Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Pinpoint Diagnoses for Common GI Issues

Tip: Know the nuances of appendicitis documentation.

Gastrointestinal (GI) pain is one of the top reasons patients head to emergency departments (EDs) every day. In some cases, however, the diagnoses can be challenging to identify. Plus, many GI-based conditions seem similar to one another, and not every progress note makes it easy to find an accurate diagnosis code.

To get to the bottom of this issue, we've shared three of the most common questions involving GI pain, and we've got the answer that may help you better pinpoint the right codes going forward.

Code Hernia by Location

Question: Should we be focusing on laterality when patients present to the ED with hernias? We sometimes have trouble differentiating between the many codes in ICD-10 for hernia conditions and then, on top of that, we aren't sure if we should be coding to the left or right side.

Solution: Although there are nearly 50 hernia codes available to you, the reality is that most EDs typically use these four main codes most of the time:

- 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)

However, if you have to search further, you won't need to look to laterality when coding hernias. While many ICD-10 codes specify whether the condition exists on the patient's left or right side, hernia codes are classified by location - they are either inguinal (K40), femoral (K41), umbilical (K42), ventral (K43), diaphragmatic (K44), other (K45), or unspecified (K46) - and those that occur unilaterally (e.g., inguinal or femoral) don't require you to know which side is involved.

Differentiate Epigastric Pain, Heartburn

Question: I have a question about epigastric pain versus heartburn. We have one physician who seems to think these terms are interchangeable, and even if the notes are identical, they may use one term versus the other. But the codes are different - R12 for heartburn and R10.13 for epigastric pain - so we want to educate the physician but aren't sure how to describe the differences to them from a coding standpoint, since we don't quite know the specific differences from a medical standpoint. Can you help us find the intersection that both the coder and the physician will understand so everyone can know how to differentiate these two terms?

Solution: "The provider should use the term that best describes what the patient is complaining about; epigastric pain is the upper abdomen region below the rib cage, and heartburn is a discomfort or pain that radiates upward along the sternum toward the throat," says **Glenn D. Littenberg, MD, MACP, FASGE, AGAF,** a gastroenterologist and former CPT® Editorial Panel member in Pasadena, California.

"They can overlap and then there's a choice," he notes. "It shouldn't matter ordinarily for reimbursement purposes, but the diagnosis should be supported by the note, and if the note describes epigastric pain, then the ICD-10 should be R10.13. Neither are specific codes; they are both just symptom descriptions, but at the time of the encounter if the

provider can't be more specific, the R codes are fine," he adds.

Get the Details With Appendicitis

Question: We code most of our appendicitis visits as unspecified. How do we get the information necessary to code this condition as "specified?"

Solution: When your physician sees a patient with appendicitis, specific information from the progress note should guide you to the correct diagnosis code so you can look beyond the unspecified codes.

Acute: The first information you need is whether the case is acute appendicitis, "other," or "unspecified." An acute condition is severe, with sudden onset, and leads to the K35 (Acute appendicitis) code family.

If the progress note indicates acute appendicitis, you'll need to decipher the following details from the documentation:

- Generalized or local peritonitis
- Rupture
- Perforation
- Abscess
- Gangrene

Armed with that information, you can choose the correct, specific code from the following list:

- K35.20 (Acute appendicitis with generalized peritonitis, without abscess)
- K35.21 (... generalized peritonitis, with abscess)
- K35.30 (... localized peritonitis, without perforation or gangrene)
- K35.31 (... localized peritonitis and gangrene, without perforation)
- K35.32 (... perforation and localized peritonitis, without abscess)
- K35.33 (... perforation and localized peritonitis, with abscess)
- K35.80 (Unspecified acute appendicitis)
- K35.890 (Other acute appendicitis without perforation or gangrene)
- K35.891 (... without perforation, with gangrene)

If the appendicitis is not acute, or the progress note or pathology report doesn't specify, look to the following code options:

- K36 (Other appendicitis)
- K37 (Unspecified appendicitis)

The bottom line is that you must review the documentation carefully to get a detailed view of the appendicitis type before selecting a code.