ICD-10 Documentation for Gastroenterology
Objectives

At the completion of this lesson the learner will be able to:

• Understand the structure for ICD-10 diagnosis coding

• Identify the primary GI intervention documentation requirements for ICD-10
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Gastroenterology Documentation Overview

While the actual number of GI diagnoses has increased from ICD-9 to ICD-10, the structure and function of coding has improved to better represent the diagnosis and acuity of GI patients.

Gastroenterology Provider Documentation Overview:

- Document location with as much specificity as possible
- Document related, secondary, or causal illness whenever appropriate
- Document the clinical findings/indicators to support the diagnosis documented
- Recall the procedure code axes and ensure documentation required to support the required specificity
- Partner with the Clinical Documentation Improvement Specialist if you have questions, are queried, are documenting an infrequently performed procedure
ICD-10 Diagnostic Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
Most Common GI Diagnosis

This module is focused on the most frequently documented diagnoses that will have the greatest impact on the provider including:

- Nausea/Vomiting
- Abdominal Pain
- Ulcers
- Hernias
- Diverticulosis/Diverticulitis
- Pancreatitis and Cholecystitis
- Overweight/Obesity/BMI
- Gastritis
- Digestive System Complications
- Varices, Esophageal and Other
- Esophagitis
- General documentation for Digestive System Diseases
- Chrohn’s Disease and Ulcerative Colitis
- Liver Cirrhosis

Note: This training module is not intended to be an all-inclusive training tool to teach the provider every coding nuance within ICD-10.
Nausea and Vomiting

Nausea and Vomiting are symptoms that can be documented together or independently.

When documenting the presence of nausea and/or vomiting include the following in documentation:

1. Any causal or related problem that might provide a coding diagnosis: associated with migraine, presence of bulimia, following GI procedure, etc...

2. Any characteristics of the symptoms that would impact severity of illness: projectile vomiting, hematemesis, vomiting of fecal matter
Abdominal Pain

Documentation for the finding of abdominal pain requires the following considerations:

- **Location** — requires the specification of upper, lower, right, left, pelvic and perineal (excludes GU referable pain)

- **Pain vs Tenderness** — codes allow for the distinction between pain vs. tenderness dependent on the provider documentation, but still requires the specificity of location

- **Rebound tenderness** — requires specificity of right, left, upper, lower, epigastric, periumbilic, generalized

**Acute abdomen:** distinct code for severe, generalized abdominal pain that may include abdominal rigidity
# Ulcers

## Ulcers of the Digestive Tract
- Document the anatomical location and site
- Identify if acute, chronic, or acute ON chronic
- Document id with or without:
  - Perforation
  - Abscess
  - Hemorrhage
- Document the causal relation between the ulcer complications
- Document other related diagnosis e.g. H. Pylori
- Document any associated medication or drugs use and the purpose of its usage e.g. ibuprofen for headache
- Document alcohol use, abuse or dependence

## Ulcerative Colitis
- Document the anatomic location/site
- Document the site of bleeding e.g. rectal
- Document the presence of any complication e.g.:
  - Intestinal obstruction
  - Bleeding
  - Fistula
  - Abscess
  - Other complications
- LINK the complication with the underlying condition
Complications with a procedure or a device requires the same specificity of documentation regardless of the initial cause or patient presentation:

1. Clearly defining the complication either of procedure or device
2. Identifying the complication as causal to the patient presentation
3. Clearly identifying if this was an expected or unexpected outcome
Hernia Documentation for coding hernias is consistent with many location specific conditions, requiring the following documentation: **location, complication, instance**

**Location**
- Clarify if inguinal and femoral hernias are unilateral, bilateral or recurrent
  
**Examples:**
- Bilateral inguinal hernia
- Unilateral inguinal hernia

**Complication**
- Specify the presence or absence of obstruction and gangrene
  
**Examples:**
- Umbilical hernia with gangrene
- Incisional hernia with obstruction, without gangrene

**Instance**
- Used to identify recurrence
  
**Examples:**
- Bilateral femoral hernia, with gangrene, recurrent
Pancreatitis

Documentation for pancreatitis should contain:

- Distinction of acute or chronic
- Cause of pancreatitis
- Identification of drug, where appropriate

NOTE: When documenting Chronic, alcohol-induced pancreatitis, it is important to document alcohol abuse and dependence as a concurrent condition.
Body Mass Index

Many quality measures as well as ICD-10 diagnoses require documentation of weight status

BMI categories include:

\[ \leq 19 \]

20-40 (each whole number)

40-44

45-49

50-60

\[ \geq 70 \]

**NOTE:** In pediatric patients, document their weight percentile

Who can Document BMI?

- Coding guidelines allow any clinician to capture and record a patient’s BMI
- However, the provider is ultimately responsible for the completeness of diagnosis documentation
- Find where BMI is routinely captured at your facility and partner with other clinicians to ensure this is properly documented
Overweight/Obesity

Overweight → should be accompanied by documentation of BMI

Obesity → Is further subdivided into three groups:

- **From Excess Calorie Intake**
  - Severe
  - Morbid

- **Drug Induced**
  - Identify causal agent

- **With Alveolar**
  - Hypoventilation
Gastritis

• Clarify the acuity (i.e., acute or chronic).
• Provide the type of gastritis (e.g., alcoholic, superficial, atrophic, etc.).
• Identify the presence or suspicion of gastric bleeding.
• List any alcohol abuse or dependence.
• Describe any associated medication or drug use and the purpose of its use.
• Differentiate between gastritis, duodenitis, and gastroduodenitis
Digestive System Complications

• Abnormal conditions that develop due to a medical device being left in place or because of other medical care are classified as complications (e.g., dumping syndrome)
• Clarify complications of ostomies such as bleeding and infection
• Detail the significance of a postoperative ileus as being expected versus problematic
• Clearly document any surgical misadventures (e.g., accidental bladder laceration)
Varices, Esophageal and Other

• Identify associated:
  – Bleeding
  – Alcohol abuse, dependence, or history
  – Underlying disease (e.g., liver cirrhosis)

• Report other varices such as:
  – Sublingual.
  – Scrotal
  – Gastric
  – Pelvic
  – Vulval
Esophagitis

- Identify the acuity (i.e., acute or chronic)
- Ascertain any underlying conditions (e.g., congenital syphilis, infection, GERD, etc.)
- Clarify if esophagitis is present or absent when patients have gastroesophageal reflux disease (GERD)
- List any related alcohol or drug use, abuse, dependence, or past history
- Supply the name of any associated medication or drug use along with the purpose of its use
General Documentation for Digestive System Diseases

• Identity the acuity of the disease (i.e., acute or chronic)
• State the significance of any abnormal lab findings or link them to a related diagnosis (e.g., guaiac-positive stools due to internal hemorrhoids)
• Provide the underlying cause or state unknown cause (e.g., alcoholic cirrhosis)
• Clarify the site of any bleeding that is visualized or suspected
• Detail any associated medication or drug use (e.g., NSAIDs).
• List any related alcohol or tobacco use, abuse, dependence, past history, or smoke exposure (e.g., second hand, occupational, etc.)
Crohn’s Disease and Ulcerative Colitis

- Identify the affected bowel (e.g., small intestine, large intestine, left side, rectosigmoid, etc.)
- Specify any complications such as:
  - Intestinal obstruction
  - Rectal bleeding
  - Abscess
  - Fistula
Liver Cirrhosis

• Identify the underlying cause (e.g., alcohol, congenital, syphilis, etc.)
• List any associated ascites or fibrosis
• Detail other associated conditions (e.g., fatty liver, esophageal varices, etc.)
• Provide information regarding viral hepatitis when applicable
• Specify any alcohol or drug use, abuse, or dependence
Diagnoses of the small and large intestines follow the same principles of documentation:

1. **Location** - Small intestine, large intestine, peritoneum, retroperitoneum
2. **Character** - Acute, Chronic, Acute and Chronic
3. **Cause** - Identify the underlying cause or document unknown e.g. alcoholic cirrhosis, Crohn’s disease, ulcerative colitis, diverticulitis
4. **Complication** - Obstruction, bleeding, perforation, with abscess, without perforation, with diarrhea, state abnormal test/lab findings or link them to a related diagnosis e.g. positive guaiac stool due to internal hemorrhoids
5. **Identify** the site of bleeding that is visualized or suspected
6. **Document** medications used e.g. NSAID
7. **Tobacco** use, dependence, past history, or exposure (second hand, occupational, etc.)
8. **Alcohol** use, Abuse, Dependence

**Examples:**
- Diverticulosis of the small intestine without perforation or abscess
- Allergic gastroenteritis and colitis
- Crohn’s disease of the small intestine with fistula
- IBS with diarrhea
- Postprocedural peritoneal adhesion

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ICD-10 Procedure Documentation Recommendations

ICD-10 Diagnostic Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
Review of ICD-10 Procedure Code Structure

ICD-10 Procedure documentation: More granular and precise

Focus for Providers: Understand concepts coders capture rather than memorize every detail

- Procedure documentation can be thought of on multiple axes
- Each axis captures an increased amount of provider documentation in respect to the service or procedure provided
Axis 1: Section

Axis 1: Starting point for coding procedures.
Provides the coder with the initial criteria to class information and narrows available codes.

Examples include:
• Medical and Surgical - Polypectomy
• Administration - administering nutritional substance through PEJ tube

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**Axis 2: Body System**

**Body System:** is the next axis for understanding ICD-10 coding. As the Axes increase, so does the specificity of **documentation AND coding**.

**Depending on the section identified the axis may be:**

- Body System
- Physiologic System
- Anatomic Region

**Examples of Axis 2:**
- Gastrointestinal System
- Mouth and Throat
- Hepatobiliary System
- Pancreas
Axis 3: Root Operation

Root Operation determines the purpose of a procedure. There are 31 specific types of root operations that are in 9 groups:

1. Procedures that take out some or all of a body part
2. Procedures that take out solids/fluids/gases from a body part
3. Procedures involving cutting or separating only
4. Procedures that put in/put back or move some/all of a body part
5. Procedures that alter the diameter/route of a tubular body part - can be performed only on tubular body parts
6. Procedures that always involve a device
7. Procedures involving examination only
8. Procedures that define other repairs
9. Procedures that define other objectives
Axis 3: Root Operation

GI Examples of Axis 3-Root Operation:

Extirpation—Removal of foreign body, removal of calculus
Dilation—Renal vessel stent placement
Destruction—Fulguration of rectal polyp

Documenting for Axis 3:

• Don’t attempt to memorize the coding verbiage for each root operation
• Ensure documentation of the procedure has a clear objective/purpose
• Ensure one of the 9 groupings of operations can be identified
Axis 4: Very specific and detailed, procedure dictates the specificity of documentation:

- A body part
- Some of a body part
- Area around a body part
- In or On a body Part
- Conduction mechanism (brain or heart)

Gastrointestinal Examples of Axis 4:

- Stomach
- Colon
- Small Bowel
- Duodenum
- Jejunum
- Rectum
Body Part List for GI Med-Surg Procedures

Esophagus, Upper
Esophagus, Middle
Esophagus, Lower
Esophagogastric Junction
Esophagus
Stomach
  Stomach, Pylorus
Small Intestine
Duodenum
Jejunum
Ileum
Ileocecal Valve
Large Intestine
Large Intestine, Right
Large Intestine, Left
Cecum

Appendix
Ascending Colon
Transverse Colon
Descending Colon
Sigmoid Colon
Rectum
Anus
Anal Sphincter
Greater Omentum
Lesser Omentum
Mesentery
Peritoneum

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Axis 4: Body Part

Documenting for Axis 4:

- Be as specific as the body part and procedure allow
- If there is laterality capture right, left or bilateral
- If there is distance capture proximal and distal
- Multiple procedures in the same organ or vessel need to have clear documentation
Axis 5: Approach

Axis 5: Based on access location, method and types of instrumentation used:

• **Open**- Cutting through the (skin/mucous membrane/other body layers) to expose the site of the procedure

• **Open Endoscopic**- Instrumentation to reach and visualize the procedure site

• **Open with Percutaneous Endoscopic Assistance**- Instruments used to assist with procedure

• **Percutaneous**- Entry, by puncture or minor incision, of instrumentation through the (skin/mucous membrane/other body layers) to reach procedure site

• **Percutaneous Endoscopic**- Instrumentation to reach and visualize the procedure site

• **Via Natural or Artificial Opening**- Entry of instrumentation through a natural or artificial external opening to reach the procedure site

• **Via Natural or Artificial Opening Endoscopic**- Instrumentation to reach and visualize the procedure site

• **External**- Performed directly on the skin or mucous membrane
Axis 6: Devices left in place at the completion of a procedure require a code.

Examples include:

- Endotrachial Tube
- Radioactive Element
- Stent or Catheter

Device Placement for GI Procedures:
It is important to document specifically what type of device is placed, and also how it is placed. Qualifying codes will often capture additional details about a device placement.
Axis 7: Qualifier

Axis 7: Defines “qualifier” or an additional attribute of the procedure when appropriate.

– Not all procedure codes require qualifiers
– Data adds specific, clarifying information that is not contained in another axis

Examples of Qualifiers:
• Procedures including biopsy for diagnostic purposes
• Identifies source of tissue if placed during a procedure: autologous, non-autologous
• Identifies source of blood product: frozen vs. fresh
Bariatric Procedures

The changes related to bariatric procedures follow the same axes as all other procedures, the predominate change seen with the identification of post-procedural complications

*Example: malabsorption of nutrients, osteoporosis secondary to malabsorption of nutrients*

Important documentation or bariatric procedures includes:

1. *Specificity of location*
2. *Clear documentation of procedure*
3. *Specificity of approach*
4. *Identity of any device placed during procedure*
Blood Transfusions

The single data point captured in ICD-9 for blood transfusion was the occurrence of the transfusion. With ICD-10 there are multiple data points that will be captured:

1. Type of cells transfused (RBC or Frozen RBC)
2. Document location or infusion site (Peripheral artery, Peripheral vein, Central Vein, Central Artery)
3. Document the approach
4. Specify if Autologous or non-Autologous

Important Note:
The receipt of transfusions has to be acknowledged by the provider
Biopsy

• Document the root operation e.g. excision, resection, etc.

• Document specific site and laterality (if applicable)

• Document approach e.g. open, percutaneous endoscopic, etc.
Putting It All Together:

Removal of Foreign Body From Sigmoid Colon >
  Open >
  0DCN0Z No Device >
    0DCN0ZZ Extirpation of Matter from Sigmoid Colon, Open Approach
  0DCN3 Percutaneous >
    0DCN3Z No Device >
      0DCN3ZZ Extirpation of Matter from Sigmoid Colon, Percutaneous Approach
  0DCN4 Percutaneous Endoscopic >
    0DCN4Z No Device >
      0DCN4ZZ Extirpation of Matter from Sigmoid Colon, Percutaneous Endoscopic Approach
  0DCN7 Via Natural or Artificial Opening >
    0DCN7Z No Device >
      0DCN7ZZ Extirpation of Matter from Sigmoid Colon, Via Natural or Artificial Opening
  0DCN8 Via Natural or Artificial Opening Endoscopic >
    0DCN8Z No Device >
      0DCN8ZZ Extirpation of Matter from Sigmoid Colon, Via Natural or Artificial Opening Endoscopic
Gastroenterology Documentation

Conclusion

While the actual number of GI-related procedure codes has increased from ICD-9 to ICD-10, the structure and function of coding has improved to better represent the diagnosis and acuity of GI patients and procedures performed.

This training is not inclusive of every procedure but the themes GI documentation include:

- Recall the procedure code axes and ensure documentation required to support the required specificity
- Document location with as much specificity as possible
- Document related, secondary or causal illness whenever appropriate
- Partner with the Clinical Documentation Improvement Specialist if you have questions, are queried, are documenting an infrequently performed procedure