BlueCross BlueShield of Alabama

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Complete Picture of Health
Documentation and Coding Improvement Initiative

Coding Coach Coding Tips

Category E78 – New Codes for ICD-10-CM Effective October 1, 2016 *(December 2016)*

Effective October, 1, 2016, ICD-10-CM codes for patients with disorders of lipoprotein metabolism and other lipidemias were added.

The new codes/descriptions are as follows:

E78.00 Pure hypercholesterolemia, unspecified
Fredrickson's hyperlipoproteinemia, type IIa
Hyperbetalipoproteinemia
Low-density-lipoprotein-type [LDL] Hyperlipoproteinemia

E78.01 Familial hypercholesterolemia

ICD-10-CM Coding Guideline Change *(October 2016)*

New ruling on Z00.00 and Z00.01 Codes for Routine Adult Health Examinations and Z00.121 and Z00.129 for Routine Child Health Examinations

As of October 1, 2016, the guidelines have been updated /clarified as follows:

"An examination with abnormal findings refers to a condition/diagnosis that is newly identified or a change in severity of a chronic condition (such as uncontrolled hypertension, or an acute exacerbation of chronic obstructive pulmonary disease) during a routine physical examination." (ICD-10-CM, 2017)

When to use code Z00.01: Patient presents for an Annual Wellness Visit (AWV). The patient has hypertension, which has been stable in the past, but upon examination today it was discovered that the patient's blood pressure was elevated, and no longer controlled.

- Use code **Z00.01** as the primary code as well as the codes for the chronic condition(s).

When to use code Z00.00: Patient presents for an Annual Wellness Visit (AWV). He also has diabetes type II and hypertension, which are both stable with no medication changes.

- Use code **Z00.00** as the primary code as well as the codes for the chronic condition(s).

Examples for Routine Child Health Examinations should follow the same as Adult:

Z00.121 – Encounter for routine child health examination with abnormal findings

Z00.129 –Encounter for routine child health examination without abnormal findings.

Use the above codes as the primary codes. For **Z00.129**, use also the codes for the chronic condition(s), which are either new condition discovered during the exam or a current chronic condition that is no longer controlled.

Colonoscopy Coding Basics and Guidelines *(September 2016)*

Colonoscopies can be preventive, diagnostic and/or therapeutic; therefore, **a screening colonoscopy is always coded as a screening procedure no matter what the outcome is during the test**.

Current Procedural Terminology (CPT®) developed **modifier "33"** for preventive services (excluding Blue Advantage®). As stated by CPT, **modifier 33** is used when the "primary purpose of the service is the delivery of an evidence-based service in accordance with a U.S. Preventive Task Force A or B rating effect and other preventive services identified in preventive services mandates (legislative or regulatory)."

For Blue Advantage, when colorectal cancer screening tests become diagnostic, you would append **modifier "PT"** to the diagnostic test or other procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy Healthcare Common Procedure Coding System (HCPCS) code (or as a result of the barium enema when the screening test becomes diagnostic).

Example: A physician performs a screening colonoscopy on a patient and finds a polyp. He/she then removes the polyp using the snare technique. He/she would use code using **45385** with **modifier 33** appended to the procedure to show that the colonoscopy is a preventive service. If this were a Blue Advantage patient, **modifier PT** would be added to the diagnostic test or other procedure code. Current clinical guidelines recommend that adults ages 50-75 receive a screening colonoscopy every 10 years.

Most Common Colonoscopy Codes:

HCPCS
G0105
G0121

CPT			
45378	45380	45382	45385
45379	45381	45384	45388

Use HCPCS Code G0452 Correctly *(August 2016)*

Healthcare Common Procedure Coding System (HCPCS) code G0452 (molecular pathology procedure; physician interpretation and report) is used to report a medically necessary interpretation and written report of a molecular pathology test, above and beyond the report of laboratory results.

It has come to our attention that certain genetic laboratories are encouraging primary care providers to utilize this code when reviewing the submitted molecular laboratory results. However, this is not the purpose of this code. It is intended to be used by more specialized providers, such as pathologists, molecular pathologists or geneticists, who process the samples, interpret the results, and create a written report. The review of the test results is considered to be part of the medical decision-making key component and is not separately billable.

Bilateral Procedures *(July 2016)*

A bilateral service, as defined by CMS, is "one in which the same procedure is performed on both sides of the body during the same operative session or on the same day."

Current Procedural Terminology (CPT®), from the American Medical Association (AMA) says that "unless otherwise identified in the listing, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate CPT code."

Example:

Bilateral total knee arthroplasty (TKA)

27447

27447-50

The Healthcare Common Procedure Coding System (HCPCS) uses modifiers LT (left) and RT (right) to show which side of the body a procedure is performed. If a procedure is performed only on one side of the body, the RT or LT is used in conjunction with one unit of service to indicate which side of the body that the service is performed on.

Example:

Myringotomy performed on left ear

69420-LT Myringotomy, including aspiration and/or Eustachian tube inflation

Bilateral total knee arthroplasty (TKA)

27447-RT Total knee arthroplasty
27447-LT Total knee arthroplasty

RT and LT can be used to identify contralateral anatomic sites such as bones and joints, paired organs (ears, eyes, nasal passages), or extremities like arms and legs.

However, some CPT codes indicate within the description of the code if they are unilateral or bilateral codes. You would not use the RT or LT modifier with these types of codes because the modifier is built into the code itself.

Example:

Bilateral fallopian tube ligation

58600 Ligation of fallopian tube(s), unilateral or bilateral

2016 Coding Update for 95165 *(June 2016 – edited November)*

According to the "CPT® 2016 Standard Edition," Current Procedural Terminology (CPT) code **95165** is "professional services for the supervision of preparation and provision of antigens for allergy immunotherapy; single or multiple antigens (specify number of doses)." The number of dosages prepared and provided must be included for CPT codes **95145 – 95170**.

When calculating the total number of units, *do not multiply the total number of antigens in the mixture by the total number of injections the patient is expected to receive during the build-up immunotherapy phase*. Instead, multiply the number of vials by the doses per vial. (Total doses prepared: 2 vials x 10 doses per vial = 20 total doses.) If the units are not calculated correctly, the resulting highly inflated unit totals could lead to audits and/or reimbursement "take backs."

CPT code **95165** requires the physician to provide supervision of the preparation and provision of the antigens for allergy immunotherapy. If direct supervision is not provided, this code should not be used.

Effective 12/3/2016, billing for CPT code **95165** will have the following limits applied and are addressed in our medical policy #081, *Allergy Immunotherapy*:

Allergy immunotherapy meets Blue Cross and Blue Shield of Alabama's medical criteria for coverage in patients with demonstrated hypersensitivity that cannot be managed by medications or avoidance when delivered based on **ALL** of the following guidelines:

- Maximum of 180 units for the first year of therapy during escalation, **and**
- Maximum of 120 units for yearly maintenance therapy thereafter, **and**
- Per unit reimbursement for allergy immunotherapy is based on the number of dosages prepared and intended for administration.

2016 Coding Update for Drug Testing HCPCS G Codes *(May 2016)*

Blue Cross and Blue Shield of Alabama medical policy #566, Drug Testing, has undergone a major coding update for 2016. **Here** is an overview of the coding changes that have occurred. Coding for drug testing relies on a structure of "screening" (known as "presumptive" testing) followed by quantitative or "definitive" testing to confirm and identify the specific drug and quantity. Blue Cross will continue to follow the guidance of the Centers for Medicare & Medicaid Services (CMS) and **not** recognize the American Medical Association's (AMA) Current Procedural Terminology (CPT®) codes 80300-80377. Coverage for any of the codes listed below is still subject to the medical criteria set forth in the policy.

Effective January 1, 2016

The following HCPCS codes were **deleted**:

- G0431, G0434 (presumptive/qualitative testing)
- G6030-G6058 (definitive/quantitative testing)

The following HCPCS codes were **added**:

- G0477-G0479 (presumptive/qualitative testing)
- G0480-G0483 (definitive/quantitative testing)

Diabetic Eye Exams *(April 2016)*

Diabetic patients are at risk for diabetic retinopathy, glaucoma and cataracts. Thus, it is very important for these patients to have vision screenings. Retinopathy is the most common diabetic eye disease and leading cause of blindness in American adults.

The code 92250 is considered reimbursable by Blue Cross; however, in order to close the Diabetic Care eye Exam gap, Current Procedural Terminology® (CPT) Category II codes 2022F, 2024F or 2026F should be used in conjunction with the CPT code 92250 when performing the service.

New Noncompliance ICD-10-CM Codes *(February 2016)*

The noncompliance codes can be helpful in tracking patients who have beyond normal circumstances; these codes should be used for reporting purposes only and may not affect scores that determine value-based reimbursement scores.

ICD-10-CM Codes	Description
Z91.11	Patient's noncompliance with dietary regimen
Z91.120	Patient's intentional underdosing medication regimen due to financial hardship
Z91.128	Patient's intentional underdosing of medication regimen for other reasons
Z91.130	Patient's unintentional underdosing of medication regimen due to age related debility
Z91.138	Patient's unintentional underdosing of medication regimen for other reasons
Z91.14	Patient's other noncompliance with medication regimen
Z91.15	Patient's noncompliance with renal dialysis
Z91.19	Patient's noncompliance with other medical treatment and regimen

Guidelines for Use of Modifier 77 *(January 2016)*

Generally, Blue Cross and Blue Shield of Alabama only pays for one interpretation of a procedure, such as an EKG or X-ray. Payment for a second or repeated interpretation is only considered under unusual circumstances, and appropriate documentation of medical necessity is required. In order to identify and report the repeated interpretation, modifier 77 should be appended to the procedure code, but never appended to an Evaluation and Management (E/M) code. Modifier 77 is used to signify a "repeat procedure by another physician or other qualified healthcare professional."

An example of when modifier 77 would be used is when a questionable finding occurs for which the provider giving the initial interpretation believes another provider's professional opinion is needed. This modifier could also be used if a diagnosis is changed based on the results of the repeated procedure interpretation. Modifier 77 should not be utilized in the case where a second reviewing provider is confirming the initial interpretation given by another provider or when reviewing the same day.

For additional information on the use of modifier 77, refer to the *2016 CPT Current Procedural Terminology* manual.

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(International Classification of Diseases 10th Revision, Clinical Modification [ICD-10-CM, 2016])