Part B Insider (Multispecialty) Coding Alert

CPT: 6 Steps Promise Diabetes Coding Success

Complications need special attention

Diabetes refers to diabetes mellitus or, less often, to diabetes insipidus, and both conditions are characterized by excessive urination (polyuria). When physicians use -diabetes- alone, they-re referring to diabetes mellitus. The two main types of diabetes mellitus (insulin-requiring type I diabetes and adult-onset type II diabetes) are distinct and different diseases.

Know the CPT Codes

Medicare pays physicians for most diabetes screenings. If your physician wants to screen a Medicare patient for diabetes, you should report one of the following lab codes:

- 82947--Glucose; quantitative, blood (except reagent strip). Assign this code when the provider draws the patient's blood to check for glucose after the patient has fasted for 12 hours.

- 82950--- post glucose dose (includes glucose). Report this code when the provider checks the patient's glucose following the patient's ingestion of a dose of glucose.

- 82951--- tolerance test (GTT), three specimens (includes glucose). This code is appropriate when the provider draws blood for a fasting glucose determination, and then following that the patient ingests a glucose solution before having another blood draw at half-hour and one-hour intervals.

Diagnosis: When you report any of the above three codes, you should list V77.1 (Special screening for diabetes mellitus) as your primary diagnosis code.

Must-have modifier: The three Medicare-approved diabetes-screening tests carry a -waived status.- That means if your office has obtained the Clinical Laboratory Improvement Amendments (CLIA) certification, your physician can perform the tests in the office. Be sure to append modifier QW (CLIA waived test) to the codes.

And if your physician performs a screening test on a patient with -prediabetes,- Medicare requires that you attach modifier TS (Follow-up service). For example, if your provider performs the glucose tolerance test on a prediabetes patient, you would report 82951-QW-TS.

Coverage guidelines: You may bill one test every six months for patients with prediabetes. But you should report only one test every 12 months for patients whom the physician has not diagnosed with prediabetes, or whom a physician has never tested.

Also, before reporting a screening code, make sure the patient has at least one of these diabetes risk factors: hypertension, dyslipidemia, obesity (with a body mass index greater than or equal to 30 kg/m2), and/or previous identification of elevated impaired fasting glucose or glucose intolerance.

If you-re not reporting the right fourth and fifth digits on 250.xx, you may be undermining patient complexity and thereby billing for lower-level services than your physician provides.

Patients with diabetes often have one or multiple complications that require the physician's extra attention and consideration, and these added complications can have a significant effect on the E/M level you bill. Use these six steps

for definitive diabetes diagnosis coding to ensure that your ICD-9 codes justify the services you bill.

1. Select Fourth Digit First

Coders must determine the fourth digit for 250.xx (Diabetes mellitus) according to the type of diabetic complication the patient suffers from, if any. Diabetes patients may suffer from more than one complication, and if this is the case you should code only the complication relevant to services your physician renders that day.

2. Identify Type for Fifth Digit

The fifth digit provides the final two pieces of information on the patient's diabetic condition: the diabetes type (I or II) and whether it is controlled. To select the proper fifth digit, you first must know what the following ICD-9 descriptor terms mean:

Type I: The patient's pancreatic beta cells no longer produce insulin. People with type I diabetes must take insulin. ICD-9 descriptors also refer to type I as -juvenile type- diabetes.

Type II: The patient's beta cells do not produce sufficient insulin or the beta cells have developed insulin resistance. Unlike people with type I, people with type II may or may not have to take insulin.

Not stated as uncontrolled: The patient's diabetes is managed sufficiently by diet and/or insulin.

Uncontrolled: A patient can have uncontrolled diabetes when the physician documents that blood sugar levels are not acceptably stable, when the patient is not in compliance with his diabetes management plan or if the patient is taking medications for another illness that interfere with diabetes management.

First, check your physician's documentation to see what type of diabetes the patient has and if the condition is controlled. Then choose from one of the fifth digits listed with the 250.xx category.

Example: Suppose your physician treats an uncontrolled, type II diabetic suffering from peripheral circulatory disorders. You would report 250.72.

3. Determine if Diabetes Is Primary

After you-ve chosen the patient's correct 250.xx code, a new question can arise: Is diabetes the primary or secondary diagnosis? Your physician could treat a patient for a problem not directly related to the diabetes, but you may still need to indicate the patient's complete medical condition with a 250.xx code.

Because every diabetes case is different, there is no hard and fast rule regarding when the diabetes should be the patient's primary or secondary diagnosis. The nature of the presenting problem should govern the diagnosis code.

Study these three scenarios to help you determine if you should list diabetes first as the primary diagnosis:

A. Diabetic patient with new foot ulcer: Code the foot ulcer as the primary diagnosis, and list the diabetes mellitus as the secondary diagnosis. Diabetes is secondary because it is a relevant condition that influences the patient's treatment and care, as well as the ulcer's cause.

And the patient saw the doctor specifically for the foot ulcer, not for diabetes management. Listing the appropriate 250.xx code can also help justify a higher-level E/M because the condition complicates the physician's treatment plan and requires extra time and more complex decision-making on the physician's part.

B. Diabetic with slow-healing arm laceration: The wound is the primary diagnosis because it is the problem the physician is actively treating. You should report the diabetes as secondary because the condition is causing the wound to heal slowly and also complicates the physician's treatment plan.

C. Diabetes management visit and physician finds diabetic ulcer: You would code the diabetes as the primary diagnosis and the wound as secondary because the diabetes is the acute condition the patient initially presented with for treatment.

4. Mind Your Manifestations

Five diabetes code fourth-digit descriptors require that you report a manifestation diagnosis code as well. Always report the manifestation code as a secondary diagnosis. And remember, not all diabetes fourth digits require a manifestation code. The code descriptor tells you if you need one.

Here's a partial list of the diabetes codes that require a corresponding manifestation code, paired with some possible diabetic manifestations:

- 250.5x--366.41 (Cataract associated with other disorders; diabetic cataract)
- 250.6x--357.2 (Inflammatory and toxic neuropathy, polyneuropathy in diabetes)
- 250.7x--443.81 (Peripheral angiopathy in diseases classified elsewhere).

Keep in mind: The ICD-9 manual does not list all possible manifestation codes that you might need to choose from when you report one of the 250.xx codes above.

You can report them all: If a patient has more than one diabetic complication, you can code the multiple complications and their manifestations on a single claim, making sure to link the manifestations to the correct diabetes codes.

For example, if a physician treats a patient for diabetes with renal manifestations and the patient also has ophthalmic manifestations, report both sets of codes. Usually the prescription management or plan of care needs to consider these other manifestations.

Sequence matters: Remember to report first the particular manifestation your physician treats that day. Or if the physician is dealing with multiple complications, code according to the order in which the physician renders treatment. Finally, if the documentation does not indicate the treatment order, you should report the most prominent or advanced complication and corresponding manifestation first.

5. Insert V Codes for Pump

Just as fourth and fifth digits paint a more complete picture of a patient's diabetes, V codes are also important for telling the carrier the whole story. Assign V58.67 (Long-term [current] use of insulin) as a secondary code for patients who take insulin on a regular basis.

V codes also come into play for diabetes patients receiving their insulin via insulin pumps. Three V codes apply to different stages of the insulin pump treatment process. When you code an E/M visit concerning an insulin pump, report the appropriate 250.xx code and one of the following insulin pump V codes as a secondary diagnosis:

- V65.46 (Encounter for insulin pump training) for when a patient first considers an insulin pump and receives education about the device.
- V53.91 (Fitting and adjustment of insulin pump) for when the patient first receives the insulin pump from the physician.
- V45.85 (Insulin pump status) for all other follow-up visits associated with the pump.
- Use 996.57 (Mechanical complication ... due to insulin pump) to report insulin pump mechanical complications.

6. Go to 648.8x for Gestational Diabetes

One type of diabetes you won't find within the 250.xx series is gestational diabetes--a condition that only develops during pregnancy and disappears after delivery. For this type of diabetes, use 648.8x and choose the fifth digit (0-4) to indicate when the condition or complication occurred. Include V58.67 if the physician is treating the gestational diabetes with insulin.

Distinction: For pregnant women who are diabetic (suffering from diabetes before becoming pregnant), you should assign 648.0x as the primary code and then the appropriate 250.xx code to identify the type of diabetes.

Warning: You should never report 648.0x and 648.8x together.

MNT Coding for Diabetes Prevention Services

When your practice takes part in diabetes prevention efforts by offering nutritionist- or dietician-run nutrition therapy sessions, here's how you can ensure that you collect reimbursement. As long as you closely adhere to five basic steps, you-ll find fewer denials waiting for you.

Step 1: Choose Between CPT and HCPCS Codes: When an individual nutritionist consults with a patient in a noncertified physician setting, you-re likely to report diabetic sessions with 97802-97804. But if your practice has an American Diabetes Association-approved program, you may also use Medicare-specific codes G0108-G0109.

Here's how: For noncertified programs, select the nutrition session code based on the patient's diagnosis and the number of individuals involved. Use 97802 (Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes) for initial medical nutrition therapy involving a single patient.

Report a follow-up patient session with 97803 (... re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes). For group sessions, assign 97804 (... group [2 or more individuals], each 30 minutes).

Example: After a patient is diagnosed with diabetes and a physician orders medical nutrition therapy (MNT), the practice's certified nutritionist meets with the patient for a 45-minute initial assessment and intervention. The patient later returns for a two-hour group session that involves re-assessment and intervention. You should report the initial session with three units of 97802 and the group follow-up session with four units of 97804. One unit of the individual code represents 15 minutes, and a group unit consists of 30 minutes.

To code ADA-certified diabetes self-management training (DSMT) sessions, determine how many patients attended the service. Code individual sessions with G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes). When two or more patients attend the session, assign G0109 (Diabetes self-management training services, group session [2 or more], per 30 minutes).

Step 2: Report Under the Nutritionist's ID Number: Prompt payment for MNT sessions depends on avoiding one common filing mistake: reporting these sessions as incident-to. Because 97802-97804 are nutritionist-specific codes, you should not report these codes incident-to a physician. Always use the nutritionist's PIN.

Step 3: Verify Limitations: If you-re using the correct MNT/DSMT code and associated PIN but your payer is still denying claims, double-check the insurer's coverage limitations. Many insurers allow a one-hour initial MNT visit and two hours of follow-up after the initial visit in the first year. Other coverages vary.

Some insurers allow all of their patients (regardless of diagnosis) to see a nutritionist for up to $200 in benefits each year. After that, the visits must be deemed medically necessary, and the insurer will then pay just 80 percent of the nutritionist's fees, even if the registered dietitian (RD) is considered -in network.-

Other insurers will cover 100 percent of medically necessary MNT or DSMT for certain diagnoses, so you should get your payers- policies in writing.

Ultimately, verifying the plan benefit design is the patient's obligation, and if the plan doesn't cover the service, you can balance-bill the patient for those services provided.

Step 4: Check Diagnostic Requirements: To ensure nutrition therapy coverage, check the documentation to make sure the patient's diagnosis is listed as a covered condition according to the insurer's policy.

If your insurer does not cover the documented diagnosis listed in the patient's chart, let the patient or patient's family know upfront that the MNT may not be covered.

Step 5: Make Sure Referral Is Clear: Many insurers will not reimburse for MNT or DSMT unless the treating physician provides a written referral for the service. When you bill for nutrition counseling, make sure you have the certificate number of the referral.

Best practice: Keep a copy of the physician referral in your patient's file in case the insurer ever requests it.

Medical and Surgical Supplies

The following codes are common diabetes patient supplies that you might file with Medicare. Consult your local Medicare contractor for coverage specifics.

- A4231--Infusion set for external insulin pump, needle type
- A4233-A4236--Replacement batteries ... for use with medically necessary home blood glucose monitor owned by patient, each
- A4253--Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
- A4258--Spring-powered device for lancet, each
- A4259--Lancets, per box of 100
- A5503-A5513--Diabetic shoes, fitting and modifications
- E0607, E2100-E2101--Blood glucose monitors
- J1815-J1817--For insulin drugs such as Humalin, Humalog and Novolin.

Inject a Reason to Use HCPCS Codes

Question: A patient presents with elevated blood sugar. A physician administers an insulin injection to control the patient's diabetes. Should you link the injection to E932.3? Which other ICD-9 and CPT codes should you report?

Answer: No, in this case you should not report E932.3 (Drugs, medicinal and biological substances causing adverse effects in therapeutic use; hormones and synthetic substitutes; insulins and antidiabetic agents).

The patient was not having an adverse reaction to insulin as E932.3 describes. Instead, the physician administered the insulin as a therapeutic injection to control the patient's diabetes. Consequently, you should link the injection (90772, Therapeutic, prophylactic or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular) to the diagnosis for diabetes, such as 250.03.

Of course, the doctor would have to evaluate a patient who presents with elevated blood sugar to determine necessary treatment. Therefore, the physician should also report the appropriate-level office visit (99211-99215, Office or other outpatient visit for an established patient ...), which he should link to 790.6 (Other abnormal blood chemistry).

Some carriers, such as Medicare, do not pay the injection administration code (90772) when submitted with an E/M code (9921x). But most commercial insurers will pay for both the procedures and the service without a modifier. Thus, unless you know that the payer disallows the administration charge, you should file it.

In addition to reporting the payer-preferred injection and E/M combination, don't forget to code for the insulin medication. For carriers that accept HCPCS level-two supply codes, you should report J1815 (Injection, insulin, per 5 units) per five units of insulin used.

Otherwise, use CPT supply code 99070 (Supplies and materials [except spectacles], provided by the physician over and above those usually included with the office visit or other services rendered [list drugs, trays, supplies, or materials provided]).