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ICD-10 for Gastroenterology

UConn Health

Just himagine what we can accomplish together.

Introductions

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Agenda

- After attending this session participants will be able to:
  - Describe the challenges associated with ICD-10 implementation
  - Identify documentation standards necessary for complete and accurate code assignment for the most frequent diagnoses used by physicians and hospitalists
  - Identify the importance of physician documentation and coding
  - Discuss the importance of the query writing process and physician response

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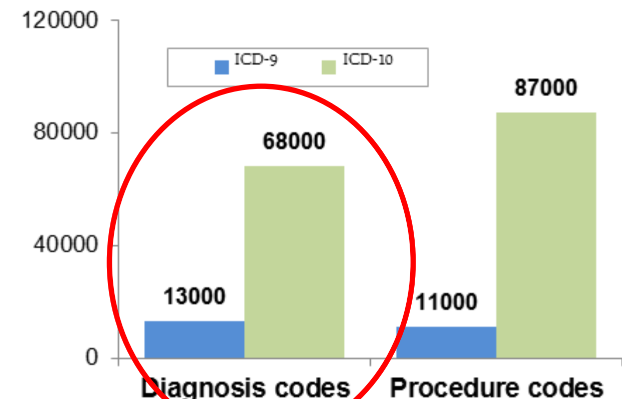
Changes to Diagnosis Codes

The most significant difference between ICD 9 and ICD 10 is the size and composition of the new codes

- ICD 9 is five digits where ICD 10 is 7 alphanumeric characters
- Re-structured classification
- Specificity and detail have been expanded

ICD 10 better describes acuity, complexity and laterality of the patients under your care

Number of ICD 9 and ICD 10 codes for diagnoses and procedures



(Source: ICD-10-CM and ICD-10-PCS Update, Thirteenth National HIPAA Summit, 9/26/2006; Rand Study, March 2004)

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Considerations

ICD-10 requires collaboration*, collaboration and more collaboration* ***between all members of the*** *clinical and non-clinical* ***healthcare team****:*

- Education of CDI/coder staff
- Template revisions
- Query revisions

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Challenges

Documentation by the physician of specific components of a particular classification (diagnosis code) ***is required***:

- Test results, labs, x-rays, EKGs, echo reports, path reports, studies performed for diagnosis ***are not sufficient documentation*** for classifying (coding) a disease/injury
- ***Coders are only allowed to use physician documentation to classify a disease/injury or procedure***

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Documentation for Diagnoses

Requirements for Detailed Documentation for Diagnoses	
Acuity	Acute, chronic or both
Specific site	Sigmoid colon, wrist, upper forearm
Laterality	Right, left, bilateral
Specific type of condition	Acute blood loss anemia, type 2 diabetes with hyperglycemia
Etiology of diagnosis	Chest pain due to gastroesophageal reflux, anxiety due to alcohol abuse
Link must be established between manifestations and underlying diseases	Hypertension due to cardiovascular disease, vascular insufficiency secondary to diabetic PVD
Complications of care	Intraoperative, postoperative, mechanical malfunctions, infections
Degree of severity	Mild, moderate, severe, e.g., malnutrition: mild, moderate, severe

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Documentation for Diagnoses

Requirements for Detailed Documentation for Diagnoses	
Stages (I, II, III, IV)	Stage IV decubitus ulcer
Injury details	Place of occurrence, activity causing the injury
Episode of care	Initial treatment, subsequent treatment (for routine or delayed healing), sequela
Drug reactions/interactions/adverse reactions	Poisoning (accidental/intentional/assault/undetermin-ed), adverse effect, underdosing (due to financial hardship, age-related)
Cerebral and myocardial infarctions	Site and artery specificity
Non-pressure skin ulcers	Site, laterality and depth of tissue involvement

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Gastroenterology Diagnoses Documentation Examples

Top Diagnosis Codes

Gastroenterology - Diagnosis
V76.51 - SPECIAL SCREENING FOR MALIGNANT NEOPLASMS, COLON
530.81 - ESOPHAGEAL REFLUX
211.3 - BENIGN NEOPLASM LG BOWEL
562.10 - DIVERTICULOSIS OF COLON W/O HEMORRHAGE
564.00 - UNSPECIFIED CONSTIPATION
787.91 - DIARRHEA
V12.72 - PERSONAL HISTORY OF COLONIC POLYPS
789.00 - ABDOMINAL PAIN, UNSPECIFIED SITE
787.20 - DYSPHAGIA, UNSPECIFIED
569.3 - RECTAL ANAL HEMORRHAGE
553.3 - DIAPHRAGMATIC HERNIA
V05.3 - NEED FOR INOCULATION AGAINST VIRAL HEPATITIS
070.54 - CHRONIC HEPATITIS C WITHOUT MENTION OF HEPATIC COMA
285.9 - ANEMIA NOS
455.6 - HEMORRHOIDS NOS
536.8 - STOMACH FUNCTION DIS NEC
V76.50 - SPECIAL SCREENING FOR MALIGNANT NEOPLASMS, UNSPECIFIED INTESTINE
578.9 - GASTROINTEST HEMORR NOS
280.9 - IRON DEFIC ANEMIA NOS
535.50 - UNSPECIFIED GASTRITIS AND GASTRODUODENITIS, W/O HEMORRHAGE
V16.0 - FAMILY HX-GI MALIGNANCY
530.10 - ESOPHAGITIS,UNSPECIFIED
556.9 - ULCERATIVE COLITIS, UNSPECIFIED
530.85 - BARRETT'S ESOPHAGUS
535.10 - ATROPHIC GASTRITIS, W/O HEMORRHAGE

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Crohn’s Disease

Classifications now include

- Without complications
- With complications
  - Rectal bleeding
  - Intestinal obstruction
  - Fistula
  - Abscess
  - Other or unspecified

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Crohn's Disease ICD-10 Code Examples

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Crohn's Disease (sm. intestine, large intestine, both, unspecified)

- K50.0 – Crohn's disease of small intestine
  - K50.00 – Crohn's disease of small intestine without complications
  - K50.01 – Crohn's disease of small intestine with complications
  - K50.011 – Crohn's disease of small intestine with rectal bleeding
  - K50.012 – Crohn's disease of small intestine with intestinal obstruction
  - K50.013 – Crohn's disease of small intestine with fistula
  - K50.014 – Crohn's disease of small intestine with abscess
  - K50.018 – Crohn's disease of small intestine with other complication
  - K50.019 – Crohn's disease of small intestine with unspecified complication

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Ulcerative Colitis

Document the portion of the bowel that is affected by the disease

To properly classify **ulcerative colitis** in ICD-10-CM, physicians must specify:

Ulcerative colitis
- Without complications
- With complications
  - Rectal bleeding
  - Intestinal obstruction
  - Fistula
  - Abscess
  - Other/unspecified complication

Ulcerative (chronic) pancolitis
Ulcerative (chronic) proctitis
Ulcerative (chronic) rectosigmoiditis
Inflammatory polyps of colon
Left sided colitis
Other/unspecified

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Documentation Examples

Insufficient Documentation Detail	Sufficient Documentation Detail
39-year-old male with mild abdominal pain, some nausea and diarrhea. Bloodwork and stool test reviewed, BUN/creatinine elevated. Will admit for hydration and enteritis.	29-year-old male with abdominal pain, nausea, and severe diarrhea, recent exposure to stomach virus at home. Bloodwork and stool test negative for bacteria or other organism but shows moderate dehydration. Admit for hydration. Diagnosis: Moderate dehydration due to viral enteritis
52-yr-old female past history colitis, loss of appetite, and some vomiting. Patient with bloody diarrhea, loss of appetite, and chronic abdominal pain for 3 days. Patient normally managed as outpatient by GI service. CBC shows a drop in H/H. Patient admitted for her colitis anemia.	62-yr-old female extensive past history of chronic ulcerative colitis. Patient with bloody diarrhea, loss of appetite, and chronic abdominal pain for 3 days. Patient normally managed as outpatient by GI service. CBC shows a 30% drop in H/H. Transfusion ordered. Diagnosis: Patient has an acute flare-up of chronic ulcerative colitis with GI hemorrhage and acute blood-loss anemia

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GERD

ICD-9-CM offers **one code**:

530.81. ICD-10-CM includes two codes (but doesn't include the abbreviation GERD):

- K21.0, gastro-esophageal reflux disease with esophagitis
- K21.9, gastro-esophageal reflux disease without esophagitis

The only difference is in ICD-10-CM, we need to know whether the patient has esophagitis, any inflammation, irritation, or swelling of the esophagus.

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Anal and rectal fissures, fistulas, and abscesses

To properly classify **anal and rectal fissures, fistulas, and abscesses** in ICD-10-CM, physicians must specify:

- Fissure and fistula of anal and rectal regions
  - Acute anal fissure
  - Chronic anal fissure
  - Unspecified anal fissure
  - Anal fistula
  - Rectal fistula
  - Anorectal fistula
- Abscess of anal and rectal regions
  - Anal abscess
  - Rectal abscess
  - Anorectal abscess
  - Ischiorectal abscess
  - Intrasphincteric abscess

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Hemorrhoids

Hemorrhoids are further classified to degree:

K64.0 First degree hemorrhoids

- Grade/stage I hemorrhoids (bleeding) without prolapsed outside of anal canal

K64.1 Second degree hemorrhoids

- Grade/stage II hemorrhoids (bleeding) that prolapsed with straining, but retract spontaneously

K64.2 Third degree hemorrhoids

- Grade/stage III hemorrhoids (bleeding) that prolapsed with straining and require manual replacement back inside anal canal

K64.3 Fourth degree hemorrhoids

- Grade/stage IV hemorrhoids (bleeding) with prolapsed tissue that cannot be manually replaced

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Blood in Stool ICD-9

578 Gastrointestinal hemorrhage

- 578.0 Hematemesis
- 578.1 Blood in stool
  - Excludes occult blood (792.1)
- 578.9 Hemorrhage of GI tract, unspecified

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Blood in Stool ICD-10

K92 Other diseases of digestive system

- K92.0 Hematemesis
- K92.1 Melena
  - Excludes occult blood in feces (R19.5)
- K92.2 Gastrointestinal hemorrhage, unspecified
- K92.8 Other specified diseases of the digestive system
- K92.9 Disease of digestive system, unspecified

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Pain

The following are important documentation tips and strategies for this disease/condition as required by the specificity needed in ICD-10:

- State the acuity (i.e., acute or chronic).
- Identify the cause
- Detail the following:
  - When patients are admitted for pain management or control.
  - Psychological pain.
  - The site of the pain.

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Malnutrition and other Nutritional Deficiencies

The following are important documentation tips and strategies tor this disease/condition as required by the specificity needed in ICD-10:

- **Identify the type** or degree of malnutrition.
- **List conditions resulting from** malnutrition (e.g., nutritional short stature).
- Detail the **specific vitamin and/or mineral deficiency or disorder**.
- Provide information regarding any **adverse effects of a vitamin, mineral, or fatty acid deficiency** (e.g., Bitot's spot).
- Specify **any nutritional anemia** (e.g., EFA deficiency with secondary thrombocytopenia).

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Choledocholithiasis

ICD-10 has a combination code for bile duct calculus with cholangitis

- K80.30 Calculus of bile duct with cholangitis, unspecified, without obstruction
- K80.31 Calculus of bile duct with cholangitis, unspecified, with obstruction
- K80.32 Calculus of bile duct with acute cholangitis without obstruction
- K80.33 Calculus of bile duct with acute cholangitis with obstruction

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Cholelithiasis

Surgeons **must document the location of the stones in the biliary tract** (i.e., in the gallbladder, bile duct, or common duct) **with or without obstruction as well as the presence of any acute or chronic cholangitis** (i.e., the presence of any infection of the biliary tract above the stone) or cholecystitis

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Cholecystitis and Cholelithiasis

Physicians **must determine and document cause-and-effect relationships between cholecystitis and cholelithiasis** and the underlying condition. Some possible causes include the following:

Bacterial or helminthic biliary tract infections
Cirrhosis
Diabetes mellitus (type 2)
Dyslipidemia
Gastric bypass surgery
Hemolysis
Neoplastic disease
Sickle cell disease
Total parenteral nutrition (TPN)

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Diverticular disease

- Surgeons **must document the specific section of the bowel** that includes the diverticulosis or acute diverticulitis.
- When operating on the large intestine (colon), **specify whether the disease affects the right colon** (specify cecum, ascending colon, hepatic flexure, or transverse colon) **or left colon** (specify splenic flexure, descending colon, sigmoid colon, recto-sigmoid junction, or rectum).

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Gastrointestinal ulcers

Gastrointestinal ulcers are categorized by acuity, location, type and severity, which must be documented using the following terminology.

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Gastrointestinal ulcers

Acuity and Severity	Location	Type
• Acute • Chronic • With hemorrhage • Without hemorrhage • With perforation • Without perforation	• Esophagus • Cardia (esophageal) • Gastroesophageal • Stomach (gastric) • Pylorus • Gastro (duodenal) (jejunal) • Duodenum • Jejunum • Intestine (cecum, ileum, sigmoid) • Colon (bowel) • Rectosigmoid • Rectum • Anorectal • Anus	• Barrett's • Curling's (peptic) • Cushing's • Dysenteric • Gangrenous • Infectious (amebic, bacterial, fungal, parasitic, tubercular, viral) (specify) • Peptic • Primary small intestinal ulcer • Stercoraceous, stercoral • Stomal • Stress

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Barrett's Esophagus

Classified to **with/without dysplasia** and if dysplasia is present, it is identified as **high or low grade dysplasia.**

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Barrett's Esophagus

ICD-9

- 530.85 Barrett's esophagus

ICD-10

- K22.7 Barrett's esophagus
  - K22.70 Barrett's esophagus without dysplasia
    - Barrett's esophagus NOS
  - K22.71 Barrett's esophagus with dysplasia
    - K22.710 Barrett's esophagus with low grade dysplasia
    - K22.711 Barrett's esophagus with high grade dysplasia
    - K22.719 Barrett's esophagus with dysplasia, unspecified

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GI bleeds

GI bleeds are also classified by location and associated underlying cause, both of which must be documented for accurate coding and reporting.

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GI ulcers and bleeding always have an underlying cause, which should be documented if determined.

Use the **adjective** form or the words **"due to," "secondary to," "caused by,"** or **"resulting from"** to connect GI ulcers or bleeds to their underlying cause.

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GI bleeds

Location	(See portions of the GI tract listed for ulcer on previous screen)
Infectious or Inflammatory Causes of GI Bleeding	• Esophagitis • Gastritis (specify type or cause, such as allergic, atrophic, hypertrophic, and so forth) • Duodenitis • Enteritis (specify type or cause, such as Crohn's) • Colitis • Diverticulitis (specify with or without perforation)
Varices as Cause of GI Bleeding	• Esophageal • Gastric (stomach) • Sigmoid colon
	• Angiodysplasia or ectasia of GI vessels

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GI Bleeds and Timing

Document the timing and sequence of the events surrounding the onset, course, and resolution of the GI ulcer or bleed, or any associated condition or complications.

- Document whether the patient was admitted with a known or suspected GI ulcer or GI bleed.
- State whether the treatment and reason for admission were directed primarily at treating the GI ulcer or bleed, at the underlying cause, or at an associated condition or complication.
- If the GI ulcer or bleed was not known or suspected at admission, identify when it was first diagnosed, or when it became apparent.
- Note the occurrence of any complications or exacerbations of associated conditions that developed during the stay.
- Date and describe any medical services or surgical procedures used to diagnose or treat the GI ulcers or bleeds.
- Indicate the resolution of the GI ulcer or bleed and any associated conditions or complications.

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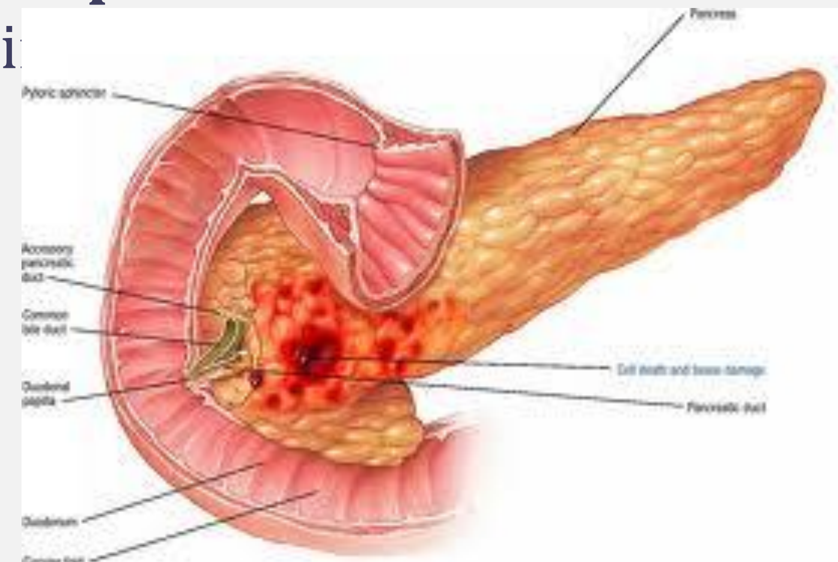
Diseases of the Pancreas

To properly classify **diseases of the pancreas** in ICD-10-CM, physicians must speci

type:

Acute pancreatitis
- Idiopathic acute pancreatitis
- Biliary acute pancreatitis
- Alcohol-induced acute pancreatitis
- Drug-induced acute pancreatitis
- Other acute pancreatitis
- Acute pancreatitis, unspecified

Other diseases of pancreas
- Alcohol-induced chronic pancreatitis
- Other chronic pancreatitis
- Cyst of pancreas
- Pseudocyst of pancreas
- Other specified/unspecified diseases of pancreas



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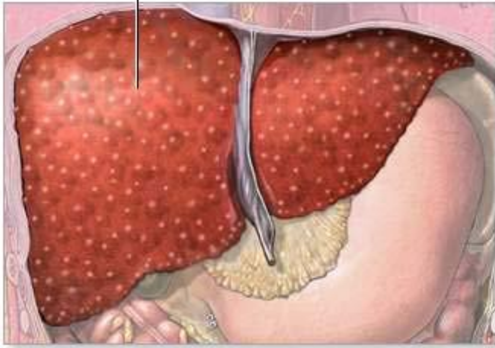

Toxic Liver Disease

To properly classify **toxic liver disease** in ICD-10-CM, physicians must specify by type.

- With cholestasis
- With hepatic necrosis
- With/without coma
- With acute hepatitis
- With chronic persistent hepatitis
- With chronic lobular hepatitis
- With chronic active hepatitis
- With/without ascites
- With hepatitis, NEC
- With fibrosis and cirrhosis of liver
- With other disorders of liver
- Unspecified

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Hemorrhage and Bleeding

In ICD-10 there have been terminology changes and revisions to the classification of some digestive conditions.

The term "hemorrhage" is used for ulcers, and the term "bleeding" is used when classifying gastritis, duodenitis, diverticulosis, and diverticulitis.

For example:

K25.0 Acute gastric ulcer with hemorrhage
K29.01 Acute gastritis with bleeding
K57.3 Diverticulitis of large intestine without perforation or abscess with bleeding

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Peritoneal adhesions

Peritoneal adhesions further classified to:

- with obstruction
- congenital
- female pelvic
- postpartal
- uterus

The more challenging aspect to this condition is when there is a procedure to lyse the adhesions**. In ICD-10-PCS it is very specific to site**, i.e., duodenum, jejunum, ileum, right/left intestine, ascending/transverse/descending and sigmoid colon as well as greater/lesser omentum, abdominal wall and peritoneum.

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Peritoneal adhesions

Each site must be coded separately; however, the lack of specificity in operative reports is challenging as physicians usually only document lysis of adhesions and don't specify the organs being "released".

Document each site being "released"

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Benign Neoplasm Colon ICD-9

211 Benign neoplasm of other parts of digestive system

- 211.0 Esophagus
- 211.1 Stomach
- 211.2 Duodenum, jejunum, and ileum
- 211.3 Colon
  - Includes appendix, cecum, ileocecal valve, large intestine NOS
- 211.4 Rectum and anal canal
- 211.5 Liver and biliary passages
- 211.6 Pancreas, except islets of Langerhans
- 211.7 Islets of Langerhans
- 211.8 Retroperitoneum and peritoneum
- 211.9 Other and unspecified site

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Benign Neoplasm Colon ICD-10

D12 Benign neoplasm of colon, rectum, anus, and anal canal

- D12.0 Cecum
- D12.1 Appendix
- D12.2 Ascending colon
- D12.3 Transverse colon
- D12.4 Descending colon
- D12.5 Sigmoid colon
- D12.6 Colon, unspecified
- D12.7 Rectosigmoid junction
- D12.8 Rectum
- D12.9 Anus and anal canal

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Smoking ICD-9

Category F17 is a separate category for nicotine dependence

With subcategories to identify the specific tobacco product

And nicotine-induced disorders. ICD-9-CM has one single

Code (305.1) for tobacco use disorder or tobacco dependence.

305 Nondependent abuse of drugs

- 305.0 Alcohol abuse
- 305.1 Tobacco use disorder
- 305.2 Cannabis abuse.....

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Smoking ICD-10

Z72 Problems related to lifestyle

Z72.0 Tobacco use

Excludes hx tobacco dependence, use in pregnancy

F17.2 Nicotine dependence

F17.21 Nicotine dependence, cigarettes

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Smoking ICD-10

F17.2 Nicotine dependence

- F17.20 Nicotine dependence, Unspecified
  - F17.200 – Uncomplicated
  - F17.201 – In remission
  - F17.203 – With withdrawal
  - F17.208 – With other nicotine-induced disorders
  - F17.209 – With unspecified nicotine-induced disorders
- F17.21 Nicotine dependence, cigarettes
  - F17.210 – Uncomplicated
  - F17.211 – In remission
  - F17.213 – With withdrawal
  - F17.218 – With other nicotine-induced disorders
  - F17.219 – With unspecified nicotine-induced disorders
- F17.29 Nicotine dependence, other tobacco products
  - F17.290 – Uncomplicated
  - F17.291 – In remission
  - F17.293 – With withdrawal
  - F17.298 – With other nicotine-induced disorders
  - F17.299 – With unspecified nicotine-induced disorders

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Treatment of ongoing chronic conditions

Documenting treatment of ongoing chronic conditions i.e. Diabetes Mellitus and the use of insulin.

- If your patient is using insulin (independently or being administered) the medical record must document the same.
- This is even more important if you are treating a patient s/p surgery or for wound care as this demonstrates existing conditions that may delay the progress or justify additional visits due to medical necessity.

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Gastritis/Gastroduodenitis ICD-9

- Gastritis and duodenitis
  - 535.0 Acute gastritis
  - 535.1 Atrophic gastritis
  - 535.2 Gastric mucosal hypertrophy
  - 535.3 Alcoholic gastritis
  - 535.4 Other specified gastritis
  - 535.5 Unspecified gastritis and gastroduodenitis
    - 535.50 without mention of hemorrhage
    - 535.51 with hemorrhage
  - 535.6 Duodenitis
  - 5357 Eosinophilic gastritis

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Gastritis/Gastroduodenitis ICD-10

- K29 Gastritis and duodenitis
  - K29.0 Acute gastritis
  - K29.2 Alcoholic gastritis
  - K29.3 Chronic superficial gastritis
  - K29.4 Chronic atrophic gastritis
  - K29.5 Unspecified chronic gastritis
  - K29.6 Other gastritis
  - K29.7 Gastritis, unspecified
    - K29.70 without bleeding
    - K29.71 with bleeding
  - K29.8 Duodenitis
    - K29.80 without bleeding
    - K29.81 with bleeding
  - K29.9 Gastroduodenitis, unspecified
    - K29.90 without bleeding
    - K29.91 with bleeding

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Gastro-esophageal Reflux ICD-9

- 530.8 Other specified disorders of esophagus
  - 530.81 Esophageal reflux
    - Includes gastroesophageal reflux
    - Excludes reflux esophagitis (530.11)
  - 530.82 Esophageal hemorrhage
  - 530.83 Esophageal leukoplakia
  - 530.84 Tracheoesophageal fistula
  - 530.85 Barrett's esophagus
  - 530.86 Infection of esophagostomy
  - 530.87 Mechanical complication of esophagostomy
  - 530.89 Other

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Gastro-esophageal Reflux ICD-10

- K21 Gastro-esophageal reflux disease
  - K21.0 Gastro-esophageal reflux disease with esophagitis
  - K21.1 Gastro-esophageal reflux disease without esophagitis

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Diaphramatic hernia ICD-9

- 553 Other hernia of abdominal cavity without mention of obstruction or gangrene
  - 553.0 Femoral hernia
  - 553.1 Umbillical hernia
  - 553.2 Ventral hernia
  - 553.3 Diaphramatic hernia

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Diaphramatic hernia ICD-10

Hernia (K40-K46)

- K44 Diaphramatic hernia
  - K44.0 Diaphramatic hernia with obstruction, without gangrene
  - K44.1 Diaphramatic hernia with gangrene
  - K44.9 Diaphramatic hernia without obstruction or gangrene

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Anemia ICD-9

- 285 Other and unspecified anemias
  - 285.0 Sideroblastic anemia
  - 285.1 Acute posthemorrhagic anemia
  - 285.2 Anemia of chronic disease
  - 285.3 Antineoplastic chemotherapy induced anemia
  - 285.8 Other specified anemias
  - 285.9 Anemia, unspecified

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Anemia ICD-10

- D62 Acute posthemorrhagic anemia
- D64 Other anemias
  - D64.0 Hereditary sideroblastic anemia
  - D64.1 Secondary sideroblastic anemia due to disease
  - D64.2 Secondary sideroblastic anemia due to drugs and toxins
  - D64.3 Other sideroblastic anemias
  - D64.4 Congenital dyserythropoietic anemia
  - D64.8 Other specified anemias
  - D64.9 Anemia, unspecified

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Benign neoplasm colon ICD-9

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  - 211.5 Liver and biliary passages
  - 211.6 Pancreas, except islets of Langerhans
  - 211.7 Islets of Langerhans
  - 211.8 Retroperitoneum and peritoneum
  - 211.9 Other and unspecified site

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Benign neoplasm colon ICD-10

- D12 Benign neoplasm of colon, rectum, anus, and anal canal
  - D12.0 Cecum
  - D12.1 Appendix
  - D12.2 Ascending colon
  - D12.3 Transverse colon
  - D12.4 Descending colon
  - D12.5 Sigmoid colon
  - D12.6 Colon, unspecified
  - D12.7 Rectosigmoid junction
  - D12.8 Rectum
  - D12.9 Anus and anal canal

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Correct use of “R” (symptom) codes

In both ICD-9-CM and ICD-10-CM, sign/symptom and unspecified codes have acceptable, even necessary, uses.

- Each healthcare encounter should be coded to the level of certainty known for that encounter.
- If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis.
- When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (e.g., a diagnosis of pneumonia has been determined, but not the specific type).

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Abdominal Pain ICD-9

- 789.0 Abdominal pain
  - 789.00 unspecified site
  - 789.01 RUQ
  - 789.02 LUQ
  - 789.03 RLQ
  - 789.04 LLQ
  - 789.05 periumbilic
  - 789.06 epigastric
  - 789.07 generalized
  - 789.09 other specific site
    - includes multiple sites

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Abdominal Pain ICD-10

- R10 Abdominal and pelvic pain
  - R10.0 Acute abdomen
  - R10.1 Pain localized to upper abdomen
  - R10.2 Pelvic and perineal pain
  - R10.3 Pain localized to other parts of lower abdomen
  - R10.8 Other abdominal pain
  - R10.9 Unspecified abdominal pain

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Abdominal Pain ICD-10

- R10 Abdominal and pelvic pain
  - R10.8 Other abdominal pain
    - R10.81 Abdominal tenderness
      - R10.811 RUQ
      - R10.812 LUQ
      - R10.813 RLQ
      - R10.814 LLQ
      - R10.815 Periumbilic
      - R10.816 Epigastric
      - R10.817 Generalized
      - R10.819 Unspecified site
    - R10.81 Rebound abdominal tenderness
      - R10.821 RUQ
      - R10.822 LUQ
      - R10.823 RLQ
      - R10.824 LLQ
      - R10.825 Periumbilic
      - R10.826 Epigastric
      - R10.827 Generalized
      - R10.829 Unspecified site
    - R10.83 Colic
    - R10.84 Generalized abdominal pain
  - R10.9 Unspecified abdominal pain

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Diarrhea ICD-9

787.9 Other symptoms involving digestive system

- 787.91 Diarrhea
  - Diarrhea NOS
- 787.99 Other

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Diarrhea ICD-10

R19.7 Diarrhea, unspecified

- Diarrhea NOS
- "R" codes are symptom codes. In ICD-10 there are many specific codes for diseases that occur with diarrhea (for example, gastroenteritis with specified and unspecified infectious causes).
- Whenever possible, it is important to code the specific disease process, not the symptom.

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Dysphagia ICD-9

787.2 Dysphagia

- 787.20 Dysphagia, unspecified
  - Difficulty in swallowing NOS
- 787.21 Dysphagia, oral phase
- 787.22 Dysphagia, oropharyngeal phase
- 787.23 Dysphagia, pharyngeal phase
- 787.24 Dysphagia, pharyngoesophageal phase
- 787.29 Other dysphagia

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Dysphagia ICD-10

R13 Aphagia and dysphagia

- R13.0 Aphagia
- R13.1 Dysphagia
  - R13.10 Dysphagia, unspecified
  - R13.11 Dysphagia, oral phase
  - R13.12 Dysphagia, oropharyngeal phase
  - R13.13 Dysphagia, pharyngeal phase
  - R13.14 Dysphagia, pharyngoesophageal phase
  - R13.19 Other dysphagia

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Nausea with Vomiting ICD-9

- 787.0 Nausea and vomiting
  - 787.01 Nausea with vomiting
  - 787.02 Nausea alone
  - 787.03 Vomiting alone
  - 787.04 Bilious emesis

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Nausea with Vomiting ICD-10

- R11 Nausea and vomiting
  - R11.0 Nausea
  - R11.1 Vomiting
    - R11.10 Vomiting, unspecified
    - R11.11 Vomiting, without nausea
    - R11.12 Projectile vomiting
    - R11.13 Vomiting of fecal matter
    - R11.14 Bilious vomiting
  - R11.2 Nausea with vomiting, unspecified

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Colonoscopy/Breast Screening ICD-9

- V76 Special screening for malignant neoplasms
  - V76.0 Respiratory organs
  - V76.1 Breast
  - V76.8 Other neoplasm
  - V76.9 Unspecified

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Colonoscopy/Breast Screening ICD-10

- Z12 Encounter for screening for malignant neoplasms
  - Z12.0 Stomach
  - Z12.2 Respiratory organs
  - Z12.3 Breast

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Colonoscopy/Prostate Screening ICD-9

- V76 Special screening for malignant neoplasms
  - V76.0 Respiratory organs
  - V76.1 Breast
  - V76.2 Cervix
  - V76.3 Bladder
  - V76.4 Other sites
    - V76.41 Rectum
    - V76.42 Oral cavity
    - V76.43 Skin
    - V76.44 Prostate
    - V76.45 Testis
    - V76.46 Ovary
    - V76.47 Vagina
    - V76.49 Other sites
  - V76.5 Intestine
    - V76.50 Intestine, unspecified
    - V76.51 Colon
    - V76.52 Small intestine
  - V76.8 Other neoplasm
  - V76.9 Unspecified

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Colonoscopy/Prostate Screening ICD-10

- Z12 Encounter for screening for malignant neoplasms
  - Z12.0 stomach
  - Z12.1 intestinal tract
    - Z12.10 unspecified
    - Z12.11 colon
    - Z12.12 rectum
    - Z12.13 small intestine
  - Z12.2 respiratory organs
  - Z12.3 breast
  - Z12.4 cervix
  - Z12.5 prostate
  - Z12.6 bladder
  - Z12.7 other GU organ
  - Z12.8 other sites
  - Z12.9 site unspecified

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Underdosing

Underdosing – new concept in ICD-10

Taking less of a medication than prescribed by physician or manufacturer's instruction

- Noncompliance
- Complication of care

Underdosing – ***Documentation Needed:***

If a patient is purposely stopping or altering their medication regimen this needs to be documented to provided accurate coding

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Underdosing

Underdosing of drugs specifies documentation of intentional or unintentional underdosing:

- Intentional underdosing
  - Due to financial hardship
  - Other reasons
- Unintentional underdosing
  - Age-related debility
  - Other reasons

Separate "Z" code that is submitted alongside the code for underdosing.

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Gastroenterology Procedure Documentation Examples

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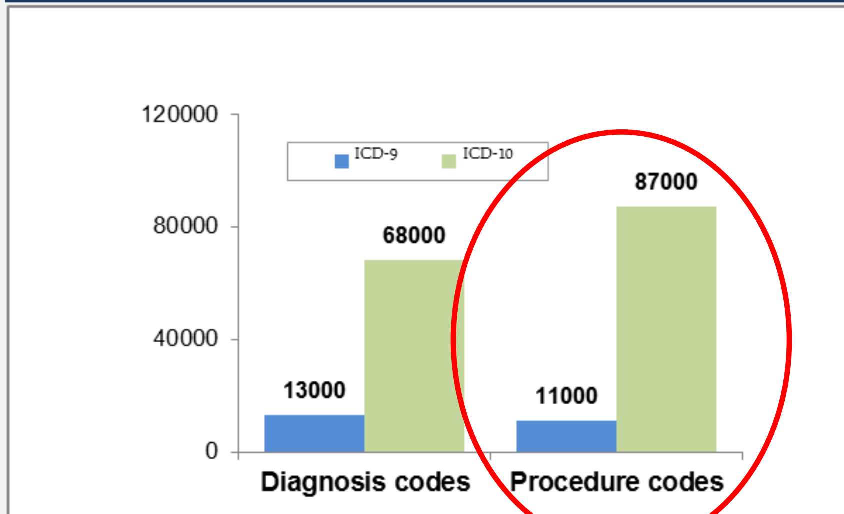
Changes to procedure codes



(Source: ICD-10-CM and ICD-10-PCS Update, Thirteenth National HIPAA Summit, 9/26/2006; Rand Study, March 2004)

ICD-10 procedure codes will require additional and significant detail in surgical reporting

- Key ICD-10 characteristics
  - ICD-10 is a "dramatic departure" from current practice
  - Surgical codes lack decimals
  - The new code set will allow for incorporation of new procedures and technologies
  - Terminology is precisely defined and used consistently across all codes

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Overview of ICD-10-PCS

- PCS stands for **Procedure Classification System.**
- It is a multiaxial system with a 7 character alphanumeric code classification providing a **unique code** for all substantially different procedures and with **easy expandability**, incorporating new procedures, technologies and devices utilized in medical/surgical procedures.
- The classification for the general surgery procedures has undergone significant revision focusing primarily on section, body system, root operation, body part, approach, device and qualifier.

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Colonoscopy/EGD with biopsy

- Documentation of "EGD with multiple biopsies" will no longer be sufficient to classify these procedures as **specific sites of the biopsies must be documented.**
- Documentation of "random" biopsies is also insufficient to classify these procedures.
- **Documentation of the specific body part is necessary for classification of these procedures**.
- Body part examples include upper esophagus, middle esophagus, lower esophagus, pylorus, other parts of the stomach, duodenum, jejunum and ileum, etc.
- **Each location of biopsy requires a separate code**

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EGD with Biopsy Example

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Section	**0**	Medical and Surgical
Body System	**D**	Gastrointestinal System
Operation	**B**	Excision: Cutting out or off, without replacement, a portion of a body part

Body Part	*Approach*	*Device*	*Qualifier*
1 Esophagus, Upper **2** Esophagus, Middle **3** Esophagus, Lower **4** Esophagogastric Junction **5** Esophagus **7** Stomach, Pylorus **8** Small Intestine **9** Duodenum **A** Jejunum **B** Ileum **C** Ileocecal Valve **E** Large Intestine **F** Large Intestine, Right **G** Large Intestine, Left **H** Cecum **J** Appendix **K** Ascending Colon **L** Transverse Colon **M** Descending Colon **N** Sigmoid Colon **P** Rectum	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**Z** No Device	**X** Diagnostic **Z** No Qualifier

Each biopsy site requires a ICD-10-PCS code. Biopsy of the duodenum is coded to 0DB98ZX

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Choledocholithotomy: ICD-9 vs. ICD-10

ICD-9-CM	ICD-10-PCS

• Method of removal or fragmentation
  • Laparoscopic
  • ERCP
  • Open
	• Type of procedure performed
	  • Calculus Fragmentation?
	  • Calculus Removal?
	• Specific site of fragmentation or removal
	• Approach
	  • Open
	  • Percutaneous
	  • Percutaneous endoscopic
	  • Via natural or artificial opening
	  • Via natural or artificial opening endoscopic

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Choledocholithotomy Example

Section	**0**	Medical and Surgical
Body System	**F**	Hepatobiliary System and Pancreas
Operation	**C**	Extirpation: Taking or cutting out solid matter from a body part

Body Part	*Approach*	*Device*	*Qualifier*
0 Liver **1** Liver, Right Lobe **2** Liver, Left Lobe **4** Gallbladder **G** Pancreas	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**Z** No Device	**Z** No Qualifier
5 Hepatic Duct, Right **6** Hepatic Duct, Left **8** Cystic Duct **9** Common Bile Duct **C** Ampulla of Vater **D** Pancreatic Duct **F** Pancreatic Duct, Accessory	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic (Via laparoscopy) **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic (Via ERCP)	**Z** No Device	**Z** No Qualifier

Removal of a stone from a body part (usually tubular) is classified to "extirpation". A laparoscopic removal of a stone from the common bile duct is coded 0FC94ZZ. If performed via ERCP the procedure is classified as 0FC98ZZ.

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Cholecysectomy

Section	0	Medical and Surgical	
Body System	F	Hepatobiliary System and Pancreas	
Operation	T	Resection: Cutting out or off, without replacement, all of a body part	

Body Part	Approach	Device	Qualifier
0 Liver **1** Liver, Right Lobe **2** Liver, Left Lobe **4** Gallbladder **G** Pancreas	**0** Open **4** Percutaneous Endoscopic	**Z** No Device	**Z** No Qualifier
5 Hepatic Duct, Right **6** Hepatic Duct, Left **8** Cystic Duct **9** Common Bile Duct **C** Ampulla of Vater **D** Pancreatic Duct **F** Pancreatic Duct, Accessory	**0** Open **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**Z** No Device	**Z** No Qualifier

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Stent Insertion Documentation Requirements

Section	**0**	Medical and Surgical
Body System	**F**	Hepatobiliary System and Pancreas
Operation	**7**	Dilation: Expanding an orifice or the lumen of a tubular body part

Body Part	*Approach*	*Device*	*Qualifier*
5 Hepatic Duct, Right **6** Hepatic Duct, Left **8** Cystic Duct **9** Common Bile Duct **C** Ampulla of Vater **D** Pancreatic Duct **F** Pancreatic Duct, Accessory	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**D** Intraluminal Device **Z** No Device	**Z** No Qualifier

Stent insertion into a tubular part is classified as an "dilation" utilizing a "device" (stent) intentionally left in the body for a therapeutic purpose; code is 0F798DZ for a stent insertion via ERCP.

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Drainage of Bile Duct

- Drainage
  - Can be performed for therapeutic and diagnostic purposes
  - With or without a drainage device left in the patient at the conclusion of the procedure
  - Via many different approaches
    - Open
    - Percutaneous
    - Percutaneous endoscopic
    - Via natural or artificial opening
    - Via natural or artificial opening endoscopic
  - Site specificity required
    - Organ specificity (liver, pancreas, gallbladder)
    - Duct specificity (common bile, cystic, pancreatic, hepatic, etc.)

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Drainage of Bile Duct Example

Section	**0**	Medical and Surgical
Body System	**F**	Hepatobiliary System and Pancreas
Operation	**9**	Drainage: Taking or letting out fluids and/or gases from a body part

Body Part	*Approach*	*Device*	*Qualifier*
0 Liver **1** Liver, Right Lobe **2** Liver, Left Lobe **4** Gallbladder **G** Pancreas	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**0** Drainage Device	**Z** No Qualifier
0 Liver **1** Liver, Right Lobe **2** Liver, Left Lobe **4** Gallbladder **G** Pancreas	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**Z** No Device	**X** Diagnostic **Z** No Qualifier
5 Hepatic Duct, Right **6** Hepatic Duct, Left **8** Cystic Duct **9** Common Bile Duct **C** Ampulla of Vater **D** Pancreatic Duct **F** Pancreatic Duct, Accessory	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**0** Drainage Device	**Z** No Qualifier
5 Hepatic Duct, Right **6** Hepatic Duct, Left **8** Cystic Duct **9** Common Bile Duct **C** Ampulla of Vater **D** Pancreatic Duct	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**Z** No Device	**X** Diagnostic **Z** No Qualifier

Via ERCP

If T-tube (or other drainage device) is left in at end of procedure

Therapeutic

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Cholangiogram

To properly classify **cholangiograms** in ICD-10, physicians must specify by the type of contrast being used for imaging.

ICD-9 Code:

- **8753 –** Intraoperative cholangiogram

ICD-10 Codes:

- **BF030ZZ** - Radiography of Gallbladder & Bile Duct using H Osm Contrast (Plain Radiography of Gallbladder and Bile Ducts using **High Osmolar Contrast)**
- **BF031ZZ** - Radiography of Gallbladder & Bile Duct using L Osm Contrast (Plain Radiography of Gallbladder and Bile Ducts using **Low Osmolar Contrast)**
- **BF03YZZ** - Radiography of Gallbladder & Bile Duct using Other Contrast (Plain Radiography of Gallbladder and Bile Ducts using **Other Contrast)**

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ICD-10-PCS Laparascopic Cholecystectomy with Cholangiogram

1st	2nd	3rd	4th	5th	6th	7th
Section 0	Body System F	Root Operation T	Body Part 4	Approach 4	Device Z	Qualifier Z

1st	2nd	3rd	4th	5th	6th	7th
Section B	Body System F	Root Operation 0	Body Part 3	Approach 1	Device Z	Qualifier Z

The ICD-10-PCS code structure tells a story

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Physician Queries

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Query…why?

A query is a communication tool used to clarify documentation in the health record for accurate code assignment.

The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment.

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

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Query…when?

A query is written when the Health record Documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear for present on admission indicator assignment

"A proper query process ensures that appropriate documentation appears in the health record"

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

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Query…when?

“A proper query process ensures that appropriate documentation appears in the health record”

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

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Query… answer?

- Coding data is incorporated into the information used by insurance companies to determine which physicians they are going to contract.

- ***Coded information is made available to consumers on various platforms, such as HealthGrades, which uses coding data as well as other information to 'rate' facility and provider service***

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Query… answer how?

Queries are generated to elicit more information from the Provider.

- A response is ***necessary*** from the provider to fulfill this process.

- A. ***signature alone on a generated query does not fulfill this requirement***

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Query… answer how?

Queries are generated in various formats depending on the information being requested:

- *Written response* format
  - Requesting provider to freehand a response
- *Multiple Choice* format
  - Requesting provider select one of the offered responses

Please sign, date and time Queries!

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Query… answer how?

A Physician response, ***'see notes'*** does not fulfill the request generated by the query.

- The coder has already reviewed the notes and Medical Record Documentation
- ***Although the response may seem 'obvious' coders are only 'reporters'*** of the medical record and ***cannot code a diagnosis*** that is ***not documented by the Provider.***

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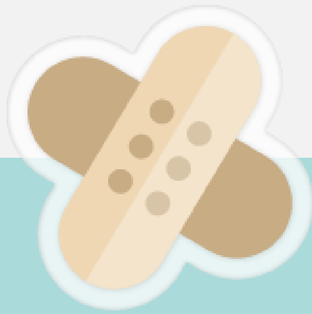

Questions?

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