Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Corner Constipation Encounters With This Coding Insight

Boost your coding prowess with complex condition knowledge.

Frequent constipation results in 2.5 million doctor visits each year, and it's estimated that about 4 million people in the United States suffer from it, according to John Hopkins Medicine. Common codes aren't always straight-forward though, since the condition can occur under so many different circumstances. How would you code the two encounters below?

Encounter 1: A patient comes in complaining of severe bloating, gas, and some nausea and reports not having a bowel movement in five days. Patient history includes 12 months of intermittent constipation, as well as previous tests for celiac disease and diverticulitis, which were both negative. Patient's father had irritable bowel syndrome (IBS) and hypothyroidism. The maternal grandfather had colon cancer.

The PCP orders a test to check thyroid levels, recommends a week of laxative use, suggests a temporary diet change, and asks the patient to come back in one month.

Encounter 2: Patient returns feeling somewhat better, but unable to defecate comfortably without laxatives. Thyroid test came back normal. At this subsequent visit, the provider diagnoses chronic functional constipation and possible IBS.

Keep reading to see if you agree with what our experts have to say about proper coding.

Navigate the Patient Record and Separate Symptoms From Diagnosis

"Constipation can be caused by a change in diet and exercise, lack of water intake, side effects of medication, or the beginning of something more serious such as irritable bowel syndrome (IBS), or cancer … It is one of the hardest conditions for providers to properly diagnose," says **Keisha Wilson, CCS, CPC, CRC, CPMA, CPB**, Approved Instructor, manager of compliance operations at a medical center in Brooklyn, New York.

"Since constipation is a symptom and also a diagnosis, it's important to therefore first recognize if the provider is describing a symptom or diagnosing the patient definitively," says **Chelsea Kemp, RHIT, CCS, COC, CDEO, CPMA, CRC, CCC, CEDC, CGIC**, AAPC Approved Instructor, outpatient coding educator/auditor for Yale New Haven Health, New Haven, Connecticut.

Code Each Encounter Independently

First, code the E/M for the first visit: "I see a new problem with uncertain prognosis, a minimal amount of complexity of data with one test ordered, and a low risk of morbidity. That puts the visit at 99203/99213 (Office or other outpatient visit for the evaluation and management of a new/established patient, which requires a medically appropriate history and/ or examination and low level of medical decision-making…)," Kemp says. Wilson agrees.

Then, code signs and symptoms: "There is no definitive diagnosis documented. But right away, I see the patient has not had a bowel movement in five days, and that constipation has been taking place intermittently for 12 months," explains Wilson. This brings into question whether the presenting problem is chronic constipation or the patient not having had a bowel movement in five days.

"We have R14.0 (Abdominal distension (gaseous), R14.3 (Flatulence), and R11.0 (Nausea). We also have R19.4 (Change in bowel habit) to account for the five days without a bowel movement. Constipation and changes in bowel habits cannot be coded together, per the Excludes1 note under R19.4. I favor coding the changes in bowel habits for this case since the presenting problem is documented as 'not having a bowel movement in five days,'" Kemp argues.

This is the kind of situation that might require confirmation from the provider, and our experts agree on the importance of thorough provider documentation. "Every patient encounter is different, and some key words may change the way you code one encounter from the next. It's important to read the record thoroughly, query the provider when necessary, and capture the full clinical picture for the visit," Kemp says.

Next, code the history: "Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease," according to ICD-10-CM Official Guidelines, Section I.C.21.c.4. The guidelines go on to explain the reason for the encounter should be sequenced first, followed by the appropriate personal or family history codes. For the first encounter, this would mean coding Z80.0 (Family history of malignant neoplasm of digestive organs), Z83.49 (Family history of other endocrine, nutritional and metabolic diseases), and Z83.79 (Family history of other diseases of the digestive system). "This gives the full clinical picture for this visit by identifying the other factors that could influence decision making," Kemp says.

Code the second visit: The notes from the second visit are vague but do contain a diagnosis. "The diagnosis of chronic functional constipation codes to K59.04 (Chronic idiopathic constipation), but the 'possible IBS' cannot be coded in the outpatient setting. Only a confirmed diagnosis can be used," Wilson explains. "Also, during the follow-up visit, there is no clear assessment and plan," Wilson says. This makes coding to the highest specificity and most accurate E/M level almost impossible without having to ask the provider for more information.

"It goes beyond receiving reimbursement for services rendered. It's important to the patient's health and ongoing care that everything be properly documented. Also, if another provider assumes care, they will need to know the accurate status of the patient as well as treatment plan," Kemp adds.