malformations of genitourinary system

You will notice that there is no code for a “history of ovarian cysts.” That means that the appropriate code for that condition will be Z87.42-Personal history of other diseases of female genital tract.

Another grouping of “status” codes are the “acquired absence of organs” codes. Typically, this is done after the patient has had an organ removed because of a serious health issue related to that organ. For women’s health, the codes that will be used with a degree of frequency will be:

Z90  Acquired absence of organs, not elsewhere classified
• Z90.1-  Acquired absence of breast and nipple
  • Z90.10  Unspecified
  • Z90.11  Right
  • Z90.12  Left
  • Z90.13  Bilateral

• Z90.7-  Acquired absence of genital organ(s)
  • Z90.710  Both cervix and uterus
  • Z90.711  Uterus with remaining cervical stump

Billing and Coding Experts for OB/GYN Specialists
The remaining codes that will be used from this block of codes include the following:

- **Z90.712** Cervix with remaining uterus
- **Z90.721** Acquired absence of ovaries, unilateral
- **Z90.722** Acquired absence of ovaries, bilateral

The use of the Z92 codes will be relatively rare because they are to be used only if they have been on contraceptives or estrogen therapy, but not for a long period of time. If they've been on the medication on a long-term basis, codes from the Z79 category should be used. These codes will be used rarely because the clinical significance of their use is not as meaningful if they have not been on the medication for a long time.

Similarly, Z97.5 will be used only when the management of the IUD is not addressed during the course of the encounter. Typically, this will simply be reported as a piece of information when some other genitourinary issue is being addressed.

Finally, the “postprocedural states” codes will be used only to indicate that the patient has had a historical medical event, which may or may not be relevant at the present time.

**Call for Documentation Specificity**

- If the patient is being seen for a routine (preventive) service, is there an abnormality that needs to be reported?
- If an immunization is not provided at a time that it would typically be expected, what is the reason?
- What specific type of contraception is being initiated or monitored?
- Is the patient’s BMI clinically significant? If so, what is it?
- Has the patient been on any long-term drug therapy that, in itself, may be a hazard to health? If so, what kind?
- Does the patient have a family or personal history of diseases that may prompt more intensive surveillance? If so, what is the specific circumstance?
CODES FROM OTHER ICD-10-CM CHAPTERS
USED BY OB/GYN PROVIDERS

As we’ve indicated previously there are five chapters that will be used most frequently by those in the practice of women’s health.

- Chapter 14 Genitourinary System
- Chapter 15 Obstetrics
- Chapter 18 Signs and Symptoms, Abnormal Findings
- Chapter 19 Complications (T80-T88)
- Chapter 21 Factors Influencing Health Status and Reasons for Contact with Health Services

However, there will be occasions (at some point) when codes from virtually every chapter will be used. In this portion of the training, attention will be drawn to the codes that will be used with some frequency.

In Chapter 1-Certain infectious and parasitic diseases, gynecologists will be using codes from this chapter to report infectious diseases when the specific cause of the disease is known. The most commonly used code block will be A50-A64-

Infections with a predominantly sexual mode of transmission.

- A50-A53 Syphilis
- A54 Gonococcal
- A55-A56 Chlamydial
- A57 Chancroid
- A58 Granuloma inguinale
- A59 Trichomoniasis
- A60 Anogenital herpes infections
- A63 Other predominantly sexually transmitted diseases, not elsewhere classified
- A64 Unspecified sexually transmitted disease

The most common codes within this block are:

- A56.02 Chlamydial vulvovaginitis
- A56.11 Chlamydial female pelvic inflammatory disease
- A59.01 Trichomonal vulvovaginitis
- A60.03 Herpesviral cervicitis
- A60.04 Herpesviral vulvovaginitis
- A63.0 Anogenital (venereal) warts

Other codes that may be used with frequency are:

- B20 HIV
- B37.3 Candidiasis of vulva and vagina (yeast infections)
In many cases, codes in other chapters have instructional messages indicating that when the cause of infection is known, a code from B95-B97 should be used. These B95-B97 codes will typically be secondary diagnoses, to explain the infection reported by the primary diagnosis.

**Chapter 2 - Neoplasms** are far more specific in ICD-10-CM than they are in ICD-9-CM. With regard to C50-Malignant neoplasms of the breast, three different factors must be known in order to select the appropriate code.

- **C50.XXX** Malignant neoplasms of breast
  - **Location**
  - **Gender**
    - 0 = female
    - 1 = male
  - **Laterality**
    - 1 = right
    - 2 = left
    - 9 = unspecified

Then the patient has a condition in both breasts (bilateral), then both 1 and 2 are reported. There is no compelling reason to ever use a code for an “unspecified” breast.

Other malignant neoplasms of the genitourinary system are reported with the following code categories:

- **C51.-** Malignant neoplasm of vulva
- **C52** Malignant neoplasm of vagina
- **C53.-** Malignant neoplasm of cervix
- **C54.-** Malignant neoplasm of uterus
- **C55** Malignant neoplasm of uterus, part unspecified
- **C56.-** Malignant neoplasm of ovary
- **C57.-** Malignant neoplasm of other and unspecified female genital organs
  - **C57.0-** Fallopian tube
  - **C57.1-** Broad ligament
  - **C57.2-** Round ligament
  - **C57.3** Parametrium
  - **C57.4** Uterine adnexa, unspecified
  - **C57.7** Other specified
  - **C57.8** Overlapping sites
  - **C57.9** Unspecified

When there is a 4th or 5th character, it is used to report the precise location in/on the organ and/or, in the case of C56.-, C57.0-, C57.1-, and C57.2-, the laterality of the malignancy.

Other types of neoplasms are reported in a similar fashion:
• D05 Carcinoma in situ of breast
  • D05.XX
    • Type of carcinoma
    • Laterality
• D06.- Carcinoma in situ of cervix
• D07.- Carcinoma in situ of other and unspecified genital organs
  • D07.0 Endometrium
  • D07.1 Vulva
  • D07.2 Vagina
  • D07.39 Other female genital organs
• D24.- Benign neoplasm of breast
  • 4th character reports laterality
• D25.- Leiomyoma of uterus
  • D25.0 Submucous
  • D25.1 Intramural
  • D25.2 Subserosal
  • D25.9 Unspecified
• D26.- Other benign neoplasms of uterus
• D27.- Benign neoplasm of ovary
• D28.- Benign neoplasm of other female genital organs

Chapter 3- Blood, blood forming organs, immune system codes are used most frequently to report anemias. The three most common codes are:
  • D50.0 Iron deficiency anemia secondary to blood loss (chronic)
  • D50.9 Iron deficiency anemia, unspecified
  • D62 Acute posthemorrhagic anemia

Chapter 4- Endocrine, nutritional and metabolic disorders codes are used to report a variety of different conditions that will be seen in the practice of gynecology. They are grouped by the disease process.

Thyroid
  • E03.- Hypothyroidism
  • E05.-- Thyrotoxicosis

In each case, the 4th character reports the specific disease type and, in the case of E05, the 5th character reports the severity of the disease.

Diabetes
  • E10 Type 1
    • E10.9 Type 1 diabetes without complications
    • E10.65 Type 1 diabetes with hyperglycemia
  • E11 Type 2
    • E11.9 Type 2 diabetes without complications
• E11.65 Type 2 diabetes with hyperglycemia

The reporting of diabetes in ICD-10-CM is different than in ICD-9-CM. Instead of reporting “controlled” or “uncontrolled,” the type of diabetes is reported, as well as any complications. “Uncontrolled” diabetes is the presence of blood glucose levels that are too high (hyperglycemia). Therefore, if the patient has type 2 diabetes with high blood sugar levels, code E11.65 would be used. If the patient has multiple diabetes-related complications, multiple codes are reported.

Ovarian dysfunction
• E28 Ovarian dysfunction
  • E28.0 Estrogen excess
  • E28.1 Androgen excess
  • E28.2 Polycystic ovarian syndrome
  • E28.3 Primary ovarian failure
    • E28.31 Premature menopause
    • E28.39 Other primary ovarian failure
  • E28.8 Other ovarian dysfunction
• E28.9 Ovarian dysfunction, unspecified

Because the ovaries are part of the endocrine system, when there is ovarian dysfunction, codes from Chapter 4 are used. The clinician has the responsibility for clinically whether or not the patient has polycystic ovarian syndrome (PCOS), but it should not be used if PCOS is only suspected.

Obesity
• E66 Obesity due to excess calories
  • E66.01 Morbid (severe) obesity due to excess calories
  • E66.3 Overweight
  • E66.9 Obesity, unspecified

By definition, if a patient has a BMI greater than 25 but less than 30, diagnosis E66.3 would be used. If the patient has a BMI greater than 30, but less than 40, they are characterized as obese (E66.9). If the patient’s BMI is greater than 40, they are considered morbidly obese (E66.01).

Disorders of lipoprotein metabolism and other lipidemias
• E78.0 Pure hypercholesterolemia
• E78.1 Pure hyperglyceridemia
• E78.2 Mixed hyperlipidemia

If the patient has excessive lipid/cholesterol levels in their blood, one of these codes from Chapter 4 would be used.
While **Chapter 5-Mental and behavioral disorders** are typically considered to be part of the practice of mental health professionals, women’s health professionals will frequently address certain issues in this chapter. They include:

- F17.21 - Nicotine dependence, cigarettes
- F32.9 - Major depressive disorder, single episode, unspecified
- F41.1 - Generalized anxiety disorder
- F41.9 - Anxiety disorder, unspecified
- F52.0 - Hypoactive sexual desire disorder
- F52.22 - Female sexual arousal disorder

When reporting nicotine dependence on cigarettes, the final sixth character is used to describe the exact circumstance (e.g. uncomplicated, in remission, with withdrawal, other complications, etc.).

The use of codes from F52 are limited to circumstances that go beyond decreased libido (R68.82). The clinician’s documentation will need to specify the precise nature of the patient’s condition.

In **Chapter 6-Diseases of the nervous system**, the primary category that will be used is G43-Migraine.

- G43.821 - Menstrual migraine, not intractable, with status migrainosus
- G43.829 - Menstrual migraine, not intractable, without status migrainosus
- G43.831 - Menstrual migraine, intractable, with status migrainosus
- G43.839 - Menstrual migraine, intractable, without status migrainosus
- G43.9-- - Migraine, unspecified

These codes should only be used when a migraine diagnosis is documented, as opposed to a headache (R51).

When reporting services from **Chapter 9-Diseases of the circulatory system**, there are three primary categories from which codes will be reported. They are I10—Essential (primary) hypertension, I80-Phlebitis and thrombophlebitis, and I82-Other venous embolism and thrombosis.

The number of codes for reporting hypertension have decreased in ICD-10-CM. There is no longer a distinction between “benign” and “malignant” hypertension. Instead, there is a single code for primary hypertension—I10. If the patient has other systemic diseases caused by the hypertension, then codes from other categories within this chapter should be used.

The codes for phlebitis, thrombophlebitis, venous embolisms, and thrombosis all have six characters. They are formatted in the following manner:

- I80 - Phlebitis and thrombophlebitis
  - I80.XXX
It will not be unusual for patients to present to their gynecologist with respiratory symptoms, which are found in Chapter 10-Diseases of the respiratory system. There are three blocks in which the codes most commonly used will be found.

- J00-J06 Acute upper respiratory infections
- J09-J18 Influenza and pneumonia
- J30-J39 Other diseases of the upper respiratory tract

The most commonly used categories will be:

- J00 Common Cold
- J01.-- Acute sinusitis
- J06.- Acute upper respiratory infection of multiple and unspecified sites
- J11.- Influenza due to unidentified influenza virus
- J30 Vasomotor and allergic rhinitis
- J31 Chronic rhinitis, nasopharyngitis and pharyngitis
- J32 Chronic sinusitis

For acute sinusitis, 4th character is used to identify the precise location and the 5th character is used to identify the exact type (acute vs. recurrent). For the URI category, the two primary codes will be J06.0 for acute layrngopharyngitis and J06.9 for an acute URI, unspecified.

The reporting of the flu when the precise flu virus is not known is accomplished by using codes from J11. J11.1 is used when the patient has respiratory manifestations and J11.89 is used when the patient has other manifestations. The notes instruct the user to include additional (secondary) codes to identify the specific manifestations.

The primary code used in Chapter 11-Diseases of the digestive system will be K64.- to report hemorrhoids and perianal venous thrombosis. The fourth character will be determined based on the degree and/or type of hemorrhoid.

Chapter 12-Diseases of skin and subcutaneous tissues are used to report these three common conditions:

- L65.9 Nonscarring hair loss, unspecified (alopecia)
- L68.0 Hirsutism
- L70.- Acne
For the reporting of acne, the fourth character defines the specific type of acne.

Typically, older patients seen by gynecologists may have conditions that are reported from **Chapter 13-Diseases of the musculoskeletal system and connective tissue**. The most common codes will be:

- M81.0  Age-related osteoporosis without current pathological fracture
- M81.8  Other osteoporosis without current pathological fracture
- M84  Disorder of continuity of bone
  - M84.3XX  Stress fracture
  - M84.4XX  Pathological fracture
  - X = General location
  - X = Specific location
- M85.8--  Osteopenia (other specified)

Codes from Chapter 13 are only used when non-traumatic fractures occur. If a traumatic fracture occurs, codes from Chapter 19 are used to report the condition. For the osteopenia codes, the 5th & 6th characters are used to report the precise location and laterality, when appropriate.

**Call for Documentation Specificity**

- What specific infectious disease does the patient have?
- What is the exact type of neoplasm and where is it located?
- What type of diabetes does the patient have and what are the complications, if any?
- If the patient is overweight, into what classification does it fall (based on BMI)?
- If the patient has osteoporosis, is there a fracture or not? If so, where is it located?

**Coming in Section 3:**

- Coding for Obstetrics (Chapter 15)
- Persons encountering health services for examinations related to pregnancy (Chapter 21)