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	Lung and Other Severe Cancers
Pancreatic Cancer	C25.X	C25.0-C25.4, C25.7-C25.9	
Malignant Neoplasm of Extrahepatic Bile Duct	C24.0	-	
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	185.X	l85.00-l85.11	
Chronic Pancreatitis	K86.X	K86.o-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.o-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.oX	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	-	

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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).

Special thanks to Specialty Solutions and Portland Gastroenterology for their participation in this project. For more information visit: http://mainehealthaco.org/cdi

Monitored

Disease progression/ regression, ordering labs/rads/diagnostic tests

Review of logs (blood sugar, BP)

Evaluated

Reviewing labs/ test results
Relevant physical examination
Medication/ treatment effectiveness

M.E.A.T.

Assessed

Stable, improving, worsening, etc
Exacerbation of condition
Discussion/ counseling
Relevant record review

Treated

Referral to specialist
Adjusting, refilling, prescribing
medication

- •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

Limbs

Hemiplegia, Amputation, Paralysis status

Organs

Dialysis status, Transplant status, respiratory failure

L.O.S.T.

Secondary Dx

diabetic nephropathy+chronic kidney disease stage IV, tie conditions togeter (because of/ related to/ secondary to)

Tubes/Tummy

any "ostomy", morbid obesity

*other commonly lost conditions: substance abuse. HIV. mental health severity

- 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

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