Overview of ICD-10-CM

Obstetrics and Gynecology
The Facts

- World Health Organization (WHO)
- Extension of ICD-9-CM
- CM (Clinical Modification)
  - Modified in the United States

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Physician Impacts

• Reporting of quality healthcare indicators is directly related to data quality and data quality is directly correlated to documentation quality.

• ICD-10 supports current clinical practice, terminology, greater detail in specifying the care being provided, and has the ability to expand as new technologies and procedures are developed.

• Managing patients with multiple comorbidities demands documentation accuracy which consistently reflects care provision across the health care spectrum.
Impact of ICD-10-CM and ICD-10-PCS

- Physician
  - ICD-10-CM
  - CPT / HCPCS

- Hospital
  - Inpatient
    - ICD-10-CM
    - ICD-10-PCS
  - Outpatient
    - ICD-10-CM
    - CPT / HCPCS

- All Others
  - ICD-10-CM
  - CPT / HCPCS
ICD-10-CM Structure and Format

Category

Etiology, Anatomical Site, Severity

7th Character
Basic 7th Characters for Injury/Adverse effects

A = Initial encounter
D = Subsequent encounter
S = Sequela

Example:
O9A.211A  Injury, poisoning and certain other consequences of external causes complicating pregnancy, first trimester
Basic 7th Characters for Multiple Gestation

0 = Not applicable or unspecified
1 = Fetus 1
2 = Fetus 2
3 = Fetus 3
4 = Fetus 4
5 = Fetus 5
9 = Other fetus

Example:
O32.1XX2 Maternal care for breech presentation, fetus 2 affected, twin term pregnancy
ICD-10-CM Code Examples

082  Encounter for cesarean delivery without indication

Z37.2  Twins, both liveborn

N70.03  Acute salpingitis and oophoritis

O98.711  HIV disease complicating pregnancy, first trimester

O33.3XX1  Maternal care for disproportion due to outlet contraction of pelvis, fetus 1
Key Documentation Impacts

Key documentation issues that will be seen in ICD-10-CM:

Pregnancy Related
  • Trimester
  • Pre-existing condition
  • Condition of fetus
  • Identify affected fetus
  • Outcome of delivery
  • Abnormal test results
Trimester and/or Weeks of Gestation

It is important to document the patient’s current trimester for each encounter:

• To identify the level of risk and severity of the condition
• To support necessity of the treatment rendered and future care of related disease

Example:

O21.0 Intrauterine pregnancy, 12 weeks gestation, with mild hyperemesis gravidarum
Pre-Existing Conditions

Documentation should identify conditions that predate the pregnancy and that continue to affect patient care. These conditions should be documented in detail, indicating whether the disease is still present, and whether it is affecting the pregnancy.

Example:

- E11.630  Type 2 diabetes mellitus with periodontal disease
- O99.613  Diseases of the digestive system complicating pregnancy, third trimester
- O24.113  Pre-existing type 2 diabetes mellitus, on insulin, third trimester
- Z79.4  Long term current use of insulin
Condition of Fetus

Documentation should identify any known or suspected condition of the fetus that was diagnosed prior to delivery.

Example:

O76 Abnormality in fetal heart rate and rhythm complicating labor and delivery
Identify Affected Fetus

Documentation is needed to identify the fetus by the designated numerical value (1-9) and list the associated condition affecting that fetus.

Documentation is needed to identify the number of placentas and amniotic sacs.

Example:

O32.1XX2  Twin term pregnancy with breech presentation of fetus 2
O30.043  Twin pregnancy, dichorionic/diamniotic, third trimester
Outcome of Delivery

Documentation is needed to identify the outcome of a pregnancy and delivery. This would include information such as liveborn or stillborn, and the number of infants in a multiple gestation.

Example:

Z37.3 Twins, one liveborn, and one stillborn
Abnormal Test Results

Documenting the abnormal findings (e.g., lab, radiology, ultrasound, and pathology) will ensure that all diagnostic work performed is supported by medical necessity.

Example:

- O28.3  Abnormal ultrasonic finding on antenatal screening of mother
- O34.13 Maternal care for benign tumor of corpus uteri, third trimester
Key Documentation Impacts

General key documentation issues that will be seen in ICD-10-CM:

- Acuity of Disease
- Infectious Agent
- Site of Disease
- Laterality
- Underlying Conditions
- Disease Manifestations
- Poisoning and Adverse effects
- Drugs, Tobacco, and Alcohol
- Underdosing
Acuity

- Acuity should be included in documentation to identify the severity of a patient’s illness or disease.
- “Acute”, “chronic”, “mild”, “moderate”, and “severe” are terms that add specificity to the medical record.
- Remember that chronic disease impacts each patient encounter in terms of utilization and intensity of service.
- It is important to identify the acuity to support medical necessity for services provided and for future identification of other disease manifestations.

Example:

N76.1 Subacute and chronic vaginitis
O14.12 Severe pre-eclampsia, second trimester
Infectious Agent

The infectious agent, or other causative agent, needs to be documented due to the impact this agent can have on treatment and drug therapy management.

Example:

O98.211 Gonorrhea complicating pregnancy, first trimester
N39.0 Urinary tract infection
Site of Disease

ICD-10-CM requires documentation of the anatomical site affected by the disease.

**Example:**

N80.2  Endometriosis of the fallopian tube
O23.03  Infections of the kidney in pregnancy, third trimester
Laterality

• Identify right, left, or bilateral in paired organs and anatomical sites
• This type of documentation impacts continuity and quality of care.
• Common conditions requiring laterality include:
  – Breast masses
  – Ovarian and tubal malignancies

Example:

N60.01  Solitary cyst of the left breast
Underlying Conditions

Documentation of any underlying conditions, for many diseases, permits greater specificity in code selection and supports the care provided.

Example:

- **O11.2** Pre-existing hypertension with pre-eclampsia, second trimester
- **O10.012** Pre-existing essential hypertension complicating pregnancy, second trimester
Disease Manifestations

Documentation of the common manifestations, for many diseases, supports greater specificity.

Example:

O24.111 Pre-existing diabetes mellitus, type 2, in pregnancy, first trimester

E11.620 Type 2 diabetes mellitus with diabetic dermatitis
Drugs, Tobacco, and Alcohol

• In ICD-10, it will be required to document drug, alcohol, and tobacco use, abuse, and dependence; and their impact on other disease processes that are being treated.
• It is important to document the impact of alcohol, drugs, and tobacco on the treatment of cancer.
• ICD-10 also identifies the cause and effects of occupational/environmental exposures.
Drugs Tobacco and Alcohol

O99.31 Alcohol use complicating pregnancy, childbirth, and the puerperium
   Use additional code(s) from F10 to identify manifestations of the alcohol use
   O99.310 Alcohol use complicating pregnancy, unspecified trimester
   O99.311 Alcohol use complicating pregnancy, first trimester
   O99.312 Alcohol use complicating pregnancy, second trimester
   O99.313 Alcohol use complicating pregnancy, third trimester
   O99.314 Alcohol use complicating childbirth
   O99.315 Alcohol use complicating the puerperium

O99.32 Drug use complicating pregnancy, childbirth, and the puerperium
   Use additional code(s) from F11-F16 and F18-F19 to identify manifestations of the drug use
   O99.320 Drug use complicating pregnancy, unspecified trimester
   O99.321 Drug use complicating pregnancy, first trimester
   O99.322 Drug use complicating pregnancy, second trimester
   O99.323 Drug use complicating pregnancy, third trimester
   O99.324 Drug use complicating childbirth
   O99.325 Drug use complicating the puerperium

O99.33 Smoking (tobacco) complicating pregnancy, childbirth, and the puerperium
   Use additional code from F17 to identify type of tobacco
Drugs, Tobacco, and Alcohol

Documentation of single substance is noted in the hierarchy of use, abuse, and dependence:

• Single substance documented dependence with abuse and use of same substance is coded to dependence
• Single substance documented as abuse with recreational use is assigned to abuse
• Single substance use documented with dependence is assigned to dependence
• Single substance dependence with documentation of use and abuse is assigned as dependence
• Smokers are classified as dependent in ICD-10-CM
Code Examples

F17.21 Nicotine dependence, cigarettes
   F17.210 Nicotine dependence, cigarettes, uncomplicated
   F17.211 Nicotine dependence, cigarettes, in remission
   F17.213 Nicotine dependence, cigarettes, with withdrawal
   F17.218 Nicotine dependence, cigarettes, with other nicotine-induced disorders
   F17.219 Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders

F17.22 Nicotine dependence, chewing tobacco
   F17.220 Nicotine dependence, chewing tobacco, uncomplicated
   F17.221 Nicotine dependence, chewing tobacco, in remission
   F17.223 Nicotine dependence, chewing tobacco, with withdrawal
   F17.228 Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
   F17.229 Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders

F17.29 Nicotine dependence, other tobacco product
   F17.290 Nicotine dependence, other tobacco product, uncomplicated
   F17.291 Nicotine dependence, other tobacco product, in remission
   F17.293 Nicotine dependence, other tobacco product, with withdrawal
   F17.298 Nicotine dependence, other tobacco product, with other nicotine-induced disorders
Adverse Effects/Poisoning

Documentation to identify adverse effect of a drug, and poisoning by a substance/drug, should include the associated intent of the drug/substance (accidental, self-harm, assault, undetermined), adverse effect of treatment, and/or underdosing.

Examples:

- T48.0X5A  Patient experienced tetanic contractions due to Pitocin, initial encounter (adverse effect)

- T37.3X1A  Patient consumed ETOH and experienced severe nausea while taking Flagyl, prescribed for PID, initial encounter accidental
New in ICD-10-CM: Underdosing

T38.5X6A  Underdosing of Premarin, initial encounter

<table>
<thead>
<tr>
<th>Substance</th>
<th>Poisoning, Accidental</th>
<th>Poisoning, Intentional self-harm</th>
<th>Poisoning, Assault</th>
<th>Poisoning, Undetermined</th>
<th>Adverse effect</th>
<th>Underdosing</th>
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OB/GYN Screening and Abnormal Findings
Key Documentation Issues

For screening for malignant neoplasms, documentation should:

- Specify the test performed (e.g., mammogram, pap smear)
- Identify the type of malignancy (e.g., breast, cervical, vaginal, ovarian)
- Specify any previous personal history and/or family history of the malignancy
- Document any abnormal result(s)
- Identify any postsurgical status (e.g., hysterectomy, mastectomy)
- Identify any underlying conditions and/or manifestations
Code Examples

Z12.31  Encounter for screening mammogram for malignant neoplasm of breast

Excludes1: inconclusive mammogram (R92.2)

Z12.39  Encounter for other screening for malignant neoplasm of breast

Z12.4   Encounter for screening for malignant neoplasm of cervix

Encounter for screening pap smear for malignant neoplasm of cervix

Excludes1: encounter for screening for human papillomavirus (Z11.51)

when screening is part of general gynecological examination (Z01.4-)

Z12.5   Encounter for screening for malignant neoplasm of prostate

Z12.6   Encounter for screening for malignant neoplasm of bladder

Z12.7   Encounter for screening for malignant neoplasm of other genitourinary organs

Z12.71  Encounter for screening for malignant neoplasm of testis

Z12.72  Encounter for screening for malignant neoplasm of vagina

Vaginal pap smear status-post hysterectomy for non-malignant condition

Use additional code to identify acquired absence of uterus (Z90.71-)

Excludes1: vaginal pap smear status-post hysterectomy for malignant conditions (Z08)

Z12.73  Encounter for screening for malignant neoplasm of ovary

Z12.79  Encounter for screening for malignant neoplasm of other genitourinary organs
Key Documentation Issues

For antenatal care, documentation should:

• Specify the test performed (e.g., ultrasound, radiology, cytology, chemistries, genetic testing)
• Document the abnormal finding and/or test result (e.g., abnormal glucose tolerance test)
Code Examples

028 Abnormal findings on antenatal screening of mother

*Excludes1:* diagnostic findings classified elsewhere - see Alphabetical Index

028.0 Abnormal hematological finding on antenatal screening of mother
028.1 Abnormal biochemical finding on antenatal screening of mother
028.2 Abnormal cytological finding on antenatal screening of mother
028.3 Abnormal ultrasonic finding on antenatal screening of mother
028.4 Abnormal radiological finding on antenatal screening of mother
028.5 Abnormal chromosomal and genetic finding on antenatal screening of mother
028.8 Other abnormal findings on antenatal screening of mother
028.9 Unspecified abnormal findings on antenatal screening of mother
Key Documentation Issues

For abnormal pap smears and cultures, documentation should:

• Specify the test performed (e.g., cytologic smear, ThinPrep pap)
• Identify the site of the collected specimen (e.g., cervix, vagina)
• Document the findings (HPV positive – cervix)
• Specify the findings as atypical, low grade and/or high grade (e.g., low grade SIL)
• Specify if any malignancy is noted on smear results
• Note any inadequate sample(s)
**Code Examples**

**Excludes2:** cervical high risk human papillomavirus (HPV) DNA test positive (R87.810)
cervical low risk human papillomavirus (HPV) DNA test positive (R87.820)

- **R87.610** Atypical squamous cells of undetermined significance on cytologic smear of cervix (ASC-US)
- **R87.611** Atypical squamous cells cannot exclude high grade squamous intraepithelial lesion on cytologic smear of cervix (ASC-H)
- **R87.612** Low grade squamous intraepithelial lesion on cytologic smear of cervix (LGSIL)
- **R87.613** High grade squamous intraepithelial lesion on cytologic smear of cervix (HGSIL)
- **R87.614** Cytologic evidence of malignancy on smear of cervix
- **R87.615** Unsatisfactory cytologic smear of cervix
  - Inadequate sample of cytologic smear of cervix
- **R87.616** Satisfactory cervical smear but lacking transformation zone
- **R87.618** Other abnormal cytological findings on specimens from cervix uteri
- **R87.619** Unspecified abnormal cytological findings in specimens from cervix uteri
  - Abnormal cervical cytology NOS
  - Abnormal Papanicolaou smear of cervix NOS
  - Abnormal thin preparation smear of cervix NOS
  - Atypical endocervical cells of cervix NOS
  - Atypical endometrial cells of cervix NOS
  - Atypical glandular cells of cervix NOS
Supervision of Pregnancy
Key Documentation Issues

For supervision of pregnancy, documentation should:

• Identify if patient presents for first pregnancy
• Identify any associated complications and/or pre-existing conditions (e.g., hypertension, diabetes)
• Note any abnormal antenatal screening results
• Identify the trimester and/or weeks of gestation in the current episode of care
• Specify if encounter is for pregnancy testing only
• Specify any tobacco, drug, and/or alcohol usage, and/or exposure
**Code Examples**

**Excludes**: any complication of pregnancy (O00-O9A)
- encounter for pregnancy test (Z32.0-)
- encounter for supervision of high risk pregnancy (O09.-)

**Z34.0**  Encounter for supervision of normal first pregnancy
- **Z34.00**  Encounter for supervision of normal first pregnancy, unspecified trimester
- **Z34.01**  Encounter for supervision of normal first pregnancy, first trimester
- **Z34.02**  Encounter for supervision of normal first pregnancy, second trimester
- **Z34.03**  Encounter for supervision of normal first pregnancy, third trimester

**Z34.8**  Encounter for supervision of other normal pregnancy
- **Z34.80**  Encounter for supervision of other normal pregnancy, unspecified trimester
- **Z34.81**  Encounter for supervision of other normal pregnancy, first trimester
- **Z34.82**  Encounter for supervision of other normal pregnancy, second trimester
- **Z34.83**  Encounter for supervision of other normal pregnancy, third trimester

**Z34.9**  Encounter for supervision of normal pregnancy, unspecified
- **Z34.90**  Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
- **Z34.91**  Encounter for supervision of normal pregnancy, unspecified, first trimester
- **Z34.92**  Encounter for supervision of normal pregnancy, unspecified, second trimester
- **Z34.93**  Encounter for supervision of normal pregnancy, unspecified, third trimester
Key Documentation Issues

For high risk pregnancies, documentation should:

• Identify the associated risk (e.g., history of infertility, pre-term labor, poor and/or insufficient obstetric care, use of reproductive technology)
• Identify the age of the patient
• Specify if primigravida or multigravida
• Identify any underlying conditions and/or manifestations
• Identify any pre-existing conditions
• Identify the trimester and/or weeks of gestation during the episode of care
Pregnancy for a female 35 years and older at expected date of delivery

**009.51** Supervision of elderly primigravida
- **009.511** Supervision of elderly primigravida, first trimester
- **009.512** Supervision of elderly primigravida, second trimester
- **009.513** Supervision of elderly primigravida, third trimester
- **009.519** Supervision of elderly primigravida, unspecified trimester

**009.52** Supervision of elderly multigravida
- **009.521** Supervision of elderly multigravida, first trimester
- **009.522** Supervision of elderly multigravida, second trimester
- **009.523** Supervision of elderly multigravida, third trimester
- **009.529** Supervision of elderly multigravida, unspecified trimester

**009.6** Supervision of young primigravida and multigravida
Supervision of pregnancy for a female less than 16 years old at expected date of delivery

**009.61** Supervision of young primigravida
- **009.611** Supervision of young primigravida, first trimester
- **009.612** Supervision of young primigravida, second trimester
- **009.613** Supervision of young primigravida, third trimester
- **009.619** Supervision of young primigravida, unspecified trimester
Pregnancy and Related Disorders
Key Documentation Issues

For hypertension, documentation should:

• Specify if hypertension is a pre-existing condition or gestational
• Identify the trimester and/or weeks of gestation
• Specify acuity (e.g., mild, moderate, severe)
• Specify any associated complication and/or condition (e.g., pre-eclampsia, HELLP syndrome, eclampsia)
• For eclampsia, specify if during pregnancy, labor, delivery, and/or in the puerperium.
Code Examples

014.0  Mild to moderate pre-eclampsia
   014.00  Mild to moderate pre-eclampsia, unspecified trimester
   014.02  Mild to moderate pre-eclampsia, second trimester
   014.03  Mild to moderate pre-eclampsia, third trimester

014.1  Severe pre-eclampsia
   Excludes1: HELLP syndrome (014.2-)
   014.10  Severe pre-eclampsia, unspecified trimester
   014.12  Severe pre-eclampsia, second trimester
   014.13  Severe pre-eclampsia, third trimester

014.2  HELLP syndrome
   Severe pre-eclampsia with hemolysis, elevated liver enzymes and low platelet count (HELLP)
   014.20  HELLP syndrome (HELLP), unspecified trimester
   014.22  HELLP syndrome (HELLP), second trimester
   014.23  HELLP syndrome (HELLP), third trimester

014.9  Unspecified pre-eclampsia
   014.90  Unspecified pre-eclampsia, unspecified trimester
   014.92  Unspecified pre-eclampsia, second trimester
   014.93  Unspecified pre-eclampsia, third trimester
Code Examples

O15  Eclampsia
    Includes: convulsions following conditions in O10-O14 and O16

O15.0  Eclampsia in pregnancy
    O15.00  Eclampsia in pregnancy, unspecified trimester
    O15.02  Eclampsia in pregnancy, second trimester
    O15.03  Eclampsia in pregnancy, third trimester

O15.1  Eclampsia in labor

O15.2  Eclampsia in the puerperium

O15.9  Eclampsia, unspecified as to time period
    Eclampsia NOS

O16  Unspecified maternal hypertension
    O16.1  Unspecified maternal hypertension, first trimester
    O16.2  Unspecified maternal hypertension, second trimester
    O16.3  Unspecified maternal hypertension, third trimester
    O16.9  Unspecified maternal hypertension, unspecified trimester
Key Documentation Issues
For diabetes complicating pregnancy, documentation should:

• Identify if pre-existing and/or gestational diabetes
• Identify the trimester and/or weeks of gestation
• Specify type 1 or type 2 in pre-existing diabetes
• Specify any associated manifestation(s) and their affect on the management of the pregnancy
• Specify if persists in puerperium.
• Specify if insulin and/or diet-controlled gestational diabetes
Code Examples

O24.01 Pre-existing diabetes mellitus, type 1, in pregnancy
  O24.011 Pre-existing diabetes mellitus, type 1, in pregnancy, first trimester
  O24.012 Pre-existing diabetes mellitus, type 1, in pregnancy, second trimester
  O24.013 Pre-existing diabetes mellitus, type 1, in pregnancy, third trimester
  O24.019 Pre-existing diabetes mellitus, type 1, in pregnancy, unspecified trimester

O24.02 Pre-existing diabetes mellitus, type 1, in childbirth
O24.03 Pre-existing diabetes mellitus, type 1, in the puerperium

O24.1 Pre-existing diabetes mellitus, type 2, in pregnancy, childbirth and the puerperium
Insulin-resistant diabetes mellitus in pregnancy, childbirth and the puerperium
Use additional code (for):
  from category E11 to further identify any manifestations
  long-term (current) use of insulin (Z79.4)

O24.11 Pre-existing diabetes mellitus, type 2, in pregnancy
  O24.111 Pre-existing diabetes mellitus, type 2, in pregnancy, first trimester
  O24.112 Pre-existing diabetes mellitus, type 2, in pregnancy, second trimester
  O24.113 Pre-existing diabetes mellitus, type 2, in pregnancy, third trimester
  O24.119 Pre-existing diabetes mellitus, type 2, in pregnancy, unspecified trimester

O24.12 Pre-existing diabetes mellitus, type 2, in childbirth
O24.13 Pre-existing diabetes mellitus, type 2, in the puerperium
Code Examples

O24.31  Unspecified pre-existing diabetes mellitus in pregnancy
  - O24.311  Unspecified pre-existing diabetes mellitus in pregnancy, first trimester
  - O24.312  Unspecified pre-existing diabetes mellitus in pregnancy, second trimester
  - O24.313  Unspecified pre-existing diabetes mellitus in pregnancy, third trimester
  - O24.319  Unspecified pre-existing diabetes mellitus in pregnancy, unspecified trimester

O24.32  Unspecified pre-existing diabetes mellitus in childbirth

O24.33  Unspecified pre-existing diabetes mellitus in the puerperium

O24.4  Gestational diabetes mellitus
  - Diabetes mellitus arising in pregnancy
  - Gestational diabetes mellitus NOS

O24.41  Gestational diabetes mellitus in pregnancy
  - O24.410  Gestational diabetes mellitus in pregnancy, diet controlled
  - O24.414  Gestational diabetes mellitus in pregnancy, insulin controlled
  - O24.419  Gestational diabetes mellitus in pregnancy, unspecified control

O24.42  Gestational diabetes mellitus in childbirth
  - O24.420  Gestational diabetes mellitus in childbirth, diet controlled
  - O24.424  Gestational diabetes mellitus in childbirth, insulin controlled
  - O24.429  Gestational diabetes mellitus in childbirth, unspecified control

O24.43  Gestational diabetes mellitus in the puerperium
Key Documentation Issues

For other conditions during pregnancy, documentation should:

• Specify the trimester and/or weeks of gestation
• Specify if the condition is pre-existing and/or gestational
• Identify any associated condition(s) (e.g., hyperemesis with metabolic disturbances)
• Specify any management of fetal abnormality(ies)
• Identify any tobacco, drug, and alcohol use, abuse, and/or dependence
Key Documentation Issues

For other conditions associated with the pregnancy, documentation should:

• Identify any long term medicinal and/or drug therapy (e.g., DVT patient on anticoagulants)
• Document any environmental exposure(s)
• Identify any infectious organism(s), when applicable
Key Documentation Issues

For multiple gestations, documentation should:

• Identify the number of fetuses
• Specify the trimester and/or weeks of gestation
• Identify the number of placenta(s) and amniotic sac(s), when known
• Specify any known complications of multiple pregnancies (e.g., malposition of a fetus)
• Identify the fetus affected by the complication(s)
• Identify any pre-existing condition(s)
• Specify any underlying condition and/or manifestation
• Identify any tobacco, drug, and/or alcohol use, abuse, and/or dependence
Code Examples

- O32.1 Maternal care for breech presentation
  Maternal care for buttoks presentation
  Maternal care for complete breech
  Maternal care for frank breech

  Excludes1: footling presentation (O32.8)
  incomplete breech (O32.8)

0  not applicable or unspecified
1  fetus 1
2  fetus 2
3  fetus 3
4  fetus 4
5  fetus 5
9  other fetus

+ O32.2 Maternal care for transverse and oblique lie
  Maternal care for oblique presentation
  Maternal care for transverse presentation

+ O32.3 Maternal care for face, brow and chin presentation

+ O32.4 Maternal care for high head at term
  Maternal care for failure of head to enter pelvic brim

+ O32.6 Maternal care for compound presentation

+ O32.8 Maternal care for other malpresentation of fetus
Code Examples

O33 Maternal care for disproportion

Includes: the listed conditions as a reason for observation, hospitalization or other obstetric care of the mother, or for cesarean delivery before onset of labor

Excludes1: disproportion with obstructed labor (065-066)

O33.0 Maternal care for disproportion due to deformity of maternal pelvic bones
Maternal care for disproportion due to pelvic deformity causing disproportion NOS

O33.1 Maternal care for disproportion due to generally contracted pelvis
Maternal care for disproportion due to contracted pelvis NOS causing disproportion

O33.2 Maternal care for disproportion due to inlet contraction of pelvis
Maternal care for disproportion due to inlet contraction (pelvis) causing disproportion

O33.3 Maternal care for disproportion due to outlet contraction of pelvis
Maternal care for disproportion due to mid-cavity contraction (pelvis)
Maternal care for disproportion due to outlet contraction (pelvis)

Note: One of the following 7th characters is to be assigned to code O33.3. 7th character 0 is for single gestations and multiple gestations where the fetus is unspecified. 7th characters 1 through 9 are for cases of multiple gestations to identify the fetus for which the code applies. The appropriate code from category O30, Multiple gestation, must also be assigned when assigning code O33.3 with a 7th character of 1 through 9.
Code Examples

- **036.812** Decreased fetal movements, second trimester
  0 not applicable or unspecified
  1 fetus 1
  2 fetus 2
  3 fetus 3
  4 fetus 4
  5 fetus 5
  9 other fetus

+ **036.813** Decreased fetal movements, third trimester
+ **036.819** Decreased fetal movements, unspecified trimester

**036.82** Fetal anemia and thrombocytopenia
  + **036.821** Fetal anemia and thrombocytopenia, first trimester
  + **036.822** Fetal anemia and thrombocytopenia, second trimester
  + **036.823** Fetal anemia and thrombocytopenia, third trimester
  + **036.829** Fetal anemia and thrombocytopenia, unspecified trimester

**036.89** Maternal care for other specified fetal problems
  + **036.891** Maternal care for other specified fetal problems, first trimester
  + **036.892** Maternal care for other specified fetal problems, second trimester
  + **036.893** Maternal care for other specified fetal problems, third trimester
Labor and Delivery
Key Documentation Issues

During labor and delivery, documentation should:

• Identify type of delivery (e.g., vaginal vs. cesarean)
• Specify the outcome of delivery
• Specify any assistance to facilitate delivery (e.g., use of forceps, fetal manipulation)
• Specify any complications of anesthesia
• Identify any complication(s) associated with the labor and delivery of the fetuses (e.g., failed trial of labor, obstruction of labor due to CPD, prolapsed cord)
Key Documentation Issues

During labor and delivery, documentation should:

• Identify, in multiple pregnancies, the fetus that is affected by any complication(s) of labor and delivery
• Identify any condition(s) associated with the complication (e.g., placenta previa with or without hemorrhage)
• Identify any pre-existing condition
• Specify any underlying condition and/or manifestation
• Document any environmental exposure(s)
Encounter for delivery (080-082)

**080  Encounter for full-term uncomplicated delivery**  
Delivery requiring minimal or no assistance, with or without episiotomy, without fetal manipulation [e.g., rotation version] or instrumentation [forceps] of a spontaneous, cephalic, vaginal, full-term, single, live-born infant. This code is for use as a single diagnosis code and is not to be used with any other code from chapter 15. This code must be accompanied by a delivery code from the appropriate procedure classification.

*Use additional code to indicate outcome of delivery (Z37.0)*

**082  Encounter for cesarean delivery without indication**  
This code must be accompanied by a delivery code from the appropriate procedure classification.

*Use additional code to indicate outcome of delivery (Z37.0)*
Code Examples

+069.0  Labor and delivery complicated by prolapse of cord

-069.1  Labor and delivery complicated by cord around neck, with compression
  **Excludes1:** labor and delivery complicated by cord around neck, without compression (069.81)

0  not applicable or unspecified
1  fetus 1
2  fetus 2
3  fetus 3
4  fetus 4
5  fetus 5
9  other fetus

+069.2  Labor and delivery complicated by other cord entanglement, with compression
  Labor and delivery complicated by compression of cord NOS
  Labor and delivery complicated by entanglement of cords of twins in monoamniotic sac
  Labor and delivery complicated by knot in cord
  **Excludes1:** labor and delivery complicated by other cord entanglement, without compression (069.82)
Code Examples

069.8  Labor and delivery complicated by other cord complications

-069.81  Labor and delivery complicated by cord around neck, without compression
  0  not applicable or unspecified
  1  fetus 1
  2  fetus 2
  3  fetus 3
  4  fetus 4
  5  fetus 5
  9  other fetus

+069.82  Labor and delivery complicated by other cord entanglement, without compression

+069.89  Labor and delivery complicated by other cord complications

+069.9  Labor and delivery complicated by cord complication, unspecified
Code Examples

066.1 Obstructed labor due to locked twins
066.2 Obstructed labor due to unusually large fetus
066.3 Obstructed labor due to other abnormalities of fetus
  Dystocia due to fetal ascites
  Dystocia due to fetal hydrops
  Dystocia due to fetal meningomyelocele
  Dystocia due to fetal sacral teratoma
  Dystocia due to fetal tumor
  Dystocia due to hydrocephalic fetus
  *Use additional code to identify cause of obstruction*

066.4 Failed trial of labor
  066.40 Failed trial of labor, unspecified
  066.41 Failed attempted vaginal birth after previous cesarean delivery
  *Code first rupture of uterus, if applicable (071.0-, 071.1)*

066.5 Attempted application of vacuum extractor and forceps
  Attempted application of vacuum or forceps, with subsequent delivery by forceps or cesarean delivery

066.6 Obstructed labor due to other multiple fetuses

066.8 Other specified obstructed labor
  *Use additional code to identify cause of obstruction*

066.9 Obstructed labor, unspecified
  Dystocia NOS
Code Examples

044 Placenta previa

044.0 Placenta previa specified as without hemorrhage
Low implantation of placenta specified as without hemorrhage
044.00 Placenta previa specified as without hemorrhage, unspecified trimester
044.01 Placenta previa specified as without hemorrhage, first trimester
044.02 Placenta previa specified as without hemorrhage, second trimester
044.03 Placenta previa specified as without hemorrhage, third trimester

044.1 Placenta previa with hemorrhage
Low implantation of placenta, NOS or with hemorrhage
Marginal placenta previa, NOS or with hemorrhage
Partial placenta previa, NOS or with hemorrhage
Total placenta previa, NOS or with hemorrhage

Excludes1: labor and delivery complicated by hemorrhage from vasa previa (069.4)

044.10 Placenta previa with hemorrhage, unspecified trimester
044.11 Placenta previa with hemorrhage, first trimester
044.12 Placenta previa with hemorrhage, second trimester
044.13 Placenta previa with hemorrhage, third trimester
Contraceptive Management and Surveillance
Key Documentation Issues

For contraception management, documentation should:

• Specify the reason for the encounter (e.g., counseling, insertion of device, surveillance of previous management)
• Identify the type of contraception prescribed (e.g., IUD, oral contraceptives, injectable)
• Specify if encounter is for sterilization
• Identify if removal and re-insertion of a contraceptive device is during the same episode of care
Code Examples

- **Z30.013** Encounter for initial prescription of injectable contraceptive
- **Z30.014** Encounter for initial prescription of intrauterine contraceptive device
  - Excludes1: encounter for insertion of intrauterine contraceptive device (Z30.430, Z30.432)
- **Z30.018** Encounter for initial prescription of other contraceptives
- **Z30.019** Encounter for initial prescription of contraceptives, unspecified
- **Z30.02** Counseling and instruction in natural family planning to avoid pregnancy
- **Z30.09** Encounter for other general counseling and advice on contraception
  - Encounter for family planning advice NOS
- **Z30.2** Encounter for sterilization
- **Z30.4** Encounter for surveillance of contraceptives
  - **Z30.40** Encounter for surveillance of contraceptives, unspecified
  - **Z30.41** Encounter for surveillance of contraceptive pills
    - Encounter for repeat prescription for contraceptive pill
  - **Z30.42** Encounter for surveillance of injectable contraceptive
  - **Z30.43** Encounter for surveillance of intrauterine contraceptive device
    - **Z30.430** Encounter for insertion of intrauterine contraceptive device
    - **Z30.431** Encounter for routine checking of intrauterine contraceptive device
    - **Z30.432** Encounter for removal of intrauterine contraceptive device
Routine Care and Follow Up
Key Documentation Issues

For routine GYN care and follow-up, documentation should:

• Specify the reason for the encounter (e.g., GYN routine visit, postpartum visit)
• Document any abnormal finding(s) or test result(s) during encounter
• Specify postpartum care for lactating mother
• Identify if removal and reinsertion of a conception device is during the same episode of care
• Identify any postmenopausal status
• Identify any postsurgical and/or postprocedural status (e.g., TAH)
Use additional code:
for screening for human papillomavirus, if applicable, (Z11.51)
for screening vaginal pap smear, if applicable (Z12.72)
to identify acquired absence of uterus, if applicable (Z90.71-)

Excludes1: gynecologic examination status-post hysterectomy for malignant condition (Z08)
screening cervical pap smear not a part of a routine gynecological examination (Z12.4)

Z01.411  Encounter for gynecological examination (general) (routine) with abnormal findings
Z01.419  Encounter for gynecological examination (general) (routine) without abnormal findings

Use additional code to identify abnormal findings

Z01.42  Encounter for cervical smear to confirm findings of recent normal smear following initial abnormal smear
Code Examples

Z39  Encounter for maternal postpartum care and examination

Z39.0  Encounter for care and examination of mother immediately after delivery
  Care and observation in uncomplicated cases when the delivery occurs outside a healthcare facility
  Excludes1: care for postpartum complication- see Alphabetic index

Z39.1  Encounter for care and examination of lactating mother
  Encounter for supervision of lactation
  Excludes1: disorders of lactation (092.-)

Z39.2  Encounter for routine postpartum follow-up
Summary

Appropriate Documentation

• Supports treatment provided
• Supports the severity of the patient’s illness
• Improves communication between healthcare providers
Overview of PCS
The Facts

- Centers for Medicare and Medicaid Services contracted with 3M Health Information Systems in 1993 to design and develop a new classification system
- To be implemented in the US on October 1, 2014 to capture hospital inpatient procedures
- Replaces the current classification system used in ICD-9

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>ICD-10-PCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>68.23</td>
<td>0U5B8ZZ Destruction of Endometrium, Via Natural or Artificial Opening Endoscopic Approach</td>
</tr>
</tbody>
</table>
Impacts of PCS

• ICD-10 PCS supports current clinical practice, terminology, greater detail in specifying the care being provided, and the ability to expand as new technologies and procedures are developed
• Reinforces specificity of physician documentation to support medical necessity and correct reporting of services provided
• May improve reimbursement by diminishing the reporting of unspecified procedure codes for emerging technologies which can now more easily be expanded in the ICD-10 PCS code set
Key Attributes of PCS Coding System

Multi-axial codes
• Contains independent characters
• Individual axis that maintains its meaning across a range of codes

Standardized terminology
• Definitions of each character value are well-defined with no multiple meanings, and each character value is assigned a specific meaning

Completeness
• Unique code for each substantially different procedure

Expandability
• Structure allows for easy expansion and flexibility to incorporate new procedures as well as emerging technology
Format and Structure

0U5B8ZZ  Destruction of Endometrium, Via Natural or Artificial Opening Endoscopic

<table>
<thead>
<tr>
<th>Section</th>
<th>Body system</th>
<th>Root Operation</th>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Surgical</td>
<td>Female Reproductive System</td>
<td>Destruction</td>
<td>Endometrium</td>
<td>Natural or Artificial Opening Endoscopic</td>
<td>No Device</td>
<td>No Qualifier</td>
</tr>
<tr>
<td>0</td>
<td>U</td>
<td>5</td>
<td>B</td>
<td>4</td>
<td>Z</td>
<td>Z</td>
</tr>
</tbody>
</table>
General Character Definitions

Character 1 - The first character specifies the section, or general type of procedure e.g. medical and surgical, obstetrics, imaging, etc.

Character 2 - Defines the body system – the general physiological system or anatomical region involved

Character 3 - Defines the root operation, or the objective of the procedure

Character 4 - Defines the body part, or specific anatomical site where the procedure was performed
Character Definitions

Character 5 - Defines the technique used to reach the site of the procedure
Character 6 - Defines the presence of a device, prosthesis, implant, graft, mechanical and/or electronic appliance left in place at the end of the procedure
Character 7 - Defines unique values for individual procedures as needed and specifies additional attributes of the procedure, if applicable. Examples of qualifiers include “diagnostic” (biopsy) and “transplant of an organ” (by donor type)
Medical and Surgical Section PCS Characters
Female Reproductive System
<table>
<thead>
<tr>
<th>Root Operation</th>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Bypass</td>
<td>0 Ovary, Right</td>
<td>0 Open</td>
<td>0 Drainage Device</td>
<td>0 Allogenic</td>
</tr>
<tr>
<td>2 Change</td>
<td>1 Ovary, Left</td>
<td>3 Percutaneous</td>
<td>1 Radioactive Element</td>
<td>1 Syngeneic</td>
</tr>
<tr>
<td>5 Destruction</td>
<td>2 Ovaries, Bilateral</td>
<td>4 Percutaneous Endoscopic</td>
<td>3 Infusion Device</td>
<td>2 Zooplastic</td>
</tr>
<tr>
<td>7 Dilation</td>
<td>3 Ovary</td>
<td>7 Via Natural or Artificial Opening</td>
<td>7 Autologous Tissue Substitute</td>
<td>5 Fallopian Tube, Right</td>
</tr>
<tr>
<td>8 Division</td>
<td>4 Uterine Supporting Structure</td>
<td>8 Via Natural or Artificial Opening Endoscopic</td>
<td>C Extraluminal Device</td>
<td>6 Fallopian Tube, Left</td>
</tr>
<tr>
<td>Root Operation</td>
<td>Body Part</td>
<td>Approach</td>
<td>Device</td>
<td>Qualifier</td>
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<td>----------------</td>
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</tr>
<tr>
<td>9  Drainage</td>
<td>5  Fallopian Tube, Right</td>
<td>F  Via Natural or Artificial Opening With Percutaneous Endoscopic Assistance</td>
<td>D  Intraluminal Device</td>
<td>9  Uterus</td>
</tr>
<tr>
<td>B  Excision</td>
<td>6  Fallopian Tube, Left</td>
<td>X  External</td>
<td>G  Intraluminal Device, Pessary</td>
<td>X  Diagnostic</td>
</tr>
<tr>
<td>C  Extirpation</td>
<td>7  Fallopian Tube, Bilateral</td>
<td></td>
<td>H  Contraceptive Device</td>
<td>Z  No Qualifier</td>
</tr>
<tr>
<td>D  Extraction</td>
<td>8  Fallopian Tubes</td>
<td></td>
<td>J  Synthetic Substitute</td>
<td></td>
</tr>
<tr>
<td>Root Operation</td>
<td>Body Part</td>
<td>Approach</td>
<td>Device</td>
<td>Qualifier</td>
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</tr>
<tr>
<td>F Fragmentation</td>
<td>9 Uterus</td>
<td></td>
<td>K Nonautologous Tissue Substitute</td>
<td></td>
</tr>
<tr>
<td>H Insertion</td>
<td>B Endometrium</td>
<td></td>
<td>Y Other Device</td>
<td></td>
</tr>
<tr>
<td>J Inspection</td>
<td>C Cervix</td>
<td></td>
<td>Z No Device</td>
<td></td>
</tr>
<tr>
<td>L Occlusion</td>
<td>D Uterus and Cervix</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>M Reattachment</td>
<td>F Cul-de-sac</td>
<td></td>
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</tr>
<tr>
<td>N Release</td>
<td>G Vagina</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>P Removal</td>
<td>H Vagina and Cul-de-sac</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q Repair</td>
<td>J Clitoris</td>
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### Female Reproductive System – Characters (Continued)

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<td>S Reposition</td>
<td>K Hymen</td>
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<td>T Resection</td>
<td>L Vestibular Gland</td>
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<td>U Supplement</td>
<td>M Vulva</td>
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<tr>
<td>V Restriction</td>
<td>N Ova</td>
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</tr>
<tr>
<td>W Revision</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>X Transfer</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Y Transplantation</td>
<td></td>
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Obstetrics Section PCS Characters Pregnancy
## Obstetrics – PCS Characters (Continued)

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<th>Qualifier</th>
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<tr>
<td>2 Change</td>
<td>0 Products of Conception</td>
<td>0 Open</td>
<td>3 Monitoring Electrode</td>
<td>0 Classical</td>
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<tr>
<td>9 Drainage</td>
<td>1 Products of Conception, Retained</td>
<td>3 Percutaneous</td>
<td>Y Other Device</td>
<td>1 Low Cervical</td>
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<tr>
<td>A Abortion</td>
<td>2 Products of Conception, Ectopic</td>
<td>4 Percutaneous Endoscopic</td>
<td>Z No Device</td>
<td>2 Extraperitoneal</td>
</tr>
<tr>
<td>D Extraction</td>
<td></td>
<td>7 Via Natural or Artificial Opening</td>
<td>3 Low Forceps</td>
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## Obstetrics – PCS Characters (Continued)

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<tr>
<td>E Delivery</td>
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<td>8 Via Natural or Artificial Opening Endoscopic</td>
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<td>H Insertion</td>
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<td>High Forceps</td>
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<td>J Inspection</td>
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<td>Vacuum</td>
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<td>P Removal</td>
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<td>7</td>
<td>Internal Version</td>
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<tr>
<td>Q Repair</td>
<td></td>
<td></td>
<td>8</td>
<td>Other</td>
</tr>
<tr>
<td>S Reposition</td>
<td></td>
<td></td>
<td>9</td>
<td>Fetal Blood</td>
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# Obstetrics – PCS Characters

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<tr>
<td>T Resection</td>
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<td>A Fetal Cerebrospinal Fluid</td>
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<tr>
<td>Y Transplantation</td>
<td></td>
<td></td>
<td></td>
<td>B Fetal Fluid, Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C Amniotic Fluid, Therapeutic</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D Fluid, Other</td>
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<td></td>
<td></td>
<td></td>
<td>E Nervous System</td>
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<td>F Cardiovascular System</td>
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<td>G Lymphatics &amp; Hemic</td>
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<td></td>
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<td></td>
<td>H Eye</td>
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# Obstetrics – PCS Characters

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<th>Root Operation</th>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
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<td>1   Obstetrics</td>
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<td></td>
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</tr>
<tr>
<td>0   Pregnancy</td>
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</table>

<table>
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<th>Root Operation</th>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>J    Ear, Nose &amp; Sinus</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>K    Respiratory System</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>L    Mouth &amp; Throat</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M    Gastrointestinal System</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N    Hepatobiliary &amp; Pancreas</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>P    Endocrine System</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>Q    Skin</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td>R    Musculoskeletal System</td>
</tr>
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</table>
Obstetrics – PCS Characters (Continued)

<table>
<thead>
<tr>
<th>Root Operation</th>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>1   Obstetrics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0   Pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **S** Urinary System
- **T** Female Reproductive System
- **U** Amniotic Fluid, Diagnostic
- **V** Male Reproductive System
- **W** Laminaria
- **X** Abortifcient
- **Y** Other Body Systems
- **Z** No Qualifier
### Example of Delivery – Vaginal

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Products of Conception</strong></td>
<td>X External</td>
<td>Z No Device</td>
<td>Z No Qualifier</td>
</tr>
</tbody>
</table>

Selected Code: **10E0XZZ**

*Delivery of Products of Conception, External Approach*

Current book is ICD-10-PCS Procedure Tabular

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Example of Extraction – Low Forceps Delivery

<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Operation</th>
<th>Description</th>
<th>Selected Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Obstetrics</td>
<td>D Extraction</td>
<td>Pulling or stripping out or off all or a portion of a body part by the use of force</td>
<td>10D07Z3</td>
</tr>
</tbody>
</table>

**Extraction of Products of Conception, Low Forceps, Via Natural or Artificial Opening**

**Current book is ICD-10-PCS Procedure Tabular**

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0 Products of Conception</strong></td>
<td><strong>0 Open</strong></td>
<td><strong>Z No Device</strong></td>
<td><strong>3 Low Forceps</strong></td>
</tr>
<tr>
<td>1 Products of Conception, Retained</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Products of Conception, Ectopic</td>
<td>7 Via Natural or Artificial Opening</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Example of Extraction – Cesarean Section

Selected Code: **1OD0OZ1**

**Extraction of Products of Conception, Low Cervical, Open Approach**

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Products of Conception</td>
<td>0 Open</td>
<td>Z No Device</td>
<td>0 Classical</td>
</tr>
<tr>
<td>1 Products of Conception, Retained</td>
<td>7 Via Natural or Artificial Opening</td>
<td>✓</td>
<td>1 Low Cervical</td>
</tr>
<tr>
<td>2 Products of Conception, Ectopic</td>
<td></td>
<td></td>
<td>2 Extraperitoneal</td>
</tr>
</tbody>
</table>
Tubal Ligation
## Example of Occlusion

### ICD-10-PCS Coding Example

**Section:** 0 Medical and Surgical  
**Body System:** U Female Reproductive System  
**Operation:** L Occlusion - *Completely closing an orifice or the lumen of a tubular body part*

**Selected Code:** **0UL74CZ**

**Occlusion of Bilateral Fallopian Tubes with Exraluminal Device, Percutaneous Endoscopic Approach**

**Current book is ICD-10-PCS Procedure Tabular**

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Fallopian Tube, Right</td>
<td>0 Open</td>
<td>C Extraluminal Device</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>6 Fallopian Tube, Left</td>
<td>3 Percutaneous</td>
<td>D Intraluminal Device</td>
<td></td>
</tr>
<tr>
<td>7 Fallopian Tubes, Bilateral</td>
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<td>F Cul-de-sac</td>
<td>7 Via Natural or Artificial Opening</td>
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<tr>
<td>G Vagina</td>
<td>8 Via Natural or Artificial Opening Endoscopic</td>
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</table>
Example of Destruction

Section 0 Medical and Surgical
Body System U Female Reproductive System
Operation 5 Destruction - Physical eradication of all or a portion of a body part by the direct use of energy, force, or a destructive agent

Selected Code: 0U574ZZ

Destruction of Bilateral Fallopian Tubes, Percutaneous Endoscopic Approach

Current book is ICD-10-PCS Procedure Tabular

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
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<tbody>
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<td>4 Uterine Supporting</td>
<td>3 Percutaneous</td>
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<td>7 Via Natural or</td>
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<td>8 Via Natural or</td>
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Hysterectomy
Example of Resection

**Section:** Medical and Surgical  
**Body System:** Female Reproductive System  
**Operation:** T Resection – *Cutting out or off, without replacement, all of a body part*

Selected Code: **0UT90ZZ**

Resection of Uterus, Open Approach

Current book is ICD-10-PCS Procedure Tabular

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Summary

Appropriate Documentation

• Supports appropriate procedure performed; identified by the root operation
• Supports emerging technology
• Improves continuity of care in relation to diagnosis and procedures performed
Thank You
For Your Time and Attention!
References

All screen shots used in this document are the property of: