Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: Is Your Ob-Gyn Practice Up to Date? Take This 5- Part Challenge to Find Out

If your physician documents 'puerperal infection,' you've got 4 new options.

This year, ICD-9 2010 brought new hyperplasia, mammogram, and fertility preservation codes. In some cases, these codes simply expanded on existing options, and it's up to you to spot when you should report the new versus old alternatives.

Dig in to these five scenarios to see if you can choose the proper code for services performed on or after Oct. 1.

Scenario 1: Pick Apart New Puerperal Options

Your ob-gyn documents "a puerperal infection," a bacterial illness following childbirth. How would you report this? A. 670.0 -- Major puerperal infection B. 670.1x [0,2,4] -- Puerperal endometritis

C. 670.2x [0,2,4] -- Puerperal sepsis

D. 670.3x [0,2,4] -- Puerperal septic thrombophlebitis

E. 670.8x [0,2,4] -- Other major puerperal infection

Answer: Trick question. Your ob-gyn must document more specifically the infection type. That means with more information, your best options are B-D. You'll need to include a fifth digit for these codes. A fifth digit of "0" represents "unspecified as to episode of care or not applicable." A fifth digit of "2" means"delivered with mention of postpartum complication." Your other option, a fifth digit of "4," represents "postpartum condition or complication" (which you would report only after the obgyn discharges the patient after delivery).

Watch out: Prior to Oct. 1, you would lump all puerperal infections into one code (670.0). You can still report this for unspecified puerperal infections, but here's the problem: If the patient requires hospitalization, your payer will most likely deny your claim at your first submission. That means wasted time appealing the claim.

Scenario 2: Don't Overlook 671 Category Notes

You're reporting a code from the 671 (Venous complications in pregnancy and the puerperium) category, but you need to provide what additional information? Select one of these options:

A. If the patient has deep phlebothrombosis, either in the c antepartum (671.3x) or postpartum (671.4x) period, you should also apply a secondary diagnosis from code category 453 (Other venous embolism and thrombosis).

B. If the patient has been using anticoagulants for a long time and is currently using them, report V58.61 to indicate this.

C. Both of the above, if applicable.

D. None of the above.

Answer: C. ICD-9 added some notes under the 671 category to clarify that your ob-gyn's documentation needs to supply additional information, and your coding must reflect that. In other words, if you report a code from the 671 category and the patient has been using anticoagulants, you need to include V58.61. Otherwise, your payer could reject your claim.

Scenario 3: Update Your Hyperplasia Codes

Your ob-gyn diagnoses a patient with endometrial hyperplasia (either endometrial intraepithelial neoplasia [EIN] or benign hyperplasia). How would you report these conditions? Choose two of the options.

A. For EIN, you would use either 233.2 (Carcinoma in situ of other and unspecified parts of uterus) or 621.33 (Endometrial hyperplasia with atypia) B. For benign hyperplasia, use 621.30 (Endometrial hyperplasia, unspecified) or 621.31 (Simple endometrial hyperplasia without atypia).

C. 621.34 -- Benign endometrial hyperplasia

D. 621.35 -- Endometrial intraepithelial neoplasia (EIN)

Answer: C and D. You should use new codes 621.34 and 621.35. "ICD-9 introduced these new codes because pathologists increasingly use a disease classification that distinguishes the benign hormonal effects of unopposed estrogens (benign hyperplasia) from emergent precancerous lesions (EIN)," explains **Melanie Witt, RN, CPC, COBGC, MA,** a coding expert based in Guadalupita, N.M.

Heads up: If you chose A and B, you're not entirely incorrect.

You can still use the old codes in answer A or B. Older physicians still use the older, four-tier hyperplasia statements, but "over time, the more accurate distinctions between types of hyperplasia will replace the old," Witt says. A note in ICD-9 will instruct providers to use newer codes rather than the older ones.

An additional note accompanying the EIN diagnosis indicates that if the ob-gyn diagnoses the patient with malignant neoplasm of endometrium with endometrial intraepithelial neoplasia, you should report the code for the malignancy (182.0, Malignant neoplasm of body of uterus; corpus uteri, except isthmus) instead.

Scenario 4: Mark New Mammogram Code

A routine mammogram proves questionable due to the patient's breast density. You could consider this an:

A. abnormal finding, so payers will cover further testing.

B. inconclusive mammogram.

Answer: B. Dense breasts may require testing beyond a mammogram to confirm no malignancies, and the request for an appropriate code to describe this resulted in the new ICD-9 code 793.82 (Inconclusive mammogram).

"The new code may help get insurance companies to pay for additional testing," says **Cheryl Scott, CPC, CPC-H, CCS, CCSP,** with HealthTexas in Dallas. "Prior to the 2010 code, the choices were to bill it as screening or to code dense breasts as an 'abnormality'" -- which they aren't, she says.

And precisely because these inconclusive mammogram findings are not "abnormal," ICD-9 2010 will revise the 793.0-793.7 range so that "abnormal" findings aren't a requirement for using these codes:

• 2009: Nonspecific abnormal findings on radiological and other examination of ...

• 2010: Nonspecific (abnormal) findings on radiological and other examination of ...

Codes 793.89 and 793.99 will have the same change, adding parentheses:

• 2010: 793.89 -- Other (abnormal) findings on radiological examination of breast

• 2010: 793.99 -- Other nonspecific (abnormal) findings on radiological and other examination of body structure.

Scenario 5: Fine-Tune Fertility Preservation Dx

Your ob-gyn performs an ovarian transposition (58825, Transposition, ovary[s]) to preserve ovarian function prior to radiation. In addition to the cancer diagnosis, report this with:

A. V26.42 -- Encounter for fertility preservation counseling

B. V26.82 -- Encounter for fertility preservation procedure

Answer: B. Reporting V26.82 in addition to the cancer diagnosis supports medical necessity. ICD-9 added these two new codes at the request of the American Society for Reproductive Medicine (ASRM) and the American College of Obstetricians and Gynecologists (ACOG). They will help substantiate visits and procedures aimed at preserving fertility for women who will undergo chemotherapy, surgery, or radiation therapy that might otherwise leave them sterile.