Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: 2004 ICD-9 Update: Use New V Codes For All Your Insulin Pump Visits

If your physician is using insulin pumps for Type I diabetics, you should know how to use three new codes (V45.85, V53.91, V65.46) to improve reimbursement for your physician's insulin pump-related services.

The recent increase in insulin pump use created a need for the new insulin pump V codes, which went into effect Oct. 1, 2003. ICD-9 includes a V codes section to help you code for patients with already-existing diseases and conditions, as well as for various treatment regiments and extenuating circumstances.

Justify Insulin Pump Complexity

Diabetics who need insulin pumps are generally more complicated patients that require a higher level of service and adequate diagnosis coding to make the situation clear to payers. Usually, eligible patients "have already tried an aggressive regimen of shots, either three or four shots a day, and they're not getting their blood sugars controlled on that," explains **Anthony Azzi, MD**, an endocrinologist with Raleigh Endocrine Associates in Raleigh, N.C.

The new codes "are going to help paint a better picture" of these complicated patients, says Elaine Rehmer, an administrator at the Cosmopolitan Diabetes Center in Columbia, MO, which has a large insulin pump clinic practice. The codes will help justify the higher level of E/M service codes billed, which in turn will improve reimbursement and reduce denials, explains Rehmer.

Remember: No matter what insulin pump V code you use, always report the diabetes diagnosis code 250.xx as well. Make sure you apply the fourth and fifth digits whenever possible. See the next page for a refresher on how to choose the right diabetes code.

Know Your V Code Distinctions

You should use each of the three insulin pump V codes during different stages of the patient's treatment process (education/training, fitting/adjustment, and follow-up care). Use the following expert guidelines to ensure proper usage of these three codes:

1. Use V65.46 (Encounter for insulin pump training) when a patient is first considering an insulin pump. During this preliminary period, perhaps spanning one or two visits, we're doing more education than anything else, Rehmer says. The patient watches educational videos, receives basic training on how to use the pump, and gets to try actual pumps to see which models are most comfortable.

Insulin pumps are fabulous, "but they do take a little bit of technical knowledge and you do have to have a very good understanding of carb counting, how your pump works," when you need adjust glucose levels, etc, adds Rehmer.

For example, an established patient with insulin dependent, uncontrolled Type I diabetes (250.03) considers an insulin pump and comes in for a preliminary education and training session. If a nurse is doing the training, you report 99211 (Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician) with diagnosis code V65.46 and secondary diagnosis 250.03. You may report a higher level E/M if the physician does the training.

2. Report V53.91 (Fitting and adjustment of insulin pump) when the patient first receives the insulin pump. Adjustment and fitting is the second step in the process, explains Rehmer. A nurse or the physician may perform these

CPT® 2023 American Medical Association. All rights reserved.

services, depending on the office and level of staff expertise. V53.91 code is probably appropriate for the first two visits after a patient starts using the pump, when the physician is making initial adjustments and fine-tuning the device, Rehmer adds.

For instance, the patient discussed above with insulin dependent, uncontrolled Type I diabetes (250.03) decides to get an insulin pump. During the initial adjustment and fitting visits, you report 99211-99215, based on the extent of the E/M service performed, with diagnosis code V53.91 and secondary diagnosis 250.03.

3. Apply V45.85 (Insulin pump status) for all other follow-up visits associated with the pump. "Especially at the outset, we bring patients back on a fairly regular basis," says Rehmer. This could mean daily visits or several times a week. During this period, "you want to check the readings very frequently and change the settings" accordingly, Azzi explains. Once you're past the initial set-up stages, this V code is what you'll use for all follow-up visits as long as the patient has the insulin pump.

Continuing with the example from above, the patient with insulin dependent, uncontrolled Type 1 diabetes (250.03) now has his insulin pump and only comes in for quarterly check-ups. For one of these routine check-ups, you report the appropriate established patient E/M code along with diagnosis code V45.85 and secondary diagnosis 250.03. Be sure to bill for all in-person insulin pump status sessions with V45.85 and secondary diagnosis 250.03.

Although a routine diabetes check-up involves the physician checking not only the insulin pump's status but also the patient's other diabetes-related health issues, you should include V45.85 as one of the diagnoses. This will help describe the complications of the patient and justify your level of service. If the patient comes in for a special visit because the insulin pump causes a problem, report diagnosis code 996.57 (Complication due to insulin pump).

Coding 101: Define Your Diabetes Diagnosis

You'll need to report the most specific diabetes diagnosis code possible if you want full payment for all your physician's E/M services. Follow these easy steps to success:

1. Start with **250.xx** (Diabetes mellitus)

2. Select the fourth digit by determining what, if any, complications the patient has. If the patient has more than one complication, as is often the case, code only for the complications addressed at a particular visit. You should also use additional codes to identify the actual manifestations of the complications, if possible (ex: 365.44 - Glaucoma). Fourth-digit choices for 250.xx:

250.0 - Diabetes mellitus without mention of complication

250.1 - Diabetes with ketoacidosis

250.2 - Diabetes with hyperosmolarity

250.3 - Diabetes with other coma

250.4 - Diabetes with renal manifestations

250.5 - Diabetes with ophthalmic manifestations

250.6 - Diabetes with neurological manifestations

CPT® 2023 American Medical Association. All rights reserved.

250.7 - Diabetes with peripheral circulatory disorders

250.8 - Diabetes with other specified manifestations (ex: Hypoglycemic shock)

250.9 - Diabetes with unspecified complication

3. Choose the fifth digit based on if the patient is Type I or Type II and is controlled or uncontrolled. This is a determination that only the physician can make, so consult the medical chart documentation. Fifth-digit choices for the 250.xx series:

0 - Type II, non-insulin dependent type or unspecified type, not stated as uncontrolled
1 - Type I, insulin dependent type, not stated as uncontrolled
2 - Type II, non-insulin dependent type or unspecified type, uncontrolled
3 - Type I, insulin dependent type, uncontrolled

4. Report the diabetes code first and the complication manifestation code second when dealing with a patient that has diabetes complications. For example, for a patient with Type I diabetes with glaucoma complications, you report 250.51 (Diabetes with ophthalmic manifestations...) listed first, with manifestation code for glaucoma, 365.44 (Glaucoma associated with systemic syndromes), listed second.

CPT® 2023 American Medical Association. All rights reserved.