STEERING YOUR WAY BEYOND ROUTINE ENDOCRINOLOGY CODING

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OBJECTIVES

- Correct coding of thyroid biopsies and aspirations
- Accurate coding of evocative and suppression testing
- Commonly missed ICD-9 codes
- Appropriate billing of dietary/nutrition patient education
- Easy documentation and coding of care plan oversight services

THYROID BIOPSIES

- First determine what type of biopsy is being performed:
  - Fine needle aspiration (FNA), without imaging guidance
    - 10021
  - Fine needle aspiration, with imaging guidance
    - 10022 + CPT® for imaging guidance
THYROID BIOPSIES

- Percutaneous core-needle (PCN) biopsy
  - 60100 (+ CPT® for imaging guidance if used)

THYROID BIOPSIES

- All three services have 0 global days
- All three services have a 0 bilateral surgery indicator in the CMS 2011 Physician Fee Schedule, meaning:
  - Payment for bilateral biopsies is paid at 100% of the fee schedule and is not subject to a surgical reduction, and
  - It does not matter if you bill with modifier 50 for bilateral, or with modifiers RT, LT, reimbursement will remain at 100% for all bilateral biopsies during the same session
  - Multiple FNA or PCN biopsies that are NOT bilateral are paid at the surgical reduction rate of 100% for the first, 50% for the second, third, and fourth, and then by report for any after that
FNA THYROID BIOPSIES

- For CPT® codes 10021 and 10022:

  - Remember that multiple biopsies, or samples, taken from the same nodule, are considered ONE biopsy for billing purposes
    - Several needle insertions into the same nodule is often necessary to obtain an adequate sample for pathology
    - FNA involves removing small samples of cells
  
  - Only separate needle insertions into separate nodules can be coded as individual multiple biopsies

PCN THYROID BIOPSIES

- For CPT® 60100:

  - Remember this code is used when a large bore needle is placed through the skin, through muscle, and into the thyroid itself, removing thyroid tissue for biopsy
    - This involves removing a relatively larger piece of tissue
  
  - Remember that multiple biopsies, or samples, taken from the same nodule, are considered ONE biopsy for billing purposes

  - If this is performed after FNA, due to specimen inadequacy, only CPT® 60100 is billed
THYROID BIOPSY IMAGING GUIDANCE

- For imaging guidance, there are four CPT® code options to use with 10022 and 60100:
  - 76942 – Ultrasound (US) guidance
  - 77002 – Fluoroscopic guidance
  - 77012 – Computed Tomography (CT) guidance
  - 77021 – Magnetic Resonance Imaging (MRI) guidance

IMMEDIATE FNA CYTOHISTOLOGIC EXAMINATION

- 88172 is the CPT® code to add if your office has the ability to perform an immediate cytohistologic examination of the specimen to determine specimen adequacy
- This code is used for FNA specimens ONLY!
- 88172 is billed for each separate site biopsied (per CMS 2011 Physician Fee Schedule), NOT per specimen
- 88172 requires a CLIA certification in order to bill
  - Verify with your local Medicare Carrier what your office needs prior to billing 88172
THYROID CYST ASPIRATION AND/OR INJECTION

- 60300 describes the aspiration and/or injection of a thyroid CYST – the needle goes through skin and into the cyst where either aspiration or injection is performed.

- 60300 may only be billed once when performing an aspiration and injection of the same cyst during the same service.

- This service has 0 global days, and a 0 indicator in the bilateral surgery indicator in the 2011 CMS Physician Fee Schedule.
  - Please refer back to slide 5 for meaning.

THYROID CYST ASPIRATION AND/OR INJECTION IMAGING GUIDANCE

- For imaging guidance, there are two CPT® code options with 60300.
  - 76942 – Ultrasound (US) guidance
  - 77012 – Computed Tomography (CT) guidance
MODIFIERS WITH FNA AND PCN BIOPSIES OR THYROID CYST ASPIRATION AND/OR INJECTION

- Modifier RT, LT, 50, 76, and/or 59, may be necessary when billing for bilateral or multiple services:
  - RT – Right side
  - LT – Left Side
  - 50 – Bilateral service
  - 76 – Repeat procedure or service by the same physician
  - 59 – Distinct procedural service

CLONIDINE SUPPRESSION TESTING

- A consent form for the infusion procedure should be presented and signed by the patient
- Hep-lock placed and Clonidine is given
**Clonidine Suppression Testing**

- The patient then has 10 blood draws every 24 minutes
- The Hep-lock is irrigated after each blood draw
- The patient is monitored over the four-hour-period

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**Clonidine Suppression Testing**

- 96365 – Intravenous infusion, for therapy, prophylaxis, or diagnosis; initial, up to 1 hour
  - + 96366 – each additional IV infusion hour
- J1642 – Injection, heparin sodium (heparin lock flush), per 10 units
  - This equals a quantity of 1, in billing, for each 10 units of heparin sodium
**CLONIDINE SUPPRESSION TESTING**

- And, if collecting the blood samples from the hep-lock;

- 36592 – Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified

- OR, if collecting samples from blood draws NOT from hep-lock;

- 36415 – Collection of venous blood by venipuncture

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**CLONIDINE SUPPRESSION TESTING**

- Modifier 76 – Repeat procedure or service by the same physician:
  
  - It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.
CLONIDINE SUPPRESSION TESTING

- A separate evaluation and management service (e.g., 99212, 99213) may be billed only if it was medically necessary

- Modifier 25 (significantly separate evaluation and management service by the same physician on the same day as other procedure or service) must be appended to the E/M

- Prolonged service codes (99354-99357 office setting) are not appropriate as the prolonged time is already billed for with the infusion codes.

OTHER EVOCATIVE/SUPPRESSION TESTING

- CHAP 10.doc, Version 16.3, CHAPTER X, PATHOLOGY / LABORATORY SERVICES, CPT CODES 80000 – 89999, FOR NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES
OTHER EVOCATIVE/SUPPRESSION TESTING

- **Evocative/Suppression Testing**
  - “Evocative/suppression testing requires the administration of pharmaceutical agents to determine a patient’s response to those agents. CPT codes 80400-80440 describe the laboratory components of the testing. Administration of the pharmaceutical agent may be reported with CPT codes 96365-96376. In the facility setting, these codes may be reported by the facility, but not the physician. In the non-facility setting, these codes may be reported by the physician..."

...While supplies necessary to perform the testing are included in the testing CPT codes, the appropriate HCPCS level II J code for the pharmacologic agent may be reported separately. Separate evaluation and management services including prolonged services (e.g., prolonged infusion) should not be reported separately unless a significant, separately identifiable service medically reasonable and necessary E&M is provided and documented.”
OTHER EVOCATIVE/SUPPRESSION TESTING

- NCCI contains edits pairing each panel CPT code (column one code) with each CPT code corresponding to the individual laboratory tests that are included in the panel (column two code). These edits allow use of NCCI-associated modifiers to bypass them if one or more of the individual laboratory tests are repeated on the same date of service. The repeat testing must be medically reasonable and necessary. Modifier 91 may be utilized to report this repeat testing. Based on the Internet-Only Manuals (IOM), Medicare Claims Processing Manual, Publication 100-04, Chapter 16, Section 100.5.1, the repeat testing cannot be performed to “confirm initial results; due to testing problems with specimens and equipment or for any other reason when a normal, one-time, reportable result is all that is required.”

OTHER EVOCATIVE/SUPPRESSION TESTING

- Follow the same premise as Clonidine Suppression Testing, e.g.;
  - CPT® code(s) for IV, IM, or Subcutaneous injections/infusions
  - HCPCS codes for medications and/or heparin
  - CPT® code for blood specimen collection from appropriate site
  - E/M only if significantly separate E/M performed in addition to procedure/service

- Documentation of time elements is essential
COMMONLY MISSED ICD-9 CODES

- ICD-9 codes support medical necessity of services
- Specificity in diagnosis is vital to provide medical necessity for more frequent services and/or ordering of testing or other services
- Provides a clear word-picture to the insurance carrier of why a service is necessary
- Some diagnoses are commonly missed or left off a claim and may be the reason for denials for non-medical necessity

Since DM is an underlying systemic disease:
- Condition should be coded if documented even in absence of documented active intervention for diabetes itself during patient encounter
- Coding guidelines for coding DM has not changed with code revisions
- Code selection based on physician’s documentation of Type I versus Type II, manifestations of the disease and whether the current treatment regimen keeps the glucose levels within acceptable levels (controlled versus uncontrolled)
COMMONLY MISSED ICD-9 CODES

○ Official Guidelines:
  - All type I diabetics must use insulin to replace what their bodies do not produce. However, the use of insulin does not mean that a patient is a type I diabetic.
  - Some patients with type II diabetes mellitus are unable to control their blood sugar through diet and oral medication alone and do require insulin. If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, the appropriate fifth-digit for type II must be used.

○ Official Guidelines
  - For type II patients who routinely use insulin, code V58.67, Long-term (current) use of insulin, should also be assigned to indicate that the patient uses insulin. Code V58.67 should not be assigned if insulin is given temporarily to bring a type II patient’s blood sugar under control during an encounter.
COMMONLY MISSED ICD-9 CODES

○ Official Guidelines
  - The age of a patient is not the sole determining factor, though most type I diabetics develop the condition before reaching puberty. For this reason type I diabetes mellitus is sometimes also referred to as juvenile diabetes.

  - If the type of diabetes mellitus is not documented in the medical record the default is type II.

○ Official Guidelines:
  - When assigning codes for diabetes and its associated conditions, the code(s) from category 250 must be sequenced before the codes for the associated conditions. The diabetes codes and the secondary codes that correspond to them are paired codes that follow the etiology/manifestation convention of the classification (See Section I.A.6., Etiology/manifestation convention). Assign as many codes from category 250 as needed to identify all of the associated conditions that the patient has.
COMMONLY MISSED ICD-9 CODES

- Official Guidelines:
- The corresponding secondary codes are listed under each of the diabetes codes.
  - (a) Diabetic retinopathy/diabetic macular edema
    Diabetic macular edema, code 362.07, is only present with diabetic retinopathy. Another code from subcategory 362.0, Diabetic retinopathy, must be used with code 362.07. Codes under subcategory 362.0 are diabetes manifestation codes, so they must be used following the appropriate diabetes code.

COMMONLY MISSED ICD-9 CODES

- Official Guidelines:
- Certain conditions have both an underlying etiology and manifestation due to etiology
- Coding convention requires underlying condition (DM) sequenced first
  - Followed by manifestation
  - Example: Diabetic neuropathy
- Pay attention to code first “Diabetes” or “Use additional code to identify manifestation”
ICD-9 CODING

250.xx - DIABETES MELLITUS

4th Digit Denotes Complication

250XX DIABETES MELLITUS

- 250.0x – Without mention of complication
- 250.1x - With ketoacidosis
- 250.2x - With hyperosmolarity
- 250.3x - With other coma
- 250.4x - With renal manifestations
- 250.5x – With ophthalmic manifestations
- 250.6x - With neurological manifestations
- 250.7x - With peripheral circulatory disorders,
- 250.8x - With other specified manifestations,
- 250.9x – With unspecified complication
DIABETES

- 5th digit describes type

- 0 – Type II or unspecified type, not stated as uncontrolled
  - use additional code, if applicable, for associated long-term (current) insulin use V58.67

- 1 - Type I [juvenile type] not stated as uncontrolled

- 2 - Type II or unspecified type, uncontrolled
  - use additional code, if applicable, for associated long-term (current) insulin use V58.67

- 3 - Type I uncontrolled [juvenile], uncontrolled
**DOCUMENTATION**

**THREE THINGS**

- Type of Diabetes
  - Type I or II
- Insulin dependent or not
- Controlled or uncontrolled

**EXAMPLE**

- A 30 year old Type I patient has presented with a foot ulcer due to diabetic atherosclerosis
  
  - 250.81-Diabetes with other specified manifestations, Type I, not stated as uncontrolled “use additional code to identify manifestation”
  - 440.23-Artherosclerosis of the extremities with ulceration
  - 707.14-Ulcer, except decubitus, of the heel and mid-foot
EXAMPLE

A 30 year old Type I diabetic patient who also has atherosclerosis of the right leg extremity, presents with a foot ulcer (causal relationship not stated)

- 707.12 - Ulcer of ankle
  - Diabetes
  - Atherosclerosis
- 250.01 – Diabetes without mention of complication; Type I, [juvenile type], not stated as uncontrolled
- 440.20 – Atherosclerosis of extremities, unspecified

ALTERNATIVE CODES

- 440.23 – Atherosclerosis of extremities with ulceration
  - Use additional code for any associated ulceration
- 250.81-Diabetes with other specified manifestations, Type I, not stated as uncontrolled “use additional code to identify manifestation”

PRE-DIABETES

- AKA “insulin resistant”
- Condition that occurs when a person's blood glucose levels are higher than normal but not high enough for a diagnosis of DM II
- There are 54 million Americans who have pre-diabetes
PRE-DIABETES

ICD-9 SECTION: Non-specific findings on examination of blood

- Abnormality of red blood cells
  - Abnormal glucose
    - 790.29 Other abnormal glucose

SECONDARY DIABETES

- Caused by an outside factor
  - May result from late effects of poisoning
  - May result from disease processes
    - Cushing’s syndrome
    - Malignant neoplasm
    - Hyperthyroidism
    - Cystic Fibrosis
    - Genetic disorders
SECONDARY DIABETES

- Requested by American Academy of Pediatrics
  - 5 years in process
- Characterized by elevated blood sugar levels
- <2% reported cases diabetes

DOCUMENTATION

THREE THINGS

- Type of Diabetes
  - Type I or II
- Insulin dependent or not
- Controlled or uncontrolled

OR ..... is it 4 Things?
OFFICIAL CODING GUIDELINES
SECONDARY DIABETES MELLITUS

- Codes under category 249, Secondary diabetes mellitus, identify complications/manifestations associated with secondary diabetes mellitus. Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning).
  (a) Fifth-digits for category 249:
  - A fifth-digit is required for all category 249 codes to identify whether the diabetes is controlled or uncontrolled.
  (b) Secondary diabetes mellitus and the use of insulin
  - For patients who routinely use insulin, code V58.67, Long-term (current) use of insulin, should also be assigned. Code V58.67 should not be assigned if insulin is given temporarily to bring a patient’s blood sugar under control during an encounter.

(c) Assigning and sequencing secondary diabetes codes and associated conditions

- When assigning codes for secondary diabetes and its associated conditions (e.g. renal manifestations), the code(s) from category 249 must be sequenced before the codes for the associated conditions. The secondary diabetes codes and the diabetic manifestation codes that correspond to them are paired codes that follow the etiology/manifestation convention of the classification.
Assign as many codes from category 249 as needed to identify all of the associated conditions that the patient has. The corresponding codes for the associated conditions are listed under each of the secondary diabetes codes. For example, secondary diabetes with diabetic nephrosis is assigned to code 249.40, followed by 581.81.

(d) Assigning and sequencing secondary diabetes codes and its causes

- The sequencing of the secondary diabetes codes in relationship to codes for the cause of the diabetes is based on the reason for the encounter, applicable ICD-9-CM sequencing conventions, and chapter-specific guidelines.
If a patient is seen for treatment of the secondary diabetes or one of its associated conditions, a code from category 249 is sequenced as the principal or first-listed diagnosis, with the cause of the secondary diabetes (e.g., cystic fibrosis) sequenced as an additional diagnosis.

If, however, the patient is seen for the treatment of the condition causing the secondary diabetes (e.g., malignant neoplasm of pancreas), the code for the cause of the secondary diabetes should be sequenced as the principal or first-listed diagnosis followed by a code from category 249.
(i) Secondary diabetes mellitus due to pancreatectomy
For postpancreatectomy diabetes mellitus (lack of insulin due to the surgical removal of all or part of the pancreas), assign code 251.3, Postsurgical hypoinsulinemia. A code from subcategory 249 should not be assigned for secondary diabetes mellitus due to pancreatectomy. Code also any diabetic manifestations (e.g. diabetic nephrosis 581.81).

(ii) Secondary diabetes due to drugs
Secondary diabetes may be caused by an adverse effect of correctly administered medications, poisoning or late effect of poisoning.

See section I.C.17.e for coding of adverse effects and poisoning, and section I.C.19 for E code reporting
249.0 SECONDARY DIABETES MELLITUS
WITHOUT MENTION OF COMPLICATION

Secondary diabetes mellitus NOS

- 249.00 - Secondary diabetes mellitus without mention of complication, not stated as uncontrolled, or unspecified
- 249.01 - Secondary diabetes mellitus without mention of complication, uncontrolled

249.XX SECONDARY DIABETES MELLITUS

- 249.1x - Secondary diabetes mellitus with ketoacidosis
- 249.2x - Secondary diabetes mellitus with hyperosmolarity
- 249.3x - Secondary diabetes mellitus with other coma
- 249.4x - Secondary diabetes mellitus with renal manifestations
- 249.5x – Secondary diabetes with ophthalmic manifestations
- 249.6x - Secondary diabetes mellitus with neurological manifestations
- 249.7x - Secondary diabetes mellitus with peripheral circulatory disorders,
- 249.8x - Secondary diabetes mellitus with other specified manifestations
DIABETIC COMPLICATIONS

- **Heart Disease**
  - Increased risk for heart attack, stroke, and complications related to poor circulation

- **Kidney Disease (Nephropathy)/Kidney Transplantation**
  - May cause damage to the kidneys
    - Failure
    - May lose ability to filter out waste products.

DIABETIC COMPLICATIONS

- **Diabetic Neuropathy and Nerve Damage**
  - Most common complications
    - Damage to the nerves that run throughout the body, connecting the spinal cord to muscles, skin, blood vessels, and other organs.

- **Foot Complications**
  - Nerve damage in the feet
  - When blood flow is poor
  - Basic foot guidelines
DIABETIC COMPLICATIONS

- Skin Complications
  - 1/3 of diabetics will have a skin disorder caused or affected by diabetes at some time in their lives
  - May also be first sign that a person has diabetes

- Eye Complications
  - At higher risk of blindness
  - Early detection and treatment.

- Depression

DIABETIC COMPLICATIONS

- Gastroparesis
  - Affects people with both type 1 and type 2 diabetes
  - Gastroparesis is a condition that affects the ability of the stomach to empty its contents
**DIABETIC NEPHROPATHY**

- Over 40% of new cases of end-stage renal disease (ESRD) are attributed to diabetes
- In 2001, 41,312 people with diabetes began treatment for end-stage renal disease
- In 2001, it cost $22.8 billion in public and private funds to treat patients with kidney failure
- Minorities experience higher than average rates of nephropathy and kidney disease

![Incidence of ESRD Resulting from Primary Diseases (1998)](image)

**DIABETIC NEUROPATHY**

- About 60-70% of people with diabetes have mild to severe forms of nervous system damage, including:
  - Impaired sensation or pain in the feet or hands
  - Slowed digestion of food in the stomach
  - Carpal tunnel syndrome
  - Other nerve problems
- More than 60% of nontraumatic lower-limb amputations in the United States occur among people with diabetes
RISK FACTORS

- Glucose control
- Duration of diabetes
- Damage to blood vessels
- Mechanical injury to nerves
- Autoimmune factors
- Genetic susceptibility
- Lifestyle factors
  - Smoking
  - Diet

COMPLICATIONS OF POLYNEUROPATHY

- Ulcers
- Charcot arthropathy
- Dislocation and stress fractures
- Amputation - Risk factors include:
  - Peripheral neuropathy with loss of protective sensation
  - Altered biomechanics (with neuropathy)
  - Evidence of increased pressure (callus)
  - Peripheral vascular disease
  - History of ulcers or amputation
  - Severe nail pathology
**ESSENTIALS OF FOOT CARE**

- **Examination**
  - Annually for all patients
  - Patients with neuropathy - visual inspection of feet at every visit with a health care professional

- **Advise patients to:**
  - Use lotion to prevent dryness and cracking
  - File calluses with a pumice stone
  - Cut toenails weekly or as needed
  - Always wear socks and well-fitting shoes
  - Notify their health care provider immediately if any foot problems occur

**FOOT CARE MODIFIERS**

- **Q7** - One CLASS A findings
- **Q8** - Two CLASS B findings
- **Q9** - One CLASS B and two CLASS C findings
FOOT CARE MODIFIERS

○ CLASS A findings
  Non-traumatic amputation of foot or integral skeletal portion

○ CLASS B findings
  Absent posterior tibial pulse
  Absent dorsalis pedis pulse
  Advanced trophic changes such as:
  
  Note - Three of the following are required to equal one class B finding:
  Hair growth (decrease or absence)
  Nail changes (thickening)
  Pigmentary changes (discoloration)
  Skin texture (thin, shiny)
  Skin color (elevation pallor or dependence rubor)

○ CLASS C findings
  - Claudication
  - Temperature changes (e.g., cold feet)
  - Edema
  - Paresthesias (abnormal spontaneous sensations in the feet)
  - Burning
  - Marked diminished or absent sensation in the foot, secondary to systemic disease or injury resulting in damage to the sensory nerves to the lower extremity
DIABETIC RETINOPATHY

• Most common cause of new cases of blindness among adults 20-74 years of age

• Each year, between 12,000 to 24,000 people lose their sight because of diabetes.

• During the first two decades of disease, nearly all patients with type 1 diabetes and over 60% of patients with type 2 diabetes have retinopathy
RISKS OF DIABETIC RETINOPATHY-RELATED VISION LOSS

- Duration of diabetes disease
  - Type 1 patients
    - 25% rate of retinopathy after 5 years of disease
    - 80% at 15 years of disease
  - Up to 21% of newly diagnosed type 2 patients have some degree of retinopathy at time of diagnosis
- Puberty
- Pregnancy
- Lack of appropriate ophthalmic examination

RETINOPATHY SCREENING

- Type 1 diabetes - screen within 3-5 years of diagnosis after age 10
- Type 2 diabetes - screen at time of diagnosis
- Pregnancy - women with preexisting diabetes should be screened prior to conception and during first trimester
NATURAL HISTORY OF DIABETIC RETINOPATHY

- Mild nonproliferative diabetic retinopathy (NPDR)
- Moderate NPDR
- Severe NPDR
- Very Severe NPDR
- Proliferative diabetic retinopathy (PDR)

DIABETIC RETINOPATHY AND MACULAR EDEMA

- New codes in 2006 added to identify more specificity:
  - 362.03 Nonproliferative diabetic retinopathy NOS
  - 362.04 Mild nonproliferative diabetic retinopathy
  - 362.05 Moderate nonproliferative diabetic retinopathy
  - 362.06 Severe nonproliferative diabetic retinopathy
  - 362.07 Diabetic macular edema
Prevention of Diabetic Retinopathy Associated Vision Loss

- Intensive glycemic control
- Tight blood pressure control (<130/80 mmHg)
- Comprehensive eye examinations

Documentation for BMI & Pressure Ulcer Stages

- For the Body Mass Index (BMI) and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient.

ICD-9-CM Official Guidelines 2010
DOCUMENTATION FOR BMI & PRESSURE ULCER STAGES

Cont’d
- Associated diagnosis must be documented by the patient’s provider.
  - Ie. Overweight, obesity, or pressure ulcer
- Query the attending provider for clarification if there is conflicting documentation
  - Same clinician
  - Different clinicians
- BMI and Ulcer staging are secondary diagnosis codes if they meet standard of “other diagnoses”

BMI ICD-9 CODING

- BMI adult codes are used for persons over 20 years old
- A BMI of 26-27 is considered to be overweight
- A BMI of 30 or higher is considered obese; the higher the BMI the greater the chance of disease
BMI ICD-9 CODING

- V58.21 – BMI 25.0-25.9, adult
- V58.30 – BMI 30.0-30.9, adult
- V58.22 – BMI 26.0-26.9, adult
- V58.31 – BMI 31.0-31.9, adult
- V58.23 – BMI 27.0-27.9, adult
- V58.32 – BMI 32.0-32.9, adult
- V58.24 – BMI 28.0-28.9, adult
- V58.33 – BMI 33.0-33.9, adult
- V58.25 – BMI 29.0-29.9, adult
- V58.34 – BMI 34.0-34.9, adult
- V85.41 Body Mass Index 40.0-44.9, adult
- V85.42 Body Mass Index 45.0-49.9, adult
- V85.43 Body Mass Index 50.0-59.9, adult
- V85.44 Body Mass Index 60.0-69.9, adult
- V85.45 Body Mass Index 70 and over, adult

The body mass index (BMI) code section has been expanded for 2010, and additional codes have been added to allow for specificity of BMI over 40. The new codes will allow for tracking patients at increased health and surgical risk.
PRESSURE ULCER STAGES

- Two codes are needed to completely describe a pressure ulcer: A code from subcategory 707.0, Pressure ulcer, to identify the site of the pressure ulcer and a code from subcategory 707.2, Pressure ulcer stages.
  - The codes in subcategory 707.2, Pressure ulcer stages, are to be used as an additional diagnosis with a code(s) from subcategory 707.0, Pressure Ulcer. Codes from 707.2, Pressure ulcer stages, may not be assigned as a principal or first-listed diagnosis. The pressure ulcer stage codes should only be used with pressure ulcers and not with other types of ulcers (e.g., stasis ulcer).
  - The ICD-9-CM classifies pressure ulcer stages based on severity, which is designated by stages I-IV and unstageable.

UNSTAGEABLE PRESSURE ULCERS

- Assignment of code 707.25, Pressure ulcer, unstageable, should be based on the clinical documentation. Code 707.25 is used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma.
  - This code should not be confused with code 707.20, Pressure ulcer, stage unspecified. Code 707.20 should be assigned when there is no documentation regarding the stage of the pressure ulcer.
**DOCUMENTED PRESSURE ULCER STAGE**

- Assignment of the pressure ulcer stage code should be guided by clinical documentation of the stage or documentation of the terms found in the index. For clinical terms describing the stage that are not found in the index, and there is no documentation of the stage, the provider should be queried.

**BILATERAL PRESSURE ULCERS**

- **Bilateral pressure ulcers with same stage**
  - When a patient has bilateral pressure ulcers (e.g., both buttocks) and both pressure ulcers are documented as being the same stage, only the code for the site and one code for the stage should be reported.

- **Bilateral pressure ulcers with different stages**
  - When a patient has bilateral pressure ulcers at the same site (e.g., both buttocks) and each pressure ulcer is documented as being at a different stage, assign one code for the site and the appropriate codes for the pressure ulcer stage.
MULTIPLE PRESSURE ULCERS OF DIFFERENT SITES AND STAGES

- When a patient has multiple pressure ulcers at different sites (e.g., buttock, heel, shoulder) and each pressure ulcer is documented as being at different stages (e.g., stage 3 and stage 4), assign the appropriate codes for each different site and a code for each different pressure ulcer stage.

PRESSURE ULCERS THAT ARE HEALING

- *Patients admitted with pressure ulcers documented as healed*
  - No code is assigned if the documentation states that the pressure ulcer is completely healed.

- *Patients admitted with pressure ulcers documented as healing*
  - Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign code 707.20, Pressure ulcer stage, unspecified.
  - If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider.
PRESSURE ULCERS EVOLVING INTO ANOTHER STAGE

- Patient admitted with pressure ulcer evolving into another stage during the admission

  - If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, assign the code for highest stage reported for that site.

PRESSURE ULCER ICD-9 CODING

- 1st – use a code from 707.0X, Pressure Ulcer
  - 707.00 – Unspecified site
  - 707.01 – Elbow
  - 707.02 – Upper back
    - [including,] shoulder blades
  - 707.03 – Lower back
    - [including,] coccyx and/or sacrum
  - 707.04 – Hip
  - 707.05 – Buttock
  - 707.06 – Ankle
  - 707.07 – Heel
  - 707.09 – Other site
PRESSURE ULCER ICD-9 CODING

- 2nd – use a code from 707.2X, Pressure ulcer stages
  - 707.20 – Pressure ulcer, unspecified stage
    - Healing pressure ulcer, NOS
    - Healing pressure ulcer, unspecified stage
  - 707.21 – Pressure ulcer, stage I
    - Healing pressure ulcer, stage I
    - Pressure pre-ulcer skin changes limited to persistent focal erythema
  - 707.22 – Pressure ulcer, stage II
    - Healing pressure ulcer, stage II
    - Pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis
  - 707.23 – Pressure ulcer, stage III
    - Healing pressure ulcer, stage III
    - Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue
  - 707.24 – Pressure ulcer, stage IV
    - Healing pressure ulcer, stage IV
    - Pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon, or bone
  - 707.25 – Pressure ulcer, unstageable

PRESSURE ULCERS – DON’T FORGET!

- The underlying condition, e.g., diabetes mellitus, must be coded first
- The correct code(s) from 707.0X, Pressure Ulcer category must be listed before the 707.2X, Pressure ulcer stages category code(s).
- That, code 707.25 is used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma.
MEDICAL NUTRITION THERAPY (MNT)

- For Medicare, MNT can only be billed by and paid to a Registered Dietician (RD), or appropriate Nutrition professional, and cannot be paid “incident-to” a physician’s services.

- The RD, or Nutrition professional, must be licensed in the state they are providing services, and must have a Medicare Provider ID Number (NPI).

- The benefit is available for patient’s with diagnoses of renal disease (non-dialysis) or Diabetes with a referral from a physician to an RD or Nutritionist professional.

MEDICAL NUTRITION THERAPY (MNT)

- The MNT benefit allows for renal and diabetes patients to receive three (3) hours in the initial year and two (2) hours in subsequent years for follow-up.

- The MNT service is coordinated but separate from the DSMT benefit.

- Medicare will cover fully MNT in the same episode of care as DSMT up to their specified limits in the initial year, but MNT and DSMT must be provided on different days. This is because the two benefits provide different behavioral modifications techniques (i.e., classroom study for basic knowledge and individual attention that focuses on results over time) which may prove to be complementary.
**Medical Nutrition Therapy (MNT)**

- The three hours allowed for MNT coverage can be spread over any number of visits, but each visit must be a minimum of 15 minutes since billing is in 15-minute increments.
- Medicare will rely on the referring physician to determine the medical need for a beneficiary to receive both MNT and DSMT in the same year for follow-up services.

**Medical Nutrition Therapy (MNT)**

- Codes for billing by RD or Nutrition Professional:
  - 97802 - Medical Nutrition Therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes. (NOTE: This CPT® code must only be used for the initial visit.)
  - 97803 - Medical Nutrition Therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
  - 97804 - Medical Nutrition Therapy; group (2 or more individuals), face-to-face with the patient, each 30 minutes.
MEDICAL NUTRITION THERAPY (MNT)

- Two G codes have been created for MNT when there is a change in condition of the beneficiary:
  - G0270 - Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
  - G0271 - Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes

- The G codes on the prior slide are for additional hours of coverage and should be used after the completion of the 3 hours of basic coverage under 97802-97804 when a second referral is received during the same calendar year

- No specific limit is set for the additional hours. Contractors will use dietary protocols from the American Dietetic Association and the National Kidney Foundation as guides if local medical review limits are established for the additional hours of coverage
**Medical Nutrition Therapy (MNT)**

- For Medicare, the National Coverage Decision Policy for MNT and DSMT can be found under: Phys-041, Nutrition Training Benefits

- Other carriers pay, or not, for MNT based upon policy

**Diabetes Self-Management Training (DSMT)**

- Medicare covers these services when they are furnished by a certified provider who meets certain quality standards. The training must be ordered by the physician or qualified non-physician practitioner treating the beneficiary's diabetes. The program providing the DSMT must be certified by the American Diabetes Association (ADA) or the Indian Health Service (IHS).

  - This means that if your office employs a professional who would be eligible to provide this service, that professional and program must be certified through an agency above.
**DIABETES SELF-MANAGEMENT TRAINING (DSMT)**

- The Centers for Medicare and Medicaid Services (CMS) has ruled that DSMT can be rendered in a local health department. Health departments, which have a Medicare provider number and are ADA certified, are permitted to bill the Medicare Part B carrier for DSMT. However, it is essential that a physician or qualified non-physician practitioner must first make a referral for the beneficiary requesting diabetes training. A physician referral is separate and distinct from the "incident to" requirements. Therefore, the "incident to" rule is not applicable for DSMT because this is a "stand alone" benefit.

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**DSMT THINGS TO KNOW:**

- Beneficiary is eligible to receive 10 hours of initial training within a continuous 12-month period.

- The 12-month period is a rolling calendar (beginning with the date of first service.)

- Up to nine hours of initial training must be provided in a group setting consisting of two to 20 individuals.

- One hour of training may be provided on an individual basis for the purpose of conducting an individual assessment and providing specialized training.
DSMT THINGS TO KNOW:

- If any special condition or circumstance exists that makes it impossible for a beneficiary to attend a group training session that beneficiary may attend individual training as long as individual training has been requested by the physician or qualified non-physician practitioner treating the beneficiary’s diabetes.

- Two hours of follow-up training is covered each year starting with the calendar year following the year in which the beneficiary completes the initial 10 hours of training. The two hours of training may be given in any combination of half-hour increments within each calendar year on either an individual or group basis without the certification of the ordering physician or non-physician practitioner that special conditions exist.

DSMT THINGS TO KNOW:

- DSMT procedure codes are:
  - G0108 Diabetes outpatient self-management training services, individual, per 30 minutes
  - G0109 Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes

- Effective for dates of service on or after April 1, 2002, Common Work File (CWF) will track the number of hours of DSMT and MNT. Contractors will review claims when a beneficiary has received over the maximum number of hours of training allowed under DSMT or MNT.
SO...WHAT DOES THIS MEAN FOR EDUCATION IN THE REGULAR OFFICE SETTING?

- CPT® codes for evaluation and management services have time elements.

- These time elements are to be used when counseling and/or coordination of care dominate greater than 50% of the physician/non-physician practitioner face-to-face time with the patient.

SO...WHAT DOES THIS MEAN FOR EDUCATION IN THE REGULAR OFFICE SETTING?

- Counseling is a discussion with the patient and consists of:
  - Diagnostic results, impressions, or recommended diagnostic studies
  - Prognosis
  - Risks and benefits of management (treatment) options
  - Instructions for management (treatment) and/or follow-up
  - Importance of compliance with chosen management (treatment) options
  - Risk factor reductions
  - Patient and family education
SO...WHAT DOES THIS MEAN FOR EDUCATION IN THE REGULAR OFFICE SETTING?

- Document a summarization of the counseling
  - It is not necessary to document every word, a brief summarization highlighting the main elements of counseling and patient responsibilities

- Document the face-to-face time element
  - Spent 20 min of this 30 min appt counseling as described
  - Start time: 2:13pm End time: 2:43pm

- Select the appropriate E/M based upon patient status (Office/Outpatient, Inpatient, New, Established)

OFFICE/OUTPATIENT TIME ELEMENTS

- 99201 - 10 min
- 99202 - 20 min
- 99203 - 30 min
- 99204 - 45 min
- 99205 - 60 min
- 99211 - 5 min
- 99212 - 10 min
- 99213 - 15 min
- 99214 - 25 min
- 99215 - 40 min
HEALTH AND BEHAVIORAL ASSESSMENT CODES

- Codes are used to identify psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.

- Focus of the assessment is not on mental health.
  - CPT® 2010

HEALTH AND BEHAVIORAL ASSESSMENT CODES

- Focus is on biopsychosocial factors important to physical health problems and treatments.

- The focus of the intervention is to improve the patient’s health and well-being utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate the specific disease-related problems.
  - CPT® 2010
HEALTH AND BEHAVIORAL ASSESSMENT CODES

- These codes cannot be reported by a physician
- May not be reported on the same day as Preventive Medicine Counseling codes (99401-99412)
- May be used by ancillary personnel employed by the practice (RN, pharmacist, etc.)
  - Incident-to requirements must be met

GOOD OPTION TO REPORT EDUCATION PROVIDED BY NURSING STAFF WHEN A STANDARDIZED CURRICULUM IS NOT FOLLOWED

CODE BASED ON TIME - 15 MINUTE INCREMENTS