ICD-10 Diagnosis Documentation Tips – Gastroenterology

Enhanced Specificity in ICD-10

- ❖ Anatomic / pathologic specificity
  - ➢ Example: Conditions of the appendix
    - New category of acute appendicitis – with localized peritonitis
    - New specified diseases of the appendix – appendicular concretions, diverticulum of appendix, fistula of appendix

Hepatic Encephalopathy:

- ➢ Be sure to document with specificity if the underlying hepatic failure is acute or subacute (impacts severity assigned)

Acute Pancreatitis: (1 code in ICD-9) – far greater specificity in ICD-10

- ❖ Idiopathic, biliary, alcohol-induced, drug-induced, other, cytomegaloviral, mumps, syphilitic

Cholecystitis: document location, acuity, and w/ or w/o obstruction

- ❖ Calculus of gallbladder, with
  - ➢ Acute, chronic or acute on chronic cholecystitis or w/o any
- ❖ Calculus of bile duct, with
  - ➢ Cholangitis, cholecystitis (acute, chronic or acute on chronic) or without either
- ❖ Calculus of gallbladder and bile duct, with
  - ➢ Cholecystitis (acute, chronic or acute on chronic) or w/o
- ❖ <u>All above: Document also whether obstruction or no obstruction</u>

Hepatitis:

- ❖ Specify type: acute, chronic persistent, chronic lobular, chronic active, fibrosis and cirrhosis, granulomatous, nonalcoholic steatohepatitis (NASH), etc.

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ICD-10 [INPATIENT] Procedural Coding Tips – Gastroenterology

Section – almost always medical/surgical, don't need to state

Body system – generally the gastro-intestinal system

Root operation – describes the intent of the procedure

- **Drainage** – paracentesis, aspiration, etc.
- **Excision** – removal of a portion of a body part (biopsies)
- **Resection** – removal of all of a body part
- **Inspection** – example, colonoscopy
- **Dilation** – ERCP dilation common bile duct

Body part – the specific body part (or subsection thereof) addressed in an procedure (chest tube place in R pleural space)

Approach – open, percutaneous, via natural opening, via natural opening endoscopic, via natural opening endoscopic with percutaneous endoscopic assistance

Device – describe the type or simply state the exact device(s) left in the patient at the conclusion of the procedure

Qualifier – if aspiration is diagnostic, be sure to state so

Recommendation: Always document at the beginning each separate procedure performed (the coder can figure out which can be separately coded)

- Example: Colonoscopy with biopsy rectal and sigmoid polyps
  - Procedure 1: Excision (biopsy) rectum, via natural opening endoscopic
  - Procedure 2: Excision (biopsy) sigmoid, via natural opening endoscopic

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