**Coding Coach**

### New Healthcare Common Procedure Coding System (HCPCS) Codes for Dexcom® G5 (December 2017)

HCPCS codes **A9276**, **A9277** and **A9278** are no longer accepted for the Dexcom G5 device, but as of July 1, 2017, HCPCS codes **K0553** and **K0554** can be used.

- **K0553**: Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 unit of service = 1 month’s supply*
- **K0554**: Receiver (Monitor), dedicated, for use with therapeutic continuous glucose monitor system

If you have a system limitation that doesn’t allow you to file HCPCS code **K0553** (supply allowance) and **K0554** (receiver), submit the manufacturer’s invoice and file HCPCS code **A9999** and **E1399**.

Use HCPCS code **A9999** for the Dexcom G5 continuous glucose monitoring supply allowance and accessories. Also file HCPCS code **E1399** for the Dexcom G5 continuous glucose monitoring system receiver.

Please refer to [Medical Policy #038 Continuous or Intermittent Monitoring of Glucose in the Interstitial Fluid](#) for coverage guidelines.

*Bill only 1 unit of service monthly.

### Medication Reconciliation Measure for Blue Advantage® (November 2017)

You can use **Current Procedural Terminology (CPT®) codes 99495-99496** or **CPT Category II code 1111F** to help close the medication reconciliation "gap in care" measure for Transitional Care Management (TCM) and to meet the HEDIS Transitions of Care Quality Measure*. You can also meet a Merit-based Incentive Payment System (MIPS) measure by reconciling medication after discharge.

Use the TCM **CPT codes 99495** and **99496** when:

- The patient is contacted within 2 business days of discharge;
- A face-to-face visit is made with the patient within 7 (99495) or 14 (99496) calendar days of discharge; and
- The reconciliation of the patient’s medication is performed and updated in the patient’s medical record (see code requirements in the CPT manual).

If you miss the time period to file the TCM codes, it’s still necessary to update the patient’s medical record to reflect reconciliation between the patient’s discharge medications and their current medications using **CPT Category II code 1111F**.

For example, if the patient presents to the office after the **7-14 calendar days** (described above), but is still **within the 30-day hospital discharge window**, **CPT Category II code 1111F** should be used with supporting documentation in the patient’s medical record to show that the patient’s medication has been reconciled.

*HEDIS® Measure Description: Medicare members 18 years of age and older who had a discharge from January 1 – December 1 and for whom medications were reconciled on the date of discharge through 30 days after discharge (31 total days).
New Method for Bundling Services by Tax ID and Specialty (October 2017)

Effective September 26, 2017, edits were modified to bundle procedures when billed for the same date of service by any provider under the same Tax ID with the same specialty. Edits are applied to all claims received on or after September 26, 2017, regardless of the date of service.

Note: No changes are being made to the criteria allowing a modifier to be used to bypass the bundling edits, when appropriate. Reimbursement also depends on our fragmented coding edits for proper reimbursement.

Below is an explanation of the difference between the previous processing method and the current method:

<table>
<thead>
<tr>
<th>Prior to September 26, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims submitted by two providers with the same Tax ID on the same date of service:</td>
</tr>
<tr>
<td>When two claims were received for services performed on the same date of service, payment was bundled when the second claim was filed by the same provider but not when it was filed by another provider with the same Tax ID number (whether it was at a different practice location or not).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>On and after September 26, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims submitted by two providers with the same Tax ID on the same date of service:</td>
</tr>
<tr>
<td>When two claims are received for services performed on the same date of service, bundling will occur*, whether it is the same provider or another provider in the same tax ID and stated specialty (even if it is from a different practice location). *Payment is subject to fragmented coding edits.</td>
</tr>
</tbody>
</table>

Modifier BO for Oral Enteral Nutrition (September 2017)

Enteral tube nutrition is provided for patients who have a functioning gastrointestinal tract, but they cannot ingest enough nutrients orally because they are unable or unwilling to take oral feedings.

Effective November 1, 2017, add modifier BO to HCPCS codes B4149-B4162 when billing for oral administration of enteral formulas. Oral nutrition is noncovered but should still be added to the claim with modifier BO to show that the nutrition was given orally and NOT through a feeding tube*.

If the nutrition is given through a feeding tube, file one of the HCPCS codes above without modifier BO, indicating that the feedings were given through a tube.

*Remember that the patient’s medical record documentation should always match the actual service provided. If the medical record states nutrition can be received orally, BO modifier should be present on the claim for dates of service on or after November 1, 2017. If you are audited and the patient’s medical record does not match what was submitted on your claim(s), a refund request may be made.

Women’s Preventive/Wellness Visits - The Key Is the Diagnosis Code! (August 2017)

Women may see their primary care physician (PCP) or their obstetrician/gynecologist (OB/GYN) for their preventive/wellness visits. The ICD-10 diagnosis code is the key to making sure benefits are applied correctly. Please see the chart below for assistance in proper billing:

<table>
<thead>
<tr>
<th>Service Provided By</th>
<th>ICD-10 Codes for Preventive/Wellness Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician</td>
<td>Z00.00 or Z00.01</td>
</tr>
<tr>
<td>Obstetrician/Gynecologist</td>
<td>Z01.411 or Z01.419</td>
</tr>
</tbody>
</table>

When appropriate, members will receive benefits for both encounters.

Many members have benefits for one visit each year for preventive history and physical examinations.* In addition, benefits are available for two visits through Women’s Preventive Services Guidelines. See our Preventive Care Services document for more information. Following are guidelines for filing claims for a new patient versus an established patient.
## Women’s Preventive Services Guidelines

<table>
<thead>
<tr>
<th>Established Patient</th>
<th>Number of Visits Covered</th>
<th>CPT or HCPCS Code</th>
<th>ICD-10 Code</th>
</tr>
</thead>
</table>
|                     | Two per calendar year    | 99393-99397, G0439, S0612 or S0613 | Z00.00 – Encounter for general adult medical examination without abnormal findings  
Z00.01 – Encounter for general adult medical examination with abnormal findings  
Z01.411 – Encounter for gynecological examination (general) (routine) with abnormal findings  
OR  
Z01.419 - Encounter for gynecological examination (general) (routine) without abnormal findings |

| New Patient         | Two per calendar year; can only be billed once by the same provider | 99383-99387, G0438 or S0610  
99383-99387, G0438 or S0610 | Z00.00 or Z00.01 – limited to one per calendar year  
Z01.411 or Z01.419 – limited to one per calendar year |

**There should be no cost for members in Affordable Care Act (ACA)-compliant plans for these services.**

**Reminder:** Diagnosis codes are the key to making sure benefits are applied correctly.

*Female members who have Affordable Care Act-compliant plans have benefits for more than one preventive/wellness visit per year. Be sure to check the member’s eligibility and benefits to verify their plan is healthcare reform compliant. You can also find this information in the routine services section of the summary plan description. Blue Advantage® (PPO) plans do not have benefits for more than one preventive/wellness visit per year.

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**Pediatrics - Weight Assessment Measure (July 2017)**

The HEDIS® measure Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) is a combination measure. Each of the following indicators must be addressed during the patient’s visit and documented in the medical record to close gaps in care for WCC.

- Body mass index (BMI) percentile
- Nutrition or physical activity counseling (combination measure)

Only specific ICD-10-CM, CPT and HCPCS codes will fulfill these measures, according to HEDIS® 2017 Technical Specifications for Physician Measurement criteria.

Refer to the Frequently Asked Questions/Answers and Pediatric Quality Initiative for more information.

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**Physician Extender “Incident To” Guidelines (June 2017) (Revised August 2017)**

Blue Cross and Blue Shield of Alabama does not recognize “incident to” billing for most plans (see below for Blue Advantage®). For evaluation and management (E&M) services, claims must be billed under the name and National Provider Identifier (NPI) of the provider who physically evaluates the patient to collect or confirm the patient’s:

- History of Present Illness (HPI);
- Review of System (ROS); and  
- Past/Family/Social/History (PFSH).

This information should be considered preliminary if it is taken by ancillary staff. The billing provider must confirm and complete own synopsis. Under no circumstances should services performed solely by the physician extender be billed under a physician name and NPI.

“Incident to” services are defined as services furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness.
Members may not be eligible for reimbursement for services provided by a non-participating physician extender and may be reimbursed at the out-of-network benefit level.

A physician extender is a specially trained, certified and licensed provider who renders medical services within the scope of his/her license. Blue Cross recognizes the following physician extenders:

- Certified registered nurse practitioner (CRNP)
- Certified nurse midwife (CNM)
- Certified registered nurse anesthetist (CRNA)
- Physician assistant (PA)
- Physician assistant/surgical assistant (PA/SA)

Blue Advantage follows Medicare policies for “incident to” services. To qualify, services must be part of the patient’s normal course of treatment in which a physician personally performed the initial service and is actively involved in the course of treatment. The physician does not have to be physically present in the patient’s treatment room while the services by the physician extender are being provided, but the physician should be available for direct supervision and be present in the office suite to give assistance if needed. The patient record should document the requirements for “incident to” services. Qualifying “incident to” services must be provided by a physician extender who the physician directly supervises and who is employed by the practice.

**CPT® 76942 Ultrasound Guidance with Arthrocentesis (Joint Injections) (May 2017)**

As a reminder, CPT code 76942 (ultrasonic guidance for needle placement) should not be billed with the joint injection CPT codes 20600-20611 (arthrocentesis, aspiration and/or joint injection) since the joint injection codes include ultrasound guidance. These codes should not be billed together for the same date of service. In addition, CPT code 76942 should not be submitted with a modifier in order to receive inappropriate payment or circumvent bundling logic.

**Example:** For arthrocentesis, aspiration or injection of a major joint or bursa, you may use CPT code 20611. Since CPT code 20611 includes *ultrasound guidance*, you would not also report CPT code 76942 separately. For more information, refer to your 2017 CPT manual.


Physician Performance Assessment (PPA) measures related to BMI and weight assessments will impact scoring for value-based payment initiatives for adult primary care on **January 1, 2018**, but will not affect scoring for pediatrics at this time.

For patients who are 20-74 years of age, documentation must include height, weight, BMI value and the date the measurement was taken.

For patients who are under 20 years of age, documentation of BMI must indicate the patient’s height, weight, and BMI percentile. Note: The BMI percentile may be documented as a value (e.g., 85th percentile) or plotted on the age-growth chart.

**Providers must include the appropriate Z68.** **category diagnosis code to report BMI for adults and the BMI percentile for pediatrics on a claim.**

**Exclusions:** Pregnancy diagnosis codes exclude the patient from this measure. If this applies to the patient, the condition must be documented in the patient’s medical record and the pregnancy code must be submitted on a claim in order for the patient to be removed from the measure.
**New CPT Drug Screening Codes for January 1, 2017** *(March 2017)*

Drugs, or classes of drugs, are commonly examined by a presumptive screening method followed by a definitive drug identification method.

Effective January 1, 2017, Current Procedural Terminology (CPT) created the following new presumptive drug screening class codes:

- 80305
- 80306
- 80307

These codes replaced HCPCS codes G0477, G0478 and G0479 for Blue Cross and Blue Shield of Alabama claims.

For billing purposes for Alabama-based providers, we require that you discontinue the use of “G” codes G0477, G0478 and G0479 for claims filing.

For more information on these codes, please refer to the 2017 CPT and the 2017 HCPCS manuals.

**New 2017 ICD-10-CM Codes Added for Cerebral Infarction** *(February 2017)*

The 2017 International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM) has added a “use additional code” note for cerebral infarction (Category I63) to indicate National Institutes of Health Stroke Scale (NIHSS) score, if known. Directions state to first code I63 then add R29.7 as a second code.

The codes range from R29.700 – R29.742. Below are *examples* from this category:

- R29.700 NIHSS 0
- R29.701 NIHSS 1
- R29.702 NIHSS 2
- R29.703 NIHSS 3
- R29.704 NIHSS 4

Please refer to your 2017 ICD-10-CM coding manual for the rest of these codes or for more information.

**New Hypertension Code Changes for October 1, 2016, ICD-10-CM** *(January 2017)*

Category change for Elevated Blood Pressure and New Hypertension Codes:

- For Elevated Blood Pressure reading without diagnosis of hypertension, continue to use the symptom category R03.
- As of October 1, 2016, hypertension category I10 now includes high blood pressure.
- A new category has been added to Hypertensive Disease, which is I16. Included in this category are the following new codes:
  - I16.0 Hypertensive urgency
  - I16.1 Hypertensive emergency
  - I16.9 Hypertensive crisis, unspecified