ICD-9-CM Coding Guidelines

The below listed esophagitis, gastroenteritis and miscellaneous digestive disorders guidelines are not inclusive. The coder should refer to the applicable Coding Clinic guidelines for additional information. The Centers for Medicare & Medicaid Services considers Coding Clinic, published by the American Hospital Association, to be the official source for coding guidelines. Hospitals should follow the Coding Clinic guidelines to assure accuracy in ICD-9-CM coding and DRG assignment.

Definition of Principal Diagnosis

The principal diagnosis is that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Two or more diagnoses may equally meet the definition for principal diagnosis as determined by the circumstances of admission, diagnostic work-up and/or therapy provided. Be aware that there is a difference between admitting a patient to treat two conditions and two conditions being present at the time of admission. The principal diagnosis is always the reason for admission.

Coding Guidelines

Abdominal pain

If abdominal pain is integral to an identified condition, abdominal pain should not be assigned a code. Effective October 1, 1994, fifth digits were added to the 789.x series to identify the specific site of abdominal pain. (See Coding Clinic, fourth quarter 1994, pages 38 and 39.)

Acute esophagitis

As of October 1, 2001, acute esophagitis is assigned code 530.12, acute esophagitis. Prior to October 1, 2001, it was assigned code 530.10, esophagitis, unspecified. (See Coding Clinic, fourth quarter 2001, page 45.)

Acute neutropenic enterocolitis

A patient with acute lymphoblastic leukemia, who had recently completed his chemotherapy, was diagnosed with acute neutropenic enterocolitis.

If this is infectious neutropenic enterocolitis, assign codes 288.0, agranulocytosis, 009.1, colitis, enteritis, and gastroenteritis of presumed infectious origin, and E933.1, adverse effect of antineoplastic and immunosuppressive drugs.

If this is not infectious, assign codes 288.0, agranulocytosis, 558.9, other and unspecified noninfectious gastroenteritis and colitis, and E933.1, adverse effect of antineoplastic and immunosuppressive drugs. (See Coding Clinic, first quarter 2001, page 18, and Coding Clinic, third quarter 1999, pages 6 and 7.)

Blue rubber bleb syndrome/Bean’s syndrome/blue rubber-bleb nevus

This terminology is used for the same condition, a cavernous-type hemangioma. When it is found in intra-abdominal structure, (intestinal wall, spleen, or liver) it is assigned code 228.04, hemangioma of intra-abdominal structures. (See Coding Clinic, fourth quarter 1988, page 6.)
Candidal esophagitis/enteritis
Candidal esophagitis is assigned code 112.84 and candidal enteritis is assigned code 112.85. Prior to October 1, 1992, both were assigned code 112.89. (See Coding Clinic, fourth quarter 1992, page 19; Coding Clinic, first quarter 1992, page 17; and Coding Clinic, third quarter 1991, page 20.)

Changes in status/bowel movements
Changes in status in bowel movements is assigned code 780.9. (See Coding Clinic, third quarter 1993, page 11.)

Chronic infectious gastritis/Helicobacter pylori (H.pylori)
Assign codes 535.10, atrophic gastritis without mention of hemorrhage, and 041.86, H. pylori (041.85 prior to October 1, 1985). (See Coding Clinic, first quarter 1994, page 18.)

Collagenous colitis
Collagenous colitis is assigned code 558.9, other and unspecified noninfectious gastroenteritis and colitis. (See Coding Clinic, November-December 1987, page 8.)

Congestive portal gastropathy/portal hypertensive gastropathy
Congestive portal gastropathy, also referred to as portal hypertensive gastropathy, is assigned code 537.89, other specified disorders of stomach and duodenum. (See Coding Clinic, third quarter 2005, pages 15 and 16.)

Cryptosporidiosis
Cryptosporidiosis is assigned code 007.4 (007.8 prior to October 1, 1997). If an AIDS patient is admitted with cryptosporidiosis, the principal diagnosis is human immunodeficiency virus (HIV) disease, 042, (HIV guidelines were revised October 1, 1994.) with cryptosporidiosis sequenced as a secondary diagnosis. (See Coding Clinic, fourth quarter 1997, pages 30 and 31.)

Diabetic gastroparesis (gastroparalysis)
Three codes are required; diabetes mellitus with neurological manifestations, 250.6x, peripheral autonomic neuropathy, 337.1 and gastroparesis, 536.3. Prior to October 1, 1994, when code 536.3 was created, code 536.8, dyspepsia and other specified disorders of the function of the stomach was assigned. (See Coding Clinic, fourth quarter 1994, page 42; Coding Clinic, second quarter 1993, page 6; and Coding Clinic, November-December 1984, page 9.)

Diarrhea, unspecified
Effective October 1, 1995, a new code, 787.91, diarrhea, was created so that diarrhea due to an unspecified cause could be distinguished from gastroenteritis, 558.9. (See Coding Clinic, fourth quarter 1995, page 54.)

Diverticula of colon/Meckel’s diverticulum
When diverticula of the colon is specified as congenital, assign code 751.5. Meckel’s diverticulum is considered congenital. A diagnosis of diverticula of the colon is coded as acquired unless otherwise specified. (See Coding Clinic, January-February 1985, pages 1-6.)

Esophageal obstruction/impacted foreign body
Assign code 935.1, foreign body in esophagus, for this condition. The use of 530.3, stricture and stenosis of esophagus, with code 935.1 is incorrect. Code 530.3 only applies to obstruction caused by stenosis, tumor, etc. and not that which is due to the presence of foreign body. (See Coding Clinic, first quarter 1988, page 13.)
**Esophageal reflux with reflux esophagitis**
Assign one code, 530.11, reflux esophagitis, for esophageal reflux with esophagitis. (See Coding Clinic, fourth quarter 1995, page 82.)

**Gastroenteritis/dehydration**
When a patient is admitted with dehydration and gastroenteritis, the sequencing of the diagnoses depends on the reason for admission and whether both conditions required admission to acute care. (See Coding Clinic, second quarter 1988, pages 9 and 10, and Coding Clinic, July-August 1984, pages 19 and 20.)

**Gastrointestinal (GI) bleeding**
As of September 15, 2005, if the physician does not establish a causal relationship between gastrointestinal bleeding and endoscopic findings (e.g., gastritis, duodenitis, esophagitis, diverticulosis of colon and/or colon polyp) the combination codes describing hemorrhage should not be assigned. If the documentation provides more specific information and the bleeding is linked to a specific condition, assign the appropriate combination code to include bleeding. (See Coding Clinic, third quarter 2005, pages 17 and 18 and second quarter 1992, pages 8 and 9.)

A diagnosis of acute gastritis with bleeding must be documented by the physician when the only documentation is a guaiac positive stool. Assign code 535.01, acute gastritis with hemorrhage. The code (792.1) for guaiac positive stool would not be assigned since codes from categories 790-796 are not used when a probable or definitive diagnosis has been made. (See Coding Clinic, second quarter 1992, pages 9 and 10.)

As of October 1, 1991, the conditions angiodysplasia of the intestines and stomach, diverticulitis, diverticulosis, gastritis and duodenitis with mention of hemorrhage (previously assigned code 578.x) are sequenced using one code for the condition with a fifth digit to indicate hemorrhage. Use of category 578, gastrointestinal hemorrhage, is now limited to cases in which GI bleeding is documented but no bleeding site or cause is identified. (See Coding Clinic, second quarter 1992, page 10.)

Most bleeding gastric ulcers will bleed intermittently, so it is possible for an endoscopy not to demonstrate bleeding. A diagnosis of gastric ulcer with bleed may be made by the physician in the absence of bleed on an endoscopy if the history and/or physical examination documents a bleed. (See Coding Clinic, first quarter 1991, page 15.)

**Intestinal pseudo-obstruction/acute intestinal pseudo-obstruction (Ogilvie's syndrome)**
The underlying cause of an intestinal pseudo-obstruction is a severe dysmotility of the intestine. Intestinal pseudo-obstruction is assigned code 564.89, other functional disorders of intestine. Prior to October 1, 1998, the code was 564.8. (See Coding Clinic, first quarter 1988, pages 6 and 7.)

Acute intestinal pseudo-obstruction (Ogilvie’s syndrome) is assigned code 560.89, other specified intestinal obstruction, other. (See Coding Clinic, first quarter 1988, page 7.)

**Neurocysticerosis**
A patient is admitted for seizure and cerebral edema. After study, the final diagnosis was neurocysticerosis. The principal diagnosis is neurocysticerosis, assigned code 123.1. Cysticercosis with seizure, 780.39, is sequenced as a secondary diagnosis. (780.3 prior to October 1, 1997). (See Coding Clinic, second quarter 1997, page 8.)
**Nutcracker esophagus**

Nutcracker esophagus is assigned code 530.5. (See Coding Clinic, first quarter 1988, page 13.)

**Peptic ulcer disease**

Clarification is needed to correctly assign a code for peptic ulcer disease. Determination must be made as to whether it is a chronic peptic ulcer, 533.7x, peptic acid disease (patient is being maintained on an antacid), 536.8, dyspepsia and other specified order of function of stomach, or a healed ulcer, V12.7, personal history of diseases of digestive system. Effective October 1, 1994, the correct code is V12.71, personal history of diseases of digestive system, peptic ulcer disease. (See Coding Clinic, second quarter 1989, page 16.)

**Pseudomembranous colitis/pseudomonas enterocolitis**

Pseudomembranous colitis is assigned code 008.45 (008.49 prior to October 1, 1992) and is a different condition than pseudomonas enterocolitis, 008.42. (See Coding Clinic, second quarter 1989, page 10, and Coding Clinic, first quarter 1988, page 6.)

**Reduction of intussusception by nonoperative reduction**

Nonoperative reduction of intussusception is assigned code 96.29, reduction of intussusception of alimentary canal. Code 96.29 was effective October 1, 1998. Code 96.29 excludes intra-abdominal manipulation of intestine, not elsewhere specified (46.80). (See Coding Clinic, fourth quarter 1998, pages 82 and 83.)

**Ruled out diagnosis**

Once a condition is ruled out, it is not assigned a code. If no diagnosis or symptom is present, which is the reason for admission, assign a code from category V71 (observation and evaluation for suspected conditions not found). (See Coding Clinic, March-April 1986, page 8.)

**Sandifer syndrome**

Sandifer syndrome is assigned codes 530.81, esophageal reflux and 723.5, torticollis, unspecified. (See Coding Clinic, first quarter 1995, page 7.)

**Status post gastrectomy**

Assign code V45.89, other postsurgical state if no problem exists. If a specific problem exists, code to the problem. (See Coding Clinic, first quarter 1993, page 11.)

**Symptom/final diagnosis**

When the final diagnosis is stated as a symptom and a code from Chapter 16 is assigned and documented to probably be due to a specified condition, there are several guidelines that must be considered to determine the correct code assignment. (See Coding Clinic, first quarter 1991, page 12.)

The definition of principal diagnosis.

If the final diagnosis is qualified as probable, suspected, likely, possible, or still to be ruled out, sequence the condition as if it existed or was established, providing that the diagnostic work-up, arrangements for further work-up or observation, and initial therapeutic approach correspond most closely with the established diagnosis. This applies only to the acute care hospital inpatient setting. (See Coding Clinic, second quarter 2002, pages 5 and 65, Coding Clinic, third quarter 2001, page 17, and Coding Clinic, March-April 1985, page 3.)
Codes for symptoms, signs, and ill-defined conditions from Chapter 16 are not to be assigned as the principal diagnosis when a related definitive diagnosis has been established. (See PDX #1, *Coding Clinic*, second quarter 1990, page 3.)

Conditions that are integral to the disease process should not be assigned as additional codes. (See ODX #3, *Coding Clinic*, second quarter 1990, page 15, and *Coding Clinic*, fourth quarter 1994, pages 38 and 39.)

**Ulcerative esophagitis**

Ulcerative esophagitis is assigned code 530.19, other specified esophagitis. This is not the same as an ulcer of the esophagus. (See *Coding Clinic*, third quarter 2001, pages 10-11.)

**Viral syndrome with associated diarrhea**

Viral syndrome with associated diarrhea is assigned code 008.8, viral enteritis, not elsewhere classified. (See *Coding Clinic*, January-February 1987, page 16.)