BlueCross BlueShield of Alabama
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Complete Picture of Health
Documentation and Coding Improvement Initiative

Coding Coach Monthly Coding Tips

Quality Tracking for HEDIS Prenatal and Postpartum Maternity Care *(posted December 2015)*

In support of quality tracking and in accordance with HEDIS guidelines, Blue Cross Blue Shield of Alabama requires that claims (outside of the global billing claim) for Prenatal and Postpartum care be submitted with **both** of the following:

- Date of first prenatal visit
- Date of postpartum visit

Date of first prenatal visit - Submit a claim reflecting the actual date of the first visit for prenatal care. Use CPT Category II code **0500F** (Initial prenatal care visit) or **0501F** (Prenatal flow sheet documented in medical record by first prenatal visit) **AND** any of the applicable diagnosis codes as outlined in the "Quality Reporting" section of the Corporate Reimbursement Policy, "Guidelines for Global Maternity Reimbursement".

Date of postpartum visit - The postpartum visit should occur 4-6 weeks after delivery. Submit a claim with the actual date the postpartum service was rendered. Use CPT Category II Code **0503F** (Postpartum care visit) and Routine postpartum follow-up. (As of 10/1/2015) use ICD -10 code Z39.2.

Laterality *(posted October 2015)*

When ICD-9-CM transitioned to ICD-10-CM*, a guideline for laterality was added. The guideline states the following:

"Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side." (2016 ICD-10-CM Official Guidelines for Coding and Reporting).

You can find this and all other coding guidelines in the front section of your ICD-10-CM coding book, or you can go to the Centers for Disease Control and Prevention (CDC) Web page.

Remember that it is always a good idea to review the coding guidelines yearly in order to become familiar with the guidelines that have changed. Because of the transition from ICD-9-CM to ICD-10-CM, it is especially important to check for such changes this year.

*ICD-10-CM International Classification of Diseases, Tenth Revision, Clinical Modification

Does Your Documentation Support the E/M Codes You Are Choosing? *(posted August 2015)*

It is important to always choose the level of care that best describes the evaluation and management (E/M) services performed in the practice, especially when reporting high-level care codes such as **99205** and **99215**. These codes are often misused, and in the future, could be targeted for auditing.

There are specific documentation requirements for the use of these codes. The code **99205** is used for high-level care of new patients. The following three components should be present in the documentation: a comprehensive history, a comprehensive examination and high complexity medical decision-making. The code **99215** is used for high-level care of an exisiting patient and requires two of these three components. These codes should only be used when high-level care is reported.

Component Key Points:

High Complexity Medical Decision-Making

This involves:

- The number of possible diagnoses and/or the number of management options that must be considered.
- Extensive amount of data to be reviewed and analyzed
- Risk of significant complications, morbidity and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedures(s) and management options.

Comprehensive Examination

- General exam of whole body or...
- Complete exam of one single organ system

Comprehensive History

- Chief complaint; extended history of present illness
- Review of systems directly related to the problem(s) identified in the history of present illness
- Review of all additional body systems
- Complete past, family and social history

For both codes, moderate to high severity is required in order to use them. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals or other agencies should show consistent information with the nature of the problem. With code **99205**, typically 60 minutes are spent face to face with the patient and/or family. With code **99215**, typically 40 minutes are spent face to face with the patient and/or family.

If the following components do not apply to the situation, consider preventive medicine service codes **99381 – 99397**.

Coding Rheumatoid Arthritis vs. Osteoarthritis *(posted July 2015 – Updated)*

Arthritis is a general term used to describe conditions that cause pain, stiffness and inflammation of the joints. The two most common types are rheumatoid arthritis (RA) and osteoarthritis (OA). Although categorized together, they are very different disease processes. The most common is OA, a degenerative disease of the joints. RA is an autoimmune disease in which the body attacks its own healthy tissue around the joint areas. It is important to recognize the difference between the two types so that the patient is properly diagnosed and the medical record is correctly coded.

Coding

RA is normally confirmed by a series of tests. Once the diagnosis of RA is confirmed, the following International Classification of Diseases, 9th Revision (ICD-9) diagnosis codes will apply and should be used for billing purposes: 714.0, 714.1, 714.2 and 714.81. For International Classification of Diseases, 10th Revision (ICD-10), there are numerous RA codes in the M05-M06 category codes, which should be chosen according to the specific condition.

Treatment

For patients diagnosed with RA, the preferred method of treatment is with a disease-modifying anti-rheumatic drug (DMARD). DMARD treatment is effective in slowing the progression of RA, especially when started within the first few months after initial diagnosis. There is a Healthcare Effectiveness Data and Information Set (HEDIS) measure around drug therapy for members with RA. RA members with two visits between January 1 and November 30 of the measurement year should have at least one DMARD dispensed or injected during the measurement year (January 1– December 31).

The ICD-9 and ICD-10 Official Coding Guidelines specifically state:

"Do not code diagnoses documented as ***probable, suspected, questionable, rule out, working diagnosis or other similar terms indicating uncertainty****. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit."*

"Codes that describe symptoms and signs as opposed to diagnoses are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider."

Chronic Care Management Services for Non-Face-to-Face Services *(posted June 2015)*

New Code as of January 1, 2015

99490 – Chronic Care Management (CCM) Services, **at least 20 minutes of non-face-to-face clinical staff time** directed by a physician or other qualified healthcare professional, per calendar month, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- Comprehensive care plan established, implemented, revised, or monitored.

(Chronic Care Management services of less than 20 minutes duration, in a calendar month, are not reported separately).

Chronic Care Management services are provided when medical and/or psychosocial needs of the patient require establishing, implementing, revising, or monitoring the care plan. (CPT 2015)

The following are some helpful tips when billing for the CCM code:

- A signed consent must be maintained in the member's medical record. Also required is documentation which includes the comprehensive care plan for the member and care coordination.
- It is recommended that the member's care plan and written consent is obtained and developed/updated during the member's Annual Wellness Visit (AWV), Initial Preventive Physical Exam (IPPE), or office visit and maintained in the medical record. *These face-to-face services are billed separately.*

Documentation in the member's record should include the:

- Date and amount of time spent providing non-face-to-face Chronic Care Management Services, preferably start/stop time, **for each month billed.**
- Clinical staff that is furnishing services (with credentials).
- Brief description of services.

The Blue Advantage® Plan reimburses for this code (subject to a patient copayment), but other plan reimbursement depends upon contract benefits and services may or may not be reimbursable by all Blue Cross contracts. The Federal Employee Program (Federal BC with "R" prefix) does not reimburse for this code.

Current Procedural Terminology (CPT®) Definition of New and Established Patient *(posted May 2015)*

Professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services (E/M). A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice within the past three years. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician."

Practice Management (PM) Software Diagnosis Code Test Instructions *(posted April 2015)*

What is Blue Cross and Blue Shield of Alabama's Practice Management (PM) software diagnosis code exercise? The practice management software diagnosis code exercise tool will allow providers to test their practice management (PM) or electronic health record (EHR) software capability and verify the number of diagnosis codes submitted on an electronic claim and received by Blue Cross. The following is the link which includes questions and answers of why this information is needed and instructions on how to send a test claim. This test is not required, but is highly recommended to give insight into your PM or EHR software capabilities. Following are some resources to help you as you test your PM or EHR software capability:

- Diagnosis Code Exercise Instructions
- Diagnosis Code Exercise FAQs

NEW! Coding Consultant Email Box *(posted March 2015)*

We have a new email box specifically set up to provide assistance with any questions regarding coding, documentation and coding guidelines. All questions will be answered by certified coders, and responses will be supplied within a 24-hour time period, when possible, from the date and time the email was received (weekends and holidays excluded).

Email: CodingConsultant@bcbsal.org

Annual Wellness Visits for Members (Non-Blue Advantage) *(posted February 2015)*

Free annual wellness visits are often promoted by employer groups insured through Blue Cross. However, members might not understand that copayments for these visits may apply when an illness, chronic condition or injury is treated at the time of the annual wellness visit. Providers can minimize confusion by explaining the need for their expanded services, if necessary, and following the coding guidelines below.

CPT® Codes for New Patients

- **99381-99384 –** These codes are for children and adolescents (ages 0-17)
- **99385 –** Initial comprehensive preventive medicine age 18-39 years old
- **99386 –** Initial comprehensive preventive medicine age 40-64
- **99387 –** Initial comprehensive preventive medicine age 65 and older

CPT Codes for Established patients

- **99391-99394** – These codes are used for children and adolescents (ages 0-17)
- **99395** – Periodic comprehensive preventive medicine age 18-39
- **99396** – Periodic comprehensive preventive medicine age 40-64
- **99397** – Periodic comprehensive preventive medicine age 65 and older

The primary diagnosis codes to use with these visits are ICD-9 code V70.0 for adults, and code V20.2 for children. Chronic condition codes such as diabetes, hypertension, etc. that are being considered during the visit can be used as secondary codes with the preventive medicine code.

Annual Wellness Visits for Members (Non-Blue Advantage) – *Continued* *(posted February 2015)*

If the patient's visit is for an annual physical and the provider treats an illness or injury during the visit that is "significant and separately identifiable", an Evaluation and Management Service (E/M) code can be added, using modifier -25 to the E/M code. The illness or injury should be significant enough to require additional work to perform the key components of a problem-oriented E/M service (CPT codes 99201-99215). When using two procedure codes, make sure that the documentation supports both codes and there are no overlapping components. An insignificant or trivial abnormality encountered while performing the annual wellness visit should not be reported if it does not require additional work and the performance of the key components of a problem-oriented E/M service.

When these codes are used, this helps Blue Cross to know the reason for the members visit so that they will not be charged a copayment following the visit. A copayment will be charged, however, if the practice bills for an E/M visit and the annual physical on the same day.

Remember that this coding information does not apply to annual wellness visits for Blue Advantage members. To bill annual wellness visits for Blue Advantage members, continue to use HCPCS codes G0438-G0439.

Hypertensive Chronic Kidney Disease and Hypertensive Heart and Chronic Kidney Disease (ICD-9-CM category 403 and 404) *(posted January 2015 – Updated)*

If a patient has hypertension and chronic kidney disease or hypertensive heart and chronic kidney disease, even if they are listed separately and not linked by the provider, a combination code can be used. According to coding guidelines, *this is the one time that the coder can presume a linkage of codes, even if the provider documents the codes separately.*

Coding Guidelines for Hypertension and Kidney Disease (category 403):

"Assign codes from category **403 Hypertensive Chronic Kidney Disease**, when conditions classified to category **585** or code **587** are present with hypertension. ICD-9-CM presumes a cause-and-effect relationship and classifies kidney disease (CKD) with hypertension as hypertensive chronic kidney disease."
(Coding Guidelines in 2015 ICD-9-CM)

Example: The patient has benign hypertension and ESRD
Assume linkage, even though listed separately 14 use codes:

- 403.11 Hypertensive Chronic Kidney Disease
- 585.6 End-Stage Renal Disease (ESRD)

Hypertensive Chronic Kidney Disease and Hypertensive Heart and Chronic Kidney Disease (ICD-9-CM category 403 and 404) – ***Continued*** *(posted January 2015 – Updated)*

Coding Guidelines for Hypertensive Heart and Chronic Kidney Disease (category 404):

"Assign codes from combination category **404**, Hypertensive Heart and Chronic Kidney Disease, when both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the chronic kidney disease, whether or not the condition is so designated." (Coding Guidelines 2015 ICD-9-CM)

The appropriate 4th and 5th digits are applied to these categories. Also, the coder would use a second code from the **585** category to identify the stage of the kidney disease. Codes from these two categories would always be at least two codes. Use an additional third code from category **428** to identify the heart failure for the hypertensive heart and chronic kidney disease to specify the type of heart failure (428.0-428.43).

> ***Example:*** *The patient has benign* ***hypertensive heart disease****, diastolic heart failure, and stage III kidney disease. Use codes:*
>
> - 404.11 Hypertensive Heart and Chronic Kidney Disease
> - 585.3 Chronic Kidney Disease, Stage III (moderate)
> - 428.30 Diastolic Heart Failure, unspecified

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ICD-9 - International Classfication of Diseases, Ninth Revision
ICD-10 - International Classfication of Diseases, Tenth Revision
HCPCS - Healthcare Common Procedure Coding System