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Coding Coach

Coding Tips

Filing Superficial Radiation Therapy for Cancer *(December 2018)*

Radiation treatment delivery using superficial and/or orthovoltage energies (<1 MeV) is reported with CPT code 77401. Orthovoltage X-rays are produced by X-ray generators operating at voltages in the 200-500 kV range, which produce energy in the 200-500 keV range.

The following CPT codes cannot be reported when superficial radiation therapy is provided:

- MeV treatment delivery codes (77402, 77407, 77412)
- Clinical treatment planning codes (77261 - 77263)
- Treatment device development codes (77332 - 77334)
- Isodose planning codes (77306, 77307, 77316 - 77318)
- Radiation treatment management codes (77427, 77431, 77432, 77435, 77469, 77470, 77499)
- Continuing medical physics consultation code (77336)
- Special physics consultation code (77370)

Evaluation and management (E/M) services may still be reported separately, if appropriate, in cases when only superficial radiation therapy (77401) services are provided.

Improving Clinical Documentation in the Medical Health Record *(November 2018)*

Documentation in the medical health record is a critical component to every patient encounter and patient service. Providers are key deliverers of this information, and it is vital that they capture complete details of the patient's visit. Healthcare reimbursement methodologies rely on providers to capture:

- Patient illnesses and severity
- Risk of mortality
- Acute and chronic conditions
- Medical necessity
- Quality measures

Correctly applying procedure codes, diagnoses, signs and symptoms, and other services in the outpatient setting depends on the accuracy of the documentation in the medical record. Thorough, detailed documentation leads to accurate coding, and accurate coding leads to appropriate and timely claims payments for hospitals and providers. Most importantly, accurate documentation can lead to better, more effective patient care.

With the increased awareness of risk adjustment and Hierarchical Condition Category (HCC) codes, the focus is on greater specificity in the medical health record when capturing diagnoses, especially for risk adjustment payment accuracy. If you are interested in learning more about improving documentation in your medical records, contact your Provider Networks Consultant at 1-866-904-4130.

Combination Diagnosis Codes and Linking Manifestation Codes with Chronic Conditions *(October 2018)*

With the implementation of ICD-10-CM, many new combination codes were added to make linking diagnoses easier. The combination codes allow you to document two conditions with one code. For example, when a patient with diabetes mellitus and polyneuropathy is seen, using the E11.42 combination code is the correct code for Type II diabetes mellitus with diabetic neuropathy.

Common Coding Error for Combination Diagnosis Codes	
Incorrect	**Correct**
Reporting **E11.9** Type II diabetes mellitus, unspecified with **G62.9** polyneuropathy, unspecified	Reporting **E11.42** Type II diabetes mellitus with diabetic neuropathy

Pay close attention to the use additional code notes found in the Tabular List in the ICD-10 coding manual when you are deciding which code to use. ICD-10-CM guidelines for coding and reporting state ***code highest level of specificity***. When in doubt, coders should ask the physician for clarification when an applicable combination code is available but documentation does not clearly link the two diagnoses.

If the one condition is due to another condition, the physician's documentation must indicate this. There are a few instances where the coding guidelines allow coders to assume linkage (e.g., Type II diabetes mellitus and chronic kidney disease), but refer to the guidelines when you are unsure. Below is a short list of leading combination codes.

A Few Combination Codes Available for Use	
I25.11_	Atherosclerotic heart disease of native coronary artery with angina pectoris
E10.21	Type I diabetes mellitus with diabetic nephropathy
N30.01	Acute cystitis with hematuria
E11.321_	Type II diabetes mellitus with mild non-proliferative diabetic retinopathy with macular edema

Controlling High Blood Pressure (CBP) Quality Measure Changes for 2019 *(September 2018)*

Effective January 1, 2019, we will implement new guidelines for the CBP quality measure:

- The CBP measure will change to state all members between the ages of 18 – 85 with a diagnosis of hypertension should have their blood pressure measured.
- Under the new CBP guidelines, a patient will only be considered compliant and their blood pressure in control if their **most recent** reading during the measurement year submitted on a claim is for an in control result.
- For 2019 dates of service and beyond, the blood pressure "G" codes will be **removed** from the CBP measure.

The "G" codes will remain compliant through 2018 dates of service. **Providers should stop coding the "G" codes on a claim when reporting the blood pressure measure, and only use the "F" codes (below) for 2019 dates of service and beyond**.

Below are the CPT II codes that should be used to report blood pressure readings in control; both systolic and diastolic are required to be reported on a claim to satisfy the CBP measure:

Systolic:
3074F Most recent **systolic** blood pressure less than 130 mm
3075F Most recent **systolic** blood pressure between 130 – 139 mm

AND

Diastolic:
3078F Most recent **diastolic** blood pressure less than 80 mm
3079F Most recent **diastolic** blood pressure between 80 – 89 mm

Reporting BMI Appropriately by Patient's Age *(August 2018)*

When using ICD-10-CM BMI diagnosis code Z68.xx, be sure to use the appropriate code that correlates with your patients' age at the time of service. Make sure the BMI indicated on a claim matches the BMI documented in the patient's medical record. If you submit a claim for an old date of service with the patient's BMI, make sure to document the age of the patient at the time of the service.

Note: *Using the accurate age at the time of service will close a patient's gap in care.*

ICD-10-CM Code Specifications by Age:			
Adult ICD-10-CM Codes	Ages 21 – 74	Z68.1 – Z68.45	Calculated from documented height and weight
Pediatric ICD-10-CM Codes	Ages 3 – 20	Z68.51 – Z68.54	Based on growth charts published by the CDC

BMI Quality Measures:	
Adult BMI	Applies to patient ages 18 – 74.* Calculated and documented height and weight can be used to close the measure.
Weight Assessment BMI (Pediatrics)	Applies to patient ages 3 – 17. Growth chart percentile can be used to close the measure.

*The growth chart percentile can be used for patient ages 3 – 20 to close these measures.

Attention: Blue Advantage® Providers – Quality Measure for Statin Use in Persons with Diabetes (SUPD) *(July 2018)*

Prevention of cardiovascular disease is an important part of diabetes management. The standard of care for diabetes suggests the use of statin therapy in diabetic patients who are 40 to 75 years of age.

The SUPD gap in care is closed through pharmacy claims data received by Blue Cross when a patient fills a prescription for statins. If a patient is given samples rather than filling a prescription, the SUPD gap will not be closed. It is recommended that you document discussions with diabetic patients regarding the need for statins. When a diabetic patient is in for an office visit, it is important to document compliance or noncompliance with statin treatment.

When coding medical claims for diabetes, remember to include the patients' chronic conditions, such as diabetes with complications, chronic obstructive pulmonary disease (COPD), morbid obesity, etc. Document the conditions in the assessment when these conditions are being considered in medical decision-making.

New ICD-10-CM Codes Added for Non-Pressure Ulcers *(June 2018)*

There are new ICD-10-CM codes for additional non-pressure chronic skin ulcer diagnoses:

L97.105 – L97.108	L97.305 – L97.308	L97.505 – L97.508	L97.905 – L97.908
L97.115 – L97.118	L97.315 – L97.318	L97.515 – L97.518	L97.915 – L97.918
L97.125 – L97.128	L97.325 – L97.328	L97.525 – L97.528	L97.925 – L97.928
L97.205 – L97.208	L97.405 – L97.408	L97.805 – L97.808	L98.415 – L98.418
L97.215 – L97.218	L97.415 – L97.418	L97.815 – L97.818	L98.425 – L98.428
L97.225 – L97.228	L97.425 – L97.428	L97.825 – L97.828	L98.495 – L98.498

These codes are added to the existing non-pressure chronic ulcer codes and are based on:

- Location
- Severity (with or without necrosis)
- Breakdown of skin
- Fat layer exposure

Under categories L97 and L98, remember to first code any associated underlying condition, such as:

- Chronic venous hypertension
- Diabetic ulcers
- Gangrene
- Post-phlebitis syndrome
- Post-thrombotic syndrome
- Varicose ulcer
- Atherosclerosis of the lower extremities

Heart Failure Diagnosis Codes *(May 2018)*

New ICD-10-CM codes have been added for 2018 that allow for the use of "other" for heart failure diagnoses. According to the ICD-10-CM Official Guidelines for Coding and Reporting, you should use codes titled "other" or "other specified" when there is not a code that correlates with the information in the patient's medical record.

Coding steps in ICD-10-CM for heart failure:

1. First, code whether heart failure is due to an underlying condition, such as:
   - Hypertension
   - Hypertension with chronic kidney disease
   - Rheumatic heart failure
   - Heart failure following surgery
   - Complicating abortion and ectopic or molar pregnancy
   - Obstetric survey and procedures
2. Next, code heart failure based on the code sets found in category I50:

I50.810	**Right** heart failure, unspecified
I50.811	Acute **right** heart failure
I50.812	Chronic **right** heart failure
I50.813	Acute on chronic **right** heart failure
I50.814	**Right** heart failure due to **left** heart failure (code also the type of left ventricular failure, if known (I50.2-I50.43)
I50.82	**Biventricular** heart failure (code also the type of left ventricular failure, as systolic, diastolic, or combined, if known (I50.2-I50.43)
I50.83	**High** output heart failure
I50.84	**End stage** heart failure
I50.89	**Other** heart failure
I50.9	Heart failure, unspecified

New 2018 ICD-10-CM Diagnosis Codes – Digestive System for Intestinal Obstructions *(April 2018)*

New codes have been created to help providers more accurately specify the cause of intestinal obstructions and indicate if it is partial or complete. See the charts below for examples of codes used for intestinal adhesions and obstructions.

Intestinal Adhesions	Partial Intestinal Obstruction	Complete Intestinal Obstruction	Unspecified Intestinal Obstruction
K56.50	K56.690	K56.601	K56.600
K56.51	K91.31	K56.691	K56.609
K56.52		K91.32	K56.699
			K91.30

Note: *Refer to the ICD-10-CM coding manual for code descriptions.*

Alzheimer's and Parkinson's Disease With Dementia *(March 2018)*

ICD-10-CM 2018 requires at least two diagnosis codes to be coded for patients who have dementia in addition to Alzheimer's or Parkinson's disease.

Code the underlying physiological condition first (e.g., Alzheimer's [G30. _]), and then code dementia (F02.8_) as the secondary diagnosis. The fifth digit indicates whether the dementia is with or without behavioral disturbances. If a dementia patient has been diagnosed by the provider with the additional risk factor of wandering, include the additional code Z91.83.

Examples:

Alzheimer's Disease With Dementia

G30._	Alzheimer's (Digit 4 indicates early or late onset, or other/unspecified)
F02.8_	Dementia (Digit 5 indicates with or without behavioral disturbances)

Dementia is an inherent part of the diagnosis of Alzheimer's disease. The provider does not have to give diagnosis of Alzheimer's disease **and** dementia in order to report both codes. Per the ICD-10-CM Alphabetic Index, G30. _ should be reported first, followed by F02.80 or F02.81 to show dementia with or without behavioral disturbances.

Parkinson's Disease Caused by Another Condition With Dementia

When Parkinson's is caused by another condition, use a secondary diagnosis code (e.g., G21. _ due to other external agents). In this case, code the primary cause first and then the secondary Parkinson's code plus dementia.

G21.4	Vascular parkinsonism
G20	Parkinson's disease
F02.8_	Dementia (Digit 5 indicates with or without behavioral disturbance)

Diabetes Mellitus: Diagnosis Guideline Change *(February 2018)*

As of October 1, 2017, coding guidelines changed for use of insulin and oral hypoglycemic medications in diabetes mellitus treatment. For a diabetes mellitus diagnosis that is not indicated, type 2 is the default.

If a patient uses insulin, a code from ICD-10-CM category E11 type 2 diabetes mellitus should be assigned, unless type 1 diabetes mellitus is documented in the medical record. Do not use code E11 itself, as there are multiple codes that contain a greater level of detail for this situation.

An additional code from ICD-10-CM category Z79 should be used to identify current long-term use of insulin or oral hypoglycemic drugs. The additional code for insulin is Z79.4, but there are different codes from this category for oral hypoglycemic medications.

Also, as stated in the ICD-10-CM coding guidelines:

- If the patient is treated with both oral medications and insulin, only the code for long-term (current) use of insulin should be assigned.
- Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient's blood sugar under control during an encounter.

Example:

Patient A has diabetes mellitus (not documented as type 1 in the medical record) and is currently on insulin and oral medication. Code the following:

E11.9 Diabetes mellitus, type 2

Z79.4 Long-term (current) use of insulin

Current Procedural Terminology (CPT) Laboratory Codes to Indicate "Per Specimen" *(January 2018)*

For specimens where multiple immunostains are performed to identify positive or negative antibody responses, report a primary procedure code for the initial single antibody stain procedure and the appropriate add-on codes for each additional single antibody stain procedure.

Example:

88342 – *Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure.*

CPT code **88342** is a primary procedure code and includes "per specimen" in the description. You should report it for the initial single antibody stain procedure on each separate specimen. Add-on CPT code **88341** would be used for each additional single probe stain procedure per specimen. When multiple separately identifiable antibodies are applied to the same specimen (i.e., multiplex antibody stain procedure), use one unit of **88344**. If a separate multiplex antibody procedure is performed on a different patient specimen, then an additional unit of code **88344** may be appropriate to report. CPT code **88342** and other primary procedure codes should be used **once per specimen**, and the other appropriate add-on codes should be added to identify additional antibodies found "per specimen."

Primary Procedure Code Examples	Add-on Code Examples for Single Probe Stain Procedure
88342	88341
88365	88364
88367	88373
88368	88369

The unit of service for this family of services is the antibody stain procedure per specimen (i.e., the single antibody stain procedure or the multiplex antibody stain procedure).

Note: *Do not use more than one unit of 88341, 88342, 88344 for each separately identifiable antibody per specimen.*