ICD-10 and Gastroenterology

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ICD-10 and Gastroenterology

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For the past thirty-one (31) years, we have learned and used ICD-9-CM when diagnosis coding for our providers. ICD stands for International Classification of Diseases. We’ve been using the 9th Revision to code a documented medical condition. We will be replacing the 9th Revision with the 10th revision. As someone once said, just when we learned the answers, they changed the questions. Also, for years, there has been rumor that ICD-10 would be replacing ICD-9, and now this will soon be a reality.

ICD-10 will replace ICD-9-CM as of October 1, 2014.
There is a new rumor that ICD-10 will be bypassed with ICD-11. The problem with this new rumor is that there is nothing, in writing, about this rumor. The fact that ICD-10 will be effective as of October 1, 2014 is published by the Centers for Medicare and Medicaid Services and the World Health Organization. Anytime someone tells you something, GET IT IN WRITING! Rumors can ruin a practice and can cost a practice a lot of money because you trust the person who told you the rumor and you want to believe it, so you or you have your staff search the internet for anything that provides provenance to the rumor. In coding, there is a rule, If it isn’t documented, it doesn’t exist. If an employee or a doctor told you something, make sure that they provide you with documentation to back it up. How do I know this? My boss went to a conference and during a break, heard people talking about something. One of the speakers even said the same thing. When my boss came back, he had me stop my work and find out if what he heard was true. After a week of searching, I went back to my boss and told him that what he heard didn’t exist. His reply was, I don’t believe you. I am a speaker at conferences. Anything I present has laws, rules, or policies provided to show that what I’m saying is true, accurate, and correct. I personally attended a conference where I heard a speaker say something that didn’t sound right. I wasn’t the only one because many hands went up. The speaker had many respected certifications, yet the speaker failed to provide any proof to his statement. When I asked for his documentation, he smiled and said I’ll send it to you. It’s been 10 years and nothing has come forth. All this did was lower my respect for this person and I now question everything this person provides. I refuse to attend any conference where he still speaks. My boss was correct with saying he didn’t believe me, but he learned a hard lesson. He spent about $1,000 in payroll to have me find anything that backed up what he heard at a conference. In the end, he dismissed what he heard and from that point on, when we brought anything to him, we had to provide documented proof. That made me a better researcher. To provide proof to ICD-10 being effective on October 1, 2014, can be found here:
October 1, 2014 is on a Wednesday. What this means is, on Tuesday, September 30, 2014, you will use ICD-9-CM. At the end of the day, put your ICD-9 manuals in a safe place because you may need them later on and I will explain this. When you come in the next morning, you will open the brand new ICD-10-CM manuals and code the visit using them.

One huge change with ICD-10-CM is that there will be more codes to select from. ICD-9 has about 14,000 codes. ICD-10 starts with 68,000 codes and can go higher. ICD-9 did not have a code for a cranialrectal blockage, so you couldn’t code that diagnosis or you had to select an unspecified code, but now you can have a code for a cranialrectal blockage (YOU do know that cranialrectal blockage is not a real disease or injury). ICD-10 is going to change the way YOU do business. Why? It is 100% dependent on medical record documentation. ICD-9 was forgiving to a doctor who is lax on their documentation. Steve could visit Dr Smith with pain in his right ear. All Dr Smith had to document was that Steve has OM which is short for otitis media and the coder could select a code for simple OM.

That code is **382.9** - Unspecified otitis media, Otitis media: NOS, acute NOS, chronic NOS

**ICD-10 will require more work on the provider to document the exact type of diagnosis found with the patient. ICD-10 demands documentation of the anatomical area affected and allows for coding of chronic modalities.**

**Under ICD-10-CM, you have the following codes for Otitis Media:**

H66.9 **Otitis media**, unspecified
As you can see, under ICD-9-CM, you have one code you can select if the documentation is not specific. The patient may have been a child with ear pain in both ears, but all the doctor wrote is “OM” and nothing more. Under ICD-10-CM, you have a possibility of five (5) codes and you do need more anatomical information to select the best possible code. Using a pure unspecified code such as H66.9 could cause your claim to be pended or placed under review, which could cause a significant revenue loss for the practice. A favorite doctor I’ve known for many years is an expert witness where he is called to determine if a malpractice lawsuit should proceed to court or if the malpractice insurance company should issue a check. Most of the time, after looking at the medical record, he recommends writing a check. He provides instruction to medical interns and residents and he tells them: “Document the visit as if you had to appear in court to defend your actions.” I usually add, “Document the visit as if your paycheck and career is on the line.” I spend a lot of my time returning medical records for additional information because the documentation is insufficient to code the visit with 100% truth, accuracy and correctness. I code to protect the doctor, the patient, and MY paycheck. I only code what is documented. I never code a visit just to get paid. There will be an unofficial rule with coding and that rule will be: If it isn’t documented, we don’t code it. We do NOT code something just to get it paid. With 30 years of clinical medicine in my personal background, I can say I know what should have been done during the visit, but I cant.
code based on that. I've seen doctors tell me, “I did this procedure.” I say show me where it says you did this. There is no documentation to prove that the doctor said they did what they say and the doctor loses. I also NEVER code based on what I am told on the internet. I don’t know if what I’m told is 100% true, accurate and complete. I don’t know if the person asking the question works for a doctor or if they are a coding student and I NEVER help students. If I provide them with answers, they submit my work as their own and I NEVER support fraud, including academic fraud, in any form. If I do a coders work for them, they will never learn to become self-sufficient. Lets say you have an untrained coder who needs to code a cranialrectal excision. They will go to the internet and ask, I forgot what the code is for a cranialrectal excision, can someone help me? When they don’t get a response, they become angry and then they will post, Can’t anyone here help me out? They do this hoping someone will feel guilty and give them what they want. Someone may come along with a name of ToddCPC and say we use code 99999. ToddCPC is NOT a coder. ToddCPC is a schoolkid in Omaha, Nebraska having fun punking the poster. So, now the coder enters 99999 as the code and sends the claim to the insurance company. The claim is denied payment. Claim after claim is denied payment because this coder is sending claims with bad codes. The doctor begins to notice the volume of denials and notices a huge drop in his practice revenue, so he contacts a consultant. In addition, the insurance company put a halt on all claims sent by the doctor. They send a letter demanding medical records and they’re now going back 20 years. The information on the claim is wrong and it is not documented in the medical record. The next letter the doctor receives is a demand for the return of claim payments and they are demanding a 6 figure refund. The doctor can’t fight this because the claim was sent with wrong codes, codes that are not
supported by the medical record documentation. I recently went to a doctor who received a letter demanding the return of $64,000. That would cause him to go out of business. I showed how his coder was sending claim with wrong codes and that the medical record documentation was so poor, that they didn’t support any correct code that was submitted. Again, DOCUMENT THE MEDICAL RECORD AS IF YOU HAD TO GO TO COURT!

Coding Guidelines

Many of the guidelines under ICD-9-CM wont change under ICD-10-CM. You will see new guidelines because ICD-10 will offer new codes never seen before. As an example:

ICD-9 Guideline for Symptoms:

_Signs and symptoms_

_Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the physician. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0 -799.9) contain many, but not all codes for symptoms._

7. **Conditions that are an integral part of a disease process**

_Signs and symptoms that are integral to the disease process should not be assigned as additional codes._

8. **Conditions that are not an integral part of a disease process**

_Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present._
ICD-10 Guideline for Symptoms:

**Signs and symptoms**  
Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all codes for symptoms.

5. **Conditions that are an integral part of a disease process**  
Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

6. **Conditions that are not an integral part of a disease process**  
Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

As you can see, both guidelines are virtually identical, so the change to ICD-10 wont be a shock to a trained coder.

**GASTROENTEROLOGY or Related ICD-10-CM CODING GUIDELINES** (Note, words in bold in the guideline are placed there in the actual guideline.)

The occurrence of drug toxicity is classified in ICD-10-CM as follows:

**Adverse Effect**  
Assign the appropriate code for adverse effect (for example, T36.0x5-) when the drug was correctly prescribed and properly administered. Use additional code(s) for all manifestations of adverse effects. Examples of
manifestations are tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure.

**Impending or Threatened Condition**
Code any condition described at the time of discharge as “impending” or “threatened” as follows:
If it did occur, code as confirmed diagnosis.
If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for “impending” or “threatened” and also reference main term entries for “Impending” and for “Threatened.”
If the subterms are listed, assign the given code.
If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

**Reporting Same Diagnosis Code More than Once**
Each unique ICD-10-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions when there are no distinct codes identifying laterality or two different conditions classified to the same ICD-10-CM diagnosis code.

**Laterality**
For bilateral sites, the final character of the codes in the ICD-10-CM indicates laterality. An unspecified side code is also provided should the side not be identified in the medical record. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side.

**Infectious agents as the cause of diseases classified to other chapters**
Certain infections are classified in chapters other than Chapter 1 and no organism is identified as part of the infection code. In these instances, it is necessary to use an additional code from Chapter 1 to identify the organism. A code from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified to other chapters, B96, Other bacterial agents as the cause of diseases classified to other chapters, or B97, Viral agents as the cause of diseases classified to other chapters, is
to be used as an additional code to identify the organism. An instructional note will be found at the infection code advising that an additional organism code is required.

**Infections resistant to antibiotics**
Many bacterial infections are resistant to current antibiotics. It is necessary to identify all infections documented as antibiotic resistant. Assign code Z16, Infection with drug resistant microorganisms, following the infection code for these cases.

**Sepsis**
For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection. If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified.
A code from subcategory R65.2, Severe sepsis, should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.
Sepsis with organ dysfunction
If a patient has sepsis and associated acute organ dysfunction or multiple organ dysfunction

(MOD), follow the instructions for coding severe sepsis.
(iv) Acute organ dysfunction that is not clearly associated with the sepsis

If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign a code from subcategory R65.2, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider.

**Severe sepsis**
The coding of severe sepsis requires a minimum of 2 codes: first a code for the underlying systemic infection, followed by a code from subcategory R65.2, Severe sepsis. If the causal organism is not documented, assign
code A41.9, Sepsis, unspecified, for the infection. Additional code(s) for the associated acute organ dysfunction are also required.

Due to the complex nature of severe sepsis, some cases may require querying the provider prior to assignment of the codes.

**Septic shock**
Septic shock is circulatory failure associated with severe sepsis, and therefore, it represents a type of acute organ dysfunction. For all cases of septic shock, the code for the underlying systemic infection should be sequenced first, followed by code R65.21, Severe sepsis with septic shock. Any additional codes for the other acute organ dysfunctions should also be assigned.

Septic shock indicates the presence of severe sepsis. Code R65.21, Severe sepsis with septic shock, must be assigned if septic shock is documented in the medical record, even if the term severe sepsis is not documented.

**Sequencing of severe sepsis**
If severe sepsis is present on admission, and meets the definition of principal diagnosis, the underlying systemic infection should be assigned as principal diagnosis followed by the appropriate code from subcategory R65.2 as required by the sequencing rules in the Tabular List. A code from subcategory R65.2 can never be assigned as a principal diagnosis.

When severe sepsis develops during an encounter (it was not present on admission) the underlying systemic infection and the appropriate code from subcategory R65.2 should be assigned as secondary diagnoses. Severe sepsis may be present on admission but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear whether severe sepsis was present on admission, the provider should be queried.

**Sepsis due to a postprocedural infection**
Sepsis resulting from a postprocedural infection is a complication of medical care. For such cases, the postprocedural infection code, such as, T80.2, Infections following infusion, transfusion, and therapeutic injection,
T81.4, Infection following a procedure, T88.0, Infection following immunization, or O86.0, Infection of obstetric surgical wound, should be coded first, followed by the code for the specific infection. If the patient has severe sepsis the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.

**Sepsis and severe sepsis associated with a noninfectious process (condition)**

In some cases a noninfectious process (condition), such as trauma, may lead to an infection which can result in sepsis or severe sepsis. If sepsis or severe sepsis is documented as associated with a noninfectious condition, such as a burn or serious injury, and this condition meets the definition for principal diagnosis, the code for the noninfectious condition should be sequenced first, followed by the code for the resulting infection. If severe sepsis is present a code from subcategory R65.2 should also be assigned with any associated organ dysfunction(s) codes. It is not necessary to assign a code from subcategory R65.1, Systemic inflammatory response syndrome (SIRS) of non-infectious origin, for these cases.

If the infection meets the definition of principal diagnosis it should be sequenced before the non-infectious condition. When both the associated non-infectious condition and the infection meet the definition of principal diagnosis either may be assigned as principal diagnosis. Only one code from category R65, Symptoms and signs specifically associated with systemic inflammation and infection, should be assigned. Therefore, when a non-infectious condition leads to an infection resulting in severe sepsis, assign the appropriate code from subcategory R65.2,
Severe sepsis. Do not additionally assign a code from subcategory R65.1, Systemic inflammatory response syndrome (SIRS) of non-infectious origin.

*See Section I.C.18. SIRS due to non-infectious process*

**Chapter 11: Diseases of Digestive System (K00-K94)**

Reserved for future guideline expansion

**Complications of care**

**(a)**

**Documentation of complications of care**

As with all procedural or postprocedural complications, code assignment is based on the provider’s documentation of the relationship between the condition and the procedure.

**Chapter 20: External Causes of Morbidity (V01- Y99)**

Introduction: These guidelines are provided for the reporting of external causes of morbidity codes in order that there will be standardization in the process. These codes are secondary codes for use in any health care setting. External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred the activity of the patient at the time of the event, and the person’s status (e.g., civilian, military).

a. **General External Cause Coding Guidelines**

1) **Used with any code in the range of A00.0-T88.9, Z00-Z99**
An external cause code may be used with any code in the range of A00.0-T88.9, Z00-Z99, classification that is a health condition due to an external cause. Though they are most applicable to injuries, they are also valid for use with such things as infections or diseases due to an external source, and other health conditions, such as a heart attack that occurs during strenuous physical activity.

2) **External cause code used for length of treatment**

Assign the external cause code, with the appropriate 7th character (initial encounter, subsequent encounter or sequela) for each encounter for which the injury or condition is being treated.

3) **Use the full range of external cause codes**

Use the full range of external cause codes to completely describe the cause, the intent, the place of occurrence, **and if applicable**, the activity of the patient at the time of the event, **and the patient’s status**, for all injuries, and other health conditions due to an external cause.

4) **Assign as many external cause codes as necessary**

Assign as many external cause codes as necessary to fully explain each cause. If only one external code can be recorded, assign the code most related to the principal diagnosis.

5) **The selection of the appropriate external cause code**

The selection of the appropriate external cause code is guided by the Index to External Causes, which is located after the Alphabetical Index to
diseases and by Inclusion and Exclusion notes in the Tabular List.

6) **External cause code can never be a principal diagnosis**
   
   An external cause code can never be a principal (first listed) diagnosis.

7) **Combination external cause codes**
   
   Certain of the external cause codes are combination codes that identify sequential events that result in an injury, such as a fall which results in striking against an object. The injury may be due to either event or both. The combination external cause code used should correspond to the sequence of events regardless of which caused the most serious injury.

8) **No external cause code needed in certain circumstances**
   
   No external cause code from Chapter 20 is needed if the external cause and intent are included in a code from another chapter (e.g. T360x1- Poisoning by penicillins, accidental (unintentional)).

**Selection of Principal Diagnosis**

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.
Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc).

In determining principal diagnosis the coding conventions in the ICD-10-CM, Volumes I and II take precedence over these official coding guidelines. (See Section I.A., Conventions for the ICD-10-CM)

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task.

A. Codes for symptoms, signs, and ill-defined conditions
   Codes for symptoms, signs, and ill-defined conditions from Chapter 18 are not to be used as principal diagnosis when a related definitive diagnosis has been established.

B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis.
   When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

C. Two or more diagnoses that equally meet the definition for principal diagnosis
   In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

D.
Two or more comparative or contrasting conditions.
In those rare instances when two or more contrasting or comparative diagnoses are documented as “either/or” (or similar terminology), they are coded as if the diagnoses were confirmed and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

E.
A symptom(s) followed by contrasting/comparative diagnoses
When a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be coded as additional diagnoses.

F.
Original treatment plan not carried out
Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.

G. Complications of surgery and other medical care
When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the T80-T88 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned.

H.
Uncertain Diagnosis
If the diagnosis documented at the time of discharge is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out”, or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.
Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

Abnormal findings
Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

Please note: This differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider.

C.
Uncertain Diagnosis
If the diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” or “still to be ruled out” or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

Diagnostic Coding and Reporting Guidelines for Outpatient Services

These coding guidelines for outpatient diagnoses have been approved for use by hospitals/providers in coding and reporting hospital-based outpatient services and provider-based office visits. Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-10-CM Tabular List (code numbers and titles), can be found in Section IA of these guidelines, under “Conventions Used in the Tabular List.” Information about the correct sequence to use in finding a code is also described in Section I.
The terms encounter and visit are often used interchangeably in describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other. Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that:

The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis applies only to inpatients in acute, short-term, long-term care and psychiatric hospitals.

Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

A.
Selection of first-listed condition

In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis.

In determining the first-listed diagnosis the coding conventions of ICD-10-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines.

Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.

1. Outpatient Surgery

When a patient presents for outpatient surgery (same day surgery), code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.

ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit
List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

H. **Uncertain diagnosis**

Do not code diagnoses documented as “probable”, “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

**Please note:** This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

**Chronic diseases**

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

J. **Code all documented conditions that coexist**

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

K. **Patients receiving diagnostic services only**

For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during
the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses. For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign Z01.89, Encounter for other specified special examinations. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the V code and the code describing the reason for the non-routine test. For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Please note: This differs from the coding practice in the hospital inpatient setting regarding abnormal findings on test results.

**NUMERICAL ORDER BY ICD-9-CM**

**ICD-9-CM**

289.50 - Spleen disease NOS

**ICD-10-CM**

D73.9 - Disease of spleen, unspecified

**ICD-9-CM**

455.0 - Internal hemorrhoids without mention of complication

**ICD-10-CM**

K64.8 - Other hemorrhoids

**ICD-9-CM**

530.81 - Esophageal reflux, Gastroesophageal reflux

**ICD-10-CM**

K21.0 - Gastro-esophageal reflux disease with esophagitis
530.85 - Barrett's esophagus
**ICD-10-CM**
K22.70 - Barrett's esophagus without dysplasia
**ICD-9-CM**
531.90 - Gastric ulcer; unspecified as acute or chronic; w/o hemorrhage or perforation; w/o obstruction
**ICD-10-CM**
K25.9 - Gastric ulcer, unspecified as acute or chronic, without hemorrhage or perforation
**ICD-9-CM**
533.90 - Peptic ulcer NOS
**ICD-10-CM**
K27.7 - Chronic peptic ulcer, site unsp, w/o hemorrhage or perf
**ICD-9-CM**
535.50 - Unspecified gastritis and gastroduodenitis; without mention of hemorrhage
**ICD-10-CM**
K29.70 - Gastritis, unspecified, without bleeding
**ICD-9-CM**
553.3 - Diaphragmatic hernia, Hernia: hiatal (esophageal) (sliding), paraesophageal, Thoracic stomach, Excludes:, congenital: diaphragmatic hernia
**ICD-10-CM**
K44.0 - Diaphragmatic hernia with obstruction, without gangrene
**ICD-9-CM**
V12.72 - Personal history of; colonic polyps
**ICD-10-CM**
Z86.010 - Personal history of colonic polyps
**ICD-9-CM**
Screening for malignant neoplasms; colon

**ICD-10-CM**

Z12.11 - Encounter for screening for malignant neoplasm of colon

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**Alphabetical Index of Codes by Disease**

Barrett's esophagus

**530.85** – ICD-9-CM  
**K22.70** – ICD-10-CM

Diaphragmatic hernia, Hernia: hiatal (esophageal) (sliding), paraesophageal, Thoracic stomach, Excludes:, congenital: diaphragmatic hernia

**553.3** – ICD-9-CM  
**K44.0** – ICD-10-CM

Esophageal reflux, Gastroesophageal reflux

**530.81** – ICD-9-CM  
**K21.0** – ICD-10-CM

Gastric ulcer; unspecified as acute or chronic; w/o hemorrhage or perforation; w/o obstruction

**531.90** – ICD-9-CM  
**K25.9** – ICD-10-CM

Gastritis, unspecified and gastroduodenitis; without mention of hemorrhage

**535.50** – ICD-9-CM
K29.70 - ICD-10-CM

Internal hemorrhoids without mention of complication
455.0 – ICD-9-CM
K64.8 - ICD-10-CM

Peptic ulcer NOS
533.90 – ICD-9-CM
K27.7 - ICD-10-CM

Personal history of colonic polyps
V12.72 – ICD-9-CM
Z86.010 – ICD-10-CM

Screening for malignant neoplasms; colon
V76.51 – ICD-9-CM
Z12.11 - ICD-10-CM

Spleen disease NOS
289.50 – ICD-9-CM
D73.9 - ICD-10-CM
The process for coding ICD-10 is no different than that of ICD-9, but documentation will be the success or failure of ICD-10. Improper or lack of documentation will only delay claims processing and will decrease practice revenue. The coder reads the medical record. The coder reads that the doctor documented “Chest pain”. The coder opens the ICD-10 manual, goes to the Index (words) and looks up the condition, which in this case is Pain.

Pain(s) (see also Painful) R52
- chest (central) R07.4
- - anterior wall R07.89
- - atypical R07.89
- - ischemic I20.9
- - musculoskeletal R07.89
- - non-cardiac R07.89
- - on breathing R07.1
- - pleurodynia R07.81
- - precordial R07.2
- - wall (anterior) R07.89

As you can see from the above ICD-10 index, you have chest pain listed as R07.4. Next you want to go to the tabular section to make sure that R07.4 is the correct code and to see if there are any coding conventions. Coding conventions provide us with additional information we need to ensure we have the correct code. The tabular for R07 is on the next page.

- **R07** Pain in throat and chest
  - Excludes.: dysphagia (R13) epidemic myalgia (B33.0) pain in: breast (N64.4)
  - neck (M54.2)
  - sore throat (acute) NOS (J02.9)
- **R07.0** Pain in throat
- **R07.1** Chest pain on breathing
  - Incl.: Painful respiration
- **R07.2** Precordial pain
- **R07.3** Other chest pain
  - Incl.: Anterior chest-wall pain NOS
- **R07.4** Chest pain, unspecified
If you look at the above tabular section, you can see coding conventions identical to those from ICD-9-CM. You can see NOS which means Not Otherwise Specified, Incl which means Includes and excludes which means these medical conditions are not included in this code. Code R07.4 has no coding conventions or additional information, so, based on the medical record documentation of chest pain, we can select R07.4. Again, if you can code ICD-9, you can code ICD-10. If you don’t have the training in the process of coding, you wont be able to code under ICD-10.

**CODING CHAPTERS**

Under ICD-9-CM, you have the following:

- Chapter 1: Infectious and Parasitic Diseases (001-139)
- Chapter 2: Neoplasms (140-239)
- Chapter 3: Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
- Chapter 4: Diseases of Blood and Blood Forming Organs (280-289)
- Chapter 5: Mental Disorders (290-319)
- Chapter 6: Diseases of Nervous System and Sense Organs (320-389)
- Chapter 7: Diseases of Circulatory System (390-459)
- Chapter 8: Diseases of Respiratory System (460-519)
- Chapter 9: Diseases of Digestive System (520-57)
- Chapter 10: Diseases of Genitourinary System (580-629)
- Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium (630-677)
- Chapter 12: Diseases Skin and Subcutaneous Tissue (680-709)
- Chapter 13: Diseases of Musculoskeletal and Connective Tissue (710-739)
- Chapter 14: Congenital Anomalies (740-759)
- Chapter 15: Newborn (Perinatal) Guidelines (760-779)
- Chapter 16: Signs, Symptoms and Ill-Defined Conditions (780-799)
- Chapter 17: Injury and Poisoning (800-999)
- Chapter 18: Classification of Factors Influencing Health Status and Contact with Health Service (Supplemental V01-V84) and
Supplemental Classification of External Causes of Injury and Poisoning (E-codes, E800-E999)

Under ICD-10, you have the following:

Chapter 1: Certain infectious and parasitic diseases (A00-B99)
Chapter 2: Neoplasms (C00-D48)
Chapter 3: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)
Chapter 4: Endocrine, nutritional and metabolic diseases (E00-E90)
Chapter 5: Mental and behavioral disorders (F01-F99)
Chapter 6: Diseases of the nervous system (G00-G99)
Chapter 7: Diseases of the eye and adnexa (H00-H59)
Chapter 8: Diseases of the ear and mastoid process (H60-H95)
Chapter 9: Diseases of the circulatory system (I00-I99)
Chapter 10: Acute upper respiratory infections (J00-J06)
Chapter 11: Diseases of oral cavity and salivary glands (K00-K14)
Chapter 12: Diseases of the skin and subcutaneous tissue (L00-L99)
Chapter 13: Diseases of the musculoskeletal system and connective tissue (M00-M99)
Chapter 14: Diseases of the genitourinary system (N00-N99)
Chapter 15: Pregnancy, childbirth and the puerperium (O00-O99)
Chapter 16: Certain conditions originating in the perinatal period (P00-P96)
Chapter 17 Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
Chapter 18: Symptoms and signs involving the circulatory and respiratory systems (R00-R09)
Chapter 19: Injury, poisoning and certain other consequences of external causes (S00-T98)
Chapter 20: External causes of morbidity (V01-Y98)
Factors influencing health status and contact with health services (Z00-Z99)

E Codes will become V-Y Codes
V Codes will become Z Codes.
The Table of Drugs and Biologicals that were 900 series codes and E Codes are now T Codes.

The proposed effective date for ICD-10 is October 1, 2014.

The key to the successful use and transition to ICD-10 is going to ensure our Providers are aware of their responsibility towards better documentation of the patient’s medical condition(s).

Use the following formula: PPD = Lawsuits and LOR (Loss of Revenue). (PPD stands for PISS Poor Documentation = Lawsuits and LOR.

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I wish all much success!

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