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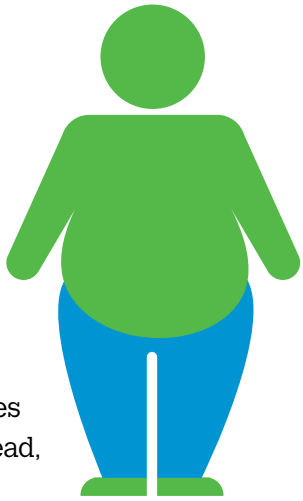
Body mass index and obesity: Tips and tools for tackling a growing issue



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.

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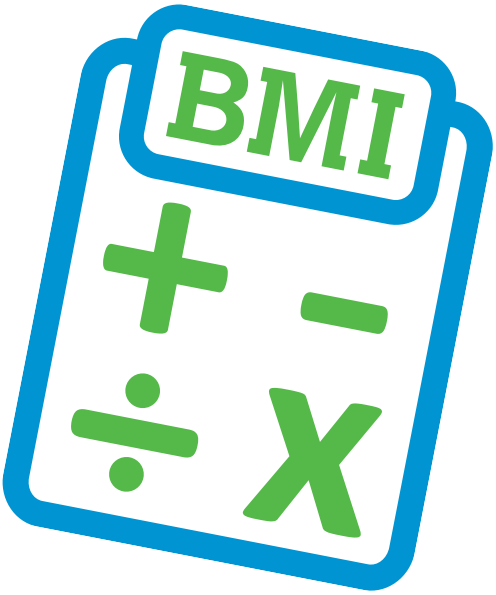

Documentation and coding

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 have been updated. 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.

Some helpful **reminders**

Below is a list of helpful tips and reminders on a number of topics, from billing procedures to where you can locate a list of member rights and responsibilities.

1. Member ID cards on smartphones

If our members show you their ID cards using the Amerigroup mobile app on their smartphone, you should accept that as valid proof of insurance coverage. The Amerigroup mobile app shows an electronic version of a member's real ID card. It has the same information and is proof of coverage. You can easily view their ID card and get all of the information you need.

2. Ambulatory surgery center (ASC) – site of service

To ensure care is provided in the most cost-effective setting, procedures for certain specialties should be performed at a participating ASC unless medically necessary criteria are met for the procedure to be performed in a hospital setting. Amerigroup reviews site of service and medical necessity for certain gastroenterology, ophthalmology, urology, and podiatry outpatient surgery. Please refer Amerigroup members to a participating specialist who has admitting privileges at a participating ASC.

3. Billing tip for family planning services

For providers who bill on a CMS 1500 form for family planning services, a valid NDC number is required on the claim when billing a Depo Provera Injection (J1050, Medroxyprogesterone acetate, 1 mg). Unit value of the dosage must be specified. For example, NDC 59762-4538-02, 150, UN having J1050 as the HCPC and the 150 in the unit field of the 1500 form. When giving the 104 mg dosage, the format should be the same, but with the 104 in place of the 150.

4. Affirmative statement about incentives

As a corporation and as individuals involved in utilization management (UM) decisions, we are governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Amerigroup does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that promote denials, result in underutilization, or create barriers to care and service.

5. Distribution of clinical practice and preventive health guidelines

Evidence-based guidelines are clinical practice guidelines known to be effective in improving health outcomes. Guideline effectiveness is determined through scientific evidence, professional standards, or expert opinion. Amerigroup provides clinical and preventive health guidelines to our network physicians.

These guidelines are based on current research and national standards. Members and providers may request a paper copy of a guideline by calling Provider Services at 1-800-454-3730. They are also available on our website at providers.amerigroup.com/MD.

6. Availability of UM criteria

If an Amerigroup physician reviewer denies your service request due to medical necessity, both you and the member will receive a notice of action letter that will include the reason for denial, note the criteria/guidelines used for the decision and explain the provider/member appeal process and rights. If you would like to arrange to speak with a physician reviewer about a medical necessity determination within 24 hours/one business day of the initial notice of action about the service request denial, call the MD Peer-to-Peer line at 1-866-696-2709. Administratively denied requests must follow the appeal process only. To request a copy of the specific criteria/guideline used for the decision, please call 1-800-600-4441 or write to:

Attn: UM Medical Management
Amerigroup Community Care
7550 Teague Road, Suite 500
Hanover, MD 21076

7. Access to utilization staff

Providers have access to clinical professionals who coordinate member care and are available 24 hours a day, 7 days a week to accept precertification requests. You can submit a precertification request by:

- Calling 1-800-474-3730
- Faxing to 1-800-964-3627
- Logging in to providers.amerigroup.com/MD and using the Precertification Lookup tool

If you have questions about utilization decisions or the UM process, call the clinical team at 1-800-454-3730, Monday through Friday, 8 a.m. to 5 p.m. Eastern time.

8. Member rights and responsibilities

Our members have defined rights and responsibilities. These can be found in your provider manual and on our website, providers.amerigroup.com/MD. If you would like a paper copy mailed to you, call Provider Services at 1-800-454-3730.

9. Pharmacy benefit manager change

Effective April 1, 2015, Amerigroup began using Express Scripts as our pharmacy benefit manager. Please continue to refer to our preferred drug list (PDL) and formulary when prescribing medications for your patients. You can access these on our provider website at **providers.amerigroup.com/quicktools/pages/pharmacytools.aspx.**

Although most drugs on the PDL are covered, some medications require prior authorization. To request authorization, go to providers.amerigroup.com/Help/Pages/login.aspx. You may also submit a pharmacy prior authorization request by calling our Pharmacy department at 1-800-454-3730 or faxing your request to 1-800-363-0728.

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.

Hypertensive diseases:
Navigating the ups and downs of documentation and coding

Blood pressure is the force of blood against the walls of the arteries. Abnormally high pressure or hypertension damages blood vessels, causing them to become scarred, hardened and brittle. The damaged vessels are no longer able to adequately supply blood to the organs and tissues of the body. Hypertenstion can lead to strokes, organ failure, or heart attacks when not properly controlled.

Treating hypertension

Hypertension is a chronic condition that requires lifelong treatment for most people. Treatment is aimed at controlling blood pressure and treating underlying or secondary conditions. The American Heart Association recommends blood pressure levels below 120/80 and screenings starting at 20 years of age. Hypertension is typically treated with medications, exercise/diet, managing stress, and not smoking.

Documentation and coding

The medical record documentation for patients with hypertension should include each of the following:

- **Type of hypertension** – benign (mildly elevated arterial pressure) or malignant (severe elevation that results in complications)
- **Complications** – body system such as heart or kidney that are affected by hypertension
- **Specific conditions** – details on the conditions that result from hypertension (i.e., heart failure, nephritis, cardiomegaly)
- **Assessment/treatment** – all measures aimed at controlling the hypertension or treating symptoms of complication(s)

Diagnosis code assignment is based on provider documentation and the medical record must support the codes submitted on the claim.

Essential (primary) hypertension 401

Code assignment is based on the type of hypertension documented (benign, malignant or unspecified). Statements such as high blood pressure, hypertension and hypertensive vascular disease are all coded with category 401 essential hypertension. When only an elevated blood pressure is noted without a diagnosis of hypertension, assign code 796.2 elevated blood pressure reading without diagnosis of hypertension. Terms such as controlled and uncontrolled indicate the status of the condition and do not have a bearing on code assignment for hypertension.

Hypertensive heart disease 402

Assign category 402 hypertensive heart disease when a cardiac condition is stated (due to hypertension) or implied (hypertensive). The physician must document cause and effect between the two conditions. Category 402 is futher specified based on the presence of heart failure. Use additional codes from (428.0-428.43) to specify type of heart failure if known.

Hypertensive chronic kidney disease 403

ICD-9 coding guidelines assume a cause and effect relationship when both hypertension and chronic kidney disease are documented. Assign codes from category 403 hypertensive chronic kidney disease along with additional codes for the stage of CKD from category 585 chronic kidney disease.

Hypertensive heart and chronic kidney disease 404

When documentation supports heart and kidney complications with hypertension, the rules of cause and effect are as follows:

- Assumed cause and effect for hypertension and chronic kidney disease.
- Requires documented cause and effect for hypertension and heart disease.

Instructional notes state to use additional codes from 428.0 to 428.43 to specify the type of heart failure (if known) and the stage of CKD from category 585 chronic kidney disease. ICD-10 equivalent code category: I13 hypertensive heart and chronic kidney disease.

Secondary hypertension 405

Hypertension caused by underlying conditions such as adrenal gland disorders, kidney disease, and drugs is called secondary hypertension. Assign codes for the underlying conditions in addition to codes from category 405 for secondary hypertension when documentation supports a cause and effect relationship.

AHA Coding Clinic advice

When the provider establishes a linkage or relationship between two conditions, they should be coded as such. The entire record for the date of service should be reviewed to determine whether a relationship between the

two conditions exists. The fact that a patient has two conditions that commonly occur together does not necessarily mean that they are related. A different cause may be documented by the provider. If it is not clear whether or not two conditions are related, coders should query the provider (AHA Coding Clinic Q3, 2012.)

Hypertensive diseases in ICD-10

An important change for hypertension is that ICD-10 does not require documentation of the type of hypertension for correct code assignment. Providers will need to document the effects of hypertension along with any underlying conditions and treatment given. The table below shows code categories for hypertensive diseases in ICD-10.

ICD10	Description
I10	**Essential (primary) Hypertension**
I11	**Hypertensive Heart Disease (with or without heart failure).** Use an additional code from I50 to specify type of heart failure (if present).
I12	**Hypertensive Chronic Kidney Disease.** Use an additional code from N18 to identify stage of chronic kidney disease.
I13	**Hypertensive Heart and Chronic Kidney Disease.** Use an additional code from I50 to specify type of heart failure (if present) and an additional code from N18 to identify stage of chronic kidney disease.
I15	**Secondary Hypertension.** Requires two codes, one for underlying cause and one from category I15 to identify secondary hypertension. Sequencing is based on circumstances of visit and documentation.

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.

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.

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.

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ProviderNews

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