

The Importance of ICD-10 Coding in Provider and Healthcare Billing

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Many neonatologists and advanced practice providers struggle with the International Classification of Diseases, 10th Revision (ICD-10) coding. The importance of correct ICD-10 coding cannot be understated, as incorrect coding may result in denial of claims at the provider level and the healthcare system. The provider is often responsible for choosing the ICD-10 code; coders typically do not extrapolate the code from provider documentation.

Typical ICD-10 coding errors occur in provider billing when performing prenatal consultations. Correct ICD-10 coding is based on the mother and fetal condition(s) and would include conditions found in the “O” Chapter, Pregnancy, Childbirth, and the Puerperium. Weeks of gestation are recorded using Z3A.XX. These code sets are to be used only on the maternal chart; neither are appropriate for coding on an infant’s chart.

Alternatively, errors occur in provider ICD-10 coding for attendance at delivery and NICU admissions. Codes found in Z37, Outcome of Delivery, are not to be used on the infant’s chart; these are reserved for use on the maternal record. For attendance at delivery, codes found in the Z38 code set, Liveborn infants according to place of birth and type of delivery, should be used. The use of this code set is limited to the birthing hospital.

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Providers also struggle with the term infant of a normal birthweight. As noted above, “O” codes and Z3A.XX codes are not to be used on the infant’s chart. Current ICD-10 codes, P05-P8, Disorders of newborns related to the length of gestation and fetal growth, exist for the subset of infants who are preterm, low birthweight large for gestation, and post-dates. ICD-10 codes include:

- P05 - Disorders of newborns related to slow fetal growth and fetal malnutrition

- P05.0X - Light for gestation, weight less than 10th percentile with normal length, ranging from < 500g to > 2500g
- P05.1X - Small for gestational age, weight and length less than 10th percentile ranging from < 500g to < 2500g
- P07 - Disorders of newborns related to short gestation and low birth weight not elsewhere classified
 - P07.0X - Extremely low birth weight newborn, from <500g – 999g
 - P07.1X - Other low birth weight newborn, from 1000g-2499g
 - P07.2X - Extreme immaturity of newborn from <23 weeks to 27 weeks completed gestation
 - P07.3 - Preterm (Premature) newborn, from 28 weeks to 36 weeks completed gestation
- P08 - Disorders of newborns related to long gestation and high birth weight
 - P08.0 - An exceptionally large newborn baby, birth weight \geq 4500g
 - P08.1 - Other heavy for gestational age newborn, birth weight from 4000g – 4499g
 - P08.2X - Late newborn, not heavy for gestational age, from > 40 weeks to > 42 weeks gestational age.

Note there are no codes for term infants of normal birthweight, nor codes for microcephaly or macrocephaly in the “P” code set.

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Beyond provider billing, ICD-10 codes are essential in healthcare system billing. Many healthcare systems are reimbursed using a Diagnosis Related Group (DRG) system. While there are multiple DRG systems, some of the most common include Medicare Severity DRG (MS-DRG), All Patient DRG (AP-DRG), All Patient, Severity Adjusted DRG (APS-DRG) and All Patient Refined DRG (APR-DRG). The APS-DRG system is perhaps the most applicable for pediatrics, including neonatology. Many of the DRGs are weight-based and associated with/without complicating factors. However, for illustration purposes, this article will focus on mapping ICD-10 codes with the MS-DRG system.

“ICD-10 codes that are not neonatal-specific and do not map to the appropriate DRG can adversely impact reimbursement. Two salient examples are the inappropriate use of hypoglycemia codes E16.1 and E16.2 and jaundice code R17. In the case of isolated transient hypoglycemia, E16.1 or E16.2 maps to a DRG associated with adult and/or familial endocrine disorders or miscellaneous disorders of nutrition, metabolism, or electrolytes.”

The MS-DRG system consists of seven codes, 789-795, which includes neonates who died or were transferred, normal newborn, extreme immaturity or respiratory distress syndrome, prematurity with/without major problems, full-term neonate with major problems and neonate with other significant problems, respectively. As might be expected, the weight and gestational age codes map into the DRGs associated with prematurity or neonates with major problems.

“In the second example, neonatal jaundice is often coded R17, which does not map to a DRG. “R” codes are signs and symptoms without additional diagnosis. Appropriate use would include cases in which a specific diagnosis cannot be made after evaluation or transient signs or symptoms where a cause could not be determined—uncomplicated jaundice in a newborn, P59.9, maps to DRG 795, Normal newborn.”

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Question: As medical director of your level IV NICU and coding expert for your practice group, the hospital coding supervisor contacts you via email to discuss the persistent use of hypoglycemia code E16.2 in the NICU. Your response is:



- A. Create a snack pantry with candy infused with high fructose corn syrup
- B. Ignore the email for two weeks and hope that the coding supervisor leaves you alone
- C. Inform the coding supervisor that this is unrelated to physician billing and not your problem
- D. Recognize that improper coding can adversely impact hospital reimbursement and suggest a documentation improvement program to address improper ICD-10 coding.

Correct answer D. Although a snack pantry is always a good idea, the medical director recognizes the importance of correct coding in physician and hospital revenue and suggests a reasonable ap-

proach to improve coding and documentation.

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Telehealth in the NICU

The thoughtful use of telehealth technology can improve care and minimize the risks of exposure to COVID-19.

Use technology to help parents bond with their babies when they can't be bedside.

The move to telehealth services can compound inequities and disparities. Assess each family's technology skills and needs - including the need to use their preferred language.



Consult with specialists.



Move family education and resources online.



Provide parents lactation support.



Screen for perinatal mood and anxiety disorders (PMADs).



Facilitate shared decision-making.



Support case management.



My Perinatal Network and My NICU Network are products of a collaboration between National Perinatal Association (NPA) and NICU Parent Network (NPN).

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