One word can make a world of difference

Clarify inflammatory bowel disease for MS-DRG assignment

by Helen Walker, MD

Physicians frequently use the term “inflammatory bowel disease” to indicate Crohn’s disease or ulcerative colitis. But in the coding world, inflammatory bowel disease does not code to either of these conditions. Instead, it codes to noninfectious gastroenteritis and colitis, completely different medical problems. This article will discuss reimbursement issues related to coding inflammatory bowel disease versus gastroenteritis. It will also provide the CDI specialist with clues to look for in the history, physical exam, labs, and patient treatment that might indicate that the patient has Crohn’s disease or ulcerative colitis instead of noninfectious gastroenteritis.

Some words just weigh more

Before tackling the clinical indicators of the disease, let’s examine the financial effect of the various possible inflammatory bowel disease coding scenarios. Correct coding of these conditions makes a difference in reimbursement depending on whether they are listed as principal or as secondary diagnoses.

If Crohn’s or ulcerative colitis is the principal diagnosis (i.e., the reason for admission), it’s unlikely a physician will document the nonspecific term “inflammatory bowel disease.”

Nevertheless, clinical documentation specialists must watch out for any potential documentation missteps. If the physician documents the principal diagnosis as Crohn’s or ulcerative colitis, the case will group to MS-DRG 387, with an average compensation of $3,986.91. But if the physician fails to be more specific than “inflammatory bowel disease,” the MS-DRG maps to 392 with a compensation of $3,433.46.

Although that may not seem like a large fiscal difference, consider other complicating factors. What if there were MCCs in the case? Then the story is far more dramatic. If the physician specifies Crohn’s or ulcerative colitis with an MCC, the DRG groups to 385. The hospital receives an average payment of $9,511.18. But if the physician only uses the term “inflammatory bowel disease,” the results are more dismal: The case maps to DRG 391 with a modest compensation of $5,560.15. What a difference a word makes. When coded with an MCC, DRG 387 pays 70% more than DRG 392 with an MCC.

Consider the scenario if the bowel condition is a secondary diagnosis. Under such conditions, it becomes imperative to obtain specific documentation from the attending physician because both Crohn’s disease and ulcerative colitis are CCs when listed as an additional diagnosis, whereas noninfectious gastroenteritis and colitis are not.

Let’s look at the documentation for a cervical fusion. If the physician merely uses the term “inflammatory bowel disease,” the case codes as MS-DRG 473, with an average compensation of $9,808.41. But if the physician specifies the

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correct term, the case will have a CC, and the compensation will be $13,364.85. Again, what a difference a word makes.

**Clinical indicators offer query opportunities**

Everyone now understands that CDI programs do not just “go for the money,” as they say. CDI specialists need to know which clinical indicators are present in the medical record and how that translates to the patient’s overall care. So what indicators do you need to watch for? How will you know when to suspect ulcerative colitis or Crohn’s disease when the physician merely documented inflammatory bowel disease? What should you look for?

Watch for the following clinical indicators in the patient’s history:
- Weight loss
- Fever
- Rectal bleeding

Take a look at the patient’s physical exam as well. Findings to watch for include:
- Eye inflammation
- Mouth sores
- Arthritis
- Skin conditions such as erythema nodosum or pyoderma gangrenosum

Instead of a normal colonoscopy, which would be expected in a patient with noninfectious gastroenteritis and colitis, a colonoscopy performed on a patient with ulcerative colitis or Crohn’s disease may reveal areas of inflammation, edema, ulcers, or fissures.

CDI specialists may also look for clues in the medical record regarding the types of medication prescribed to the patient.

The physician may prescribe items such as IV hydration and antidiarrheal agents for any of the above conditions, but if you find additional orders for steroids, sulfasalazine, 5-aminosalicylates (e.g., olsalazine or mesalamine), or antibiotics such as Metronidazole or Cipro, it is likely that the patient does not have a simple case of noninfectious gastroenteritis but potentially a more serious problem (although not necessarily ulcerative colitis or Crohn’s disease).

If you suspect that a patient with a discharge diagnosis of inflammatory bowel disease may actually have Crohn’s disease or ulcerative colitis, query the physician. (Consider adopting the sample physician query below.)

The query should elicit the clarification that best describes the condition of the patient. And it might even help your own tummy ache when you pull all the clinical pieces together.

**Sample query: Inflammatory bowel disease**

*Editor’s note: Helen Walker, MD, vice president of clinical quality at FairCode Associates, LLC, in Towson, MD, provided the following sample query to obtain accurate documentation regarding potential bowel disease specificity.*

Dear Dr. Jones,

The medical record documentation requires clarification for accurate coding. The patient presented with diarrhea, fever and weight loss, had oral aphthous ulcers on exam, was found to have inflammation and focal ulcerations in the colon on colonoscopy and was treated with sulfasalazine. The patient’s discharge diagnosis was inflammatory bowel disease. Inflammatory bowel disease codes to noninfectious gastroenteritis and colitis.

Please provide clarification as to whether noninfectious gastroenteritis and colitis accurately describes this patient’s condition or whether there is another condition that should be listed instead.

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