Internal Medicine Coding Alert

Coding Tips: Diagnosis and Management Option Should Tally For Crohn's Claims

Concentrate on the full picture for maximum ethical reimbursement.

If your physician treats patients with Crohn's disease (ileitis or regional enteritis), you'll need to be very careful to look at diagnosis, management, and the treatment to appropriately report your physician's care. Here is a quick refresher to help guide your Crohn's disease coding.

Use Consult Codes for Initial Visits

In most instances, a patient with Crohn's disease will usually present to your physician's practice as a referral patient from their primary care physician. "If documentation states that the intent of the visit is for an opinion or advice about the patient's condition, then use consultation codes appropriate for the place of service," says experts. This initial visit should be considered as a consultation and should be reported using appropriate consultation codes 99241-99245 (Office consultation for a new or established patient ...).

Consultations also require three components: request for opinion, rendering of services, and reporting of opinion. If any one component is missing then you risk denials or "take backs" of monies paid.

Keep in mind: As of Jan. 1, 2010, Medicare stopped recognizing consultation codes. They require new patient or established patient visits to be reported for the correct place of service.

If the patient has already been diagnosed with Crohn's disease prior to being referred, you still report the initial visit with the same consultation codes. If documentation states that the intent is a transfer of care for the given condition, then use appropriate new patient or established patient visit codes for the place of service.

Transfer of care means that one physician has asked another physician, who has agreed, to take over care of a specified condition. The two physicians share the patient but have specific roles in the management of the patient's healthcare. It is important to work closely with the physician to determine the appropriate code assignment.

Look for Symptoms Indicative of Crohn's Disease

Symptoms of Crohn's disease can include chronic diarrhea (787.91, Diarrhea), chronic severe lower abdominal pain (789.0, Abdominal pain), blood in stool (578.1, Blood in stool), chronic nausea with or without vomiting (787.0, Nausea and vomiting), and weight loss. Signs and symptoms should be reported until Crohn's disease is confirmed.

"We diagnose Crohn's on endoscopy. So, if the patient is suspected of Crohn's at the initial office visit, then only the symptoms are reported," says **Linh Nguyen, CPC**, Medical Coder-Gastroenterology Associates, Evansville, Indiana. "Once the patient is diagnosed with Crohn's (small, large, or both intestine), then their subsequent visits can be coded for Crohn's disease."

Report Tests Conducted for Diagnosis

Your physician might order various tests to confirm a diagnosis of Crohn's disease (555, Regional enteritis) before initiating any management of the condition. Your physician might order simple blood tests to check for ESR and WBC counts.

Also, the doctor might also collect a guaiac-based fecal-occult blood test (FOBT) (82270, Blood, occult, by peroxidase

activity [e.g., guaiac], qualitative; feces, consecutive collected specimens with single determination....) as this test is very helpful considering the sensitivity levels demonstrated to lower bowel bleeding.

"Guaiac based FOBT are not always ordered on our patients. If the patient only has anemia, our physicians may order the test. If positive, the next step could be endoscopy," says Nguyen. "However, if the patient has iron deficiency anemia or other signs of GI bleeding, we go straight to endoscopy. Just because the FOBT shows negative, it doesn't mean the patient doesn't have Crohn's."

Identify Colonoscopy Work

Another diagnostic measure that the physician will perform is a colonoscopy to check for signs of bleeding and inflammation. You can report this procedure with 45378 (Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen[s] by brushing or washing, with or without colon decompression [separate procedure]).

If he performs a biopsy, you can report the procedure with 45380 (Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple). You need not report an enteroscopy of the small bowel separately, if performed.

Based on the results of pathology reports and findings with colonoscopy, your gastroenterologist will arrive at the diagnosis of Crohn's disease. Depending on the location, you can report the diagnosis:

- 555.0 -- Regional enteritis of small intestine
- 555.1 --Regional enteritis of large intestine
- 555.2 -- Regional enteritis of small intestine with large intestine
- 555.9 -- Regional enteritis of unspecified site

Check Treatment Options

The first line of treatment for mild Crohn's disease will be lifestyle and dietary changes with medications that contain mesalamine, an anti-inflammatory agent; if more severe Crohn's disease is identified, then drugs that contain azathioprine or 6-mercaptopurine along with corticosteroids to help combat inflammation might be used.

Surgery: Your gastroenterologist might look into options such as colectomy or resection if the patient is not responding to conventional medications. "If a patient fails all lifestyle changes and medical management options, then part of the colon can be removed and/or bypassed surgically," says Copen. "In these cases, patients may undergo resections to take care of the strictures/fistulas," says Nguyen. If a patient undergoes colectomy, then you will need to report it with the appropriate code depending on the procedure conducted (44140-44160, Colectomy....).

Chemo: In patients not responding to conventional therapies, your gastroenterologist might opt for providing an intravenous infusion of infliximab (Remicade) either in the office setting or at a hospital-based infusion center.

If your physician is using Remicade in your own offices for management of the condition, you need to report the infusion procedure with 96413 (Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug), along with add-on code +96415 (Chemotherapy administration, intravenous infusion technique; each additional hour [List separately in addition to code for primary procedure]).

Reminder: You will also need to report J1745 (Injection infliximab, 10 mg) for the Remicade and J7050 (Infusion, normal saline solution, 250 cc) for every 250 cc of saline used to infuse Remicade.