ICD-10 for Digestive Disorders

- Documentation!
- Diagnosis codes that get paid.
- Diagnosis codes that accurately portray your patient population.

Why Are We Changing?

- ICD-9 is out of date and running out of space for new codes.
- ICD-10 is the international standard to report and monitor disease and mortality – USA must adopt for reporting and surveillance.
- ICD codes are core elements of many health information technology systems making the conversion to ICD-10-CM necessary to fully realize benefits of HIT adoption.
- It is mandated by CMS for all HIPAA-covered entities.
Why You Should Care About Diagnosis Coding

- **Today-payors use diagnosis codes to:**
  - Deny payment based on a lack of medical necessity/wrong ICD-10 code.
  - Build payment policies based on specific diagnosis codes.

- **Today and future- payors will use diagnosis codes to:**
  - Establish reimbursement in risk based contracting models.
  - Determine payment in ACO (shared savings) and bundled payment models.
  - Determine patient complexity to justify inpatient status and establish post-op visit benchmarks.

---

Format of Codes

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
<th>vs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 3-5 characters in length</td>
<td>• 3-7 characters in length</td>
<td></td>
</tr>
<tr>
<td>• Approximately 14,000 codes</td>
<td>• Approximately 59,000 codes</td>
<td></td>
</tr>
<tr>
<td>• Limited space for adding new codes</td>
<td>• Flexibility for adding new codes</td>
<td></td>
</tr>
<tr>
<td>• Lacks detail</td>
<td>• Very specific</td>
<td></td>
</tr>
</tbody>
</table>
Format of Codes

ICD-9-CM
Code Structure

ICD-10-CM
Code Structure

 Chapters for Digestive Disorders

<table>
<thead>
<tr>
<th>First Character</th>
<th>Chapters Pertinent to Digestive Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>C, D</td>
<td>Neoplasms</td>
</tr>
<tr>
<td>K</td>
<td>Digestive System</td>
</tr>
<tr>
<td>R</td>
<td>Symptoms/Signs</td>
</tr>
<tr>
<td>S</td>
<td>Injury</td>
</tr>
<tr>
<td>T</td>
<td>Malfunction</td>
</tr>
<tr>
<td>Z</td>
<td>Other Reasons for Health Care</td>
</tr>
</tbody>
</table>
Coding Co-Existing Conditions

ICD says:
“Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management.”

Examples:
- You send the patient to their cardiologist for a pre-op evaluation for co-existing cardiac conditions.
- The patient has ESRD and you request clearance by his physician.

Action:
- Code the primary reason for the visit (Crohn’s) and the underlying conditions if they affect your treatment/surgical plan.

Why?
- Accurately portray the complexity of your patient population.
- Patient complexity will impact payment models, risk-based contracting, ACOs, and bundled payments.
- Patient complexity also impacts inpatient status, number of post-op visits and more.
Co-Existing Conditions

- Asthma
- Kidney Disease
- Nicotine Dependence
- Diabetes
- Obesity/BMI
- COPD
- HTN/Angina/Heart Disease
- Alcohol Abuse/Dependence/Use
- Other?
- Personal History of...

Using “Other Specified” Codes

- “Other” or “Other Specified”
  - Use when information in the medical record provides needed detail, but a specific code does not exist.

- Examples:
  - K51.818 Other ulcerative colitis with other complications
  - K62.89 Other specified disorders of the anus and rectum
    - Proctitis NOS
Using “Unspecified” Codes

- **Unspecified**
  - Use when the information in the medical record is **insufficient** to assign a more specific code.
  - Beware of overuse of unspecified codes!!!

- **Example:**
  - K50.90 Crohn’s disease, unspecified, without complications
    - *Crohn's disease NOS*
  - K51.919 Ulcerative Colitis, unspecified with unspecified complications

---

ICD-10-CM: Steps to Correct Coding

**TIP**

Utilize technology to facilitate finding the right code!

EMR, [www.ICD10data.com](http://www.ICD10data.com), and more!
Chapter 18: Signs and Symptoms

Chapter Organization
R00-R99

Coding Signs and Symptoms

**Do** code signs and symptoms if a definitive diagnosis is not known. You see a patient with abdominal pain prior to an ultrasound or other imaging.

**Do not** code signs and symptoms if a more definitive diagnosis is known.

*For example*, don’t code abdominal pain if a definitive diagnosis is known.
Examples of S&S Codes

- Abdominal Symptoms (pain, rigidity, tenderness)
  - Rebound tenderness added as separate code series.
- Intra-Abdominal Swelling, Mass or Lump
- Rectal Bleeding/Blood In Stool

Clinical Documentation Tips: Anatomic Location of Symptom

For Codes: Pain, Rigidity, Tenderness, Rebound, Mass/Lump

- Right upper quadrant
- Left upper quadrant
- Right lower quadrant
- Left lower quadrant
- Periumbilical
- Epigastric
- Generalized
- Unspecified site

ICD-9 had similar sites and also had “other specified” site and multiple sites.
No multiple sites in ICD-10.
Use more than one code for multiple sites.
Clinical Documentation Tips

Abdominal Symptoms (R10-R19.8)

Do NOT Say: Abdominal pain (R10.9, unspecified)

DO Say: Right upper quadrant (R10.11) and epigastric pain (R10.13)

CHAPTER 11: DISEASES OF THE DIGESTIVE SYSTEM
Chapter 11: Digestive System

Chapter Organization
K00-K95

Code/Documentation Changes

Esophagitis (K20)

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>530.10</td>
<td>Esophagitis, unspecified</td>
</tr>
<tr>
<td>530.19</td>
<td>Other esophagitis</td>
</tr>
<tr>
<td>530.11</td>
<td>Reflux esophagitis</td>
</tr>
<tr>
<td>530.13</td>
<td>Esinophilic esophagitis</td>
</tr>
</tbody>
</table>
# Code/Documentation Changes

## Esophageal Reflux (K21)

Clinical concepts added as combination codes.

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>530.81</td>
<td>Esophageal reflux K21.0 Gastro-esophageal reflux with esophagitis</td>
</tr>
<tr>
<td>530.11</td>
<td>Reflux esophagitis K21.9 Gastro-esophageal reflux without esophagitis (Reflux NOS)</td>
</tr>
</tbody>
</table>

## Barrett’s Esophagus

Clinical concepts added as combination codes.

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>530.85</td>
<td>Barrett’s Esophagus K22.70 Barrett’s Esophagus without dysplasia</td>
</tr>
<tr>
<td></td>
<td>K22.710 ...with low grade dysplasia</td>
</tr>
<tr>
<td></td>
<td>K22.711 ...with high grade dysplasia</td>
</tr>
<tr>
<td></td>
<td>K22.719 ...unspecified</td>
</tr>
</tbody>
</table>
## Code/Documentation Changes

### Ulcers (K25, K26, K27, K28 codes)

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastric</td>
<td>Gastric</td>
</tr>
<tr>
<td>Duodenal</td>
<td>Duodenal</td>
</tr>
<tr>
<td>Peptic</td>
<td>Peptic</td>
</tr>
<tr>
<td>Gastrojejunal</td>
<td>Gastrojejunal</td>
</tr>
<tr>
<td><strong>Acute/chronic, with perforation and/or hemorrhage, with or without obstruction</strong></td>
<td><strong>Acute/chronic, with perforation and/or hemorrhage</strong></td>
</tr>
<tr>
<td><strong>With or without obstruction deleted</strong></td>
<td><strong>With or without obstruction deleted</strong></td>
</tr>
</tbody>
</table>

### Gastritis (K29)

#### Added clinical concepts:
- **Chronic-superficial or atrophic**

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute, alcoholic, with or without hemorrhage, atrophic (chronic)</td>
<td>Acute, alcoholic, with or without bleeding</td>
</tr>
<tr>
<td>Added (0) with or (1) without hemorrhage</td>
<td>Chronic superficial or chronic atrophic with or without bleeding</td>
</tr>
</tbody>
</table>
New in ICD-10: For Esophagitis, Ulcer and Gastritis Codes

- Use additional code to identify: alcohol abuse and dependence.
  - F10.- category of codes (47 codes)
  - Examples
    - F10.129 Alcohol abuse with intoxication, unspecified
    - F10.229 Alcohol dependence with intoxication, unspecified

Code/Documentation Changes

Crohn’s Disease (K51)

<table>
<thead>
<tr>
<th>ICD-9 (4 codes)</th>
<th>ICD-10 (28 codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anatomic site</strong></td>
<td><strong>Anatomic site</strong></td>
</tr>
<tr>
<td>• Small intestine</td>
<td>• Small intestine</td>
</tr>
<tr>
<td>• Large intestine</td>
<td>• Large intestine</td>
</tr>
<tr>
<td>• Small intestine with large intestine</td>
<td>• Small intestine with large intestine</td>
</tr>
</tbody>
</table>
# Code/Documentation Changes

## Crohn’s Disease (K51)

<table>
<thead>
<tr>
<th>ICD-9 (4 codes)</th>
<th>ICD-10 (28 codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complications</td>
<td>Complications</td>
</tr>
<tr>
<td>• None</td>
<td>• Rectal bleeding</td>
</tr>
<tr>
<td></td>
<td>• Intestinal obstruction</td>
</tr>
<tr>
<td></td>
<td>• Fistula</td>
</tr>
<tr>
<td></td>
<td>• Abscess</td>
</tr>
<tr>
<td></td>
<td>• Other</td>
</tr>
<tr>
<td></td>
<td>• Unspecified</td>
</tr>
</tbody>
</table>

More than one complication? → More than one code

## Crohn's Disease (K51 Codes)

### Clinical Documentation Improvement Tips

**#1 State area of intestine involved**
- Large
- Small
- Large and small

**#2 State presence or absence of complication**
- Rectal bleeding
- Intestinal obstruction
- Fistula
- Abscess
- None or other

**Do NOT Say:** Crohn’s Disease.

**DO Say:** Crohn’s disease, large intestine with rectal bleeding.
Code/Documentation Changes

Ulcerative Colitis (K51)

<table>
<thead>
<tr>
<th>Anatomic site of inflammation</th>
<th>Anatomic site of inflammation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Enterocolitis</td>
<td>• Pancolitis</td>
</tr>
<tr>
<td>• Ileocolitis</td>
<td>• Proctitis</td>
</tr>
<tr>
<td>• Proctitis</td>
<td>• Rectosigmoiditis</td>
</tr>
<tr>
<td>• Proctosigmoiditis</td>
<td>• Inflammatory polyps</td>
</tr>
<tr>
<td>• Pseudopolyposis</td>
<td>• Left sided</td>
</tr>
<tr>
<td>• Left sided</td>
<td>• Other</td>
</tr>
<tr>
<td>• Universal</td>
<td>• Unspecified</td>
</tr>
<tr>
<td>• Other</td>
<td></td>
</tr>
<tr>
<td>• Unspecified</td>
<td></td>
</tr>
</tbody>
</table>

Complications

<table>
<thead>
<tr>
<th>ICD-9 (9 codes)</th>
<th>ICD-10 (21 codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complications</td>
<td>Complications</td>
</tr>
<tr>
<td>• None</td>
<td>• Rectal bleeding</td>
</tr>
<tr>
<td></td>
<td>• Intestinal obstruction</td>
</tr>
<tr>
<td></td>
<td>• Fistula</td>
</tr>
<tr>
<td></td>
<td>• Abscess</td>
</tr>
<tr>
<td></td>
<td>• Other</td>
</tr>
<tr>
<td></td>
<td>• Unspecified</td>
</tr>
</tbody>
</table>

Do **NOT** Say: Ulcerative colitis.

**DO** Say: Ulcerative pancolitis, with abscess.

More than one complication? → More than one code
## Code/Documentation Changes

### Diverticular Disease (K57)

<table>
<thead>
<tr>
<th>ICD-9 (8 codes)</th>
<th>ICD-10 (24 codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anatomic site</strong></td>
<td><strong>Anatomic site</strong></td>
</tr>
<tr>
<td>• Small intestine</td>
<td>• Small intestine</td>
</tr>
<tr>
<td>• Colon</td>
<td>• Large intestine</td>
</tr>
<tr>
<td></td>
<td>• Both small intestine and large intestine</td>
</tr>
</tbody>
</table>

### Complications

- Hemorrhage
- Perforation and abscess without bleeding
- Perforation and abscess with bleeding
- Bleeding without perforation or abscess
### Diverticular Disease (K57 Codes) (8-24 Codes)

#### Clinical Documentation Improvement Tips

**#1 State area of intestine involved**
- Large
- Small
- Large and small – **New in ICD-10**

**#2 State presence or absence of perforation or abscess**

**#3 State presence or absence of bleeding**

---

### Code/Documentation Changes

#### Anal and Rectal Fissure or Fistula (K60)

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>565.5 Anal fissure</td>
<td>K60.0  Acute anal fissure</td>
</tr>
<tr>
<td>565.1 Anal fistula (included rectal)</td>
<td>K60.1  Chronic anal fissure</td>
</tr>
<tr>
<td></td>
<td>K60.2  Anal fissure, unspecified</td>
</tr>
<tr>
<td></td>
<td>K60.3  Anal fistula</td>
</tr>
<tr>
<td></td>
<td>K60.4  Rectal fistula</td>
</tr>
<tr>
<td></td>
<td>K60.5  Anorectal fistula</td>
</tr>
</tbody>
</table>
### Code/Documentation Changes

#### Anal and Rectal Abscess (K61)

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Do NOT Say: Rectal abscess.</th>
<th>DO Say: Ischiorectal abscess.</th>
</tr>
</thead>
<tbody>
<tr>
<td>566.0 Abscess of anal and rectal area</td>
<td>K61.0 Anal abscess K61.1 Rectal abscess K61.2 Anorectal abscess K61.3 Ischiorectal abscess K61.4 Intrasphincteric abscess</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Included ischiorectal, perirectal, perianal</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Other

**Added specific anatomic site (polyps)**

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Added with or without diarrhea (IBS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>569.0 Anal and rectal polyp</td>
<td>K62.0 Anal polyp K62.1 Rectal polyp</td>
<td></td>
</tr>
<tr>
<td>564.1 Irritable bowel syndrome</td>
<td>K58.0 Irritable bowel syndrome with diarrhea K58.9 Irritable bowel syndrome without diarrhea (Irritable bowel syndrome NOS)</td>
<td></td>
</tr>
</tbody>
</table>
Appendicitis (K35)

Similar to ICD-9.
State acute (generalized or localized peritonitis), chronic, recurrent, unspecified, other.
“Unqualified” deleted.

Digestive System: Hernias

Hernia (K40)

- Obstruction = incarcerated, irreducible, strangulated
- Inguinal and femoral
- Ventral, umbilical, diaphragmatic

Hernia with both gangrene and obstruction is coded as with gangrene.

- Unilateral or bilateral
- Recurrent or not recurrent
- With or without gangrene
- With or without mention of obstruction or gangrene

- With or without gangrene
- With or without obstruction
## Code/Documentation Changes

### Hemorrhoids and Perianal Venous Thrombosis

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>455.0-455.9</td>
<td>K64.0 First degree hemorrhoids</td>
</tr>
<tr>
<td>Internal, external, thrombosed, with other or without complication, residual tags</td>
<td>K64.1 Second degree hemorrhoids</td>
</tr>
<tr>
<td></td>
<td>K64.2 Third degree hemorrhoids</td>
</tr>
<tr>
<td></td>
<td>K64.3 Fourth degree hemorrhoids</td>
</tr>
<tr>
<td></td>
<td>K64.4 Residual hemorrhoidal skin tags</td>
</tr>
<tr>
<td></td>
<td>K64.5 Perianal venous thrombosis</td>
</tr>
<tr>
<td></td>
<td>K64.8 Other hemorrhoids</td>
</tr>
<tr>
<td></td>
<td>K64.9 Unspecified hemorrhoids (NOS)</td>
</tr>
</tbody>
</table>

### Digestive System

- **K64.0 – Hemorrhoids and Perianal Venous Thrombosis**
  - First degree – grade/stage I; without prolapse outside of anal canal
  - Second degree – grade/stage II; prolapse with straining but retract spontaneously
  - Third degree – grade/stage III; prolapse with straining and require manual replacement back inside anal canal
  - Fourth degree – grade/stage IV; with prolapsed tissue that cannot be manually replaced
Digestive System

- Hemorrhoids NOS and NEC?
  - Code K64.4 for external hemorrhoids NOS
  - Code K64.5 for thrombosed hemorrhoids NOS
  - Code K64.8 Other hemorrhoids
    - Internal without mention of degree
    - Prolapsed, degree not specified
  - Code K64.9 Unspecified hemorrhoids
    - NOS and hemorrhoids without mention of degree

Clinical Documentation Tips

Hemorrhoids (K64)

Do NOT Say: Internal hemorrhoids (K64.8)

DO Say: Third degree hemorrhoids or stage III hemorrhoids (K64.2)
Digestive System

K80-K87 Disorders of Gallbladder, Biliary Tract

Gallbladder disease – Identify Site

Similar to ICD-9

Clinical Documentation Tips

- **K80. – Gall bladder and bile duct disorders**
  - Key clinical documentation: Gall bladder
    - Calculus with or without acute and/or chronic cholyecystitis
    - With or without obstruction
  - Key clinical documentation: Bile duct
    - Calculus with or without acute and/or chronic cholangitis
    - With or without obstruction
Code/Documentation Changes

Cholecystitis (K81)

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>575.0</td>
<td>Acute cholecystitis</td>
</tr>
<tr>
<td>575.11</td>
<td>Chronic cholecystitis</td>
</tr>
<tr>
<td>575.12</td>
<td>Acute with chronic</td>
</tr>
<tr>
<td></td>
<td>cholecystitis</td>
</tr>
<tr>
<td>575.10</td>
<td>Cholecystitis,</td>
</tr>
<tr>
<td></td>
<td>unspecified</td>
</tr>
</tbody>
</table>

Clinical Documentation Tips

Gall bladder and biliary tract disorders (K80)

**Do NOT Say:** Gall stones.

**DO Say:** Calculus of gall bladder with acute cholecystitis without obstruction.
### Intraoperative Complications

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Descriptor</th>
<th>ICD-9-CM</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>K91.61</td>
<td><strong>Intraoperative</strong> hemorrhage and hematoma of a digestive system structure <strong>complicating a digestive system procedure</strong></td>
<td>998.11</td>
<td>Hemorrhage complicating a procedure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>998.12</td>
<td>Hematoma complicating a procedure</td>
</tr>
<tr>
<td>K91.62</td>
<td><strong>Intraoperative</strong> hemorrhage and hematoma of a digestive system structure <strong>complicating other procedure</strong></td>
<td>998.11</td>
<td>Hemorrhage complicating a procedure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>998.12</td>
<td>Hematoma complicating a procedure</td>
</tr>
<tr>
<td>K91.71</td>
<td>Accidental puncture and laceration of a digestive system structure <strong>during a digestive system procedure</strong></td>
<td>998.2</td>
<td>Accidental puncture or laceration during a procedure, not elsewhere classified</td>
</tr>
<tr>
<td>K91.72</td>
<td>Accidental puncture and laceration of a digestive system structure <strong>during other procedure</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Postoperative Complications

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Descriptor</th>
<th>ICD-9-CM</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>K91.840</td>
<td>Postprocedural hemorrhage and hematoma of a digestive system structure following a digestive system procedure</td>
<td>998.11</td>
<td>Hemorrhage complicating a procedure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>998.12</td>
<td>Hematoma complicating a procedure</td>
</tr>
<tr>
<td>K91.841</td>
<td>Postprocedural hemorrhage and hematoma of a digestive system structure following other procedure</td>
<td>998.11</td>
<td>Hemorrhage complicating a procedure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>998.12</td>
<td>Hematoma complicating a procedure</td>
</tr>
<tr>
<td>K91.89</td>
<td>Other postprocedural complications and disorders of the digestive system, NEC</td>
<td>997.99</td>
<td>Complications affecting other specified body systems, not elsewhere classified</td>
</tr>
</tbody>
</table>
Complications

- Complications (K91) Examples
  - You are called to the OR to repair bowel accidentally lacerated during another surgeon’s hysterectomy
    - K91.72 Accidental puncture and laceration of a digestive system organ or structure during other procedure
  - You take your patient back to the OR one day post-op to control bleeding.
    - K91.840 Postprocedure hemorrhage and hematoma of a digestive system organ or structure complicating other digestive system procedure

Chapter: Digestive Complications

- Specific Digestive System Complications (K94.-)
  - K94.0.- Colostomy
  - K94.1.- Enterostomy
  - K94.2.- Gastrostomy
  - K94.3.- Esophagostomy
  - K01.85 Intestinal pouch

New?  
-Separate codes for each stoma  
-Specific to complication- hemorrhage, infection, malfunction, or other
Chapter: Digestive Complications

- Bariatric Complications (K95.-)
  - K95.01 Infection due to gastric band procedure
  - K95.09 Other complication of gastric band procedure
    - For other – use additional code, if applicable, to further specify complication.

---

Chapter 2: Neoplasms

Chapter Organization
C00-D49

- Category
- Etiology, Anatomical Site, Severity
- Extension

Chapter 2: Neoplasms

General Guidelines: Category of Neoplasm

<table>
<thead>
<tr>
<th>Type of Neoplasm</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant, primary</td>
<td>Cancer, first site</td>
</tr>
<tr>
<td>Malignant, secondary</td>
<td>Metastatic site</td>
</tr>
<tr>
<td>Carcinoma in situ</td>
<td>The risk of transforming to cancer is high</td>
</tr>
<tr>
<td>Benign</td>
<td>Non-cancer</td>
</tr>
<tr>
<td>Uncertain behavior</td>
<td>Histologic diagnosis made by pathologist, morphology of tumor is uncertain</td>
</tr>
<tr>
<td>Unspecified</td>
<td>The pathology is unknown at the time of encounter</td>
</tr>
</tbody>
</table>

- Overlapping sites should be classified to a .8 code unless a combination code exists
  - Example: C18.8 Malignant neoplasm of overlapping sites of colon [descending and transverse colon]

- “History of” vs. “Active” neoplasms codes
  - No further treatment – no further treatment then use a Z85.- code
  - Example: Z85.3-038 – Personal history of other malignant neoplasm of large intestine [Follow-up visit 3 years post-surgical resection with no evidence of disease]
Malignant Neoplasm of Colon (C18)

- C17 Malignant neoplasm of small intestine
- C18 Malignant neoplasm of colon
- C19 Malignant neoplasm of rectosigmoid junction
- C20 Malignant neoplasm of rectum
- C21 Malignant neoplasm of anus and anal canal
- Also codes for overlapping sites of the small intestine, colon and rectum/anus/anal canal.

Clinical Documentation Tips

Colon Cancer

Do NOT Say: Colon cancer (C18.9, unspecified)

DO Say: Cancer of the sigmoid colon (C18.7)
CHAPTER 19: INJURY, POISONING AND CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES

Chapter 19: Injuries

Chapter Organization
S00-S99 and T07-T88

S
or T

Category

Etiology, Anatomic Site, Severity

Extension
7th Character

- Initial vs Subsequent Encounter – 7th character
  - A = initial encounter
  - D = subsequent encounter
  - S = sequela

Defining Initial/Subsequent/Sequela

Initial Encounter (A) = In Active Treatment

Examples include:
- surgical treatment,
- emergency department encounter and evaluation
  and continuing treatment
  by a new or the same physician.
Defining Initial/Subsequent/Sequela

Subsequent Encounter (D) =
In Healing or Recovery Phase

*Examples include:* cast change or removal, *an x-ray to check healing status of fracture*, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.

---

Defining Initial/Subsequent/Sequela

Sequela (S) = Late effect, residual effect of a prior condition but not a complication

*Examples include:* scar formation resulting from a burn, deviated septum due to nasal fracture, infertility due to tubal occlusion from prior disease.
7th Character

- Initial vs Subsequent Encounter – 7th character
  - A = initial encounter
  - D = subsequent encounter
  - S = sequela

ICD-10-CM: Placeholder “X”: New ICD-10 Concept

To keep applicable 7th characters in the 7th position when the code is less than 6 characters long.

Example: S36.00 Unspecified injury of the spleen

Incorrect code assignment: S36.00A

Correct code assignment: S36.00XA
ICD-10-CM: Placeholder “X”

√ X 7th

This notation listed before the code will indicate the codes needs “X” in the empty character positions to append the 7th character extension.

√ 7th

This notation listed before the code will indicate it needs a 7th character extension.

Coded By Anatomic Area (S00-S99)

TIP: Injuries are grouped by body part in the S block. The 7th character determines the anatomic location.
Coded By Type of Injury: Abdomen/Pelvis Injuries (S30-S39)

T Codes: Complications Not Found Elsewhere

- T81.19X_ Other post procedural shock
- T81.30X_ Disruption of wound, unspecified (NOS)
- T81.31X_ Disruption of external operation (surgical) wound, NEC (dehiscence NOS)
- T85.79X_ Infection and inflammatory reaction due to other internal device, implant or graft- *for example infected mesh*
- T81.4XX_ Infection following a procedure, post op infection, not elsewhere classified- *for example intra-abdominal abscess post-op*
T Codes: Complications Not Found Elsewhere

- T81.51. - Mechanical complications of GI prosthetic devices, implants, and grafts
  - Breakdown, displacement or other.
  - Specific codes for each complication and for each type of device (bile duct prosthesis, esophageal anti-reflux device or other).
  - Specific codes for intraperitoneal catheter, artificial skin graft or decellularized allograft.

New in ICD-10! These codes all require a 7th character and also may require an X extender!

WHAT NOW?? NEXT STEPS.
IDENTIFY YOUR TOP 20-25 PRIMARY ICD-9 CODES

Map those Top Codes to ICD-10 Codes

- The Books
- CMS
- Your EHR/practice management information system

Sources:
http://www.cms.gov/Medicare/Coding/ICD10/index.html?
ICD-9 to ICD-10 Mapping

Code/Documentation Changes

Hemorrhoids: Mapping

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Documentation Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>455.0-455.9</td>
<td>K64.0 First degree hemorrhoids</td>
<td></td>
</tr>
<tr>
<td>Internal,</td>
<td>K64.1 Second degree hemorrhoids</td>
<td></td>
</tr>
<tr>
<td>external,</td>
<td>K64.2 Third degree hemorrhoids</td>
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</tr>
<tr>
<td>thrombosed,</td>
<td>K64.3 Forth degree hemorrhoids</td>
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</tr>
<tr>
<td>with other or</td>
<td>K64.4 Residual hemorrhoidal skin tags</td>
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<tr>
<td>without</td>
<td>K64.5 Perianal venous thrombosis</td>
<td></td>
</tr>
<tr>
<td>complication,</td>
<td>K64.8 Other hemorrhoids</td>
<td></td>
</tr>
<tr>
<td>residual tags</td>
<td>K64.9 Unspecified hemorrhoids (NOS)</td>
<td></td>
</tr>
</tbody>
</table>
Create A List of Your “Favorites”

→ EHR - develop favorite “pick list”.
→ Cheat sheets: create reference guides by physician.
→ Superbills/encounter forms.
→ Prior authorization forms.
→ Recognize that paper forms are no longer feasible!!!

AKA:
Prospective “Gap Analysis”

DUAL CODE: ICD-9-CM AND ICD-10-CM