AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

# Chronic Pancreatitis

## Quick Reference Guide

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# 1 CLINICAL SNAPSHOT

**Definition**: Chronic pancreatitis (**CP**) is a progressive inflammatory disorder characterized by permanent structural damage, functional loss, and fibrosis of the pancreas, leading to exocrine insufficiency and/or endocrine dysfunction (diabetes mellitus).[1,2] In adults, alcohol-induced CP (**K86.0**) and idiopathic CP (**K86.1**) together account for **>80% of cases** in developed countries.[1,2] Diagnosis requires imaging evidence (CT, MRI/MRCP, endoscopic ultrasound) of **pancreatic atrophy**, **ductal dilation**, or **calcifications** in the clinical context of chronic abdominal pain and/or pancreatic insufficiency.[1,3] Unlike acute pancreatitis, CP is **irreversible** and requires multifaceted management: pancreatic enzyme replacement therapy (**PERT**), diabetes management, pain control, and nutritional support; particular diagnostic vigilance is required in older adults for silent disease and sarcopenia.

## ICD-10 Codes

**K86.0** (alcohol-induced chronic pancreatitis) and **K86.1** (other chronic pancreatitis, including idiopathic) are the primary codes: both **map to HCC 79** under CMS-HCC V28.[4,5] **K86.81** (exocrine pancreatic insufficiency; **EPI**) must be coded when documented, as it is a key comorbidity affecting **nutritional status**.[2] **F10.xx** (alcohol use disorder) codes must be sequenced alongside K86.0 **at every encounter** when alcoholic etiology applies: AUD is the root cause and must be documented and managed.[6] **E13.xx** (type 3c diabetes mellitus, pancreatogenic) should replace or supplement **E11.xx** when diabetes is clearly secondary to pancreatic destruction; **E13.xx** maps to **HCC 37** or **38** depending on complexity.[5] **K86.2** (pancreatic cyst), **K86.3** (pancreatic pseudocyst), **K86.89** (other specified pancreatic disorders) are coded when documented clinically or radiologically. **Do NOT use Z87.19** ('history of pancreatitis') when disease is active: this suppresses HCC mapping and **flattens risk documentation**.

**Prevalence and Burden**: The annual incidence of chronic pancreatitis (CP) in developed countries is approximately 4–10 per 100,000 population, with prevalence estimates ranging from 10–15 per 100,000 and higher rates observed in regions with elevated alcohol consumption.[7] Alcohol-induced CP typically develops **10–20 years after** sustained heavy alcohol use (>80 g/day for men, >60 g/day for women) while idiopathic CP often presents later in life with similar disease progression.[2] In Medicare populations ≥65 years, disease burden and complications increase substantially: ~40–60% develop EPI;[2] ~70–80% develop **endocrine dysfunction** with brittle diabetes and increased **hypoglycemia risk**,[2,8] and 25–50% demonstrate **osteoporosis** by bone density testing.[9] Vitamin malabsorption, weight loss, malnutrition, and sarcopenia are common and contribute to frailty, falls, and **functional decline** in older adult patients.[7,9] **Only ~50–60%** of patients receive **optimized PERT dosing**,[10] while inadequate pain control, undertreatment of diabetes, and delayed hepatocellular carcinoma screening remain important drivers of preventable complications, hospital utilization, and high-cost readmissions.[9]

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