That time of year: Turn back the clock, watch H1N1 flu return, and adopt a new ICD-9 code set

Codes have been revised, clarified, and added (swine flu, for one). Our expert explains what the newly issued set means for ObGyn practice.

Additions and revision to this year's International Classification of Diseases, Clinical Modification (ICD-9-CM)—which go **into effect on October 1**—reflect tinkering with existing codes and expansion of others to boost granularity and clarity in your reporting of diagnostic work. To that add a number of new codes—including one that acknowledges the arrival of the H1N1 (swine flu) virus nationwide.

In **obstetrics**, there are now specific codes for different types of puerperal infection and a requirement for more diagnostic information when a patient has venous complications during pregnancy and intrapartum.

On the **gynecology** side, changes include the way you report a finding of endometrial intraepithelial neoplasia. New codes have been created to report:

- visits and procedures for fertility preservation
- inconclusive mammography
- preprocedural laboratory testing.

Remember: **On October 1, 2009, the new and revised codes discussed here, plus others, will be added to the national ICD-9-CM code set.** Be cautioned that, as in past years, **there is no grace period!**

Changes to obstetric codes

PUERPERAL INFECTIONS

Before October 1, 2009, all puerperal infections were lumped into one code: **670.0** (*Major puerperal infection*). This changes now: You'll be required to document, more specifically, the type of infection that your patient has.

Continue to report code **670.0** for an unspecified puerperal infection; but, if you admit the patient to the hospital, using that unspecified code may lead to a first-submission denial of claim. A fifth digit is also required for the unspecified and new more specific codes: **0** (*unspecified as to episode of care or not applicable*), **2** (*delivered with mention of postpartum complication*), or **4** (*postpartum condition or complication*) (to be reported only once the patient is discharged after delivery).

670.1x [0,2,4] Puerperal endometritis
670.2x [0,2,4] Puerperal sepsis
670.3x [0,2,4] Puerperal septic thrombophlebitis
670.8x [0,2,4] Other major puerperal infection

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VENOUS COMPLICATIONS IN PREGNANCY AND PUERPERIUM

Code category **671** (*venous complications in pregnancy and the puerperium*) retains its current codes, but ICD-9 has added notes to clarify that additional information is required.

For example: When a patient has deep-vein thrombosis, either antepartum (**671.3x**) or postpartum (**671.4x**), assign a secondary diagnosis from code category **453** (*Other venous embolism and thrombosis*). If, in addition, the patient has been taking an anticoagulant for a long time and is currently taking it, report code **V56.81**, as well, to indicate this.

Gyn code changes

HYPERPLASIA

Over time, codes for hyperplasia have evolved from a system that described mild, moderate, severe, or atypical, to one in which hyperplasia was subdivided by architectural complexity, such as simple versus complex and whether or not atypia were present. Even this terminology fails, however, to adequately identify patients' risk of cancer to improve therapeutic triaging.

In more recent years, physicians and pathologists have begun to distinguish benign hormonal effects of unopposed estrogen, classified as benign hyperplasia, from precancerous lesions classified as **endometrial intraepithelial neoplasia** (EIN). To capture this newer terminology, ICD-9 has added two new codes.

ICD-9 has elected to retain existing codes in this area of diagnosis and assessment because the old terminology is still used by many older practicing physicians. The hope, however, is that, over time, more accurate distinctions between the types of hyperplasia will replace the older distinctions.

A note in ICD-9 will instruct providers that older codes may not be reported if one of the newer codes is assigned.

An additional note that accompanies the EIN diagnosis indicates that, if a patient is given a diagnosis of malignant neoplasm of the endometrium with endometrial intraepithelial neoplasia, the code for the malignancy (**182.0**, *Malignant neoplasm of body of uterus; corpus uteri, except isthmus*) would be reported instead of the EIN code.

621.34 Benign endometrial hyperplasia
621.35 Endometrial intraepithelial neoplasia

INCONCLUSIVE MAMMOGRAM

Routine mammograms are, as you know, sometimes labeled "inconclusive" because of what are termed "dense breasts." This finding isn't considered to represent an abnormal condition, but it does require further testing to confirm that no malignant condition exists that cannot be seen on mammogram.

Because many payers cover a repeat mammogram only when an abnormal finding is reported, a new code has been needed—and has now been added—to explain the reason for a second mammogram.

Because of the added code, ICD-9 also decided to revise wording for the **793** code category (until now, it's been *Nonspecific abnormal findings on radiological and other examination of body structure*) to a more general heading of *Nonspecific findings,* which covers inconclusive and abnormal findings.

793.82 Inconclusive mammogram

FERTILITY PRESERVATION PRIOR TO ANTINEOPLASTIC THERAPY

Two new codes have been added to this area of practice at the request of the American Society for Reproductive Medicine (ASRM) and ACOG. They allow you to report visits and procedures aimed at preserving fertility in women who must undergo chemotherapy, surgery, or radiation therapy that might otherwise leave them sterile.

The codes reflect that, before a patient is treated, you may discuss a range of options that can increase her chances of becoming pregnant, including:

- conception before cancer treatment
- banking of sperm, eggs, ovarian tissue, and embryos

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- protecting the ovaries during radiation therapy
- modifying surgery to spare the uterus.

For example: If you performed ovarian transposition (Current Procedural Terminology code **58825**) to preserve ovarian function before radiation therapy, report code **V26.82** in addition to the cancer diagnosis to support the medical necessity of the procedure.

V26.42 Encounter for fertility preservation counseling
V26.82 Encounter for fertility preservation procedure

PREPROCEDURAL EVALUATIONS

Code category **V72.6** has been expanded from four to five digits to better capture reasons for ordering or performing laboratory tests that are not specifically linked to a medical diagnosis.

For example: If you order routine tests as part of a routine, general medical or gyn annual examination, report code **V72.62**. For routine preoperative lab tests, report **V72.63** instead.

ICD-9 has clarified that **V72.61** can be reported for testing of immune status, and that current code **V72.83** (*Other specified preoperative examination*) is the one to report when an exam precedes chemotherapy.

Note: ICD-9 rules require that you list the preprocedural examination code as the primary diagnosis, followed by the code that represents the reason for the surgery or procedure.

V72.60 Laboratory examination, unspecified
V72.61 Antibody response examination
V72.62 Laboratory examination ordered as part of a routine general medical examination
V72.63 Preprocedural laboratory examination
V72.69 Other laboratory examination

PERSONAL HISTORY CODES

A history of drug therapy can affect the care that you are giving a patient now, and may require testing from time to time to assess the consequences of such therapy.

Two examples are long-term estrogen therapy, which may increase a woman's risk of developing breast cancer, and inhaled steroids, which can decrease bone density. In the absence of a known problem with these (or other) therapies in a given patient, **new history codes** listed below may be useful in communicating with a payer about ongoing follow-up care or testing that you are providing.

V87.43 Personal history of estrogen therapy
V87.44 Personal history of inhaled steroid therapy
V87.45 Personal history of systemic steroid therapy
V87.46 Personal history of immunosuppressive therapy

FAST TRACK

Under ICD-9 rules, the new code for swine flu (488.1) should be reported only for a confirmed case

Plus a number of miscellaneous additions and changes

Here are few more new codes that may better explain why you saw a patient, provided:

- the new code for swine flu is reported only for a **confirmed case,** per ICD-9 rules
- the new V codes are reported only if the personal history or family circumstance affected treatment at the time of the visit, or if the patient was receiving counseling concerning only those issues.

488.1 Influenza due to identified novel H1N1 influenza virus
995.24 Failed moderate sedation during procedure
V10.90 Personal history of unspecified type of malignant neoplasm
V15.80 Personal history of failed moderate sedation
V61.07 Family disruption due to death of family member
V61.08 Family disruption due to other extended absence of a family member
V61.42 Substance abuse in family