

BCBSM: Documentation is Key When Coding Morbid Obesity

With an increasing number of Americans becoming overweight or suffering from obesity, it's important for physicians to recognize the degree to which obesity -- and its ever-present complications -- negatively impacts patient health.

Overweight, obesity and morbid obesity are distinct diagnoses that must be properly documented.

The Centers for Medicare & Medicaid Services includes morbid obesity (ICD-9-CM code 278.01) and its associated body mass index values (40 and above, ICD-9-CM code range; V85.41-V85.45) in its 2014 Hierarchical Condition Categories Model. This categorization impacts the way providers should document the condition.

From a coding perspective, documentation of morbid obesity in the medical record makes it easier to assign code 278.01 with an associated V code. A problem may arise when obesity is documented in the medical record, but evidence indicates that the patient is morbidly obese. For example, the patient has a body mass index of 40 with co-morbid conditions.

Can a BMI value of 40 with co-morbid conditions be used to validate the HCC Model for morbid obesity when there is a different diagnosis? The answer is yes. Consider the following guidelines for making a morbid obesity diagnosis:

- Patients with a BMI greater than 35 who are seen with co-morbid conditions such as osteoarthritis, sleep apnea, diabetes, coronary artery disease, hypertension, hyperlipidemia and gastroesophageal reflux disease
- Patients with a BMI equal to or above 40

According to Dr. Laurrie Knight, associate medical director for Blue Cross Blue Shield of Michigan, you should capture all of the medical complications that are associated with an obesity diagnosis. These may include sleep apnea, uncontrolled diabetes, hypertension and hyperlipidemia, among others. "This will prompt you to define and document the specific clinical condition, such as morbid obesity," she said.

The BMI value is one of the key elements to consider when assessing morbid obesity, Dr. Knight added. "Clinical complications should also be evaluated and treated," she said. "Sometimes multiple interventions are required to evaluate and identify a clinical condition like morbid obesity. Observing the impact of weight on other medical conditions is often a clear indicator."

A provider may recommend several interventions that could include a dietician, incorporating an exercise regimen and education about managing other co-morbidities that can impact the total health of the patient.

"Morbid obesity may not be documented early in the year as you may opt to evaluate the patient over time," Dr. Knight continued. "However, once you've determined the patient to be morbidly obese, and you code it as such, the diagnosis must continue to be coded as morbid obesity on subsequent visits."

Since documentation is key to coding morbid obesity, a coder must review the medical record thoroughly when obesity is documented with a BMI of 40 or above, with co-morbid conditions affecting the patient's overall health. In such a situation, a code for the BMI (the same HCC as morbid obesity) should be used to support morbid obesity.

For more information, contact your provider consultant.

None of the information included in this article is intended to be legal advice and, as such, it remains the provider's responsibility to ensure that all coding and documentation are done in accordance with applicable state and federal laws and regulations.

Board Certification and Accreditation Required for TRUST Providers Performing Sleep Studies and Polysomnography

As announced in the October *Record*, Blue Cross Blue Shield of Michigan's new prior authorization requirement for sleep-testing services, effective Feb. 1, 2015, applies only to in-lab sleep testing. However, all sleep testing services for BCBSM commercial PPO members, whether an in-lab or home sleep test, must be performed and interpreted by a board-certified sleep medicine physician affiliated with an accredited sleep laboratory.

Providers in the TRUST network who do not meet BCBSM's credentialing requirements as outlined below should not submit sleep study claims for PPO members. This violates the TRUST Provider Agreement, and such claims will be subject to audit and recovery. Providers who continue to submit such claims will be subject to termination of their TRUST contracts.

Physician board-certification requirement

TRUST physicians performing and/or interpreting polysomnography services (*95810 -*95811-*95805- and *95808) and portable home sleep testing for Blue Cross PPO members are required to be board certified in sleep medicine. **This requirement was effective April 1, 2010.** TRUST physicians who do not have these credentials may perform the initial evaluation of patients suspected of having a sleep disorder (e.g., physical exam, medical and sleep history, etc.); however, they must refer their patients to board-certified sleep specialists in the TRUST network for all diagnostic sleep studies.

The sleep specialist is the physician responsible for determining and performing the most appropriate test(s) for the patient and obtaining preauthorization when required. It's important that providers keep their certification information, including expiration dates, current with BCBSM in order to be able to submit preauthorization requests and perform such services.

Facility accreditation requirement

As another step in improving the quality and utilization of sleep services, beginning Feb. 1, 2016 all TRUST facilities performing polysomnography and home sleep testing for Blue Cross PPO members must be accredited by a BCBSM-designated accrediting body.

For nonhospital-based sleep laboratories, Blue Cross requires accreditation by the American Academy of Sleep Medicine. Hospital-based sleep testing facilities must be accredited by AASM or an accreditation organization accepted under the *Participating Hospital Agreement*.

The offices of providers that only interpret polysomnography or other sleep testing results are not considered sleep laboratories and would not qualify for accreditation. To interpret polysomnography or home sleep test, however, the board-certified sleep specialist must be under the supervision of the director of a laboratory meeting BCBSM accreditation and board-certification requirements.

The 2016 effective date provides the opportunity for sleep-testing facilities that are not accredited to submit their application for accreditation. In the interim, providers not meeting this requirement may continue to provide services while working toward accreditation. **Note:** This accreditation requirement does not change the way BCBSM contracts with sleep-testing providers nor does it affect the billing location for services provided.

See October *Record* article

For additional information, please refer to the [October 2014 *Record* article](#) titled "Preauthorization required for in-lab sleep studies."

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Home Infusion Therapy Guidelines for Drug Deliveries Reinforced

Home infusion therapy drugs delivered to a patient shouldn't exceed a seven-day supply. The *Blue Cross HIT Provider Manual* states that, "No more than a seven-day supply of drugs may be delivered to the patient or a

10-day supply for a holiday weekend."

BCBSM understands that there will be situations when a patient needs a drug delivery quantity of more than the allowed seven days. The following drug delivery exceptions are acceptable **as long as the pharmacist receives a verbal order from the physician to send an additional quantity**:

- When the pharmacist delivers a three-day drug supply, the next delivery quantity during the same infusion week shouldn't be more than four-day supply. This delivery combination would meet the seven-day drug supply requirement.
- During the first week of drug therapy, additional drug quantities can be added to the delivery to accommodate the provider's delivery schedule.
- Because of the possibility of a drug reaction, providers who want to closely monitor a patient's first dose might not want to deliver the entire week's drug supply. In this case, the remainder of the drug delivery can be delayed until the next delivery date.
- When the length of drug therapy lasts more than seven days but less than 14 days, the delivery of the entire drug therapy is acceptable

Blue Cross also won't recover payments from HIT providers for drugs under following circumstances:

- Drugs that remain in the home when the therapy is prematurely discontinued
- The patient is unexpectedly hospitalized after a drug delivery
- The drug is changed midweek following a drug delivery

If you have any additional questions or concerns about these guidelines refer to the current *Blue Cross HIT Provider Manual*

HIT Drug Claims Need National Drug Code Information for Billings

If you're submitting a home infusion therapy drug claim, please report:

- The drug's J code with the NDC dispensed by the pharmacist, plus the appropriate dose form code for the NDC
- Each NDC separately if more than one container of the same medication is dispensed and the additional containers have a different NDC
- The NDC using the dispensed quantity with appropriate drug measurement unit. Keep in mind that not all drugs are billed according to the number of vials; some are billed according to the amount of liquid in the vial; e.g., the number of millimeters.

Important information you should know when submitting a HIT drug claim:

- The dispensed drug quantity may have up to four whole numbers, a decimal point and decimal numbers. For example, XXXX.XX
 - Not all drugs are assigned Health Care Procedure Coding Structure J codes. Some drugs are assigned Q or S codes.
 - J3490 code can only be used when HCPCS hasn't classified a drug.
 - The date of service is the date the drug is shipped to the patient.
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Beyond Checking the Box: Legalities and Practicalities of HIT



Tuesday, February 17, 2015
9:00 a.m. - 3:30 p.m.
Troy Marriott - Troy

Health information technology (HIT) is creating many challenges for physicians and other health care professionals as they work to understand how to marry technology with practice transformation goals.

The six educational sessions at **Beyond Checking the Box: Legalities and Practicalities of HIT** will provide physicians, Physician Organization leaders, medical practice managers, and medical practice consultants with practical advice to help manage the various opportunities and requirements associated with the implementation of HIT tools and resources in

medical practice.

A thorough understanding of the featured topics will help physicians and medical practices survive and thrive in the current and evolving HIT environment.

[Details & Registration >>](#)

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