Internal Medicine Coding Alert

Bust 6 Myths About Diabetes CPT, ICD-9--and HCPCS!--Coding

Experts allay your fears about reporting clinical measurements using PVRP

Don't let the rumors about the diabetes-related new lab and G codes, as well as upcoming additional diagnoses, suck you in. Here are the facts that will debunk these and other common DM myths.

Myth 1: Restrict 83037 to Home Use

Although the new 2006 effective A1C lab test code contains "home use" in its descriptor, physician's offices may report the code: 83037 (Hemoglobin; glycosylated [A1C] by device cleared by FDA for home use). "The explicit purpose of this new code is to create a new payment amount for A1C when this test is run in physician offices or other point-of-care locations where diabetes patients are treated and managed," writes **Mary E. Frank, MD, FAAFP** board chair in a "Letter to Medicare Carrier Medical Directors Regarding Carrier Pricing of New CPT Code 83037."

Frank goes on to explain why the editorial panel included the phrase "cleared by FDA for home use" in 83037's code description. The phrase distinguishes "new self-contained A1C devices for point-of-care testing from conventional laboratory and physician office methods, which are designed for high-volume use and require expensive instrumentation and capital investment." If your internist owns this expensive instrumentation, specifically bench-type analyzers, which labs and diabetes specialists more typically purchase, you should instead report A1C testing with 83036 (... glycosylated [A1C]).

Important: To indicate that the FDA has approved 83036 and 83037 as waived tests, you must attach modifier QW (CLIA-waived test) to the A1C lab codes. For a list of tests that qualify for 83037-QW, see "Are You Performing Tests That Qualify for 83037-QW? Find Out Here" included within this issue).

Myth 2: Replace E/M Service Codes With G Codes

If someone asks you about the diabetes mellitus G codes, you no longer have to be in the dark. For 2006, Medicare introduced 12 HCPCS codes (G8015-G8026) describing clinical measures for management of diabetes patients. (For complete descriptions, see "Your Measurement Coding Plan Should Conform to These Rules" included within this issue.)

Coders who have discovered the DM G series are uncertain as to whether these codes replace 99201-99215 (Office or other outpatient visit for the E/M of a patient ...). "These codes should be reported in addition to CPT and ICD-9 codes required for appropriate claims coding," says **Reinhard W. Beel, CEC**, administrator and business manager at Cumberland Valley Endocrinology Center LLC in Carlisle, Pa. Do not substitute G8015-G8026 for CPT and ICD-9 codes, he says.

Myth 3: Panic if You Haven't Been Using G8015-G8026

It's OK if your 2006 claims haven't contained the new HCPCS DM codes. Why: G8015-G8026 are part of the Physician **Voluntary** Reporting Program (PVRP) [emphasis added], which CMS created to collect clinical data for quality measures.

Great news: You're not missing out on money if your internist chooses not to participate in this program, which is connected to Pay 4 Performance. "G codes will not appear on the Medicare physician fee schedule database, because there are no relative value units or allowance for these codes," Beel says.

Myth 4: Be Suspicious of Lots of Type II Claims

Don't worry when your list of frequently used diagnoses turns up lots of 250.00s. "Ninety percent of diabetes in the United States is type II," says **Sheri Poe Bernard, CPC, CPC-H, CPC-P**, senior director for Ingenix. "The default for documented diabetes would be 250.00 (Diabetes mellitus without mention of complication; type II or unspecified type, not stated as uncontrolled)," she notes in her presentation "Understanding Diabetes" at the American Academy of Professional Coders' 2006 Conference in St. Louis, Mo.

Myth 5: Let Insulin Steer Your 250 5th-Digit Selection

If you're still using a patient's insulin use to assign a firth digit for diabetes mellitus, your coding is out-of-date. "Some type II diabetics require insulin to control blood sugars," Bernard says. Right way: You should instead assign 250's fifth-digit classification based on whether the patient's pancreatic cells are functioning.

Many internists, however, are still not focusing on the role pancreatic cell function plays in type II diabetes. "Primary-care physicians do not consistently focus on how beta cells in the pancreas work, including as they relate to the incretin system," says **S. Sethu K. Reddy, MD, MBA, FACE, FACP,** chairman and program director of the Department of Endocrinology, Diabetes and Metabolism at The Cleveland Clinic.

Reddy's finding was based on a Diabetes Roundtable survey that showed despite pancreatic beta cell function being the predominate contributor to type II diabetes progression:

• only 20 percent of the primary-care physicians surveyed acknowledged that fact.

• "The majority (78 percent) of the primary-care physicians surveyed say insulin resistance is the most important contributor to, and is primarily responsible for, the progression of type II diabetes in the majority of their patient population," Reddy says.

Myth 6: Use Secondary Diabetes Code for Current DM

Right now, you have no way to specifically indicate diabetes resulting from another condition affecting the pancreas, such as pancreatitis or cystic fibrosis, says **Amy Blum**, medical classification specialist with the National Center for Health Statistics, which creates the ICD-9 codes. You're not allowed to use the current diabetes codes for secondary diabetes, so you're stuck with an "other specified" code (251.8, Other specified disorders of pancreatic internal secretion).

Future: The ICD-9 Coordination and Maintenance Committee discussed adding new secondary DM codes at its March meeting. If secondary diabetes receives its own category, it will parallel the codes for primary diabetes. This will be the most significant change to the ICD-9 book as far as how many codes it will create and how it will affect coders, Blum says.