Artificial Openings
Documentation Best Practices

WellSense HEALTH PLAN

Status Diagnoses

Artificial openings are often missed when documenting a patient's conditions. These need to be noted in a face-to-face encounter at least once each year while present. If a patient has a takedown procedure done, the diagnosis must to be updated to a personal "history of ostomy" and the date of the takedown documented in the visit, if known.

If an ostomy is present, a "status" diagnosis should be selected and the physical exam must correspond in the visit note on the date the provider assessed the site. The ICD-10 book delineates artificial openings by location, as shown below.

Artificial Opening Classifications	
Tracheostomy	Gastrostomy
Ileostomy	Colostomy
Cystostomy	Cutaneous-vesicostomy
Appendico-vesicostomy	Nephrostomy
Ureterostomy	Urethrostomy

"Attention to" Diagnoses

"Attention to ostomy" is the language that many EMRs and the ICD-10 book will use when describing a dressing change or other procedure on an artificial opening. This option should only be selected on the date when a provider is attending to or managing the care of the ostomy.

Attention to Artificial Opening Classifications	
Tracheostomy	Gastrostomy
Ileostomy	Colostomy
Cystostomy	Nephrostomy
Ureterostomy	Urethrostomy

Underlying Causes

When documenting an artificial opening, it is important to identify the underlying need for the ostomy. Though not all inclusive, some examples of an underlying cause may include the following situations:

- Various types of cancers, stating if it is active or has been excised.
- Malnutrition if a gastrostomy or jejunostomy tube is present.
- Chronic respiratory failure when a tracheostomy is in place.

These diagnoses should be noted, along with the plan of care if the disease is still actively being treated at the time the artificial opening is assessed.

Documentation Requirements

To ensure accurate coding of ostomies, the documentation must:

- Clearly indicate if the provider performed any care or procedure on the site during the visit.
- Remember to document the presence of an artificial opening in the physical exam when assessed.
- If the patient has had a takedown completed, use the personal "history of ostomy" diagnosis and document the date of the surgery, if known.
- If the reason for an ostomy is known and still being treated, clearly document the underlying cause with a plan of care for both conditions in the note.

Documentation examples

Status of Ostomy

HPI: Patient came into the clinic today for a routine follow up of their chronic conditions. They have been doing well, no concerns at this time. All maintenance care and immunizations are up to date. Overall health is good, no concerns with current medications, stoma is well maintained and new supplies have been ordered for monthly care.

PE: Vitals normal: PE normal, colostomy in place: ROS negative

A: **Z00.00 Encounter for adult health check-up**

I10 Hypertension

Z93.3 Colostomy status

P: Follow up with primary care for any concerns. Continue medication for hypertension, refill faxed to pharmacy. Order placed for stoma cleaning and maintenance supplies. The patient has been instructed on care and cleaning, they have no concerns at this time

Attention to Ostomy

HPI: Patient is here for evaluation and cleaning of their suprapubic catheter that was recently placed. No pain, swelling, discoloration, or fever is noted. Area looks clean, no leakage or other concerns observed at the insertion site.

PE: Vitals normal: PE normal, except for cystostomy: ROS negative

A: **Z43.5 Encounter for attention to cystostomy**

C61 Prostate Cancer

P: Provider flushed the catheter, cleaned the insertion site, and redressed the wound today. Instructed patient on daily care and changing the collection bag. Follow up with primary care physician for any concerns. Continue radiation treatment per oncologist for active prostate cancer.