Part B Insider (Multispecialty) Coding Alert

PART B MYTHBUSTER: Don't Miss Out On Extra Diabetes Reimbursement

Think you can't bill Medicare for 2 screenings per year? Think again!

Fact: The U.S. spends $100 billion per year on direct and indirect health costs related to diabetes. With that kind of money changing hands, you can't afford any diabetes coding mistakes.

Here's **Sheri Bernard** with the **American Academy of Professional Coders** coming to the rescue. She listed six myths that could be eating your diabetes reimbursement:

MYTH #1: You can bill Medicare for only one diabetes screening per year.

Fact: Medicare pays for 2 diabetes screening tests per year if the patient has significant risk factors such as pre-diabetes or Dysmetabolic Syndrome X (277.7), Bernard says. You should be seeing this diagnosis code a lot, because there are approximately 41 million pre-diabetics in this country.

You can't use 277.7 unless the doctor documents three of the following, Bernard says:

- abdominal obesity,
- hypertension,
- fasting glucose of 110 or higher,
- high triglycerides in cholesterol (bad cholesterol), and /or
- low HDL in cholesterol (good cholesterol).

Don't assign 277.7 as the diagnosis automatically if you see three or more of these factors in the record. Ask the doctor first. Also, don't use the screening code if the patient has had a diagnosis of diabetes in the past, or if the patient has acute symptoms and the screening isn't -routine.-

When billing screening tests 82947-82948 and 82950, make sure to attach the QW modifier for office billing, Bernard reminds coders. Remember to append the TS modifier if the test is a follow-up service for a pre-diabetic patient. The absence of the TS modifier is a big reason carriers deny twice-yearly screenings for 277.7 patients.

Also: Don't forget to bill 36415 (Collection of venous blood by venipuncture) and include diagnosis code V77.1 (Special screening for diabetes mellitus).

MYTH #2: If the patient has been treated for a diabetes complication, you should always sequence the diabetes diagnosis code (250.xx) first.

Fact: There are a few exceptions to that rule, Bernard says. You should report the diabetes code secondarily only in case of:

- insulin pump malfunction,
- heart problems,
- cerebrovascular problems, or
- decubitus ulcer.

MYTH #3: If the patient is taking insulin, you need to list V58.67 (Long-term use of insulin for continuing use only).

Fact: Use V58.67 only when a type II diabetes patient is taking insulin long-term. You don't need this V-code for type I diabetes diagnosis codes because those patients are always taking insulin long-term, Bernard explains.

MYTH #4: Because there are only four lines on the claim, it's okay to leave out 250.xx if you-re reporting a manifestation diagnosis code specific to diabetes.

Fact: You still need to include the 250.xx code because it identifies whether the diabetes is type I or type II, controlled or uncontrolled, Bernard points out. The good news is that the new form has eight blanks. The bad news is your software may still have only four.

MYTH #5: When coding for a manifestation of diabetes, the descriptor must have the word -diabetes- in it.

Fact: The descriptor for the manifestation of diabetes doesn't need to contain the word -diabetes.-

Example: You should pair 250.40 (Diabetes with renal manifestations) with 583.81 (Nephritis and neuropathy, not specified as acute or chronic, in diseases classified elsewhere). And you should pair 250.60 (Diabetes with neurological manifestations) with 536.3 (Gastroparesis).

MYTH #6: A diabetic patient receives a successful pancreas transplant and no longer needs insulin injections. So you never report a diabetes code after this -cure.-

Fact: There are circumstances when you should code for diabetes in this post-transplant patient, such as any time the medical record documents diabetes or any time the diabetes is responsible for a complication, such as long-standing or newly diagnosed retinopathy, renal disease or neuropathy. These are examples of complications caused by the diabetes that the transplant has now -cured.-

-If the patient has a -late effect- condition as a result of the pancreas transplant even though it appeared to be successful,- then you would still need to apply the diabetes code as a secondary code, clarifies **George Ward**, billing/accounting supervisor with **South of Market Health Care** in San Francisco.

Don't forget: Also report V42.83 for a pancreas replaced by transplant.