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