

Coding Review

General Description

The Coding Review reviews inpatient claims reimbursed by DRG payment to identify incorrect coding or billing practices.

Objective

The purpose of the Coding Review is to ensure fair and equitable coding and billing practices are performed by all hospitals so that no hospital can improve reimbursement at the expense of other hospitals, as well as to protect the rights of our members. The coding review ensures that Blue Cross Blue Shield of North Dakota (BCBSND) is in agreement with the final DRG assignment. Occasionally, letters are sent to providers when a specific coding error is discovered that does not affect the DRG. These letters are meant for educational purpose. Due to the potential volume, these letters are sent at the reviewer's discretion and when future DRG assignments may be affected by the continued use of the code in question. BCBSND is committed to ensuring that our claims database represents correct DRGs and payment amounts.

- Select claims that are identified as having high potential for coding variation among providers.
- Review institutional claims and corresponding medical records for appropriate coding based on nationally accepted coding guidelines.
- Identify incorrect code assignments that affect the DRG assignment and payment to the provider.
- Inform providers of review findings.
- Inform providers of the coding conventions and guidelines used when recommending coding changes.
- Identify and monitor coding variations between facilities and promote consistency in code utilization among providers.

Process

1. All paid claims for the quarter are run through an edit process.
2. The Reimbursement Coding Coordinator selects those claims that are identified as having one or more edits for review.
3. The Reimbursement Coding Coordinator follows appropriate *ICD-9-CM* coding conventions and guidelines, UHDDS guidelines, *Coding Clinic*, and BCBSND policy when conducting coding reviews.
4. The BCBSND Medical Directors provide input for cases where insufficient or conflicting medical documentation may exist.
5. Results of review findings are provided to the facilities Medical Record Department on a quarterly basis. BCBSND provides individual case summaries and the rationale used in making a change recommendation when disagreement with the original claim submission occurs.
6. The providers have 45 days following this notification to request reconsiderations. The DRG Validation Review Program Reconsideration Process is available to providers and consists of two levels of reconsideration.
7. Reference the Rebilling chapter regarding resubmissions.

Time Line for DRG Validation Coding Reviews

1st Quarter 2013 <i>January/February/ March</i>	2nd Quarter 2013 <i>April/May/June</i>	3rd Quarter 2013 <i>July/August/September</i>	4th Quarter 2013 <i>October/November/ December</i>	1st Quarter 2013 <i>January/February/ March</i>
<p>Claims submitted and paid.</p>	<p>June: Paid claims from 1st quarter 2012 are downloaded into DRG Validation system. Claims, previously adjusted or handled, are removed from the download. The correct DRG weights and rates are applied from the appropriate fee schedules.</p> <p>The claims are processed through the coding edits and the remaining claims are then ready for reviewer to perform the select/deselect process.</p> <p>Claims for review are selected and notification is sent to providers to either submit the medical record or prepare for an on-site review. Due to staffing issues at the hospitals, a minimum of 2 weeks notice is given to facilities who retrieve large numbers of records.</p>	<p><i>July/August:</i> Coding reviews are performed.</p> <p><i>August/September:</i> Disagreement letters are sent to facilities.</p> <p>Providers may notify BCBSND in writing of those claims, which they agree with the proposed change.</p> <p>This written notice waives the 45 day Reconsideration process and expedites the refund.*</p>	<p><i>October/November:</i> Providers' 45 days to request reconsideration are ending. Refunds begin for disagreees under reconsideration.</p> <p>A majority of the disagreements will be refunded at this time.</p> <p><i>November/December:</i> BCBSND's 45 days to respond to 1st level reconsiderations is ending.</p>	<p><i>January:</i> Providers' 45 days to request reconsideration to the 2nd level ending. Refunds will begin for disagreees not under reconsideration to the second level.</p> <p><i>February/March:</i> BCBSND's 45 days to respond to 2nd level reconsiderations ending.</p> <p>Administrative assessments performed to determine if the Reconsideration process was conducted appropriately.</p> <p>Refunds performed on final disagreee claims.</p>

* Effective August 1, 2005:

Claims will be refunded. The provider needs to resubmit with the appropriate codes to receive payment.

HealthCare News Articles

The following pages contain copies of coding information pertinent to the Coding Review. Articles regarding the DRG Validation Program will periodically appear in future HealthCare News Bulletins.

- December 2004 – Anemia Coding Guidelines
- June 2012 – Malnutrition Coding Guidelines

Response: Since THOR has implemented the WebEx Meeting Center we have been working with the North Dakota State Health Department to set up immunization program trainings for our users to increase the input of immunization records into the system. If you would like to set up a training session please call THOR Support Services at 1-800-544-8467.

Survey Comments: Users indicated dissatisfaction with the requirement to change their passwords every 60 days.

Response: This requirement was implemented to comply with security regulations.

Your suggestions make a difference. Below are some of the results of your requests for improvements in past THOR Surveys:

Requested Improvement: An on-line claim correction application that would eliminate the need to resubmit some claims.

Result: The THOR On-Line Claim Correction application was implemented for electronically-submitted professional claims in February 2004.

Requested Improvement: More opportunities for THOR training.

Pharmacy

CuraScript Pharmacy Services

Correction to HealthCare News #251

Providers should not contact CuraScript for drugs other than those on the list as printed in HealthCare News #251. Additional medications may become available through CuraScript if approved by BCBSND. Providers will be notified of additions through HealthCare News bulletins.

DRG Validation Program



Anemia Coding Guidelines

Blue Cross Blue Shield of North Dakota has identified anemia as a common diagnosis where disagreement occurs between the codes as submitted by the hospitals and the findings within the DRG Validation Coding Audit. Due to the number of coding change requests, BCBSND has developed general guidelines for the coding of anemia in the inpatient setting. These guidelines are used by the medical and coding staff at BCBSND to determine when anemia is appropriate to include as a coded condition on an inpatient claim.

General Guidelines

The presence of any condition coded should be supported by documentation within the medical record. In addition, the condition should require utilization of resources during the current episode of care to receive reimbursement. Those conditions not requiring treatment, or that have already been treated and reimbursed prior to admission, are carefully monitored to ensure the integrity of the DRG database and payment system.

HealthCare News #252 **24** December 2004 BCBSND

Official guidelines from the Uniform Hospital Discharge Data Set (UHDDS) define when a diagnosis can be coded. The guidelines state that a diagnosis should be coded if documented by the physician in the patient's medical record for the current admission and the condition was:

1. Clinically evaluated during the patient's stay; or
2. Therapeutically treated during the stay; or
3. Diagnostically tested during the stay; or
4. Caused an increased length of stay; or
5. Required increased nursing monitoring and care.

In the case of newborn diagnosis coding, the condition meets criteria for coding if any of the listed conditions described above is met or documentation by the physician indicates a need for future follow-up or healthcare needs.

Acute Blood Loss Anemia (285.1)

1. The patient is expected to be anemic following surgery or trauma. Anemia is defined as below normal value of hemoglobin, hematocrit, or RBC count.
2. Since over hydration and blood loss occurs with surgery, a single postoperative blood count with minimally low values does not meet criteria for acute blood loss anemia.
3. Written prescriptions for iron, multivitamins, or recommendations for taking OTC medications, which may or may not be taken following discharge, do not constitute treatment or utilization of resources during the admission.
4. The initiation of oral iron therapy alone, without supporting laboratory and documented evidence of acute blood loss anemia, is not considered medically necessary and does not meet criteria for reporting acute blood loss anemia.
5. In situations where a significant drop in hemoglobin occurs following surgery or trauma and treatment or additional monitoring is required during the stay, it is appropriate to assign the acute blood loss anemia code.
6. Additional information regarding postoperative anemia is published in HealthCare News Bulletin #226.

Anemia of Pregnancy (648.2X, 285.X)

1. Danforth's Obstetrics and Gynecology textbook defines anemia of pregnancy as a hemoglobin concentration of <10 g/dL.
2. Patients with hemoglobin levels of >10 in the last trimester do not meet criteria for the coding of anemia of pregnancy.
3. Since over hydration and blood loss occurs with surgery, patients requiring cesarean deliveries should not be coded with anemia of pregnancy based on a single postoperative blood count.

4. Orders to continue taking prenatal vitamins, or written prescriptions for iron, multivitamins, or recommendations for OTC medications, which may or may not be taken following discharge, do not constitute treatment or utilization of resources during the admission.
5. The initiation of oral iron therapy alone, without supporting laboratory and documented evidence of anemia of pregnancy, is not considered medically necessary and does not meet criteria for reporting anemia of pregnancy.
6. Anemia present at outpatient prenatal visits prior to admission does not meet criteria for coding on the current inpatient admission when blood counts are >10 on admission.
7. In situations where the hemoglobin is <10 on admission, or falls <10 following cesarean or vaginal delivery, and treatment or additional monitoring is required during the stay; it is appropriate to assign anemia of pregnancy codes.

Chronic Blood Loss Anemia (280.0)

1. The patient should be anemic on admission. Anemia is defined as below normal value of hemoglobin, hematocrit, or RBC count.
2. Since over hydration and blood loss occurs with surgery, a single postoperative blood count with minimally low values does not meet criteria for chronic blood loss anemia.
3. Anemia present at outpatient visits prior to admission does not meet criteria for coding on the current inpatient admission when blood counts are within normal limits on admission.
4. Written prescriptions for iron, multivitamins or recommendations for OTC medications, which may or may not be taken following discharge, do not constitute treatment or utilization of resources during the admission.
5. The initiation of oral iron therapy alone, without supporting laboratory and documented evidence of chronic blood loss anemia, is not considered medically necessary and does not meet criteria for reporting chronic blood loss anemia.
6. Chronic blood loss anemia due to hyper-excessive menstrual bleeding is generally considered an outpatient disease. The diagnosis is made as an outpatient, hormone manipulation therapy controls the bleeding, and iron supplements allow the body to replace its lost red cells.
7. In situations where the anemia cannot be corrected by outpatient measures, and surgery is necessary, and the hemoglobin is less than normal on admission; it is appropriate to assign the chronic blood loss anemia code.

DRG Validation Program

Malnutrition Coding Guidelines



Blue Cross Blue Shield of North Dakota (BCBSND) has identified malnutrition as a common diagnosis in which disagreement occurs between codes submitted by hospitals and the DRG validation coding audit findings. Due to the number of coding change requests, BCBSND has developed general guidelines for coding malnutrition in the inpatient setting. These guidelines are used by BCBSND medical and coding staff to determine when it is appropriate to include malnutrition as a coded condition on an inpatient claim.

General Guidelines

Documentation within the medical record should support the presence of any coded condition. In addition, the condition should require utilization of resources during the current episode of care to receive reimbursement. Conditions not requiring treatment, or that have been treated and reimbursed prior to admission, are carefully monitored to ensure the integrity of the DRG database and payment system.

Official guidelines from the Uniform Hospital Discharge Data Set (UHDDS), which define when a diagnosis can be coded, state that a diagnosis should be coded if documented by the physician in the patient's medical record for the current admission and the condition was:

- Clinically evaluated during the patient's stay; or
- Therapeutically treated during the stay; or
- Diagnostically tested during the stay; or
- Caused an increased length of stay; or
- Required increased nursing monitoring and care.

The condition meets criteria for newborn diagnosis coding if any of these guidelines are met or the physician's documentation indicates a need for future follow-up or health care needs.

Classification of Malnutrition

BCBSND has adopted the World Health Organization (WHO) Classification of malnutrition in adults by body mass index (BMI). This information can be found at: http://www.who.int/nutrition/publications/severemalnutrition/en/manage_severe_malnutrition_eng.pdf.

Classification of malnutrition in adults by body mass index

Body mass index	Nutritional status
≥ 18.5	Normal
17.0-18.49	Mild malnutrition
16.0-16.99	Moderate malnutrition
<16.0	Severe malnutrition

The attending provider is responsible for listing the diagnoses in the patient record and must document malnutrition to justify reporting a code for the body mass index.

In addition to the patient's current BMI, the following criteria should be documented when assigning a code for malnutrition:

- A comprehensive dietary history
- The determining factors considered in making a diagnosis of malnutrition
 - Laboratory testing alone is an unreliable means to confirm the presence of malnutrition.
 - Abnormal levels of serum protein (albumin, transferrin and pre-albumin) are more likely to reflect the degree of illness in a hospitalized patient rather than the presence of malnutrition.
- Signs and symptoms commonly associated with malnutrition
- Specific interventions required to manage malnutrition (e.g. TPN, enteral feedings). These interventions should be an integral component of the patient's case management. Dietary consults and oral nutritional supplements in the form of vitamins or protein supplements such as *Boost* or *Ensure* do not constitute additional resource utilization.

BCBSND reserves the right to review clinical documentation to ensure the condition meets both UHDDS and BCBSND guidelines for reporting malnutrition.

Billing and Coding

Ambulatory Surgery Center (ASC)

Effective for services on or after July 1, 2012

Ambulatory surgery centers must be accredited by the Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission, the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), or certified by Medicare to be reimbursed according to Blue Cross Blue Shield of North Dakota's Uniform Surgical Fee Schedule (USFS)/ASC Fee Schedule.

Billing Guidelines

Licensed ASC services must be billed on the CMS-1500 claim form with the NPI for the ASC and place of service code 24, whether the ASC is hospital-based or free standing. Modifier SG is not required. Services are identified using the most appropriate CPT®/HCPCS code.

Effective for services on or after July 1, 2012, surgical procedure codes must be submitted on separate lines for correct reimbursement. Surgical codes should be submitted on the same claim for the same surgical