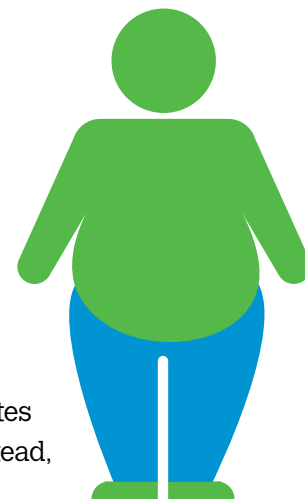




Body mass index and obesity: Tips and tools for tackling a growing issue



For adults, overweight and obesity ranges are determined by using weight and height to calculate a number called body mass index (BMI). BMI is used for most adults since it correlates with an individual's amount of body fat. However, BMI does not directly measure body fat; instead, it gives ranges of weight that show what is generally considered healthy for a given height.

The following list displays the ranges for adult BMI in relation to the corresponding clinical diagnosis per the Centers for Disease Control and Prevention (CDC):

BMI	
Less than 18.5	Underweight
18.5-24.9	Healthy weight
25.0-29.9	Overweight
30.0-39.9	Obese
40.0 or more	Morbidly obese

A child's weight status is determined by using an age- and sex-specific percentile for BMI rather than the BMI categories used for adults since a child's body composition varies as he or she ages. BMI for pediatrics ages 2-20 is based on the growth charts published by the CDC.

The list below shows pediatric BMI in relation to the corresponding clinical diagnosis:

BMI	
Less than 5th	Underweight
5th-less than 85th	Healthy weight
85th-less than 95th	Overweight
At or above 95th	Obesity

Obesity can have very harmful effects on the body. A 2007 study from the Journal of Pediatrics concluded that 70 percent of obese children had at least one cardiovascular risk factor such as high blood pressure or high cholesterol. Many health risks can be caused by obesity including diabetes, breathing issues, joint problems, fatty liver disease, gallstones and gastro-esophageal reflux (GERD, chronic heartburn). Providers should report the BMI on claims for patients with weight issues. While most providers have electronic medical records software that automatically calculates BMI for the patient, the CDC offers BMI calculators for children/teens and adults for those who do not.

Obesity-related services

Obesity-related services are those services that help address unhealthy weight. Insurance plans and health programs may cover a range of services to prevent and reduce obesity including BMI screening, education and counseling on nutrition and physical activity, prescription drugs, and surgery.

Health care providers should conduct height, weight and nutrition assessments as part of all well-child visits and adult annual checkups. If primary care providers counsel patients regarding obesity, there are procedure codes that can be billed to report the services for reimbursement. Providers should ensure the correct diagnosis and BMI codes are billed that correlate to obesity to support the counseling. For questions about benefit levels and available coverage, contact Provider Services at 1-800-454-3730.

Body mass index and obesity: Tips and tools for tackling a growing issue



Documentation and coding

Obesity codes are located in the Endocrine, Nutritional and Metabolic Diseases chapter of ICD-9-CM. The codes are to be applied when documentation supports a clinical diagnosis from physician documentation.

The ICD-9 codes for reporting weight-related clinical diagnoses include:

278.00	Obesity unspecified
278.01	Morbid obesity
278.02	Overweight

A coding instructional note listed with category 278.0 states to code BMI using codes V85.0-V85.54. Assign both the clinical diagnosis and the BMI on your claim. ICD-9 Coding Guidelines define morbid obesity as BMI greater than 40.

AHA Coding Clinic advice

Per American Hospital Association's (AHA) Coding Clinic 2010, Q2, BMI itself may be retrieved from nonphysician documentation such as a dietician; however, the clinical diagnosis must come from physician documentation.

Per AHA Coding Clinic 2011, Q3, individuals who are overweight, obese or morbidly obese are at an increased risk for certain medical conditions when compared to persons of normal weight. Therefore, these conditions are always clinically significant and reportable when documented by the provider. In addition, the BMI code meets the requirement for clinical significance when obesity is documented.

Obesity and BMI coding in ICD-10

Document the type (i.e., morbid, obese, overweight) and cause of obesity for ICD-10 (e.g., excess calories, drugs, etc.).

ICD-10	Description
E66.3	Overweight
E66.8	Obesity, other causes
E66.9	Obesity, unspecified
E66.01	Morbid obesity due to excess calories
E66.09	Other obesity due to excess calories
Z68	Body mass index

Code category Z68 is a status code and requires 4th and/or 5th digits to fully report the BMI. The 4th and 5th digits describe the BMI measurement documented in the medical record. Adult BMI codes (Z68.1-Z68.45) are for use for persons 21 years of age or older. Pediatric BMI codes (Z68.51-Z68.54) are for use for persons 2-20 years of age.

Resources

Centers for Disease Control and Prevention, cdc.gov/obesity/childhood/index.html
2012 ICD-9-CM Official Coding Guidelines
American Hospital Association Coding Clinic

Distinct procedural service coding update

On January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) established four new HCPCS modifiers to define subsets of the -59 modifier used to define a distinct procedural service.

How is the coding for this modifier changing?

Currently, the -59 modifier is used when a code for a service which would usually be bundled is being considered separate and distinct from another service.

CMS has defined four new HCPCS modifiers to selectively identify subsets of distinct procedural services (-59 modifier). These modifiers, collectively referred to as -X{EPSU} modifiers, are as follows:

- **XE separate encounter** – A service that is distinct because it occurred during a separate encounter
- **XP separate practitioner** – A service that is distinct because it was performed by a different practitioner
- **XS separate structure** – A service that is distinct because it was performed on a separate organ/structure
- **XU unusual nonoverlapping service** – The use of a service that is distinct because it does not overlap usual components of the main service

Amerigroup Community Care will begin accepting CMS Modifiers for Distinct Procedural Services. We will continue to recognize the -59 modifier; however, CPT instructions state that the -59 modifier should not be used when a more descriptive modifier is available. The -X{EPSU} modifiers are more selective versions of the -59 modifier; it would be incorrect to include both modifiers on the same line.

Amerigroup will be accepting the -X{EPSU} modifiers prior to the National Corrective Coding Initiative (NCCI) edits update. We will require the use of selective modifiers in lieu of the general -59, when the -X{EPSU} modifiers provide more clarity for the service/procedure performed.

ICD-10 made easy

We know that ICD-10 can often look daunting. But there is no need to memorize all of the new ICD-10 diagnosis and inpatient procedure codes.

If you are not an inpatient facility, you only need to be concerned with the most common ICD-10 PCS diagnosis codes your practice uses today. For example:

- If you are a cardiologist and only treat cardiac patients, focus only on those diagnoses related to your specialty during the course of your ICD-10 remediation work.
- If you practice general or pediatric medicine and therefore treat patients with a wide range of medical conditions, use the 80/20 rule to determine which ICD-10 codes are most pertinent.
- If you rarely see a particular ailment, there's no need to memorize it or convert it to the ICD-10 equivalent diagnosis code on your paper super bill or problem list in your electronic medical record. You only need to have enough clinical detail in your clinical documentation to determine the code in your ICD-10 coding tool, whether it is a book or online.

For more information, visit our ICD-10 web page at providers.amerigroup.com/Pages/ICD10.aspx.

Recovery look-back period to align with CMS



To align with the Centers for Medicare & Medicaid Services (CMS) guidelines, Amerigroup Community Care will begin recovering Medicare Advantage claim overpayments within four years of the claim payment date. Currently, Amerigroup recovers overpayments within three years of the claim payment date.

What this means to you

Effective May 1, 2015, providers will be notified in writing of any Medicare Advantage claim overpayments identified with good cause within four years of the claim payment date consistent with the CMS guidance below unless a different time frame is specifically noted for Medicare Advantage plans in the provider's contract.

CMS guidance

42 CFR § 405.980 gives guidance to Payors that overpayment recoveries can occur:

- 1 **Within one year** from the date of the initial determination or redetermination for any reason.
- 2 **Within four years** from the date of the initial determination or redetermination for good cause as defined in § 405.986.
- 3 **At any time** if there exists reliable evidence as defined in § 405.902 that the initial determination was procured by fraud or similar fault as defined in § 405.902.
- 4 **At any time** if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based.
- 5 **At any time** to effectuate a decision issued under the coverage appeals process.

In addition, CMS' Medicare Integrity program employs Recovery Audit Contractors (RAC) to identify and correct improper Medicare payments. The RAC program allows for a look-back period of up to five years.

Overpayment examples

- Billing errors, such as deviation from National Correct Coding Initiative guidelines and improper use of billing modifiers
- Payment errors, such as an incorrect fee schedule applied to the claim or identification of a member's other health insurance that would be primary

The appeals process remains unchanged.

If you have any questions, please call the Provider Services Unit at **1-866-805-4589** or contact your Provider Relations representative. We appreciate your care for our Medicare Advantage members.

Amerivantage is an HMO plan with a Medicare contract and a contract with the Georgia Medicaid program. Enrollment in Amerivantage depends on contract renewal.

Availity: Registration information and reminders

Amerigroup Community Care recently introduced Availity Web Portal, a tool to help reduce costs and administrative burden for our physicians and hospitals.

Whether you work with one managed care organization (MCO) or hundreds, Availity can help you quickly and easily file claims, check eligibility, process payments, and more. For your convenience, Availity also offers a link back to the Amerigroup provider self-service site for all other transactions.

HOW TO register

To initiate the registration process, your primary controlling authority (PCA) – the individual in your organization who is legally entrusted to sign documents – must first complete registration at www.Availity.com.

Once your PCA completes this initial process, your primary access administrator (PAA) – the individual in your organization who is responsible for maintaining users and organization information – will receive a temporary password that will allow him or her to add users, providers, and additional enrollments for the organization.

Each staff member should register with his or her own login credentials to avoid business disruptions.

ADDITIONAL training

For training, visit www.Availity.com and select Availity Learning Center under Resources in the top bar. From here, you can sign up for informative webinars and even receive credit from the American Academy of Professional Coders for many sessions.

If you need assistance

For any questions or additional registration assistance, contact

Availity Client Services at

1-800-282-4548,

Monday through Friday,

8 a.m.-7 p.m. Eastern time.

Questions?

If you have questions about this newsletter or need assistance with any other item, call Provider Services at

1-800-454-3730

or contact your local Provider Relations representative.



P.O. Box 62509
Virginia Beach, VA 23466-2509

ProviderNews

Share it with your team

The provider newsletter contains important information for you, as a provider, as well as for members of your team.

When you receive the latest edition, please take a moment to share the information with your staff.

Recent editions of the provider newsletter are available online on the provider website at providers.amerigroup.com/GA under Provider Resources and Documents > Newsletters.



The material in this newsletter is intended for educational purposes only and does not constitute a recommendation or endorsement with respect to any company or product. Information contained herein related to treatment or provider practices is not a substitute for the judgment of the individual provider. The unique needs and medical condition of each patient must be taken into account prior to action on the information contained herein.