Coding Pregnancy

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While science and research have shed light on the various stages of fetal development, the process is still fascinating. This article details each month of a fetus's development and reviews common delivery complications and where related information may be documented in the record.

Pregnancy

During the first month of pregnancy the embryo looks like a tadpole; however, it has already begun developing vital organs, such as the heart and lungs. The circulatory system develops first. The brain and spinal cord develop from a neural tube, which also begins to form at this time. During the second month, the embryo looks more like a person. All the major body organs and systems are formed during the second month, but they will continue to develop over the remaining months.

During the third month the embryo, now called a fetus, is approximately two-and-half inches long. The heartbeat can be heard during prenatal visits. During the fourth month the placenta is fully formed. The placenta is responsible for the exchange of nutrients and waste between the fetus and the mother. The umbilical cord continues to grow as well. The umbilical cord and placenta do not distinguish between beneficial and harmful items, such as drugs or alcohol, to transfer to the fetus. Therefore, it is important that mothers supply the fetus with the proper nutrients.

During the fifth month the fetus becomes more active, with regular sleep and waking intervals. If a fetus is born during the sixth month, his or her skin would be red and covered with fine soft hair called lingo. During the seventh and eighth months organs such as the brain continue to develop, though the lungs remain immature.

During the ninth month the fetus reaches full term, usually considered to begin with the 37th week. The lungs mature and are ready to start functioning, and the fetus is getting ready for the labor process.

Labor

No one is sure what triggers labor, but once it begins, it progresses through three stages. The first stage is usually the longest because it requires the cervix to completely dilate to 10 centimeters.

The first stage is divided into three phases: early, active, and transition. In early labor the contractions start and the cervix begins to dilate. Active labor involves contractions increasing in intensity and length with shorter intervals between them. The cervix continues to dilate. Transition is the shortest phase. The cervix fully dilates, the contractions continue to increase in severity, and the time between the contractions is short.

The second stage involves pushing the baby out. The third stage consists of delivering the placenta.

There are many things that can affect a woman's labor, such as the size of the baby's head, the position of the baby, and the shape and diameter of the mother's pelvis. The mother's pelvis needs to be wide enough in various areas in order to facilitate delivery so the baby's head can pass through it. The bones of the baby's skull have not fused, but if the baby moves at an awkward angle the delivery can become more difficult.

Coding Conventions

ICD-9-CM guidelines state that when a woman is pregnant a condition is considered a complication of the pregnancy unless stated by the provider. The rationale for this guideline is the provider's treatment decisions are altered based upon how the treatment will affect the baby. For example, a prescribed antibiotic may be altered based upon known side effects to the fetus.

Coding professionals should assign the appropriate complication codes for a pregnant woman with anemia or diabetes, as these conditions are considered complications of pregnancy.

The delivery may also have complications even if the pregnancy did not. A complication does not imply that the provider was negligent in any fashion. Coding professionals should review documentation carefully for complications because certain conditions are considered complications of pregnancy, labor, and delivery that are not normally, such as a woman having a prior cesarean section or being of a certain age. There are different codes in the pregnancy category for those conditions.

Fifth-Digit Selection

When coding obstetrical services the selection of fifth digits is vital to accurate coding. Fifth digits represent the episode of care, and not every fifth digit is valid for all codes in the category. A fifth digit of 1 represents a delivery occurring on admission with or without an antepartum condition. This includes conditions that were complications of the pregnancy or that occurred during the delivery, such as a delayed second stage of labor, when the mother has delivered.

A fifth digit of 2 is assigned for a delivery that occurred at the current admission but a complication developed after the delivery, such as endomyometritis. A fifth digit of 3 represents an antepartum condition or complication, which means the patient is still pregnant when the admission or encounter is completed. A fifth digit of 4 represents a postpartum condition in which the woman did not deliver during the admission.

It is important to note that not all of the fifth digits may be the same for an admission. For example, a woman with gestational diabetes who delivered during an admission and subsequently developed postpartum mastitis during the same hospitalization stay would be coded with 648.81 and 675.22. However, certain fifth digits cannot be on the same admission together. For example, a fifth digit of 1 and a fifth digit of 3 could not be on the same record, as 1 represents a delivery and 3 states the patient is still pregnant.

Documentation to Review

One of the keys to coding obstetrical records is to know where to look for conditions and complications in the documentation, because the documentation is usually different from regular acute care inpatients. A copy of the prenatal or antepartum record should be sent to the hospital from the physician's office. This is usually considered the history and physical for the admission. Progress notes are generally the same format as other inpatient admissions, though there are usually few of them as the length of stays are 24 to 48 hours.

A delivery record should be present with some pregnancy conditions and, more importantly, information about the delivery, such as whether the patient's membranes ruptured artificially or spontaneously. Other documented information includes items like whether an episiotomy was performed, whether extensions or lacerations occurred, and how the baby presented—all of which could affect the code assignment.

An anesthesia record will be present if the patient received an epidural or other types of anesthesia. Lab work and other diagnostic tests may be present depending upon the condition of the patient. A coding professional may be challenged by coding obstetrical records but understanding the guidelines and common pitfalls, such as knowing certain conditions are considered complications of pregnancy, will make coding these records easier.

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