BlueCross BlueShield of Alabama
An Independent Licensee of the Blue Cross and Blue Shield Association

Complete Picture of Health
Documentation and Coding Improvement Initiative

Documentation and Coding Frequently Asked Questions

Specifics make a difference. Use complete, accurate and comprehensive coding.

1. Why is Blue Cross and Blue Shield of Alabama encouraging more detailed documentation and coding?

Increased accuracy of diagnosis coding through International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes helps Blue Cross and Blue Shield of Alabama identify patients who may benefit from disease and medical management programs. More accurate health status information can be used to match healthcare needs with the appropriate level of care. Blue Cross uses procedure code detail through Current Procedural Terminology (CPT/CPT II) and Healthcare Procedure Coding System (HCPCS/HCPCS II) codes to identify service gaps, patient body mass index, blood pressure control, lipid levels, etc.

Accurate and comprehensive coding also conveys the complexity of our patients' health or "risk," which will impact future premium rates and provider incentive programs.

As we move to 2014, measurement of gaps in care will be more closely aligned with a true Healthcare Effectiveness Data and Information Set (HEDIS) methodology. Health plans must report quality related data to the United States Department of Health and Human Services in 2014 as required by the Affordable Care Act. The risk adjustment model captures this information through claims data.

2. Does Blue Cross want every claim to include diagnosis codes for all patient conditions even if the patient's visit was for a specific diagnosis?

Patient claims should include ICD-9-CM codes for all conditions assessed, treated or considered in the medical decision making for that encounter.

A chronic disease treated on an ongoing basis may be documented, coded and reported as many times as the patient receives treatment for that condition.

Code all documented conditions that coexist at the time of the visit and require/affect patient care, treatment or management. *Do not code conditions that were previously treated and no longer exist.* However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

CPT-II and HCPCS II informational codes can be submitted to enhance claims data.

Note: A member's medical record must support coding submitted on the member's claim(s).

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3. Am I held accountable for a CPT code(s) my practice management or electronic medical records system automatically loads on a member's claim?

Yes. Some systems automatically load CPT codes based on a combination of medical information entered. Ultimately, it is the physician's responsibility to make sure claims accurately reflect services provided. Therefore, be sure your coders are well educated on how to submit appropriate codes on claims submitted to Blue Cross.

Avoid "upcoding" of CPT codes. Typically, upcoding does not occur at the ICD-9-CM level. For example, an office visit with a new patient can be billed using one of five evaluation and management (E/M) CPT codes (i.e., 99201-99205). The level of an E/M service corresponds to the amount of skill, effort, time, responsibility and medical knowledge required for the physician to deliver the service to the patient. To accurately determine the appropriate complexity level of an E/M service, physicians must use patient history, physical examination and medical decision making.

Note: Blue Cross is working with and encouraging electronic practice management system vendors to make necessary changes to avoid upcoding and to help enhance accurate, appropriate and specific coding.

4. How many diagnosis codes can be filed on an electronic claim?

Blue Cross accepts 12 diagnosis codes on an electronic claim as allowed by the Health Insurance Portability and Accountability Act (HIPAA). Up to four diagnosis codes (of the 12) can be pointed to each line item. All diagnosis codes submitted on a claim are considered for the Complete Picture of Health Initiative even if not pointed to an individual line.

If your practice management or electronic medical records system restricts the number of diagnosis codes sent to Blue Cross, please contact your practice management vendor for assistance.

Preventive Services

1. **When is a member eligible for a preventive service visit?**
   Nine preventive service visits are covered for the first two years of life. One preventive service visit per year for ages two through six (based on birth year). Preventive visits are covered once every 12 months per calendar year for ages seven and older. Check eligibility and benefits for the most up-to-date coverage information.

2. **Who can perform a preventive service visit?**
   Check eligibility and benefits on our provider website, **www.bcbsal.com/providers**, for the most up-to-date list of eligible providers according to the member's contract.

3. **What are the correct codes for preventive service visits?**
   Refer to your CPT code book under the section titled "Preventive Medicine."

4. **Are there any specific diagnosis codes required when submitting a claim for an initial or subsequent preventive visit?**
   Providers should submit a claim for these types of visits by using a preventive diagnosis code.

5. **Is the member responsible for payment of deductibles and/or coinsurance for preventive visits**?
   Deductibles and coinsurances may apply for preventive visits. Please note that if the member is receiving care for any medical condition at the same time, deductibles and coinsurances do apply. This needs to be reinforced to the member. Check eligibility and benefits for the most up-to-date coverage information.

6. **How does a provider bill for treatment of a medical condition that the member discussed during the preventive visit?**
   A provider can report and bill for the preventive visit and the Evaluation and Management (E/M) services with a 25 modifier as long as that the treatment of the medical condition was significant and separately identifiable from the preventive visit. Please be aware that some of the components of the preventive visit may overlap with the E/M components. These components cannot be duplicated in the selected E/M code. The provider will need to select the most appropriate E/M code as defined by the American Medical Association. In this scenario, the provider may collect one copayment for the E/M service provided. You must have enough documentation in the medical record in order to bill both.

7. **When a provider sees a member for a preventive visit and orders screening or diagnostic laboratory studies, what diagnosis code should be used?**
   Any medically necessary testing should be reported using the most appropriate diagnosis code(s). Therefore, the provider should utilize preventive health diagnosis codes for screening tests and appropriate diagnosis codes specific to the medical condition being evaluated.

8. **Where can I find information regarding Blue Advantage® Annual Wellness Visits?** https://www.bcbsal.org/providers/blueAdvantage/preventiveFAQ.pdf