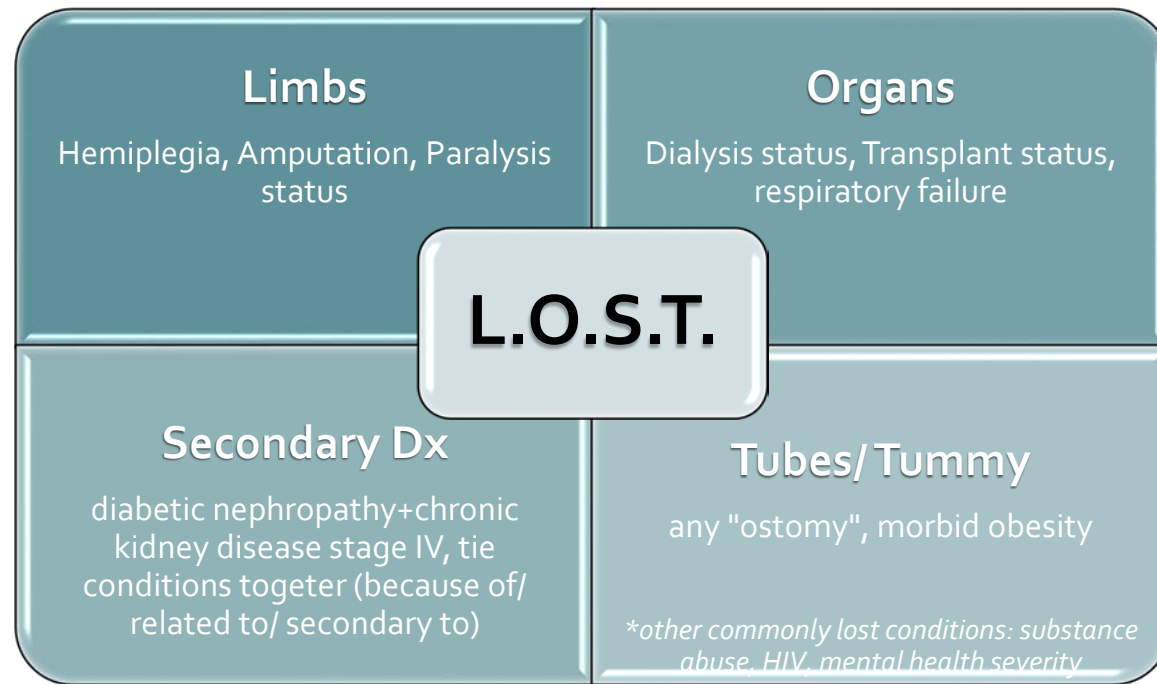
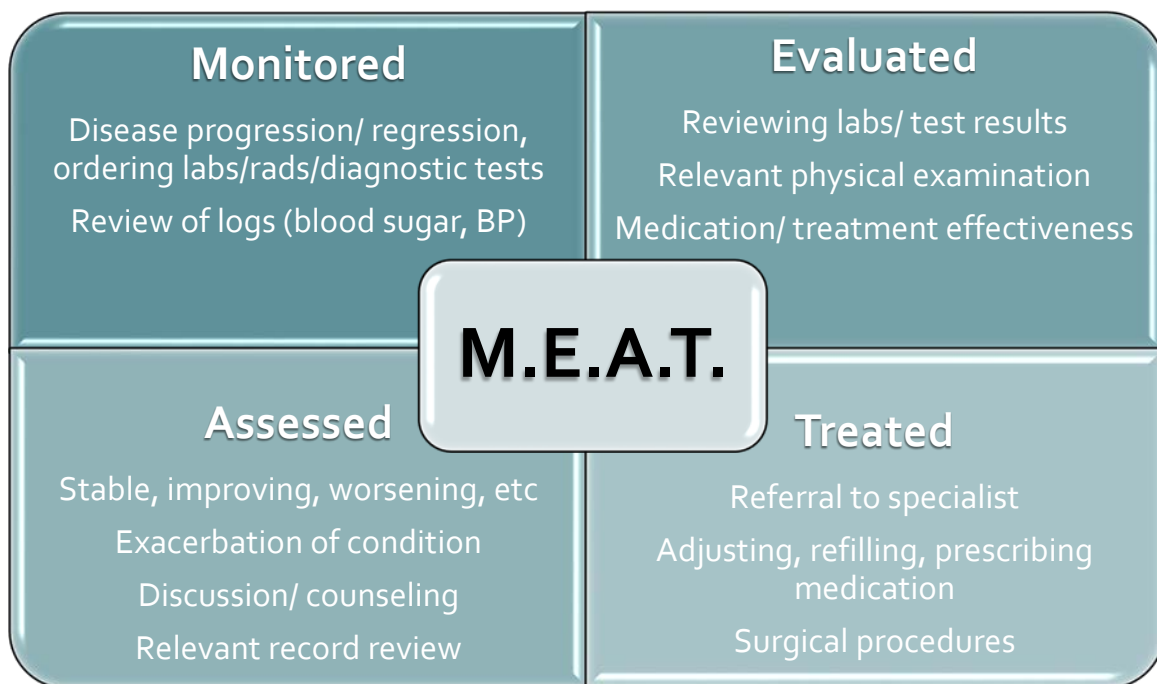


Advanced Gastroenterology Codes

DIAGNOSES	ICD-10 Code Root	Sub Codes	Hierarchical Condition Category (HCC)
Colorectal Cancer	C18.X	C18.1-C18.9	Colorectal, Bladder, and Other Cancers
Esophageal Cancer	C15.X	C15.3-C15.5, C15.8, C15.9	
Pancreatic Cancer	C25.X	C25.0-C25.4, C25.7-C25.9	
Malignant Neoplasm of Extrahepatic Bile Duct	C24.0	-	Lung and Other Severe Cancers
Malignant Neoplasm of Ampulla of Vater	C24.1	-	
Liver Cell Carcinoma	C22.0	-	
Intrahepatic Bile Duct Carcinoma	C22.1	-	
Crohn's Disease	K50.X	K50.0-K50.919	Inflammatory Bowel Disease
Ulcerative Colitis	K51.X	K51.0-K51.919	
Cirrhosis of Liver	K70.X, K74.X	K70.30-K70.9, K74.3-K74.69	Cirrhosis of Liver
Portal Hypertension	K76.6	-	End-Stage Liver Disease
Esophageal Varices	I85.X	I85.00-I85.11	
Chronic Pancreatitis	K86.X	K86.0-K86.1	Chronic Pancreatitis
Malnutrition	E4X	E40, E41, E42, E43, E44.0, E44.1, E45, E46	Protein-Calorie Malnutrition
Chronic Vascular Disorder of the Intestine	K55.X	K55.1, K55.8, K55.9	Vascular Disease
Paralytic ileus and intestinal obstruction without hernia	K56.X	K56.0-K56.7	Intestinal Obstruction/ Perforation
Gastric Ulcer	K25.X	K25.1-K25.2, K25.5-K25.6	
Duodenal ulcer	K26.X	K26.1- K26.2, K26.5- K26.6	
Gastrojejunal ulcer	K28.X	K28.1-K28.2, K28.5-K28.6	
Iron Deficiency Anemia	D50.X	D50.0, D50.1, D50.8, D50.9	Non-Specific Symptom Codes and Non-HCC Codes
Fatty (change of) Liver	K76.0	-	
Microscopic Colitis	K52.83X	K52.831, K52.832	
Angiodysplasia of Colon	K55.X	K55.20, K55.21	
Angiodysplasia of Stomach and Duodenum	K31.X	K31.819, K31.811	
Gastritis and duodenitis	K29.x	K29.00-K29.91	
Barrett's Esophagus	K22.X	K22.70, K22.710, K22.711, K22.719	
Biliary Obstruction	K83.1	-	
Cholangitis	K83.0X	K83.01, K83.09	
Acute Pancreatitis	K85	K85.00-K85.02, K85.10-K85.12, K85.20-K85.22, K85.30-K85.32, K85.80-K85.82, K85.90-K85.92	
Gastrointestinal hemorrhage	K92.2	-	

Please remember, the diagnoses chosen must meet MEAT criteria, one of the following has to be supported: M-Monitored, E-Evaluated, A-Assessed, T-Treated. Documentation must be complete and accurate before selecting the specific diagnosis code, and always choose the most specific/or combination ICD-10 CM code(s) to fully describe the patient condition(s).



- 1 element required per DX code; more is better
- These factors help providers to establish the presence of a diagnosis during an encounter (“if it wasn’t documented, it doesn’t exist”)
- Review problem list, document as ‘current’ or ‘active’
- Do not use ‘history of’ for chronic conditions unless is fully resolved. Instead use ‘stable

- Document anything that impacts your medical decision making** to reflect the complexity and level of care provided.
- Documentation improves care, coverage, costs and compliance.
- other commonly lost conditions: substance/alcohol abuse, AIDS or HIV, mental health severity and status