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Outpatient Facility Coding Alert

You Be the Coder: Determine Correct ICD-10 Code for Polyps

Question: When the gastroenterologist documents a polyp removal, how do we know which diagnosis code to report?

Nebraska Subscriber

Answer: To choose the correct ICD-10 code for a polyp, you need to carefully review the medical documentation.

Your first step will be to identify the polyp's specific location. ICD-10 codes are very location specific, and even for the colon region, there are six polyp codes (D12.0 - D12.5) based on whether the polyp is in the cecum, appendix, ascending colon, transverse colon, the descending colon, or the sigmoid colon. Only report the non-specific polyp code D12.6 (Benign neoplasm of colon, unspecified) as a last resort.

For the rectal region, the code choices expand to D12.7 (Benign neoplasm of rectosigmoid junction), D12.8 (Benign neoplasm of rectum), and D12.9 (Benign neoplasm of anus and anal canal).

You should need to be certain that the doctor did, in fact, remove a polyp. Gastroenterologists use the snare removal technique to completely remove an abnormal growth or to partially remove a piece of a larger mass for pathologic identification. Look for the key words within the procedure description, including "polyp," "lipoma," or "mass."

With colon cancer, your physician may sometimes find it difficult to pinpoint the cancer's primary site because the cancer has already metastasized to neighboring tissue. In this situation, you can report C18.8 (Malignant neoplasm of overlapping sites of colon) or C18.9 (Malignant neoplasm of colon, unspecified).

Caution: The answer above applies when the pathology is known, but without known pathology, there is a generic code K63.5 (Polyp of colon) in the ICD-10 hierarchy, as well as code K62.1 (Rectal polyp), which is appropriate for a hyperplastic (non-adenomatous) polyp in the rectum.