MSMS MICHIGAN STATE MEDICAL SOCIETY Reimbursement Advocate Alert

Are you coding adult BMI assessment correctly when reporting evaluation and management services?

It has come to BCBSM's attention that some health care providers have been reporting the ICD-9 codes for adult body mass index assessment in the primary diagnosis location on claims, which may cause the claims to reject.

To capture information about BMI for your adult patients, use ICD-9 codes V85.0, V85.1, V85.21-25, V85.30-39 or V85.41-45. The BMI codes should only be reported as secondary diagnosis for evaluation and management services.

Adult BMI assessment is a key HEDIS® measure**, so not documenting it correctly can affect HEDIS scores. These scores, as you may know, are tied to incentive payments through our Physician Group Incentive Program.

In addition to PGIP physician organizations being rewarded for their HEDIS improvement efforts (including adult BMI), PGIP participating primary care physicians are also eligible for a 5 percent fee uplift based on their overall quality performance on a variety of HEDIS metrics. Adult BMI is being added as one of the quality metrics contributing to this physician-level opportunity for elevated fees.

For more information on adult BMI assessment, see the BCBSM tip sheet on this topic by clicking here.

Note: For evaluation and management services, V codes are collected for informational purposes only and are not directly reimbursable.

**HEDIS, which stands for Healthcare Effectiveness Data and Information Set, is a registered trademark of the National Committee for Quality Assurance.

Follow these guidelines to report bilateral services

When you're reporting bilateral services on professional claims, the appropriate bilateral procedure code should be reported when services are performed on the exact same anatomical sites. This means aspects or organs on both sides of the body during the same session by the same physician.

Only use modifier 50 when the procedure code description doesn't state the procedure is bilateral. Modifier 50 should be appended to the appropriate unilateral procedure code as a one-line entry on the claim with a quantity of one.

For more information or questions regarding this process, contact your provider consultant.

WPS Medicare Educational Opportunities

Outpatient Rehabilitation Therapy

Billing and Payment
06/18/2015 - East Lansing, MI - 1:00 - 4:00 PM

Join WPS Medicare for this half day seminar to get the answers to your questions and more. The agenda will include CMS regulations and coverage, resources to understand the billing and payment, Advance Beneficiary Notice of Noncoverage (ABN), and functional reporting criteria.

Details & Registration >>

Coverage Criteria and Documentation
06/18/2015 - East Lansing, MI - 8:30 - 11:30 AM

Join WPS Medicare as they explore the coverage criteria and documentation requirements for physical therapy, occupational therapy, and speech language pathology. In this interactive session WPS will review the coverage criteria as well as actual documentation examples.

Details & Registration >>

ICD-10-CM Boot Camp: The Clock is Ticking

May 19-20, 2015
9:00 a.m. - 4:00 p.m.
Marriott - Troy

The Centers for Medicare and Medicaid Services announced there will be no more delays with the ICD-10 transition. It is imperative that physicians and their staff begin ICD-10 training. ICD-10-CM expert Jill Young CPC, CEDC, CIMC, will ensure health care professionals are prepared for the transition. This two-day program will lay the groundwork introducing participants to the ICD-10-CM coding system, anatomy, and physiology.

Details & Registration >>

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