# Coding and Documentation Tips: Ostomies

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The chronic conditions that are current and managed must be reported (and supported by the documentation for that date of service**) at least once each calendar year** for CMS to continue to count that condition towards the patient's overall risk level.[1]

- Because all the conditions reset at the beginning of each year, they need to be addressed and documented at least once a year for them to be counted

An **ostomy** is a surgery that creates an opening in the abdomen, changing the way that waste exits your body. This procedure is used to treat various diseases of the urinary or digestive systems. [2]

Examples of ostomies:

- Colostomy
- Ileostomy
- Gastrostomy
- Urostomy

Ostomy status **cannot** be captured during the surgical phase.

- During the hospital stay in which the ostomy occurred, the ICD-10-PCS codes would be used to report the procedure.
- Once the patient has been discharged, the Ostomy Status code should be reported.

Ostomy coding is dependent upon whether it is current or not.

- If the ostomy is located in the Past Medical History/Problem List, and/or if there is documentation elsewhere within the chart note (i.e., Physical Exam, Surgical History, etc.) that shows it was reversed, it **would not** be reported.
- If there is no documentation showing the ostomy as reversed, it should be reported.

The entire encounter needs to be reviewed for mention of reversal of the ostomy. If none found, then it can be coded. If there is documentation of a reversal, the ostomy is not to be coded.

- *Example: On a past medical history, the note shows patient has a colostomy documented, with no evidence of a reversal anywhere in the note. The status code Z93.3 for the colostomy can be captured from the past medical history.*

Although an ostomy is surgically reversible, it is one condition that does not require MEAT/support to report.

- Make sure you are following your facility's coding guidelines. Each facility can have different requirements when reporting an ostomy status code.

Ostomy status is one of the most commonly missed conditions. This can happen for different reasons:

- Providers – Not addressing, or documenting the ostomy status at least once annually
- Coders/Billers – Unfamiliar with CMS coding guidelines regarding ostomy status
- Coders/Billers – Unfamiliar with facility specific coding guidelines
- Coders/Billers – Unfamiliar with where ostomy status can be pulled from to code and/or report
- Conflicting documentation regarding the status of the ostomy (active or revised/reversed)

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[1] *"Risk Adjustment and Hierarchical Condition Category Coding and Auditing," Find-A-Code, December 2, 2017*

[2] *Ostomy: Definition, Types, Procedure, Care & Recovery (clevelandclinic.org)*

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