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
- All above: Document also whether obstruction or no obstruction

Hepatitis:

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