Road Map to ICD-10-CM
Swallow Digestive System Draft Guidelines

Swallow ICD-10-CM Digestive System Draft Guidelines

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Our journey using the ICD-10-CM roadmap takes us to the draft guidelines and coding issues in ICD-10-CM. We'll focus on "Understanding the ICD-10-CM Draft Guidelines for the Digestive System." The codes for the digestive system are located in Chapter 11 of ICD-10-CM. Let's review the chapter and compare the new ICD-10-CM codes to ICD-9-CM codes.

Chapter 11 includes the following blocks:

K00–K14 Diseases of oral cavity and salivary glands
K20–K31 Diseases of esophagus, stomach, and duodenum
K35–K38 Diseases of appendix
K40–K46 Hernia
K50–K52 Noninfective enteritis and colitis
K55–K63 Other diseases of intestines
K65–K68 Diseases of peritoneum and retroperitoneum
K70–K77 Diseases of liver
K80–K87 Disorders of gallbladder, biliary tract, and pancreas
K90–K94 Other diseases of the digestive system

The following instructional note was added to many category codes throughout chapter 11 of ICD-10-CM. Use an additional code to identify:

- **Alcohol abuse and dependence (F10.—)**
- **Alcohol dependence, in remission (F10.11)**
- **Exposure to environmental tobacco smoke (Z58.83)**
- **Exposure to tobacco smoke in the perinatal period (P96.6)**
- **History of tobacco use (Z86.43)**
- **Occupational exposure to environmental tobacco smoke (Z57.31)**
- **Tobacco dependence (F17.—)**
- **Tobacco use (Z72.0)**

Crosswalk Ulcer Complication

The guidelines specify the codes under ulcer categories have combination codes to identify ulcer complications, (bleeding and perforation). No secondary complication codes are necessary when using one of the ulcer combination codes. Multiple codes from each category may be used if a patient has multiple complications.

K25 Gastric ulcer
K26 Duodenal ulcer
K27 Peptic ulcer, site unspecified
K28 Gastrojejunal ulcer

In ICD-9-CM, an acute gastric ulcer is coded as 531.0x *Gastric ulcer ; acute with hemorrhage* with a fifth digit to indicate with or without mention of hemorrhage.

For example, a patient admits to the hospital with severe abdominal pain. The physician orders a computed tomography (CT) scan, which shows a gastric ulcer with perforation and signs of hemorrhage. The patient has a history of tobacco use, and quit smoking one year prior to admitting. The condition is acute and the physician schedules the patient for immediate surgery.

Review the comparison:

ICD-9-CM	ICD-10-CM
531.00 Gastric ulcer; acute with hemorrhage, without mention of obstruction	**K25.0** Acute gastric ulcer with hemorrhage
531.01 Gastric ulcer; acute with hemorrhage, with obstruction	**K25.1** Acute gastric ulcer with perforation
531.10 Gastric ulcer; acute with perforation, without mention of obstruction	**K25.2** Acute gastric ulcer with both hemorrhage and perforation
531.11 Gastric ulcer; acute with perforation, with obstruction	**K25.3** Acute gastric ulcer without hemorrhage or perforation
531.20 Gastric ulcer; acute with hemorrhage and perforation, without mention of obstruction	**K25.4** Chronic or unspecified gastric ulcer with hemorrhage
531.21 Gastric ulcer; acute with hemorrhage and perforation, with obstruction	**K25.5** Chronic or unspecified gastric ulcer with perforation
531.3 Gastric ulcer; acute without mention of hemorrhage or perforation	**K25.6** Chronic or unspecified gastric ulcer with both hemorrhage and perforation
531.30 Gastric ulcer; acute without mention of hemorrhage or perforation, without mention of obstruction	**K25.7** Chronic gastric ulcer without hemorrhage or perforation
531.31 Gastric ulcer; acute without mention of hemorrhage or perforation, with obstruction	**K25.9** Gastric ulcer, unspecified as acute or chronic, without hemorrhage or perforation

Using ICD-9-CM, the code is reported as 531.20 for the hemorrhaging acute gastric ulcer. The tobacco use can be reported as a secondary diagnosis, but is not required in ICD-9-CM.

Using ICD-10-CM, the code reported is K25.2. The specificity is similar in ICD-10-CM as in ICD-9-CM. Guidelines in ICD-10-CM instruct the user to report the history of tobacco use as well. The patient encounter would be reported as:

ICD-9-CM	ICD-10-CM
531.20	K25.2
V15.52	Z78.43

Crosswalk Crohn's Disease

Coding for Crohn's disease is comparatively different in ICD-10-CM. The codes under subcategories K50 *Crohn's disease* and K51 *Ulcerative colitis* identify a single complication of the conditions. Should a patient have multiple complications, multiple codes from K50 or K51 may be used to identify each complication. Crohn's disease (ICD-10-CM category K50) has been expanded into five to six characters from ICD-9-CM's code 555.9 *Regional enteritis; unspecified site.*

The expansion at the fourth-character level specifies the Crohn's disease site and the fifth character indicates whether a complication was present. The specific complications include rectal bleeding, intestinal obstruction, fistula, abscess, or other complication.

For example, a patient is treated by a nephrologist for small intestine Crohn's disease. The patient has experienced rectal bleeding for the past week. After the physician performs a detailed history and examination, he documents in the medical record Crohn's disease with rectal bleeding.

ICD-9-CM	ICD-10-CM
555.0 Regional enteritis of small intestine	**K50.0** Crohn's disease of small intestine Crohn's disease (regional enteritis) of duodenum Crohn's disease (regional enteritis) of ileum Crohn's disease (regional enteritis) of jejunum Regional ileitis Terminal ileitis **Excludes1**: Crohn's disease of both small and large intestine (K50.8-) **K50.00** Crohn's disease of small intestine without complications **K50.01** Crohn's disease of small intestine with complications **K50.011** Crohn's disease of small intestine with rectal bleeding **K50.012** Crohn's disease of small intestine with intestinal obstruction **K50.013** Crohn's disease of small intestine with fistula **K50.014** Crohn's disease of small intestine with abscess **K50.018** Crohn's disease of small intestine with other complication **K50.019** Crohn's disease of small intestine with unspecified complications

Based on the documentation in the medical record, using ICD-9-CM, the physician will report 555.1 for the Crohn's disease of the small intestine along with the secondary diagnosis of rectal bleeding (569.3 *Other disorders of intestine; hemorrhage of rectum and anus*). Using ICD-10-CM there is a combination code to identify the rectal bleeding with K50.011.

ICD-9-CM	ICD-10-CM
555.1 569.3	K50.0111

Crosswalk IBS

ICD-10-CM gives a specific code category for irritable bowel syndrome (IBS) (subcategory code 564.1 in ICD-9-CM) and expands at the fourth-character level:

For example, a patient with IBS is treated in an outpatient clinic by his family physician. The patient experiences diarrhea, particularly following meals. The physician prescribes medication to the patient during the encounter.

ICD-9-CM	ICD-10-CM
564.1 Functional digestive disorders, not elsewhere classified; irritable bowel syndrome	**K58** Irritable bowel syndrome **K58.0** Irritable bowel syndrome with diarrhea **K58.9** Irritable bowel syndrome without diarrhea

The encounter is coded as:

ICD-9-CM	ICD-10-CM
564.1	K58.0

Since diarrhea is a symptom of IBS, it is not coded in ICD-9-CM. In ICD-10-CM, a combination code exists to identify IBS with diarrhea.

Crosswalk Hernia

In ICD-9-CM, hernias are classified by type (inguinal, femoral, and ventral) with fourth-digit subcategories indicating whether gangrene or obstruction was present. Fifth digits specify whether the type of hernia was unilateral or bilateral and/or recurrent. Review category 550 for inguinal hernias.

This category requires a fifth digit to identify whether the hernia is unilateral, bilateral, and recurrent (if applicable).

In ICD-10-CM, hernias are still classified according to type, but the fourth (and in some cases fifth) characters indicate whether obstruction or gangrene was present as well as the laterality and recurrence status. Guidelines in the beginning of the category instruct that when both gangrene and obstruction are documented in the medical record, it is classified as hernia with gangrene.

For example, a 46-year-old male patient admits to the hospital for surgery. The documented diagnosis in the medical record is "initial bilateral inguinal hernia with gangrene and obstruction."

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ICD-9-CM	ICD-10-CM
550.0 Inguinal hernia; with gangrene, and obstruction	**K40** Inguinal hernia
550.1 Inguinal hernia; with obstruction, without mention of gangrene	**K40.1** Bilateral inguinal hernia with obstruction without gangrene
550.9 Inguinal hernia without mention of obstruction or gangrene Inguinal hernia NOS	**K40.00** Bilateral inguinal hernia, with Obstruction, without gangrene, not specified as recurrent
The following fifth digit classification	**K40.01** Bilateral inguinal hernia, with obstruction, without gangrene, recurrent
The following fifth-digit subclassification is for use with category 550:	**K40.1** Bilateral inguinal hernia, with gangrene
0 unilateral or unspecified (not specified as recurrent) Unilateral NOS	**K40.11** Bilateral inguinal hernia, with gangrene, recurrent
1 unilateral or unspecified, recurrent 2 bilateral (not specified as recurrent) Bilateral NOS	**K40.2** Bilateral inguinal hernia without obstruction or gangrene
3 bilateral, recurrent	**K40.20** Bilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent
	K40.21 Bilateral inguinal hernia, without obstruction or gangrene, recurrent
	K40.3 Unilateral inguinal hernia, with obstruction, without gangrene
	K40.30 Unilateral inguinal hernia with obstruction, without gangrene, not specified as recurrent
	K40.31 Unilateral inguinal hernia with obstruction, without gangrene, recurrent
	K40.4 Unilateral inguinal hernia, with gangrene
	K40.40 Unilateral inguinal hernia, with gangrene, no specified as recurrent
	K40.9 Unilateral inguinal hernia, without obstruction or gangrene
	K40.90 Unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent
	K40.91 Unilateral inguinal hernia, without obstruction or gangrene, recurrent

In ICD-10-CM, hernias are still classified according to type, but the fourth (and in some cases fifth) characters indicate whether obstruction or gangrene was present as well as the laterality and recurrence status. Guidelines in the beginning of the category instruct if both gangrene and obstruction is documented in the medical record it is classified to hernia with gangrene.

Review this example:
A 46-year-old male patient was admitted to the hospital for surgery. The diagnosis documented in the medical record is "initial bilateral inguinal hernia with gangrene and obstruction."

ICD-9-CM	ICD-10-CM
550.03 (recurrent, bilateral)	**K40.11** (bilateral, recurrent)

Using ICD-10-CM, there is not a code to specifically identify the obstruction and gangrene. According to the instructional notes, gangrene with obstruction is coded as hernia with gangrene.

Besides the inguinal hernias ICD-10-CM codes we've mentioned, there are numerous codes to identify femoral hernias umbilical hernias, and diaphragmatic hernias so be sure to familiarize yourself with those hernia codes as well. CE

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