

Kenneth D. Beckman, MD, MBA, CPE, CPC

Digesting THE ICD-10 GI Codes

This overview of the common gastrointestinal disorders in primary care will help you get ready for ICD-10 and avoid, say, K30 — indigestion.

K30, Functional dyspepsia



Let's be honest: ICD-10 coding does not make for the most riveting reading. But as we get closer to the launch of ICD-10, it is becoming critical that you understand the codes you are most likely to encounter so that your documentation includes the details necessary for proper code selection and reimbursement. This installment in our ICD-10 series addresses common gastrointestinal (GI) codes. (See the series overview, page 23.)

To understand the required documentation and coding for GI disorders in ICD-10, it makes sense for primary care physicians to think of their patients as belonging to one of two groups: 1) those with a known diagnosis or 2) those presenting with signs or symptoms prior to a documented diagnosis. Let's address the latter group first.

Signs and symptoms involving the digestive system and abdomen

ICD-10 offers the following advice about when to use sign and symptom codes: "While specific diagnosis codes

should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the health care encounter. . . . If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for signs and/or symptoms in lieu of a definitive diagnosis." (For more on this topic, see "ICD-10 Coding for the Undiagnosed Problem, *FPM*, May/June 2014, <http://www.aafp.org/fpm/2014/0500/p17.html>.)

Although signs and symptoms documented during an office visit may or may not result in a final diagnosis of a GI disorder, the related codes are grouped into a subsection of Chapter 18 titled "Symptoms and signs involving the digestive system and abdomen," codes R10-R19.

When using these codes, keep these three considerations in mind:

- First, a note of caution: The codes for signs and symptoms involving the abdomen follow a sequential pattern for tenderness, mass, and rigidity – R10.811, R10.812, R10.813, etc. However, the pattern does not

About the Author

Dr. Beckman is a family physician, former chief medical officer, and consultant with The Beckman Group in Milwaukee, Wis.

Author disclosure: no relevant financial affiliations disclosed.

Just when you think it is clear when to use “other” and “unspecified,” ICD-10 throws you a curve ball.

follow for pain. (See “Abdominal and pelvic pain codes.”)

- Second, a note of frustration: There are no combination codes. If you see a patient with abdominal pain, tenderness, nausea, and diarrhea, you must either make a diagnosis or code all four signs and symptoms. (See “Other common GI symptom codes,” page 21.)

- Third, a note of clarification: The common complaint of diarrhea can be coded as either a sign/symptom (“Diarrhea, unspecified,” R19.7) or a disorder (“Functional diarrhea,” K59.1) depending on your patient’s situation.

Clinical scenario: A 23-year-old female presents to your office for an urgent visit. Her history includes onset of generalized abdominal pain yesterday with nausea but no vomiting. Her last menses was two weeks ago and normal. She uses oral contraceptives for birth control. The pain has now localized to the right lower quadrant, and she has had a couple episodes of diarrhea. On examination, she has a low-grade fever, rebound tenderness over McBurney’s point, and absent bowel sounds. A pelvic examination is negative. You perform a white blood cell count in the office that shows 14,000 white blood cells per mm³ with a left shift. A urine

pregnancy test is negative. You call the emergency department and arrange to have her evaluated there with a CT scan and surgery consultation.

Deciding how to code this office visit presents an interesting dilemma. You are fairly certain that your patient has acute appendicitis, but there could be other etiologies such as ovarian torsion or tubal pregnancy. The specific diagnosis of acute appendicitis is supported by the medical record but not definitive. Therefore, per ICD-10 instructions, it would be more appropriate to code the signs and symptoms than the specific diagnosis. You would select the following codes:

- R10.823, Rebound abdominal tenderness, right lower quadrant,
- R11.0, Nausea without vomiting,
- R19.7, Diarrhea, unspecified,
- R19.11, Absent bowel sounds,
- D72.820, Lymphocytosis (symptomatic).

Specific diseases of the digestive system

Chapter 11 of the ICD-10 code book is devoted to diseases of the digestive system (K00-K95). Let’s explore some of the diagnoses you’re likely to see in primary care.

GI disorders can be coded based on signs or symptoms if the patient’s diagnosis is not yet known.

There are no combination codes, so if you see a patient with multiple signs or symptoms, you must code them all.

Some complaints, such as diarrhea, can be considered a sign or symptom or a diagnosis depending on the context.

ABDOMINAL AND PELVIC PAIN CODES

	Pain	Tenderness	Rebound tenderness	Swelling mass	Rigidity
Right upper quadrant	R10.11	R10.811	R10.821	R19.01	R19.31
Left upper quadrant	R10.12	R10.812	R10.822	R19.02	R19.32
Right lower quadrant	R10.31	R10.813	R10.823	R19.03	R19.33
Left lower quadrant	R10.32	R10.814	R10.824	R19.04	R19.34
Periumbilical	R10.33	R10.815	R10.825	R19.05	R19.35
Epigastric	R10.13	R10.816	R10.826	R19.06	R19.36
Generalized	R10.84	R10.817	R10.827	R19.07	R19.37

This table deliberately does not include codes for “unspecified.” Using unspecified in describing a physical finding is often the result of poor documentation and a red flag for an audit.

OTHER COMMON GI SYMPTOM CODES

Colic	R10.83
Nausea (without vomiting)	R11.0
Vomiting without nausea	R11.11
Nausea with vomiting	R11.2
Heartburn (excludes dyspepsia)	R12
Dysphagia, unspecified	R13.10*
Abdominal distension (bloating)	R14.0
Gas pain	R14.1
Eructation	R14.2
Flatulence	R14.3
Hepatomegaly, not elsewhere classified	R16.0
Absent bowel sounds	R19.11
Hyperactive bowel sounds	R19.12
Change in bowel habit	R19.4
Occult blood in feces/stool	R19.5
Diarrhea	R19.7
Functional dyspepsia (indigestion)	K30
Constipation	K59.00

*Dysphagia is a good example of where an unspecified code would be very appropriate. Unless you are an otolaryngologist, it is likely that your office history and examination will not allow you to differentiate between the specific dysphagia codes for oral phase, oropharyngeal phase, pharyngeal phase, and pharyngoesophageal phase. This differentiation often requires motility testing or an esophagram.

Esophagitis. The important thing to note about this section is when to use “other” and when to use “unspecified.” Consider the following codes:

- K20.0, Eosinophilic esophagitis,
- K20.8, Other esophagitis,
- K20.9, Esophagitis, unspecified.

If the esophagitis has previously been determined to be eosinophilic, then obviously you would use the K20.0 code. However, the “other” code is not for all other causes of esophagitis but is used when the information in the medical record provides details of another specific diagnosis for which a specific code does not exist. The “unspecified” code is used when the information in the medical record is insufficient to assign a more specific code. The latter situation is more likely with esophagitis.

Just when you think it is clear when to use “other” and “unspecified,” ICD-10 throws you a curve ball: “For those categories for which an unspecified code is not provided, the ‘other specified’ code may represent both ‘other’ and ‘unspecified.’”

Gastro-esophageal reflux disease (GERD).

There are only two codes for this condition:

- K21.0, Gastro-esophageal reflux disease with esophagitis,
- K21.9, Gastro-esophageal reflux disease without esophagitis.

Reflux esophagitis codes to “with esophagitis,” and esophageal reflux codes to “without esophagitis.” If you only put GERD in your documentation, it should be considered NOS (not otherwise specified) and default to K21.9.

Barrett’s esophagus.

When you’re following a patient after a definitive diagnosis has been established by biopsy, you would use the following codes:

- K22.70, Barrett’s esophagus without dysplasia,
- K22.710, Barrett’s esophagus with low-grade dysplasia,

- K22.711, Barrett’s esophagus with high-grade dysplasia,
- K22.719, Barrett’s esophagus with unspecified dysplasia.

It is important to note that when the test results use a term like “consistent with,” this is not considered a definitive diagnosis. Unfortunately, this term appears on many pathology reports.

Ulcer disease. There are separate code groups for esophagus (K22.1), gastric (K25), duodenal (K26), unspecified peptic (K27), and gastrojejunal ulcer (K28). Each group has subcodes for acute or chronic, and each subgroup further stratifies to with or without hemorrhage or perforation, neither, or both. If you are evaluating a patient prior to endoscopy, you should code the condition of hematemesis (K92.0) rather than use an unspecified peptic ulcer code. Only about 50 percent of acute upper GI bleeding is the result of peptic ulcer disease.¹ ICD-10 has determined that hematemesis is a disease, not a sign or symptom.

Hernias. For unclear reasons, although

See Chapter 11 of ICD-10 for specific diseases of the digestive system.

Remember that “other” indicates a specific diagnosis for which a specific code does not exist; “unspecified” indicates insufficient information to assign a more specific code.

If you aren’t specific in your documentation, a notation such as “GERD” will default to the NOS code – “without esophagitis.”

ICD-10 goes to great lengths to include laterality (left, right) in every orthopedic code, it does not allow you to designate which side of the body has a unilateral hernia. Hernias are classified by location – inguinal (K40), femoral (K41), umbilical (K42), ventral (K43), diaphragmatic (K44), other (K45), and unspecified (K46). Each group has additional codes for with or without obstruction, with or without gangrene, and recurrent. ICD-10 also includes the option “not specified as recurrent,” as opposed to first occurrence, but it differentiates this only for inguinal and femoral hernias. So, if you only document the location of the hernia in the medical record, your coder (if you have one) can consider that shorthand for NOS (not otherwise specified) and default to the “without obstruction or gangrene, not specified as recurrent” code.

ICD-10 includes laterality for many codes but not all; for example, it does not allow you to designate which side of the body has a unilateral hernia.

Most primary care physicians will use only four of the 45 hernia codes:

- K40.20, Bilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent,
- K40.90, Unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent,
- K42.9, Umbilical hernia without obstruction or gangrene,
- K43.2, Incisional hernia without obstruction or gangrene.

Most primary care physicians will use only four of the 45 hernia codes.

Noninfective enteritis and colitis. This grouping is limited to Crohn’s disease, ulcerative colitis, and non-specific colitis. (Irritable bowel syndrome will come later.) Each of the inflammatory bowel disorders includes specific codes for with and without complications as well as the type of complication (bleeding, obstruction, fistula, or abscess). Each is also stratified by location. Crohn’s includes the small intestine, large intestine, both small and large intestine, and unspci-

The inflammatory bowel disorder codes allow you to specify the presence and type of complication, if any, and location.

fied. Ulcerative colitis includes pancolitis, proctitis, and rectosigmoiditis.

The “without complications” codes are listed below:

- K50.00, Crohn’s disease of small intestine without complications,
- K50.10, Crohn’s disease of large intestine without complications,
- K50.80, Crohn’s disease of both small and large intestine without complications,
- K51.00, Ulcerative pancolitis without complications,
- K51.30, Ulcerative rectosigmoiditis without complications.

Diverticular disease. The acute diverticulitis codes will be used sparingly in the primary care setting. When you see an individual with known diverticular disease who presents with classic diverticulitis findings, you may choose to empirically treat the patient and use sign and symptom codes or a diverticulitis code such as the following:

- K57.30, Diverticulosis of large intestine without perforation or abscess without bleeding,
- K57.32, Diverticulitis of large intestine without perforation or abscess without bleeding.

Clinical scenario: A 57-year-old male presents with abdominal pain for two days. He has no appetite, and the pain is mostly in the left lower abdomen. Vital signs document a temperature of 101.7°F and a mild tachycardia (105 beats per minute). He tells you he normally has a bowel movement every morning but has not had one for the past two days. He had a similar episode two years ago that you empirically treated with antibiotics and resolved. He underwent a colonoscopy that showed significant diverticulosis. Biopsies were negative for inflammatory bowel disease. Today’s physical examination shows left lower-abdomen ten-

IBS-RELATED CODES

IBS associated symptoms		ICD-10 code(s)	
Diarrhea	Constipation		
Yes	No	K58.0, IBS w/ diarrhea	
Yes	Yes	K58.0, IBS w/ diarrhea	K59.00, Constipation, unspecified
No	No	K58.9, IBS w/o diarrhea	
No	Yes	K58.9, IBS w/o diarrhea	K59.00, Constipation, unspecified

derness without rebound. Rectal examination shows no mass and minimal stool, which is heme negative. Bowel sounds are absent. His white blood cell count in the office is 14,000 white blood cells per mm³ with a left shift. You determine that the most likely diagnosis is acute diverticulitis without hemorrhage or obstruction. You decide to treat with a liquid diet and broad-spectrum oral antibiotics. You discuss the need for urgent reevaluation with any worsening of the symptoms and arrange a follow-up visit in the office in 24 to 48 hours.

Unlike the appendix example discussed earlier, this diagnosis does not require additional imaging and is typically made based on the history and examination. Therefore, given the known history of diverticulosis, the past likely diagnosis of diverticulitis, and the classic presentation, it would be appropriate to diagnose the patient with acute diverticulitis, K57.32.

It also would be correct to code this based on the signs and symptoms:

- R10.32, Left lower-quadrant pain,
- R10.814, Left lower-quadrant tenderness,
- R19.11, Absent bowel sounds,
- D72.820, Lymphocytosis.

Irritable bowel syndrome (IBS). Diagnosing IBS can be tricky because there is no standardized definition of this condition. Many physicians follow the Rome III diagnostic criteria (<http://www.romecriteria.org/criteria>) for defining when an individual should be diagnosed with IBS or other functional gastrointestinal disorders,² but the World Health Organization/ICD-10 does not reference these criteria. The World Health Organization also has not recognized IBS-C (irritable bowel syndrome with constipation) as a stand-alone diagnosis, so ICD-10 requires use of both an IBS code and a constipation code. However, there are IBS codes for with and without diarrhea. (See “IBS-related codes,” page 22.)

Hemorrhoids. These codes are fairly straightforward. Just remember that the degree of hemorrhoidal disease is most often established by history rather than examination.

- K64.0, First degree hemorrhoids, without prolapse outside of anal canal,
- K64.1, Second degree, prolapse with straining but retract spontaneously,
- K64.2, Third degree, prolapse with straining and require manual replacement,

ARTICLES IN FPM'S ICD-10 SERIES

You can access the following articles in FPM's ICD-10 topic collection: <http://www.aafp.org/fpm/icd10>.

“Coding Common Respiratory Problems in ICD-10,” *FPM*, November/December 2014.

“ICD-10 Simplifies Preventive Care Coding, Sort Of,” *FPM*, July/August 2014.

“ICD-10 Coding for the Undiagnosed Problem,” *FPM*, May/June 2014.

“How to Document and Code for Hypertensive Diseases in ICD-10,” *FPM*, March/April 2014.

“10 Steps to Preparing Your Office for ICD-10 – Now,” *FPM*, January/February 2014.

“Getting Ready for ICD-10: How It Will Affect Your Documentation,” *FPM*, November/December 2013.

“The Anatomy of an ICD-10 Code,” *FPM*, July/August 2012.

“ICD-10: What You Need to Know Now,” *FPM*, March/April 2012.

- K64.3, Fourth degree, prolapsed, cannot be manually replaced.

Miscellaneous. Finally, there are a few common codes used for other portions of the digestive system outside the alimentary tract:

- K70.30, Alcoholic cirrhosis of the liver without ascites,
- K76.0, Fatty liver, not elsewhere classified (includes nonalcoholic fatty liver disease; excludes nonalcoholic steatohepatitis, K75.81),
- K80.00, Calculus of gallbladder with acute cholecystitis without obstruction,
- K80.2, Calculus of gallbladder without cholecystitis,
- K81.0, Acute cholecystitis,
- K85.0, Idiopathic acute pancreatitis,
- K85.2, Alcohol induced acute pancreatitis,
- K90.0, Celiac disease.

Breaking it down

Remember that the codes discussed above, those most common in primary care, are only a small fraction of the codes used for the digestive system. ICD-10 has over 700

■ Diverticular disease is another example where it may be appropriate to code either the disease or the signs or symptoms.

■ For IBS with constipation, you will need to report separate codes because ICD-10 does not recognize this as a single diagnosis.

■ The codes for hemorrhoids are fairly straightforward, organized by the degree of disease.

By orienting yourself to the new codes, you'll be better prepared when the code set launches.

ICD-10 codes in the chapter devoted to diseases of the digestive system and at least an additional 80 in the signs and symptoms chapter.

Also, remember that the coding scenarios presented in this article are specific to the outpatient setting, where uncertain diagnoses typically are coded with signs and symptoms codes. For inpatient care at short-term, acute, long-term, and psychiatric hospitals, an uncertain diagnosis is allowed. Per ICD-10, Section II-H, "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 basis 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."

If all of this leaves you feeling frustrated by the ICD-10 rules, rest assured that you're not alone. The author agrees that this coding is K62.9 – pain, anal. Nevertheless, by orienting yourself to the new codes, you'll be better prepared when the code set launches. **FPM**

1. Boonpongmanee S, Fleischer DE, Pezzullo JC, et al. The frequency of peptic ulcer as a cause of upper-GI bleeding is exaggerated. *Gastrointest Endosc.* 2004;59(7):788-794.

2. Drossman DA. The functional gastrointestinal disorders and the Rome III process. *Gastroenterology.* 2006;130(5):1377-1390.

Send comments to fpmedit@aafp.org, or add your comments to the article at <http://www.aafp.org/fpm/2015/0100/p19.html>.

■ The GI codes discussed in this article are those most common in primary care and represent only a fraction of the available codes.

■ For uncertain diagnoses, note that rules differ for outpatient and inpatient settings.

PCMH Planner

Right steps.
Right time.
Right for you.

Simplify your journey with the **PCMH Planner**, an online tool that guides you step-by-step through practice transformation and Meaningful Use.

You can provide personalized, coordinated, and comprehensive care *and* thrive as a practice.

Start your online subscription now.

aafp.org/planner



Two-year online subscriptions start at:
\$99.95 (AAFP Members)
\$149.00 (Nonmembers)

