ICD-10-CM Coding Workbook for OB/GYN

Specialty coding guidance for ICD-10-CM

2016
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Case Studies and Questions

This section includes case studies (titled by the type of procedure or encounter), a word search, and other types of exercises and puzzles. The case studies are followed by questions, including fill-in-the-blank, multiple choice, true or false, or matching columns. Answers with detailed rationales are in the following chapter.

Case Study #1—Excision of Mass and Bilateral Salpingo-oophorectomy

Description
Patient presented with a chief complaint of abdominal and pelvic pain and mass, confirmed by ultrasound. Patient requested removal of tubes and ovaries for pain control and evaluation of mass.

Preoperative Diagnoses
Abdominal and pelvic pain; abdominal mass; prior hysterectomy with preservation of tubes and ovaries

Postoperative Diagnoses
Benign abdominal wall neoplasm; adhesions; abdominal and pelvic pain

Procedures Performed
Exploratory laparotomy
Bilateral salpingo-oophorectomy
Lysis of adhesions
Removal abdominal wall mass

Anesthesia
General endotracheal anesthesia

Estimated Blood Loss
Minimal

Findings
Adhesions were found on the descending colon, cecum, adnexa, and vaginal cuff. Benign neoplastic mass on the abdominal wall.

Procedure
The patient was placed in the supine position and was draped and prepped in the routine sterile manner.

A transverse lower abdominal incision was made entering the abdomen. Adhesions due to prior procedures were lysed using Bovie and sharp dissection with care not to enter the bowel wall. All adhesions were freed to allow visual access to the surgical field. The adnexa were examined. They were freed from their attachment to the pelvic sidewall and vaginal cuff using sharp dissection and Bovie cautery. The ovarian pedicles were located bilaterally, clamped, cut, and ligated by suture. Next, the attachment to the vaginal cuff was clamped, cut, and ligated by suture bilaterally. The ovaries and tubes were removed and sent for pathology. Hemostasis was completed.
We then turned to the abdominal wall and identified a mass with inflammatory changes. These were consistent with benign neoplastic changes resulting from adhesion reaction versus old endometriosis. The majority of the mass was removed and sent for pathology. Residual tissues were removed by excision or Bovie cautery destruction. At the completion, there was no visible residual pathology present, and surrounding structures were patent.

A layered closure of 3-0 Vicryl suture on the peritoneum, intermittently locking PDS suture on the fascia, 3-0 Vicryl suture on the subcutaneous tissue, and a subcuticular Prolene stitch on the skin were completed.

Sponge and needle count was correct, and the patient was taken to the recovery room in good condition.

**Drains**
None

**Post-op Progress Note**
Pathology report reviewed and confirms benign neoplasm of abdominal wall.
Questions

1. **Determine the appropriate diagnosis codes to indicate why the procedure was performed.**

2. **What alphabetic index subterms are used to locate the adhesions of the abdominal wall as documented in this report?**
   - a. Abdominal wall
   - b. Peritoneum
   - c. Pelvic postpartal
   - d. Postoperative pelvic

3. **What index main term is used to identify the pelvic mass as documented?**
   - a. Mass, abdomen
   - b. Neoplasm, abdomen, wall, benign
   - c. Disease, pelvic, inflammatory
   - d. Abdomen, mass, inflammatory

4. **What code is used to report the abdominal and pelvic pain?**
   - a. R10.2
   - b. R10.33
   - c. R10.84
   - d. Do not report abdominal and pelvic pain

5. **What documents are sourced to determine how to code the mass?**
   - a. Operative note
   - b. Pathology report
   - c. Admitting history and physical
   - d. Operative note and pathology report
6. **What codes are used to report history of adhesions?**
   a. N73.6
   b. Z87.59
   c. Z98.89
   d. Included in other diagnosis codes
Case Study Answers

Number of Pregnancies and Deliveries
Throughout the case studies, the terms gravida and para are used. It is important to understand what the numbers associated with these terms mean when coding as they may hold clues to the patient’s status.

Gravida. The gravida number represents the number of times the patient has been pregnant, including current pregnancies. The outcome of the pregnancy is not included in this number.

Para. The para number represents the number of deliveries, vaginal or cesarean.

Para may also be represented as a series of four numbers, # # # #, representing full-term deliveries, preterm deliveries, abortions (spontaneous or induced), live births.

Case studies use gravida, para; or they may use the gravida, para # # # # format. See page 4 for more information.

Case Study #1—Excision of Mass and Bilateral Salpingo-oophorectomy

1. Determine the appropriate diagnosis codes to indicate why the procedure was performed.

   D21.4 Benign neoplasm of connective and other soft tissue of abdomen

   N99.4 Postprocedural pelvic peritoneal adhesions

The pathology report confirmed that the abdominal wall mass was a benign neoplasm. The neoplasm table is used to determine the correct code. As the table is organized by anatomic site, the term “Abdomen” is located first. Next, the coder looks under the subterm “wall,” indented below “Abdomen,” and then the type of lesion (benign), leading to code D21.4. This is verified in the tabular list.

The operative report also indicates that adhesions were present secondary to prior surgical procedures. To locate the appropriate code for the adhesions, the coder turns to the main term “Adhesions,” subterms “abdominal (wall),” and finds instructions to “see Adhesions, peritoneum.” The subterm “peritoneum” includes the parenthetical modifier “postprocedural.” The procedure note specifically states that the adhesions are postprocedure and are “low abdominal,” so the coder can scan the subterms to determine if a specific code is available. In this case, the subterm “pelvic, female” is more specific and includes an additional subterm “postoperative.” Code N99.4 is then verified in the tabular list.
2. What alphabetic index subterms are used to locate the adhesions of the abdominal wall as documented in this report?

   a. Abdominal wall
   b. Peritoneum
   c. Pelvic postpartal
   d. Postoperative female pelvic

   The procedure report indicates that the adhesions are due to prior surgical procedures. Under the index main term “Adhesions” is the subterm “postoperative,” which includes the parenthetical term “gastrointestinal tract.” Although care was taken to avoid the gastrointestinal tract, the adhesions really do not fit in this category. The coder then should look under the additional subterms “pelvic peritoneal,” “abdominal,” or “abdominal wall,” which directs the user to “Peritoneum,” which includes parenthetical modifier “postprocedural.” As the procedure note specifically states that the adhesions are post procedure and using the directions found in the index noted to be pelvic peritoneal a more specific and correct code is found rather than a code just for peritoneal adhesions.

3. What index main term is used to identify the pelvic mass as documented?

   a. Mass, abdomen
   b. Neoplasm, abdomen, wall, benign
   c. Disease, pelvic, inflammatory
   d. Abdomen, mass, inflammatory

   The notation in the procedure note and the progress note after pathology confirmation identify the mass as a benign neoplasm. The neoplasm table lists the anatomic sites alphabetically. At “Abdomen,” “wall,” the column representing the type of lesion (benign) lists code D21.4, which is verified in the tabular list.

4. What code is used to report the abdominal and pelvic pain?

   a. R10.2 Pelvic and perineal pain
   b. R10.33 Periumbilical pain
   c. R10.84 Generalized abdominal pain
   d. Do not report abdominal and pelvic pain

   The ICD-10-CM Official Guidelines for Coding and Reporting, sections 1.C.18.a and 1.C.18.b, state that signs or symptoms are not reported separately when they are routinely associated with that diagnosis. As the abdominal and pelvic pain are symptoms of the pelvic mass and adhesions, it should not be reported. In addition, guideline 1.C.6.b.1 states that a code from category G89 (Pain) should not be assigned when the encounter’s aim is to treat the condition causing the pain.
5. What documents are sourced to determine how to code the mass?
   
a. Operative note

b. Pathology report

c. Admitting history and physical

d. Operative note and pathology report

Surgeons frequently state that a lesion or neoplasm is benign or malignant. Although sometimes a biopsy or specimen is not submitted to the laboratory for a pathologist's confirmation, when it is, the final diagnosis should not be reported without noting or reviewing the pathology report. In this encounter, the progress note after the procedure indicates that the pathologist confirmed the lesion as benign.

6. What code is used to report history of adhesions?
   
a. N73.6 Female pelvic peritonitis, unspecified

b. Z87.59 Personal history of other complications of pregnancy childbirth and the puerperium

c. Z98.89 Other specified postprocedural states

d. Included in other diagnosis codes

ICD-10-CM guidelines 1.C.18.a and 1.C.18.b state that signs or symptoms are not reported separately when they are routinely associated with that diagnosis. The history of adhesions is redundant with the concurrent postprocedural adhesion and should not be reported.