DRG Validation Audit Program

Provider Reference Manual
# Contents

## 1 Overview of DRG Validation Program

1.1 2012 Explanation of Updates  
1.3 Graphs

## 2 DRG Validation Advisory Committee (DVAC)

2.1 Purpose  
2.1 Membership  
2.1 DRG Validation Advisory Committee  
2.2 DVAC Membership Application  
2.3 HealthCare News Articles

## 3 Coding Audit

3.1 General Description  
3.1 Objective  
3.1 Process  
3.2 Timeline for Coding Audits  
3.3 HealthCare News Articles

## 4 Level of Care Audit

4.1 General Description  
4.1 Objective  
4.1 Process  
4.2 Inpatient Status vs. Outpatient Observation Status Considerations  
4.3 McKesson InterQual Criteria  
4.3 InterQual Proprietary Notice  
4.5 HealthCare News Articles

## 5 Modifications to Criteria / Guidelines

5.1 BCBSND Modifications to InterQual’s Adult and Pediatric Criteria  
5.2 BCBSND Guidelines for Surgery and Procedures in the Inpatient Setting

## 6 Readmission Audit

6.1 General Description  
6.1 Objective  
6.1 Process  
6.3 HealthCare News Articles
Transfer Audit
7.1 General Description
7.1 Objective
7.1 Process
7.3 HealthCare News Articles

Catastrophic Audit
8.1 General Description
8.1 Objective
8.1 Process

Reconsideration Process
9.1 First Level of Reconsideration
9.1 Second Level of Reconsideration
9.1 Independent External Review
9.2 Guidelines for Requesting a Reconsideration
9.3 HealthCare News Articles

Rebilling Process
10.1 Coding Audit
10.1 Level of Care Audit
10.1 Readmission Audit
10.1 Transfer Audit
10.1 Catastrophic Audit

Communication to Health Care Providers
11.1 Communication Document Examples
11.2 Provider Reference Manual Updates
Dear BCBSND Provider:

As a member of a Utilization Management Department or Health Information Department of a participating Blue Cross Blue Shield of North Dakota (BCBSND) hospital provider, we are writing to inform you about 2013 Updates to the Diagnosis Related Group (DRG) Validation Provider Reference Manual.

Enclosed in this mailing are statistical and communication updates to the DRG Validation Program. Any future revisions or updates will be communicated in a separate mailing.

Statistical Updates

We have provided charts that detail statistics regarding reviews conducted by the DRG Validation Program staff from 2011. These charts include:

- The number of claims paid by the plan (Coding Audit)
- The number of claims by total admissions (Level of Care, Readmission/Transfer)
- The number of claims reviewed by the program
- The number of claims in which the program disagreed with the claim as submitted
- The number of reconsiderations requested
- The number of reconsiderations reversed

In the 2011 Level of Care and Readmit/Transfer Audits, the average percentage of all acute inpatient claims reviewed was 6.6 percent. BCBSND disagreed with an average of 2.3 percent of the total acute inpatient claims received by BCBSND. The facilities requested reconsiderations on an average of 11.7 percent of the claims which BCBSND disagreed. BCBSND reversed an average of 38 percent of the claims reconsidered.

In the 2011 Coding Audit, the average percentage of acute inpatient claims reviewed was 12.9 percent. BCBSND disagreed with an average of 2 percent of the total acute inpatient claims paid by BCBSND. The facilities requested reconsiderations on an average of 11.8 percent of the claims which BCBSND disagreed. BCBSND reversed an average of 30.8 percent of the claims reconsidered.

Included in the larger facility packets are enclosures that reflect facility specific information regarding the Program audits.
Communication Update

We will continue to send certified communication letters regarding Level of Care, Readmission or Transfer reviews to the facility’s Utilization Review Department regarding determinations. It will be the responsibility of the Utilization Review Department at each facility to forward the information to the Business Office.

We will continue to send certified communication letters regarding Coding reviews to the facility’s Medical Records Department.

This manual was first distributed to your departments in August 2003. All changes to the manual are updated on the BCBSND website at www.bcbsnd.com. To access the manual online, enter the BCBSND website, select THORconnect.org which is within the Providers section and then select Provider Services. The manual is located within Billing and Reimbursement.

If you have any questions regarding the DRG Validation Program, please contact Jacquelyn Walsh, VP Clinical Excellence & Quality.

Sincerely,

Eunah Fischer M.D.     Jacquelyn Walsh
Interim Chief Medical Officer   VP Clinical Excellence & Quality
Health Network Innovations   Health Network Innovations
DRG Validation Program
Level of Care
All Facilities

Claim Numbers

Total PD by paid date
Reviewed Claims
Disagrees
Reconsidered
Reversed

1st Qtr. 11
2nd Qtr. 11
3rd Qtr. 11
4th Qtr. 11
DRG Validation Advisory Committee (DVAC)

Purpose
The purpose of DVAC is to maintain an open forum to promote research and discussion of coding guidelines regarding ICD-9-CM and future ICD-10 coding for DRG reimbursement, the medical documentation necessary to support coding for DRG reimbursement and the proper use of discharge disposition codes. This committee promotes communication between payers and providers.

Membership
- Providers (large and small facilities)
- ND Quality Improvement Organization
- Workforce Safety and Insurance
- Blue Cross Blue Shield of North Dakota (BCBSND)
- ND Department of Human Services (Medicaid)

DRG Validation Advisory Committee
- Member’s choice 2 or 3 year terms
- Composed of Healthcare professionals with an interest or experience in coding
  - (coders, nurses, other healthcare professionals)
- Currently employed by a BCBSND participating facility
- Meets quarterly
DVAC Membership Application

If you are interested in becoming a DVAC member and are currently employed in a BCBSND participating healthcare facility, please complete a copy of this application. For questions concerning the DRG Validation Advisory Committee, contact Provider Service at 800-368-2312 or 701-282-1090.

Blue Cross Blue Shield of North Dakota
DRG Validation Advisory Committee
Application for Committee Appointment

Name: ____________________________________________________________

Employer Name: ____________________________________________________

Employer Address: _________________________________________________

Phone Number: _____________________________________________________

E-mail Address: ____________________________________________________

Position Held: _____________________________________________________

Number of Years in Current Position: _________________________________

Number of Years (if any) in Coding Positions: __________________________

Total Years in the Health Care Industry: ______________________________

Coding Designations/Certifications Held: _______________________________

Desired length of term (select one): 2 years _________ 3 years _____________

Training received/seminars attended within the last 3 years that would relate to DVAC:

List any committee participation or experience you have:

Why would you be a valuable member of the DRG Validation Advisory Committee?

Please return to:
Reimbursement Coding Coordinator, Health Network Innovation
Blue Cross Blue Shield of North Dakota
4510 13th Ave. S.
Fargo, ND 58121
HealthCare News Articles

The following pages are copies of coding guidelines that the DRG Validation Advisory Committee has completed. These guidelines have been published in various HealthCare News Bulletins. As further guidelines are developed, they will periodically appear in future Healthcare News Bulletins.

Previous Coding Topics Published in Health Care News

- May 2002 – Postoperative nausea and vomiting
- May 2002 – Postoperative ileus
- May 2002 – Postoperative urinary retention
- May 2002 – Postoperative atelectasis
- October 2002 – Postoperative/blood loss anemia
- October 2002 – Postoperative fever
- June 2003 – Dehydration
- September 2003 – Debridements
- March 2005 – Debridements (updated)
- May 2006 – Diabetes Mellitus
- December 2007 – Diabetes Mellitus (updated)
- December 2007 – Sepsis
- September 2009 – Pain
DVAC Coding Guideline:
Postoperative Nausea and Vomiting

It is not unusual for a patient to experience some nausea and vomiting following surgery. All patients require care and observation following surgery. When the patient has experienced these symptoms for longer than 24 hours and the significance of the symptoms requires more than routine care or extends the length of stay, the coding of postoperative nausea and vomiting may be appropriate. The physician’s documentation should link the diagnosis to the procedure before a complication code is assigned. The physician’s documentation should demonstrate that the nausea and vomiting was more than anticipated in the post surgical period.

Signs and Symptoms

- Persistent nausea and vomiting (2-3 days postoperative)
  - Documented at least twice within physician and nursing notes
- Signs of dehydation
  - Elevated BUN
  - Orthostatic blood pressure
  - Lightheaded/dizzy
  - Elevated heart rate
  - Abnormal electrolytes
  - Poor skin turgor
  - Dry mucous membranes
- Weight Loss*
  *Consider age and size of patient

Treatment/Increased Length of Stay

- IV or IM antiemetics
- IV rehydration
  - Greater than maintenance
  - Consider age and disease
  - Restarted or remained in longer than expected
- NG tube placement

Physician Documentation

- Signs and symptoms
- Treatment
- Response to treatment
- Unable to discharge patient due to nausea and vomiting
- May order I&O
- May order daily weights
- Clinical findings on examination

These guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation.
DVAC Coding Guideline:
Postoperative Ileus

It is not unusual for a patient to experience some ileus (bowel obstruction) following gastric and abdominal surgery involving extensive handling of the bowel or prolonged use of narcotics. All patients require care and observation following surgery. When the patient has experienced significant symptoms that require more than routine care or extends the length of stay, the coding of postoperative ileus may be appropriate. The physician’s documentation should link the diagnosis to the procedure before a complication code is assigned. The physician’s documentation should demonstrate that ileus is present and more than anticipated in the post surgical period. Documentation of bowel rest alone may not be indicative of ileus.

Signs and symptoms

- Abdominal distention/bloating
- Abdominal pain (lasting 48 to 72 hours postoperative)*
  *take into consideration the age of patient and type of procedure
- Lack of resumption of bowel function
- Lack of bowel sounds
- Lack of flatus
- Prolongation before resumption of normal diet
- Persistent nausea and vomiting

Major Risk Factors

- Narcotics
- GI surgery/Excessive intraoperative bowel handling
- Obesity
- Anesthesia/Nitrous Oxide
- Diabetic gastroparesis
- Elderly
- Abdominal trauma

Treatment/Increased Length of Stay

- Abdominal x-ray (optional)
- Insertion/reinsertion/prolonged use NG tube
- Bowel rest/NPO
- Reversal of diet
- IV fluids/TPN
- Antiemetics
- Motility drugs
- H2 blockers

Physician Documentation

- Signs and symptoms
- Treatment
- Response to treatment
- Unable to discharge patient due to ileus
- May order I&O
- Clinical findings on examination

These guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation.
DVAC Coding Guideline:  
Postoperative Urinary Retention

It is not unusual for a patient to experience some urinary retention (inability to void) following pelvic or perineal surgery. All patients require care and observation following surgery. When the patient has experienced significant symptoms that require more than routine care or extends the length of stay, the coding of postoperative urinary retention may be appropriate. The physician’s documentation should link the diagnosis to the procedure before a complication code is assigned. The physician’s documentation should demonstrate that urinary retention is present and more than anticipated in the post surgical period. Documentation of failed voiding trials may not be indicative of postoperative urinary retention.

Signs and symptoms
- Inability to void
- Decreased urine output with adequate intake
- Abdominal pressure and/or pain
- Dull sound over bladder
- Bladder/abdominal distention
- Residual urine (specific amount as determined by facility policy or attending physician directive)
- With all of these symptoms the age and size of the patient need to be taken into consideration

Treatment/Increased Length of Stay
- Reinsertion of foley catheter due to inability to void
- Urology/Internal Medicine consult due to inability to void
- Extended length of stay
- Straight cath. (# of times and significance as determined by facility policy or attending physician directive)

Physician Documentation
- Signs and symptoms
- Treatment
- Response to treatment
- Unable to discharge patient due to urine retention
- May order I&O
- Clinical findings on examination

These guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation.
DVAC Coding Guideline:
Postoperative Atelectasis

It is not unusual for a patient to experience some atelectasis following upper abdominal or thoracic surgery. All patients require care and observation following surgery. When the patient has experienced significant symptoms that require more than routine care or extends the length of stay, the coding of postoperative atelectasis may be appropriate. The physician’s documentation should link the diagnosis to the procedure before a complication code is assigned. The physician’s documentation should demonstrate that atelectasis is present and more than anticipated in the post surgical period. Postoperative atelectasis may be an incidental x-ray or physical finding, in which case it would not be coded or reported.

Signs and symptoms
- Dyspnea
- Diaphoresis
- Cough
- Tachycardia
- Fever within 48 hours of surgery
- Retractions
- Oxygen Saturations less than 89%
- Hypotension
- Clinical findings
  - Rales
  - Rhonchi
  - Wheezees
  - Decreased breath sounds
  - Dullness/flatness on percussion/auscultation
- Cyanosis
- Anxiety

Major Risk Factors
- Narcotics
- Tobacco abuse
- Obesity
- Pulmonary disease

Treatment/Increased Length of Stay
- Chest x-ray
- Respiratory Therapy
  - CPT
  - Incentive Spirometry (ordered by physician)
  - Suctioning
  - Postural drainage
  - Nebulizer treatments
  - CPAP
- Bronchoscopy
- Oxygen
- Antibiotics

Physician Documentation
- Signs and symptoms
- Treatment
- Response to treatment
- Unable to discharge patient due to atelectasis
- Clinical findings on examination

These guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation.
DVAC Coding Guideline: 
Postoperative Anemia

It is not unusual for anemia to be present following surgery, however it may or may not be considered a complication of surgery. A certain amount of blood loss is expected during surgery and can vary depending on the procedure. The physician’s documentation should support the anemia as a complication of surgery before assigning any complication codes (such as 998.11). All patients require care and observation following surgery. When the significance of the symptoms requires more than routine care or extends the length of stay, the coding of acute blood loss anemia (285.1) may be appropriate. The physician’s documentation should indicate the presence of blood loss anemia and that treatment and/or additional monitoring was required. Blood products (including autologous) given during surgery do not always indicate the presence of anemia, but can be given as a preventive measure to avoid anemia.

Signs and Symptoms
(It is important to consider the age and size of the patient when reviewing signs and symptoms)

- Low hemoglobin/hematocrit *
- Faintness
- Dizziness
- Thirst
- Sweating
- Weak/rapid pulse
- Rapid respiratory rate
- Orthostatic hypotension
- Pale
- Decreased blood pressure
- Fatigue
- Shortness of breath
*comorbid conditions may affect the patient’s ability to tolerate a low hemoglobin

Treatment/Workup/Increased Length of Stay

- Transfusion
- Increased monitoring of hemoglobin/hematocrit
- Iron
- Volume expanders

Physician Documentation

- Signs and symptoms
- Treatment
- Response to treatment
- Unable to discharge patient due to blood loss anemia
- Clinical findings on examination
- Documentation of abnormal laboratory findings

These guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation.
DVAC Coding Guideline: Postoperative Fever

It is estimated that between 25-50% of all patients will experience some temperature elevation following surgery. This is a normal physiologic response to surgery. The clinical examination and the physician’s documentation should substantiate whether the fever is a normal physiologic response to surgery versus a true postoperative fever. All patients require care and observation following surgery. The physician’s documentation should demonstrate that the fever was more than anticipated in the post surgical period, required more than routine care, or extended the length of stay. A code for postoperative fever should not be assigned when another diagnosis has been identified to account for the fever.

Signs and Symptoms

- Fever noted 24-48 hours following surgery
- Temperature 2-3 degrees above baseline
- Abnormal laboratory findings may include:
  - WBC
  - CRP
  - Differential with bandemia or left shift
- Unexplained confusion
- Increased heart rate

Treatment/Workup/Increased Length of Stay

- Cultures
- CBC with differential
- Analgesics
- Antibiotics (ordered due to fever rather than prophylactic use)
- Radiology
  - X-ray, CT scans, etc.
- Respiratory Therapy (ordered following identification of symptom)
  - CPT
  - Incentive Spirometry
  - Suctioning
  - Postural drainage
  - Nebulizer treatments
  - CPAP

Physician Documentation

- Signs and symptoms
- Treatment
- Response to treatment
- Unable to discharge patient due to fever
- Clinical findings on examination
- Documentation of abnormal laboratory findings

These guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation.
DVAC Coding Guidelines

Dehydration

Dehydration refers to water depletion/deprivation; the body does not have enough fluids to function at an optimal level. Dehydration can be caused by fluid loss (through vomiting, diarrhea, sweating, or polyuria). With more severe degrees of volume depletion, the patient is often lethargic, weak and obtunded, and shock or coma may occur. The treatment goal is total replacement of the fluid deficit. Depending on the severity of the dehydration and the severity of any underlying cause, dehydration may be treated by intravenous administration of fluids in combination with oral replenishment.

Signs and Symptoms*

- Elevated BUN
- Elevated creatinine
- Elevated BUN/creatinine ratio
- Low or orthostatic changes in blood pressure
- Light-headed/dizzy
- Elevated heart rate or change when going from supine to upright
- Abnormal electrolytes (increased or decreased levels of sodium, potassium, and bicarbonate)
- Poor skin turgor
- Dry mucous membranes
- Flattened neck veins
- Lack of thirst
- Mental status changes
- Elevated hemoglobin/hematocrit
- Decreased urine output
- Increased urine specific gravity
- Skin mottling
- Sunken fontanelle (infants)
- Sunken eyes
- Decreased/absence of tears
- Weight Loss

*Consider age and size of patient as well as the presence of comorbid conditions such as CHF

Treatment/Workup/Increased Length of Stay

- IV rehydration
  - Greater than maintenance
  - Consider age and size of patient
  - Potassium supplements
- I&O
- Daily weight monitoring
- Electrolyte monitoring

Physician Documentation

- Signs and symptoms
- Treatment
- Response to treatment
- May order I&O
- May order daily weights
- Clinical findings on examination

These guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation.
Debridement

General definition: The removal of nonviable tissue.

Indications for debridement:
1. Nonhealing wounds
   a. diabetic ulcers
   b. decubitus ulcers
   c. burns
   d. infections
2. Complicated wounds
   a. with foreign body
   b. with delayed healing or treatment
   c. with infection
3. Open fractures

Step 1: Determine if the debridement is excisional or nonexcisional.

Excisional
1. Excisional debridement is the surgical removal or cutting away of devitalized tissue, necrosis, or slough. Depending on circumstances such as the patient’s condition, availability of a surgical suite, or extent of area to be debrided, excisional debridement can be performed in the operating room, emergency room, or at the patient’s bedside.
2. Methods of excisional debridement:
   a. sharp, surgical cutting
   b. definite cutting away of tissue
   c. laser debridement
3. Excisional debridements may be performed by a nurse, therapist, PA, or physician.
4. Not all debridements performed by a physician would qualify as excisional.

Step 2: If excisional, determine the area and depth of debridement.
1. Assign only a code for the deepest layer of debridement when multiple layers of the same site are debrided.
2. Layers:
   a. skin
   b. dermis
   c. subcutaneous tissue (including fat)
   d. soft tissue/fascia
      (fibrous membrane that covers, supports, and separates muscles)
   e. muscle
   f. bone (including periosteum)

Step 3: Determine if the debridement of skin is preparatory to further surgery.
If it is, do not assign a separate code for the debridement. Debridement performed in preparation for a skin graft is included in the skin graft code.

Step 4: Determine code selection.
1. It is important to follow all of the ICD-9-CM instructional notes. Excludes note under category 66.3 indicates the coder to other sites for skin of anus, breast, ear, etc.
2. Other codes are provided for debridement of organs or tissue other than skin. Debridement of amputation stump codes to revision of amputation stump (68.3).
3. For debridement of areas other than skin, the code assigned is usually that for excision or destruction of lesion of that site.

Nonexcisional
1. Nonexcisional debridement is the nonoperative brushing, irrigation, scrubbing, or washing of devitalized tissue, necrosis, or slough.
2. Nonexcisional debridement includes snipping of tissue followed by Hubbard tank therapy.
3. Methods of nonexcisional debridement
   a. wet-to-dry dressing (saline)
   b. brushing
   c. irrigation
   d. scrubbing
   e. washing
   f. snipping or minor scissors removal of loose fragments
   g. enzymes/debriding agents
   h. any method other than excisional

Step 2: If nonexcisional assign code 86.28.
Debridement

General definition: The removal of nonviable tissue.

Indications for debridement:
1. Nonhealing wounds
2. Complicated wounds
3. Open fractures
   a. with foreign body
   b. with delayed healing
   c. with infection
   d. with treatment

Step 1: Determine if the debridement is excisional or nonexcisional.

Excisional
1. Excisional debridement is the surgical removal or cutting away of devitalized tissue, necrosis, or slough.
   Depending on circumstances such as the patient’s condition, availability of a surgical suite, or extent of area to be debrided, excisional debridement can be performed in the operating room, emergency room, or at the patient’s bedside.
2. Methods of excisional debridement:
   a. sharp, surgical cutting
   b. debriding cutting away of tissue beyond the wound margin into healthy vital tissue
   c. laser debridement
3. Use of a sharp instrument does not always indicate excisional debridement. Scraping away tissue is not considered excisional debridement.
4. Excisional debridement may be performed by a nurse, FNP/PA, physician or physical therapist. Debridement performed by a physical therapist is generally nonexcisional in nature.
5. Not all debridements performed by a physician would qualify as excisional.

Step 2: If excisional, determine the area and depth of debridement.
1. Assign only a code for the deepest layer of debridement when multiple layers of the same site are debrided.
2. Layers:
   a. skin
   b. subcutaneous tissue (including fat)
   c. soft tissue/fascia
   d. muscle
   e. tendon
   f. bone (including periosteum)

Step 3: Determine if the debridement of skin is preparatory to further surgery.
If debridement is preparatory to further surgery, do not assign a separate code. Debridement performed in preparation for a skin graft is included in the skin graft code.

Step 4: Determine code selection.
1. It is important to follow all of the ICD-9-CM instructional notes. Excluded note under category 64.3 directs the coder to other cites for skin of arm, breast, ear, etc.
2. Other codes are provided for debridement of organs or tissue other than skin. Debridement of amputation stump codes to revision of amputation stump (64.3).
3. For debridement of area other than skin, the code assigned is usually that for excision or destruction of lesion of that site.

Reference:
1. Nonexcisional debridement is the nonoperative dressing, irrigation, scraping, or washing of devitalized necrotic, or sloughing tissue.
2. Methods of nonexcisional debridement:
   a. wet-to-dry dressing (saline)
   b. brushing
   c. irrigation
   d. scrubbing
   e. washing
   f. scraping or minor scissors removal of loose fragments
   g. enzymes/debridement agents
   h. any method other than excision.

Step 2: If nonexcisional debridement assign ICD-9-CM procedure code 86.28.

“DIVAC submitted a question to AHA requesting clarification on “What is considered minor scissors?” They directed us to Coding Clinic 3rd Q 1991 and 4th Q 1998 for guidance.”

March 2005 BCBSHD
Diabetes Coding Guidelines

DRG Validation Advisory Committee:
Diabetes Coding Guidelines

These guidelines are for ICD-9-CM assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation.

Diabetes is a life-long disease marked by elevated levels of sugar in the blood. IDDM/NIDDM/borderline are no longer considered acceptable terms when referring to diabetes.

- **Type 1 diabetes mellitus** has an abrupt onset of symptoms, is not associated with obesity, and is usually diagnosed in children but adults may develop it. The body makes little or no insulin, and daily injections of insulin are required to sustain life.

- **Type 2 diabetes mellitus** makes up about 80-90% of all cases of diabetes. It usually occurs in adulthood but can occur in children. There is a gradual onset of symptoms, and it is associated with obesity. Here, the pancreas does not make enough insulin to keep blood glucose levels normal, often because the body does not respond well to the insulin.

- **Gestational diabetes** is high blood glucose that develops at any time during pregnancy in a person who does not have diabetes. The condition resolves after delivery of the baby. The code assignment for gestational diabetes is a pregnancy complication code 648.8x.

- **Secondary diabetes** is a condition that can develop after a bout with an unrelated disease or condition or as a result of certain treatments. It can arise from a pancreatic disease, hormonal or genetic syndromes, from the ingestion of drugs such as corticosteroids and thiazide diuretics. It usually disappears when the underlying condition is corrected. The code assignment for secondary diabetes is 251.8. It is inappropriate to assign any code from the 250.xx series for secondary diabetes mellitus.

- **Pre-diabetes** is listed in the codebook under other abnormal glucose. The code assignment for pre-diabetes is 790.29.

- **Impaired fasting glucose** is assigned code 790.21

- **Abnormal GTT** (glucose tolerance test) is assigned code 790.22

- **Metabolic syndrome** is assigned code 277.7

**Fifth Digit Assignments (0, 1)**

The use of the fifth digit 0 and 1 with a diagnosis of diabetes mellitus is determined by the physician’s description of the patient’s diabetes. The use of insulin alone is not a factor in determining the type of diabetes. Treatment often includes doses of insulin for a Type 2, non-insulin dependent patient, who is having difficulty controlling blood sugar values. Insulin may be given to the Type 2 diabetic when an infection or other illness interferes with control of the diabetes, usually done on a temporary basis. Likewise, for the Type 1 diabetic patient, the fact that the patient is not currently being treated with insulin does not change the type of diabetes. Documentation of the type of diabetes, Type 1 or Type 2, takes precedence over documentation of insulin versus non-insulin dependent.

**Control of Diabetes Mellitus**

- Uncontrolled indicates that the patient’s blood sugar level is not kept within acceptable levels by the current treatment regimen.

- Poorly controlled diabetes is not synonymous with uncontrolled diabetes. The attending physician should be queried to determine whether “poorly controlled” and/or “poor control” is indicative of uncontrolled blood glucose level.

The following table represents current (2004) published measurements of recommended levels of control. These values are reviewed and revised on a yearly basis.

**Good control**
- A1C < 7.0 (American Diabetes Association)
- A1C < 6.5 (American College of Endocrinology)

Blood glucose ideal: Before meals: 90-130
After meals: <180

**Poor control**
- A1C > 7.0 but < 9.0

**Uncontrolled**
- A1C ≥ 9.0
- Sustained glucose values (2 or more finger sticks) >200
- Ketones present in urine

**Signs and Symptoms of Diabetes**

- Increased urination (polyuria)
- Increased thirst (polydypsia)
• Weight loss despite increased appetite (polyphagia)
• Nausea
• Vomiting
• Abdominal pain
• Fatigue
• Absence of menstruation
• Dry itchy skin
• Frequent skin infections
• Vision changes
• Weakness
• Tingling - numbness in hands and feet
• Drowsiness - irritability (mental status change)

**Treatment, Workup, Increased Length of Stay**

• Glucose and ketone bodies in urine or serum
• Elevated fasting/random glucose
• Oral hypoglycemics
• Life style modifications:
  • Diabetic appropriate diet
  • Increased exercise
• Insulin
• Serum ketones
• Pancreatic transplant

**Physician Documentation**

• Type 1 or 2
• Signs and symptoms
• Uncontrolled is not based on blood glucose levels, but on physician documentation and determination
• Uncontrolled and out of control are synonymous terms
• The physician documentation should link a direct relation of diabetes to the complication or manifestation by statements such as "due to", “caused by” “secondary to” “with” “manifested by” or "complicated by"
• Query for clarification

**Comparison of Type 1 and Type 2 Diabetes**

<table>
<thead>
<tr>
<th></th>
<th><strong>Type 1</strong></th>
<th><strong>Type 2</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age at onset</strong></td>
<td>Usually under 30</td>
<td>Usually over 40</td>
</tr>
<tr>
<td><strong>Type of onset</strong></td>
<td>Abrupt</td>
<td>Gradual</td>
</tr>
<tr>
<td><strong>Body weight</strong></td>
<td>Normal</td>
<td>Obese - 80-90%</td>
</tr>
<tr>
<td><strong>Insulin in blood</strong></td>
<td>Little to none</td>
<td>Present</td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td>Polyuria, polydipsia, polyphagia, weight loss, ketoacidosis</td>
<td>Polyuria, polydipsia, pruritus, peripheral neuropathy</td>
</tr>
<tr>
<td><strong>Control</strong></td>
<td>Requires insulin, diet, and exercise</td>
<td>Hypoglycemic agents, sometimes insulin, diet (sometimes only diet), and exercise</td>
</tr>
<tr>
<td><strong>Vascular &amp; neural changes</strong></td>
<td>Eventually develop</td>
<td>Will usually develop</td>
</tr>
<tr>
<td><strong>Stability of condition</strong></td>
<td>Fluctuates, difficult to control</td>
<td>May be difficult to control with poorly motivated patients</td>
</tr>
<tr>
<td><strong>Honeymoon period</strong></td>
<td>Short symptom free periods when insulin is not required</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Complications of Diabetes Mellitus

Patients with diabetes mellitus are susceptible to one or more late complicating conditions, which particularly affect the renal, nervous, peripheral vascular systems, and the eyes. Diabetes mellitus with complicating conditions in the 250.4x - 250.8x series are coded first to the appropriate diabetic code with an additional code to identify the specific complicating condition. Conditions qualified as diabetic or due to diabetes are coded in this manner even though the index may not indicate dual coding. Conditions listed with a diagnosis of diabetes mellitus or in a diabetic patient are not necessarily complications of the diabetes. The condition should be coded as such only when the physician identifies it as a diabetic complication, describing some type of cause and effect relationship. Patients may have more than one late complication. Multiple codes from the 250 series should be assigned to capture all conditions. Sequencing of the complication codes is dependent on the circumstances of the admission.

Hypoglycemia is defined as low blood glucose. This may also be documented as insulin shock or insulin reaction. It occurs when too little food is eaten, a meal is delayed or extra exercise is done without adjustments in food intake or diabetic medication. Hypoglycemia in diabetes is coded to 250.8x.

**Signs and Symptoms**
- Cold, clammy skin
- Very hungry
- Irritability, nervousness, giddiness, hand tremors
- Trouble speaking and focusing, concentrating
- Normal breath odor
- Pale
- Profuse sweating
- Headache
- Mental status change

**Treatment**
- Administer glucose

Hyperglycemia is defined as sustained high blood glucose. It occurs when too much food is eaten and not enough diabetic medication is taken. Dietary noncompliance, infection, illness, some medications, and emotional distress can cause high blood glucose. Hyperglycemia in diabetes is coded to 250.00. To assign a code other than 250.00, documentation must support the change in code assignment. For example, to code to 250.02, documentation must support uncontrolled diabetes mellitus.

**Diabetic Ketoacidosis** (with or without diabetic coma) develops when insulin and blood glucose are so out of balance that ketones accumulate in the blood. High levels of ketones are poisonous. It usually occurs in people with Type 1 diabetes. It can result from undiagnosed diabetes, neglected treatment, infection, cardiovascular disorders, some medications, and physical and emotional stress. Onset varies from several hours to days.

**Signs and Symptoms**
- Increased thirst
- Increased urination
- Weakness
- Abdominal pain
- Nausea and vomiting
- Generalized aches
- Rapid, deep breathing (Kussmaul’s respirations)

**Treatment**
- Insulin
- IV Fluids

Cardiovascular & Peripheral Vascular Disease: Diabetes causes vascular changes in which hardening of the arteries and the possibility of stroke can occur. Stroke may result as a complication of hypertension. In peripheral vascular disease, the blood does not reach the areas farthest from the heart.

As the body chemistry changes in diabetes, blood may clot too easily, blood vessels may narrow and fat may build up in the blood vessels faster.
**Signs and Symptoms**

- Poor circulation
- Infections
- Itchy skin
- Shiny skin and loss of hair on extremities
- Calves hurt with exercise
- Erectile dysfunction
- Nonhealing wounds

**Treatment**

- Maintain controlled blood sugar levels
- Low fat diet with little salt
- Hypertensive medications
- Treat complications such as infections and nonhealing wounds
- Surgery

**Nephropathy:** The job of the kidneys is to filter wastes from the blood. Diabetes causes the kidneys to lose their ability to filter properly. As a result, protein that the body needs is lost in the urine and wastes that the body doesn’t need build up in the blood. In patients who have Type 1 diabetes for 15 to 20 years, nearly 40% will develop end-stage renal disease. About 5% of patients with Type 2 diabetes eventually develop end-stage renal disease.

**Signs and Symptoms**

- Increased protein in the urine (proteinuria)
- Edema
- Renal insufficiency
- Increased creatinine and blood urea nitrogen (BUN) levels
- Nausea and vomiting
- Lethargy
- Anemia
- Hypertension
- Metabolic acidosis

**Treatment**

- Maintain controlled blood sugar levels
- Protein restricted diet
- Control blood pressure
- Dialysis
- Kidney transplant

**Neuropathy:** Changes in the nerve cells can affect either the peripheral or autonomic nervous system. Myelin nerve fibers become demyelinated or destroyed (which prevents the proper conduction of nerve impulses), connective tissue proliferates, and the capillary basement membrane thickens.

**Signs and Symptoms**

- Prickling, tingling, burning, sudden pain in area
- Numbness - loss of feeling
- Muscle weakness
- Fainting/lightheadedness
- Vomiting
- Urinary tract infections
- Diarrhea
- Sexual problems
- Cramping of digits
- Sensory loss
- Unbalanced gait
- Foot ulcers
- Loss of fine motor skills with progression of disease

**Treatment**

- Maintain controlled blood sugar levels
- Diabetic foot care
- Corticosteroid injections
- Non-steroidal anti-inflammatory drugs
- Antidepressants
- Pain management
- Surgery (i.e. carpal tunnel release)

**Retinopathy:** Diabetic retinopathy is the leading cause of blindness in the United States. It is characterized by progressive deterioration of blood vessels in the retina. The retina is the lining at the back of the eye that senses light. In the milder form of retinopathy, blood vessels leak blood and fluid into the eye. In the more severe form, new blood vessels sprout and grow out of control. They can bleed or cause scarring, which pulls on the retina and can cause detachment. Glaucoma and cataracts are more common in people with diabetes.

**Signs and Symptoms**

- Blurry vision
- Double vision
- Spots or floaters
- Eye pain and pressure
- Decreased peripheral vision

**Treatment**

- Photocoagulation - laser seals off the leaky vessels
- Vitrectomy - surgery that removes blood and scar tissue from the eye
Diabetes is a lifelong disease marked by elevated levels of sugar in the blood. IDDM/NIDDM/borderline are no longer considered acceptable terms when referring to diabetes.

- **Type 1 diabetes mellitus** has an abrupt onset of symptoms, is not associated with obesity and is usually diagnosed in children, but adults may develop it. The body makes little or no insulin, and daily injections of insulin are required to sustain life.
- **Type 2 diabetes mellitus** comprises about 80 percent to 90 percent of all cases of diabetes. It usually occurs in adulthood but can occur in children. There is a gradual onset of symptoms, and it is associated with obesity. Here, the pancreas does not make enough insulin to keep blood glucose levels normal, often because the body does not respond well to the insulin.
- **Gestational diabetes** is high blood glucose that develops at any time during pregnancy in a person who does not have diabetes. The condition resolves after delivery of the baby. The code assignment for gestational diabetes is pregnancy complication code 648.8x.
- **Secondary diabetes** is a condition that can develop after a bout with an unrelated disease or condition or as a result of certain treatments. It can arise from a pancreatic disease, hormonal or genetic syndromes or from the ingestion of drugs such as corticosteroids and thiazide diuretics. It usually disappears when the underlying condition is corrected. The code assignment for secondary diabetes is 251.8. It is inappropriate to assign any code from the 250.xx series for secondary diabetes mellitus.
- **Pre-diabetes** is listed in the codebook under other abnormal glucose. The code assignment for pre-diabetes is 790.29.
- **Impaired fasting glucose** is assigned code 790.21.
- **Abnormal GTT** (glucose tolerance test) is assigned code 790.22.
- **Metabolic syndrome** is assigned code 277.7.

### Fifth Digit Assignments (0,1)

The use of the fifth digit 0 and 1 with a diagnosis of diabetes mellitus is determined by the physician’s description of the patient’s diabetes. The use of insulin alone is not a factor in determining the type of diabetes. Treatment often includes doses of insulin for a Type 2, non-insulin dependent patient who is having difficulty controlling blood sugar values. Insulin may be given to the Type 2 diabetic when an infection or other illness interferes with control of the diabetes, usually done on a temporary basis. Likewise, for the Type 1 diabetic patient, the fact that the patient is not currently being treated with insulin does not change the type of diabetes. Documentation of the type of diabetes, Type 1 or Type 2, takes precedence over documentation of insulin versus non-insulin dependent.

---

Vaccine Administration  
**Update to HealthCare News #286 (indicated in bold) Effective for services on or after January 1, 2008**

Administration of all immunizations and vaccinations (including influenza, pneumococcal and hepatitis B) must be billed using the appropriate CPT® code (90465-90474). HCPCS codes G0008, G0009 or G0010 will no longer be accepted for administration of influenza, pneumococcal or hepatitis B vaccines. Claims billed with these HCPCS codes will be returned to the provider for correction. Exception: Medicare crossover claims will still accept G0008-G0010.

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90465</td>
<td>Immunization administration &lt; 8 years; first injection, per day</td>
</tr>
<tr>
<td>90466</td>
<td>each additional injection, per day</td>
</tr>
<tr>
<td>90467</td>
<td>Immunization administration &lt; 8 years; intranasal or oral; first administration, per day</td>
</tr>
<tr>
<td>90468</td>
<td>each additional administration, per day</td>
</tr>
<tr>
<td>90471</td>
<td>Immunization administration; one vaccine</td>
</tr>
<tr>
<td>90472</td>
<td>each additional vaccine</td>
</tr>
<tr>
<td>90473</td>
<td>Immunization administration; intranasal or oral; one vaccine</td>
</tr>
<tr>
<td>90474</td>
<td>each additional vaccine</td>
</tr>
</tbody>
</table>

---

**Diabetes Coding Guidelines**  
These guidelines are for coding assistance only and should not be used to determine appropriate level of care. They are to be used as a tool for determining if documentation supports coding a condition, and they are not meant to replace the official coding guidelines contained in Coding Clinic. Please use physician queries to clarify ambiguous documentation.
Control of Diabetes Mellitus

Uncontrolled indicates that the patient’s blood sugar level is not kept within acceptable levels by the current treatment regimen.

Poorly controlled diabetes is not synonymous with uncontrolled diabetes. The attending physician should be queried to determine whether “poorly controlled” and/or “poor control” is indicative of uncontrolled blood glucose level.

The following table represents current (2004) published measurements of recommended levels of control. These values are reviewed and revised on a yearly basis.

### Good control

- A1C < 7.0 (American Diabetes Association)
- A1C < 6.5 (American College of Endocrinology)

Blood glucose ideal: Before meals: 90-130
After meals: <180

### Poor control

- A1C > 7.0 but < 9.0

### Uncontrolled

- A1C ≥ 9.0
- Sustained glucose values (2 or more finger sticks) >200
- Ketones present in urine

#### Signs and Symptoms of Diabetes

- Increased urination (polyuria)
- Increased thirst (polydipsia)
- Weight loss despite increased appetite (polyphagia)
- Nausea
- Vomiting
- Abdominal pain
- Fatigue
- Absence of menstruation
- Dry itchy skin
- Frequent skin infections
- Vision changes
- Weakness
- Tingling - numbness in hands and feet
- Drowsiness - irritability (mental status change)

#### Treatment, Workup, Increased Length of Stay

- Glucose and ketone bodies in urine or serum
- Elevated fasting/random glucose
- Oral hypoglycemics
- Lifestyle modifications
  - Diabetic appropriate diet
  - Increased exercise
- Insulin
- Serum ketones
- Pancreatic transplant

### Physician Documentation

- Type 1 or 2
- Signs and symptoms
- Uncontrolled is not based on blood glucose levels, but on physician documentation and determination
- Uncontrolled and out of control are synonymous terms
- The physician documentation should link a direct relation of diabetes to the complication or manifestation by statements such as “due to,” “caused by,” “secondary to,” “with,” “manifested by” or “complicated by”
- Query for clarification

### Comparison of Type 1 and Type 2 Diabetes

<table>
<thead>
<tr>
<th></th>
<th>Type 1</th>
<th>Type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at onset</td>
<td>Usually under 30</td>
<td>Usually over 40</td>
</tr>
<tr>
<td>Type of onset</td>
<td>Abrupt</td>
<td>Gradual</td>
</tr>
<tr>
<td>Body weight</td>
<td>Normal</td>
<td>Obese - 80-90%</td>
</tr>
<tr>
<td>Insulin in blood</td>
<td>Little to none</td>
<td>Present</td>
</tr>
<tr>
<td>Symptoms</td>
<td>Polyuria, polydipsia, polyphagia, weight loss, ketoacidosis</td>
<td>Polyuria, polydipsia, pruritus, peripheral neuropathy</td>
</tr>
<tr>
<td>Control</td>
<td>Requires insulin, diet, and exercise</td>
<td>Hypoglycemic agents, sometimes insulin, diet (sometimes only diet), and exercise</td>
</tr>
<tr>
<td>Vascular &amp; neural changes</td>
<td>Eventually develop</td>
<td>Will usually develop</td>
</tr>
<tr>
<td>Stability of condition</td>
<td>Fluctuates, difficult to control</td>
<td>May be difficult to control with poorly motivated patients</td>
</tr>
<tr>
<td>Honeymoon period</td>
<td>Short symptom free periods when insulin is not required</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Complications of Diabetes Mellitus

Patients with diabetes mellitus are susceptible to one or more late complicating conditions, which particularly affect the renal, nervous, peripheral vascular systems and the eyes. Diabetes mellitus with complicating conditions in the 250.4x - 250.8x series are coded first to
the appropriate diabetic code with an additional code to identify the specific complicating condition. Conditions qualified as diabetic or due to diabetes are coded in this manner even though the index may not indicate dual coding. Conditions listed with a diagnosis of diabetes mellitus or in a diabetic patient are not necessarily complications of the diabetes. The condition should be coded as such only when the physician identifies it as a diabetic complication, describing some type of cause and effect relationship. Patients may have more than one late complication. Multiple codes from the 250 series should be assigned to capture all conditions. Sequencing of the complication codes is dependent on the circumstances of the admission.

**Hypoglycemia** is defined as low blood glucose. This may also be documented as insulin shock or insulin reaction. It occurs when the patient eats too little food, delays a meal or performs additional exercise without making adjustments in food intake or diabetic medication. Hypoglycemia in diabetes is coded to 250.8x.

**Signs and Symptoms**
- Cold, clammy skin
- Very hungry
- Irritability, nervousness, giddiness, hand tremors
- Trouble speaking and focusing, concentrating
- Normal breath odor
- Pale
- Profuse sweating
- Headache
- Mental status change

**Treatment**
- Administer glucose

**Hyperglycemia** is defined as sustained high blood glucose. It occurs when the patient eats too much and does not take enough diabetic medication. Dietary noncompliance, infection, illness, some medications and emotional distress can cause high blood glucose. Hyperglycemia in diabetes is coded to 250.00. To assign a code other than 250.00, documentation must support the change in code assignment. For example, to code to 250.02, documentation must support uncontrolled diabetes mellitus.

**Signs and Symptoms**
- Increased thirst
- Increased urination
- Weakness
- Abdominal pain
- Nausea and vomiting
- Generalized aches
- Rapid, deep breathing (Kussmaul’s respirations)

**Treatment**
- Insulin
- IV Fluids

**Diabetic Ketoacidosis** (with or without diabetic coma) develops when insulin and blood glucose are so out of balance that ketones accumulate in the blood. High levels of ketones are poisonous. It usually occurs in people with Type 1 diabetes. It can result from undiagnosed diabetes, neglected treatment, infection, cardiovascular disorders, some medications, and physical and emotional stress. Onset varies from several hours to days.

**Signs and Symptoms**
- Dry mouth - crusty mucous membranes
- Excessive thirst
- Loss of appetite
- Excessive urination
- Dry and flushed skin
- Abdominal pain
- Fruity-smelling breath
- Rapid deep breathing (Kussmaul’s respirations)
- Nausea or vomiting
- Extreme weakness
- Confusion, lethargy
- Weak, rapid pulse

**Treatment**
- IV fluids
- IV glucose
- Insulin

**Cardiovascular & Peripheral Vascular Disease:** Diabetes causes vascular changes in which hardening of the arteries and the possibility of stroke can occur. Stroke may result as a complication of hypertension. In peripheral vascular disease, the blood does not reach the areas farthest from the heart. As the body chemistry changes in diabetes, blood may clot too easily, blood vessels may narrow and fat may build up in the blood vessels faster.

**Signs and Symptoms**
- Poor circulation
- Infections
- Itchy skin
- Shiny skin and loss of hair on extremities
- Calves hurts with exercise
- Erectile dysfunction
- Nonhealing wounds

**Treatment**
- Maintain controlled blood sugar levels
- Low fat diet with little salt
- Hypertensive medications
- Treat complications such as infections and nonhealing wounds
- Surgery
**Nephropathy:** The job of the kidneys is to filter wastes from the blood. Diabetes causes the kidneys to lose their ability to filter properly. As a result, protein that the body needs is lost in the urine and wastes that the body doesn’t need build up in the blood. In patients who have Type 1 diabetes for 15 to 20 years, nearly 40% will develop end-stage renal disease. About 5% of patients with Type 2 diabetes eventually develop end-stage renal disease.

**Signs and Symptoms**
- Increased protein in the urine (proteinuria)
- Edema
- Renal insufficiency
- Increased creatinine and blood urea nitrogen (BUN) levels
- Nausea and vomiting
- Lethargy
- Anemia
- Hypertension
- Metabolic acidosis

**Treatment**
- Maintain controlled blood sugar levels
- Protein restricted diet
- Control blood pressure
- Dialysis
- Kidney transplant

**Neuropathy:** Changes in the nerve cells can affect either the peripheral or autonomic nervous system. Myelin nerve fibers become demyelinated or destroyed (which prevents the proper conduction of nerve impulses), connective tissue proliferates and the capillary basement membrane thickens.

**Signs and Symptoms**
- Prickling, tingling, burning, sudden pain in area
- Numbness - loss of feeling
- Muscle weakness
- Fainting/lightheadedness
- Vomiting
- Urinary tract infections
- Diarrhea
- Sexual problems
- Cramping of digits
- Sensory loss
- Unbalanced gait
- Foot ulcers
- Loss of fine motor skills with progression of disease

**Treatment**
- Maintain controlled blood sugar levels
- Diabetic foot care
- Corticosteroid injections

**Retinopathy:** Diabetic retinopathy is the leading cause of blindness in the United States. It is characterized by progressive deterioration of blood vessels in the retina. The retina is the lining at the back of the eye that senses light. In the milder form of retinopathy, blood vessels leak blood and fluid into the eye. In the more severe form, new blood vessels sprout and grow out of control. They can bleed or cause scarring, which pulls on the retina and can cause detachment. Glaucoma and cataracts are more common in people with diabetes.

**Signs and Symptoms**
- Blurry vision
- Double vision
- Spots or floaters
- Eye pain and pressure
- Decreased peripheral vision

**Treatment**
- Photocoagulation - laser seals off the leaky vessels
- Vitrectomy - surgery that removes blood and scar tissue from the eye

**Septicemia/Sepsis/SIRS Coding Guidelines**

*These guidelines are for coding assistance only and should not be used to determine appropriate level of care. They are to be used as a tool for determining if documentation supports coding a condition, and they are not meant to replace the official coding guidelines contained in Coding Clinic. Please use physician queries to clarify ambiguous documentation.*

A diagnosis of septicemia can neither be assumed nor ruled out on the basis of laboratory values alone. Negative or inconclusive blood cultures do not preclude a diagnosis of septicemia in patients with clinical evidence of the condition. A code for septicemia is assigned only when the physician makes a diagnosis of septicemia.

Sepsis could be due to an internal device (shunt, catheter). Review documentation to determine the source of infection. The clinical symptoms should be present on admission or at least within 72 hours of admission. The unusual or imprecise diagnostic reference to a site-specific or organ-specific sepsis, such as urosepsis, cellulitis, or pneumonia may require further clarification for coding purposes.
The term "septic" refers to a site-specific infection and does not have the same meaning as sepsis (i.e. septic bursitis, septic arthritis).

Sepsis is defined as Systemic Inflammatory Response Syndrome (SIRS) due to infection. SIRS is a systemic response to infection or trauma, with symptoms including fever, tachycardia, tachypnea and leukocytosis.

Urosepsis is not sepsis. Urosepsis refers to pyuria or bacteria in the urine (not the blood). The physician should be asked if the diagnosis of urosepsis is intended to mean 1) generalized sepsis (septicemia) caused by leakage of urine or toxic urine by-products into the general vascular circulation or 2) urine contaminated by bacteria, bacterial by-products or other toxic material but without other findings.

Bacteremia indicates bacteria in the blood stream and may be transient or inconsequential. There is no pathological response in bacteremia.

Severe Sepsis is sepsis associated with organ dysfunction, hypoperfusion or hypotension. Hypoperfusion and perfusion abnormalities may include, but are not limited to, lactic acidosis, oliguria or an acute alteration in mental status.

**Signs and Symptoms**
- Toxic looking (looks acutely ill)
- Temperature >100.4 F (38 C) or <96.8 F (36 C)(sudden onset, often spiking)
- Hypotension
- Heart rate >90
- Respiratory rate >20
- WBC > 12,000 uL
- Neutrophils >10% immature
- Increased Anion Gap
- Chills
- Changes in mental status: may include comatose, unresponsiveness, irritability, lethargy, anxiety or agitation
- Thrombocytopenia
- PCO2 <30
- Shock
- Arterial PH <7.35
- Hyperglycemia in the absence of diabetes
- Decreased urine output <30 cc per hour
- Decreased skin perfusion, decreased capillary refill or mottling: may include skin that is pale, clammy or warm to touch

**Treatment/Workup/Increased Length of Stay**
- Decreased skin perfusion, decreased capillary refill or mottling: may include skin that is pale, clammy or warm to touch
- Antibiotics (oral or IV) (typically broad spectrum antibiotics)
  - i.e. combination of Vancomycin and Meropenem (Merrem), Vancomycin plus Imipenem-cilastatin (Primaxin), Vancomycin plus Piperaclillin-Tazobactam (Zosyn), or Xigris
- Remove source of infection (i.e. cholecystectomy, internal device removal)
- Oxygen
- Supportive treatment of symptoms
- Increased C Reactive Protein (CRP)
- Blood cultures
- Workup to identify source of infection
- Increased LDH
## Physician Documentation

- **Definitions**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infection</strong></td>
<td>Presence of microorganisms in a normally sterile site</td>
<td>May be confused with “colonization”, which is the presence of microorganisms on an epithelial surface</td>
</tr>
<tr>
<td><strong>Bacteremia</strong></td>
<td>Cultivatable bacteria in the blood stream</td>
<td>May be transient and inconsequential; inconsistent correlation with severe sepsis</td>
</tr>
<tr>
<td><strong>Systemic inflammatory response syndrome (SIRS)</strong></td>
<td>The systemic response to a wide range of stresses. Currently used criteria include two or more of the following: Temperature &gt;38°C or &lt;36°C Heart rate &gt;90 beats/min Respiratory rate &gt;20 breaths/min, or Paco2 &lt;32 mm Hg WBC &gt; 12,000 cells/mm3 or &lt;4000 cells/mm3, or &lt;10% immature (band) forms</td>
<td>A potentially misleading term. The evidence that the body’s early responses to infection cause systemic inflammation is controversial.</td>
</tr>
<tr>
<td><strong>Sepsis</strong></td>
<td>The systemic response to infection. If associated with proven or clinically suspected infection, SIRS is called &quot;sepsis” in the American consensus scheme.</td>
<td>With the exceptions of leukopenia and hypothermia, these changes are among the body’s normal systemic responses to infection and do not necessarily imply a poor prognosis.</td>
</tr>
<tr>
<td><strong>Hypotension</strong></td>
<td>A systolic blood pressure &lt;90 mm Hg, Mean Arterial Pressure (MAP) &lt;70 mm Hg, or a reduction of &gt;40 mm Hg from baseline</td>
<td>To be considered sepsis related, hypotension must have no other cause.</td>
</tr>
<tr>
<td><strong>Severe sepsis</strong></td>
<td>Sepsis associated with dysfunction of organ(s) distant from the site of infection, hypoperfusion, or hypotension.</td>
<td>Abnormalities may include lactic acidosis, oliguria, acutely altered mental status, and acute lung injury. To be considered severe sepsis, hypotension must be reversible by the administration of fluids. Organ dysfunction can be defined according to Marshall et al. or the Sequential Organ Failure Assessment (SOFA) score.</td>
</tr>
<tr>
<td><strong>Septic shock</strong></td>
<td>Sepsis with hypotension that, despite adequate fluid resuscitation, requires pressor therapy. In addition, there are perfusion abnormalities that may include lactic acidosis, oliguria, altered mental status, and acute lung injury.</td>
<td>If septic shock lasts for &gt; 1 hour and does not respond to pressor administration, the term refractory septic shock is often used.</td>
</tr>
</tbody>
</table>

1 Mandell, Bennett, & Dolin: Principles and Practice of Infectious Diseases, 6th ed. 2005 Churchill Livingstone, An Imprint of Elsevier
Preauthorization

Participating Provider Requirements

Preauthorization is the process of notifying Blue Cross Blue Shield of North Dakota (BCBSND) to request approval for specified services.

The participating provider is responsible for obtaining preauthorization of covered services on behalf of the member. If a patient is transferred from one type of facility to another, the provider receiving the patient is responsible for obtaining preauthorization.

- If preauthorization is not obtained prior to the receipt of care and services are determined to be medically appropriate and necessary, a $500 sanction will be deducted from the provider’s reimbursement.

- If preauthorization is not obtained prior to the receipt of care and BCBSND determines that the services are not medically appropriate and necessary, the provider will be liable for those services.

Medically appropriate and necessary services are defined as services, supplies or treatments provided by a health care provider to treat an illness or injury that satisfy all of the following criteria as determined by BCBSND:

- The services, supplies or treatments are medically required and appropriate for the diagnosis and treatment of the member’s illness or injury.

- The services, supplies or treatments are consistent with professionally recognized standards of health care.

- The services, supplies or treatments do not involve costs that are excessive in comparison with alternative services that would be effective for diagnosis and treatment of the member’s illness or injury (i.e. appropriate place of service, homebound, outpatient versus inpatient).

Preauthorization is required for the services listed below. To obtain preauthorization for these services, call Case Management at 800-336-2488 or 277-2100.

- Skilled Nursing Facility
- Long Term Acute Care Facility
- Transitional Care Unit
- Inpatient Admission to a Rehabilitation Facility
- Hospice
- Home Health Care
- Inter-facility transfers, including transfers from an acute bed to the following units: Skilled Nursing, Transitional Care, Rehabilitation or Psychiatric/Substance Abuse

Preauthorization for psychiatric and substance abuse admissions, including partial hospitalization and residential treatment, may be requested through THOR.

To register for the Preauthorization application, go to THORConnect.org, Provider Services. Under THOR Services, click Register Now and complete the THOR User Access form. If you have questions, contact Application Support Services at 800-544-8467.

This list does not apply to the Federal Employee Program (FEP).

DVAC Coding Guidelines

DRG Validation Advisory Committee

The following guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation.

PAIN CODING GUIDELINE

PREAMBLE

Pain is a complex syndrome with causes arising from a variety of sources. Three main categories include acute, chronic and neuropathic. Acute and chronic pain are classified as somatogenic indicating there is a physical cause, however, when no physical cause for the pain can be identified it is classified as psychogenic. Pain caused by damage to nervous tissue or disorders of the nervous system is classified as neuropathic pain. Trying to determine if pain is acute or chronic may present difficulty and may require querying the physician to clarify the type of pain.

For more information reference the ICD-9-CM pain coding guidelines and ICD-9-CM neoplasm coding guidelines.

CHARACTERISTICS OF ACUTE AND CHRONIC PAIN

*Per ICD-9: there is no time frame defining when pain becomes chronic pain. The provider’s documentation should be used as a guide in the selection of these codes.
1. GENERAL CODING INFORMATION

A. If the pain is not specified as acute or chronic, do not assign codes from category 338, except for post-thoracotomy pain, postoperative pain, neoplasm related pain, or central pain syndrome.

B. The ICD-9 instructional note indicates to assign 307.89 for any pain associated with psychological factors. If that kind of pain is documented as coexisting with any other pain condition classifiable to a code from the 338 category, then 307.89 should be assigned as an additional code. If the only kind of pain documented is due to psychological factors, then the only code that should be assigned is 307.80. This is per the excludes notes under the 338 code category.

C. The same principles apply to pain documented as due to trauma. Limit the use of these codes to when the encounter is primarily for pain management subsequent to or after the initial encounter for the injury. Use an additional code to specify the site of the pain.

D. When an admission or encounter is for a procedure aimed at treating the underlying condition (e.g., spinal fusion, kyphoplasty), a code for the underlying condition (e.g., vertebral fracture, spinal stenosis) should be assigned as the principal diagnosis. No code from category 338 should be assigned unless criteria is met to qualify as postoperative pain.

E. When an admission or encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is inserted for pain control during the same admission/encounter, a code for the underlying condition should be assigned as the principal diagnosis and the appropriate pain code should be assigned as a secondary diagnosis.

2. Pain due to devices, implants and grafts

A. Pain associated with devices, implants or grafts left in a surgical site (for example painful hip prosthesis) is assigned to the appropriate code(s) found in Chapter 17, Injury and Poisoning. Use additional code(s) from category 338 to identify acute or chronic pain due to presence of the device, implant or graft (338.18, 338.19 or 338.28-338.29).

3. Postoperative Pain

A. Post-thoracotomy pain and other postoperative pain are classified to subcategories 338.1 and 338.2, depending on whether the pain is acute or chronic. The default for post-thoracotomy and other postoperative pain not specified as acute or chronic is the code for the acute type of pain.

B. Postoperative pain must be documented as pain beyond that which is normal in order to be appropriate to assign a code. Routine or expected postoperative pain immediately after surgery should not be coded.

4. Acute Pain

A. Generally acute pain patients will have resources expended on finding the cause of the pain. This would include diagnostic workup (lab, ultrasounds, CTs) and may include consulting with a variety of physicians to determine the cause or probable cause of the pain. Documentation may indicate a new/recent onset of pain not present in the patient’s past medical history.

5. Chronic Pain

A. Chronic pain is usually long-lived and may stem from prolonged stimulation of nerve fibers that sense pain.
B. Persisting pain that was originally the result of an injury is also classified as chronic pain.

C. Persistent pain out of proportion of the original insult or injury.

D. Pain that persists longer than the expected healing time.

E. The focus is on controlling pain rather than expending extensive resources on finding the cause of the pain. Diagnostics may be done, but usually not as extensive as with acute or new onset of pain. Documentation may reflect a history of pain and control or attempts to control. There is no time frame for defining when pain becomes chronic. Chronic pain may require referrals to pain clinics and/or implantation of pain control pumps.

6. Acute on Chronic Pain

A. The first-listed diagnosis should be based on the principle reason for the encounter. If an acute injury was the reason for the encounter it should be sequenced first. Secondary codes may include the code for the anatomical site of the chronic pain and the chronic pain code. These codes should be assigned if the chronic condition was still present and/or affected the patient care and treatment for that particular encounter.

7. Neoplasm Related Pain

A. Code 338.3 is assigned to pain documented as related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic.

B. This code may be assigned as the principal or first-listed code when the stated reason for the admission/encounter is documented as pain control/pain.

C. Neoplasm-related pain not only results from the advancement of the disease, but also from cancer treatments that damage nervous tissue.

8. Chronic pain syndrome

A. This condition is different than the term “chronic pain,” therefore this code should only be used when the provider has specifically documented chronic pain syndrome.
Coding Audit

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

Objective
The purpose of the Coding Audit 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 audit 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 audit 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 audits.
4. The BCBSND Medical Director provides input for cases where insufficient or conflicting medical documentation may exist.
5. Results of audit findings are provided to facilities 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 Audit 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 Audits

<table>
<thead>
<tr>
<th>1st Quarter 2012</th>
<th>2nd Quarter 2012</th>
<th>3rd Quarter 2012</th>
<th>4th Quarter 2012</th>
<th>1st Quarter 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>January/February/March</td>
<td>April/May/June</td>
<td>July/August/September</td>
<td>October/November/December</td>
<td>January/February/March</td>
</tr>
<tr>
<td>Claims submitted and paid.</td>
<td>June: Paid claims from 1st quarter 2011 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. The claims are processed through the coding edits and the remaining claims are then ready for reviewer to perform the select/deselect process. 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.</td>
<td>July/August: Coding audits are performed. August/September: Disagreement letters are sent to facilities. Providers may notify BCBSND in writing of those claims, which they agree with the proposed change. This written notice waives the 45 day Reconsideration process and expedites the refund.*</td>
<td>October/November: Providers’ 45 days to request reconsideration are ending. Refunds begin for disagrees under reconsideration. A majority of the disagreements will be refunded at this time. November/December: BCBSND’s 45 days to respond to 1st level reconsiderations is ending.</td>
<td>January: Providers’ 45 days to request reconsideration to the 2nd level ending. Refunds will begin for disagrees not under reconsideration to the second level. February/March: BCBSND’s 45 days to respond to 2nd level reconsiderations ending. Administrative assessments performed to determine if the Reconsideration process was conducted appropriately. Refunds performed on final disagree claims.</td>
</tr>
</tbody>
</table>

* 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 Audit. Articles regarding the DRG Validation Program will periodically appear in future HealthCare News Bulletins.

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

**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 >10 on admission.
4. 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.

**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.
8. 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.

**Additional Information**

- 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:
- 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.

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)
  - The patient is expected to be anemic following surgery or trauma. Anemia is defined as below normal value of hemoglobin, hematocrit, or RBC count.
  - 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.
  - 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.
  - 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.
  - 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.
  - Additional information regarding postoperative anemia is published in HealthCare News Bulletin #226.

- Chronic Blood Loss Anemia (280.0)
  - The patient should be anemic on admission. Anemia is defined as below normal value of hemoglobin, hematocrit, or RBC count.
  - 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.
  - 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.
  - 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.
  - 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.

- Anemia of Pregnancy (648.2X, 285.X)
  - Danforth’s Obstetrics and Gynecology textbook defines anemia of pregnancy as a hemoglobin concentration of <10 g/dL.
  - Patients with hemoglobin levels of >10 in the last trimester do not meet criteria for the coding of anemia of pregnancy.
  - 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.
  - 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.
  - 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.
  - Anemia present at outpatient prenatal visits prior to admission does not meet criteria for reporting anemia of pregnancy.
  - 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.
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.

<table>
<thead>
<tr>
<th>Body mass index</th>
<th>Nutritional status</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 18.5</td>
<td>Normal</td>
</tr>
<tr>
<td>17.0-18.49</td>
<td>Mild malnutrition</td>
</tr>
<tr>
<td>16.0-16.99</td>
<td>Moderate malnutrition</td>
</tr>
<tr>
<td>&lt;16.0</td>
<td>Severe malnutrition</td>
</tr>
</tbody>
</table>

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 (AAASAF), 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 procedure.
Level of Care Audit

General Description
The Level of Care Audit reviews all hospital claims that have a short length of stay to identify appropriate level of care.

Objective
The purpose of the Level of Care (LOC) Audit is to ensure fair and equitable utilization 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. Blue Cross Blue Shield of North Dakota (BCBSND) is committed to ensuring that our claims database represents correct DRGs and payment amounts.

- Identify claims having variation among providers.
- Review institutional claims and corresponding medical records for appropriate level of care.
- Inform providers of audit findings.
- Educate providers regarding appropriate inpatient/outpatient surgical procedures for BCBSND.
- Educate providers regarding appropriate medical observation claims for BCBSND.

Process
1. All inpatient acute care claims submitted for payment are run through an edit process.
2. If the claim is to be reviewed, the medical record is ordered. A Registered Nurse reviews the record for severity of the illness and the intensity of the service provided to that patient to determine if the appropriate level of care was submitted for reimbursement.
3. Resources utilized for this review process include the InterQual Level of Care Guidelines, BCBSND inpatient surgical list, common medical practice within the state, and BCBSND Medical Director judgment.
4. The BCBSND Medical Director provides input for cases where inpatient criteria are not met or unusual circumstances are found.
5. BCBSND provides individual case summaries and the rationale used in making a change recommendation when disagreement with the original claim submission occurs.
6. Notification for all departments at the facility regarding a LOC adverse determination on a DRG Validation claim will be sent to the Utilization Review Department. It will be the responsibility of the Utilization Review Department at each facility to forward the information to the Business Office. Any actions that will be taken for each claim should be discussed and coordinated between the two departments.
7. The providers have 45 days following this notification to request reconsiderations. The DRG Validation Audit Program Reconsideration Process is available to all providers and consists of two levels of reconsideration.
8. Reference the Rebilling chapter regarding resubmissions.
Inpatient Status versus Outpatient Observation Status Considerations

• The provider does not need to make the determination of patient status at the time of admission.
• Providers may upgrade or downgrade a patient’s status anytime during an encounter or shortly after the stay.
• The need to change the patient status would depend on many factors including the care rendered, the intensity of the services, and the severity of the illness.
• Observation involves active treatment and care, not passive watching. A diagnosis and treatment plan may be present in observation status.
• The physical location of the service may be the same for observation and inpatient care-including ICU or CCU.
• The type of service may be similar, but the severity of illness and intensity of service are higher in the inpatient setting.
• Observation is not limited to a 24-hour period.
• Length of stay beyond one overnight does not automatically make a claim an inpatient stay.
• Observation status is appropriate when:
  – The need for an inpatient admission cannot be medically determined; or
  – Additional time is needed to evaluate the patient; or
  – The patient responds rapidly to treatment; or
  – The care needed is not intense; or
  – The patient is not acutely ill.
• Blue Cross Blue Shield of North Dakota allows the provider the opportunity to rebill a claim that should be paid at an observation level of care.
• Treatments such as IV fluids and IV antibiotics alone would not automatically qualify for inpatient status.
• It is appropriate to start as observation status when the working diagnosis is a symptom, a rule out, or a possible condition.
• Normal, expected postoperative conditions that may extend the treatment, such as pain or nausea and vomiting, would not automatically qualify for inpatient status.
• “Failed outpatient” alone may not qualify for inpatient status. Each case is reviewed on its individual circumstances and considerations.
**McKesson InterQual Criteria**

- Nationally recognized level of care criteria.
- Nurse review tool that fosters reliable, uniform, rule-based decisions and contains measurable clinical information.
- Used for screening the appropriateness of acute hospital levels of care and to screen for cases that warrant medical review.
- In 2011, InterQual began transitioning towards condition-specific subsets. If a condition-specific subset is not available for a member’s condition, the review is based on traditional subset.
- The criteria should not be used to “justify” an admission, i.e., satisfying any single criterion or group of criteria will not necessarily guarantee that an admission will be approved. Rather, the criteria represent the clinical factors that are reviewed in order to establish the necessity for acute, inpatient care.
- The BCBSND Medical Director reviews cases that do not meet the InterQual Level of Care Criteria.

**InterQual Proprietary Notice**

The following page is a copy of the proprietary notice that is included with information regarding how a determination was reached using the InterQual Criteria. The information you receive is proprietary and **may not** be disclosed to other parties.
PROPRIETARY NOTICE

The McKesson InterQual® Criteria statements in this work, including, without limitation, the review rules, directions, commentary, notes, reference summaries and other elements contained herein, and their selection, expression, format, ordering and other attributes, constitute proprietary and confidential clinical decision support criteria ("Criteria"). The Criteria is protected under United States and international copyright and other intellectual property laws. If this Criteria is delivered pursuant to a federal government contract that requires the conveyance of rights in data to the government, it is understood that the Criteria, including commercial software, clinical content, third-party software, documentation and/or other technical data, was developed exclusively at McKesson's private expense, and that McKesson will convey only limited or restricted rights in the Criteria to the government consistent with the guidance set forth in the Federal Acquisition Regulation ("FAR") and/or FAR Supplements. Conveyance of any additional rights beyond limited or restricted rights in the Criteria requires McKesson's express consent contained in a separate written agreement.

Acknowledgments: The McKesson InterQual® Criteria are developed by McKesson’s clinical research staff which includes physicians, registered nurses, and other healthcare professionals. Many of McKesson’s clinical staff hold advanced degrees and case management certification. The clinical content is reviewed and validated by a national panel of clinicians and medical experts, including those in community and academic practice settings, as well as within the managed care industry throughout the United States. The clinical content is a synthesis of evidence-based standards of care, current practices, and consensus from licensed specialists and/or primary care physicians.

Copyright © 2013 McKesson Corporation and/or one of its subsidiaries ("McKesson"). All Rights Reserved.

No portion of this publication may be copied, reproduced or incorporated into any other media without McKesson's prior written consent.

Produced in Cork, Ireland.

Trademarks: AutoBook™, CareEnhance®, InterQual®, SIM plus™, and SmartSheets™ are trademarks of McKesson Corporation and/or one of its subsidiaries.

Notice

The Criteria reflect clinical interpretations and analyses and cannot alone either resolve medical ambiguities of particular situations or provide the sole basis for definitive decisions. The Criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient.

THE CRITERIA ARE PROVIDED "AS IS." MCKESSON DISCLAIMS ANY OTHER WARRANTY, EXPRESS OR IMPLIED, INCLUDING AS TO MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE OR SERVICE OF THE CRITERIA, OR THE COMPATIBILITY OF OUTPUT USING THE CRITERIA WITH ANY LAW, REGULATION, OR ORDER. IN NO EVENT SHALL MCKESSON BE LIABLE FOR SPECIAL, INCIDENTAL, CONSEQUENTIAL, OR EXEMPLARY DAMAGES IN CONNECTION WITH, OR ARISING OUT OF, ANY USE OF THE CRITERIA.

275 Grove Street
Suite 1-210
Newton, MA 02466-2273
USA

Tel: 617.273.2800
Fax: 617.273.3777
cesupport@mckesson.com
www.mckesson.com
HealthCare News Articles

The following pages contain copies of pertinent information regarding the Level of Care Audit. Articles regarding the DRG Validation Program will periodically appear in future HealthCare News Bulletins.

- March 2001 – Observation Care Versus Inpatient Admission
- September 2002 – Outpatient/ASC Admissions
- September 2002 – Clarification of Determination of Patient Status
- November 2004 – Program Enhancements
- April 2006 – Glad You Asked Question and Response
- June 2008 – Outpatient to Inpatient Billing Clarification – Institutional
- December 2010 – Glad You Asked Question and Response
- July 2011 – Glad You Asked Question and Response
- December 2011 – Coding and Billing
- November 2012 – Glad You Asked Question and Response
Medical Policy

Application of Bilaminate Skin Substitutes

Effective for services on or after January 1, 2001

Update to HealthCare News #206 – revisions are in bold

Coding

15342 – Application of bilaminate skin substitute/ neodermis; 25 sq cm
15343 – each additional 25 sq cm
HCFA-1500
Q0185 – Dermal and epidermal tissue, of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter

UB-92
C1305 – Apligraf, per 44 square centimeters; or
Q0185 – Dermal and epidermal tissue, of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter

Description

These codes represent the application of tissue cultured and bioengineered skin substitute products designed to be used for treatment of skin ulcers due to venous insufficiency. One form of this technology is Apligraft™.

Policy

Benefits will be allowed for application of bilaminate skin substitute for patients with:

- Non-infected partial or full thickness venous stasis ulcers greater than three months duration which have failed to respond to documented conservative measures for at least two months.
- A limit of three separate applications of the skin substitute to any given ulcer will be allowed. There should be at least six weeks between applications.
- Reimbursement of the product itself (Q0185) will be based on invoice cost. The invoice will be required prior to the services being allowed. Reimbursement for C1305 will be based on the Hospital Outpatient Fee Schedule amount.

DRG Validation Program

Observation Care versus Inpatient Admission

Many questions have been received recently regarding the proper billing of observation care versus inpatient care.

The use of outpatient observation status instead of an inpatient admission is appropriate when:

- the need for an inpatient admission cannot be medically determined; and
- additional time is needed to evaluate the patient; or
- the physician believes the patient will respond rapidly to treatment.

Outpatient observation is not limited to a 24-hour period, but in general should not exceed one overnight stay. Observation should be used as an effective alternative until the need for admission can be clearly established or the patient can be safely discharged. The physician’s written orders should accurately reflect the setting and level of care required. In addition, the medical record documentation must support the medical necessity of the services provided.

Claims Submission

Pathologists and Radiologists Billing

Pathologists and Radiologists must submit the ordering physician’s Unique Physician Identification Number (UPIN) in form locator 17a on the HCFA-1500 claim form. This information is required to identify the ordering physician of the laboratory services.
The following code combinations have been deleted:

<table>
<thead>
<tr>
<th>Global</th>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>70483</td>
<td>70483*</td>
</tr>
<tr>
<td>70484</td>
<td>70484*</td>
</tr>
</tbody>
</table>

*Published in error in HCN #224

**DRG Validation**

**Clarification of Determination of Patient Status**

Reference *HealthCare News* #207

The following is a clarification of BCBSND's guidelines regarding inpatient versus outpatient status. These guidelines supersede any previous HCN articles that address determination of patient status. Providers may upgrade or downgrade a patient's status at any time during an encounter. The need to change the patient status would depend on many factors including the care rendered, the intensity of the services, and the severity of the illness. Unlike some other payers, this decision does not need to be made at the time of admission.

**Outpatient/ASC Admissions**

When performing procedures in the outpatient or ASC unit, and the intention is to safely discharge the patient from that facility, it is appropriate to initiate services in that setting. However, when it is planned that the patient will require an overnight stay, care should begin at the appropriate facility that has the resources to manage overnight care.

Admission for observation or inpatient care from an outpatient or ASC unit can occur, but should be the exception, and occur only when unanticipated problems and complications arise.
**DRG Validation**

**Program Enhancements**

*Effective January 1, 2005*

In order to accommodate concerns raised by many hospitals about the timeliness of the DRG Validation Level of Care and Readmit/Transfer audits, these audits will be completed prior to payment. Effective for claims with admission dates on or after January 1, 2005, medical records will be requested and reviewed for those inpatient claims that fall within the current audit criteria. If, after review, it is determined that the level of care is that of an observation level, the claim will be returned to the provider to resubmit as an outpatient observation claim.

BCBSND will continue to reimburse the facility for the cost of the medical record to perform these audits. BCBSND will also continue to follow the DRG Validation Reconsideration process as noted in the DRG manual. The DRG Validation Program Reconsideration Process is documented in HealthCare News #234. We will continue to use the Interqual Criteria when performing the reviews.

The Level of Care and Readmit/Transfer audits for the 3rd and 4th quarters of 2004 will be done within the next 3-4 months. Records will be requested for the identified claims and the audits will be performed at BCBSND.

The coding audit portion of the DRG Validation program will not be changing at this time.
Glad you Asked

**Question:** There are two modifiers for providers assisting at surgery (modifier 80 and AS). Is there a difference between them?

**Response:** Yes, when a provider assists a surgeon, one of two modifiers can be coded based on the particular situation:

- Modifier 80: Assistant Surgeon
- Modifier AS: Assistant at Surgery Service

Modifier 80 refers to a surgeon (a physician that performs surgery). Only the following provider types may use modifier 80:

- MD: Medical Doctor
- DO: Osteopath
- DDS: Dentist
- OD: Optometrist
- DPM: Podiatrist
- DDS/MD: Oral Surgeon

All other provider types must use modifier AS when assisting at surgery.

The procedure must be within the provider’s scope of practice and appear on the Blue Cross Blue Shield of North Dakota (BCBSND) defined Assistant at Surgery List to be reimbursed when billed with modifier 80 or AS. An assistant at surgery must be involved in the actual performance of the procedure, not simply in other ancillary services.

Claims submitted with an inappropriate modifier will be returned to the provider for correction.

---

**Question:** How should we bill for surgically implanted medical devices that have been recalled by the manufacturer and the replacements are provided to our facility at no cost?

**Response:** The recalled medical device should be identified by the appropriate revenue code and HCPCS (if outpatient) with a zero charge. If the hospital billing system requires a charge, the hospital should submit a token charge (e.g., $1.00) on the line for the device. The other charges in relation to the re-insertion of the device should be submitted as usual.

**Question:** Can our facility submit an inpatient claim for a patient who receives doctor’s orders to be admitted to inpatient status but either dies or is discharged prior to being assigned and/or occupying a room?

**Response:** An inpatient claim should not be submitted in this situation. Facilities should submit an outpatient type of bill (131) with the appropriate revenue and HCPCS codes.

**Examples:**

- A patient presents to the emergency room with orders for admission and either expires prior to admission or is transferred to another facility.
- A patient who presents to the emergency room and goes directly to the operating room but expires before an inpatient bed is occupied.
Outpatient to Inpatient Billing Clarification - Institutional

Reference HealthCare News #262

When a patient is a direct admit from an observation room or emergency room to an inpatient level of care, the admit date on the claim should be the date that the patient first received services in the outpatient setting. When the patient’s status changes from observation to inpatient, only room and board charges should be on the claim. Any observation charges should be converted to room and board and accounted for in revenue code 011X - 017X. The number of days of room and board must equal the number of days of the total stay. Inpatient claims (type of bill 11X) with revenue code 0762 will be returned.

Below is an example of a claim for a patient who enters the facility through the emergency room on January 1, 2008. This patient is admitted to observation status from January 1, 2008, to January 2, 2008, and then directly admitted to inpatient status from January 3, 2008, with discharge on January 5, 2008.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>120</td>
<td>Room - Board/Semi</td>
<td>500.00</td>
<td>2000</td>
</tr>
<tr>
<td>250</td>
<td>Pharmacy</td>
<td>50</td>
<td>200</td>
</tr>
<tr>
<td>258</td>
<td>IV Solutions</td>
<td>5</td>
<td>200</td>
</tr>
<tr>
<td>272</td>
<td>Med Surg Supplies</td>
<td>35</td>
<td>250</td>
</tr>
<tr>
<td>300</td>
<td>Laboratory</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>450</td>
<td>Emergency Room</td>
<td>1</td>
<td>120</td>
</tr>
<tr>
<td>730</td>
<td>EKG</td>
<td>3</td>
<td>200</td>
</tr>
<tr>
<td></td>
<td>Total Charges</td>
<td></td>
<td>2980</td>
</tr>
</tbody>
</table>
Glad You Asked!

Tonsillectomy and Adenoidectomy

**Question:** When a tonsillectomy and adenoidectomy are performed bilaterally, is it appropriate to append modifier 50 (bilateral procedure) to the procedure code?

**Response:** CPT® codes for tonsillectomy and adenoidectomy (42820-42836) are intended to represent bilateral procedures. Therefore, it is not appropriate to append modifier 50 when performed bilaterally. If the procedure is performed unilaterally, the appropriate code would be reported with modifier 52 (reduced services) appended.

Blood Transfusion

**Question:** If a patient receives two units of blood one day and two additional units of blood the following day, is it appropriate to report CPT® code 36430 four times?

**Response:** CPT® code 36430 (Transfusion, blood or blood components) is reported only one time per transfusion, regardless of how many units are administered. In this example, since the patient was transfused two units of blood one day and two units of blood the following day, it would be appropriate to report code 36430 one time for each day.

CPT® code 36430 can also be reported for any type of blood component (i.e. packed red blood cells and fresh frozen plasma) since the code description does not differentiate the blood components.

Observation Care vs. Inpatient Admission

**Question:** Does the physician’s admitting order have to correspond with the level of care billed on a patient’s claim?

**Response:** If the physician’s admitting order differs from the level of care determination, the level of care, which is based on severity of illness and intensity of service criteria, takes precedence and should be the determining factor regarding patient status when submitting a claim to Blue Cross Blue Shield of North Dakota.
THORConnect.org

New Look!
THORConnect.org, the unsecured provider website, has a new look. The functionality remains the same, only the layout has changed. A Popular Links section was also added so you can get to your favorite links with just one click. Take a moment to check it out!

Glad You Asked!

2011 InterQual Criteria

**Question:** When will Blue Cross Blue Shield of North Dakota (BCBSND) apply the 2011 InterQual criteria for DRG level of care audits?

**Response:** BCBSND is using the 2011 InterQual level of care criteria for dates of service on or after May 1, 2011. InterQual is transitioning away from body-system subsets organized by level of care and moving towards condition-specific subsets. If a condition-specific subset is not available for a member’s condition, the review is based on a traditional subset.

- **Adult condition-specific subsets:**
  - Acute Coronary Syndrome
  - Asthma
  - Epilepsy
  - Heart failure
  - Pneumonia
  - Stroke/TIA
- **Pediatric condition-specific subsets:**
  - Asthma
  - Croup
  - Epilepsy
  - Pneumonia
Providers licensed to provide ASAM II.1 should bill these services using H2035. These services must be billed on the UB-04 when provided by a facility-based Licensed Addiction Counselor. If the services are an integral part of another program, they cannot be identified separately. If an independent practitioner with the appropriate licensure provides IOP, the services are submitted on the CMS-1500 using H2035. IOP does not apply to psychiatric services.

**UB-04 Admit/From Date Changes for Inpatient Claims – Institutional**

*Effective for “From” dates of service on or after January 1, 2012*

Based on clarification from the National Uniform Billing Committee (NUBC), Blue Cross Blue Shield of North Dakota (BCBSND) can no longer require the Admit Date and From Date on acute inpatient claims to match.

For institutional inpatient claims submitted on the UB-04, the Statement Covers Period From date in Form Locator 6 (“From” Date) is distinctly different than the Admission Date in Form Locator 12 (“Admit” Date). There are times when these dates may be the same but there are also situations when these dates may be different.

The Admit Date is the date the patient is admitted as an inpatient to the facility. This date must be reported on all inpatient claims whether the claim is an initial, interim or final bill. The Statement Covers Period (“From” and “Through” dates) identifies the span of service dates included on the claim. The “From” date should be the earliest date of service on the bill.

BCBSND will implement the necessary change in its claims processing system to accommodate this clarification from the NUBC. Acute inpatient claims will continue to be reimbursed based on a DRG payment and all services on the claim will be considered to be part of the DRG payment. The patient must have continuous services in the facility prior to admission to be billed in this manner. For example, if the patient has an ER visit, leaves the facility and returns home, returns to the ER later and is directly admitted as inpatient, the first ER service is billed as a separate outpatient claim. The ER visit that results in a direct admission is billed on the same claim as the inpatient stay.

The following billing guidelines apply to all inpatient claims with a “From” date on or after January 1, 2012.

- “Admit” date (Form Locator 12) – Date the patient was admitted as inpatient to the facility. This is required on all inpatient claims regardless of initial, interim or final bill. An admit date for inpatient institutional claims must be indicated or the claim will be returned.

- “From” date (Form Locator 6) – The earliest date of service billed on the claim.

- “Through” date (Form Locator 6) – The last day of service billed on the claim. The appropriate discharge status code must be submitted in Form Locator 17.

- Room and Board (Form Locator 42 – Revenue Code 010x – 021x) – Units as submitted in Form Locator 17. Code may be submitted on an inpatient claim for situations when observation is provided prior to direct admission. Units reflecting number of hours may be submitted but will not be used to calculate reimbursement as observation time is considered part of the DRG payment.

- ICD-9-CM Procedure Codes (Form Locator 74) – The date may be prior to the “Admit” date but must not be prior to the “From” date.

- Revenue Code 0762 – The observation room revenue code may be submitted on an inpatient claim for situations when observation is provided prior to direct admission. Units reflecting number of hours may be submitted but will not be used to calculate reimbursement as observation time is considered part of the DRG payment.

- Claims will be monitored for duplicate billing of outpatient services that overlap billing dates of an inpatient claim. Any duplicate outpatient services will be non-covered as provider liable.

**Chiropractic**

**Coordinated Treatment Plan**

**Purpose**

Members may have condition(s) that require ongoing chiropractic services. To determine the most appropriate medical/chiropractic care and the frequency of required services, Blue Cross Blue Shield of North Dakota (BCBSND) uses a Coordinated Treatment Plan (CTP). This is not a change in chiropractic benefits and is not considered a prior approval, but rather a process to monitor and reimburse services that are effective and medically appropriate and necessary.

**Definition**

A CTP is a collaborative effort utilizing member’s claims history, medical history, provider(s) recommendations, and occasionally an independent consultation to determine the most appropriate medical/chiropractic care needed to support the member’s condition. The CTP is a recommendation of appropriate services and
Glad You Asked

Question:
When did Blue Cross Blue Shield of North Dakota (BCBSND) adopt the InterQual Supplemental Corrections/Revisions Criteria 2012.2 for Level of Care reviews?

Answer:
As you know, BCBSND uses InterQual Level of Care Criteria, a nationally recognized review tool when making decisions about level of care.

BCBSND received the supplemental criteria September 27, 2012, which was reviewed by the Internal Medical Policy Committee and officially adopted on October 5, 2012. BCBSND began using this supplemental criteria for dates of service October 5, 2012 and thereafter.

Additional information regarding the DRG Validation Program can be found in the manual located on THORconnect.org, Provider Services, Billing & Reimbursement, DRG Validation Program.
Blue Cross Blue Shield of North Dakota
Modifications to InterQual's Adult and
Pediatric Criteria

Blue Cross Blue Shield North Dakota (BCBSND) utilizes the current version of InterQual criteria as a level of care audit tool.
Blue Cross Blue Shield of North Dakota Guidelines for Surgery and Procedures in the Inpatient Setting

Blue Cross Blue Shield North Dakota (BCBSND) is utilizing the current version of InterQual’s Guidelines for Surgery and Procedures in the Inpatient Setting listing as a level of care audit tool.
Readmission Audit

General Description
The Readmission Audit reviews all hospital claims for readmissions within a 6-day period for appropriate discharge and completion of acute care. Blue Cross Blue Shield of North Dakota (BCBSND) considers a case to be a premature discharge when signs and symptoms of an acute process are documented but not addressed during the first admission, and/or treatment was initiated but not monitored, evaluated, and/or completed prior to discharge.

A planned readmission is considered a readmission due to scheduling problems for either the facility or the physician, or a readmission for physician or patient convenience.

Objective
The purpose of the Readmission Audit is to ensure fair and equitable utilization 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. BCBSND is committed to ensuring that our claims database represents correct DRGs and payment amounts.

- Claims with a readmission within 6 days are stopped to determine if conditions are related.
- If conditions appear related, the claims are reviewed for appropriate discharge and completion of care.
- Inform providers regarding the proposed combining of admissions when either a premature discharge or a planned readmission has occurred.

Process
1. Multiple admissions within a 6-day period are reviewed for possible premature discharge or planned readmission.
2. Resources utilized for this process include the medical record of each admission and the BCBSND Readmission Guidelines as published in the HealthCare News #277.
3. The BCBSND Medical Director provides input for cases where unusual circumstances are found.
4. Results of audit findings are provided to all facilities upon review of the claim. BCBSND provides individual case summaries and the rationale used in making the decision determining that the claims should be combined as one claim.
5. Notification for all departments at the facility regarding a readmission audit adverse determination on a DRG Validation claim will be sent to the Utilization Review Department. It will be the responsibility of the Utilization Review Department at each facility to forward the information to the Business Office. Any actions that will be taken for each claim should be discussed and coordinated between the two departments.
6. The providers have 45 days following this notification to request reconsideration. The DRG Validation Audit Program Reconsideration Process is available to all providers and consists of two levels of reconsideration.

7. Reference the Rebilling chapter regarding resubmissions.
HealthCare News Articles

The following page is a copy of the HealthCare News article that pertains to the Readmission Audit. Articles regarding the DRG Validation Program will periodically appear in future HealthCare News Bulletins.

- January 2007 - Readmission Policy
**Readmission Policy**

*Update to HealthCare News #204*

Effective immediately, all readmissions that occur within six calendar days from date of discharge will be subject to review. These reviews will be conducted on a pre-payment basis.

- Payment recoveries will be made if it is determined that a readmission is the result of a planned readmission or a premature discharge. The second admission will be combined with the first for purposes of DRG assignment and reimbursement. Payment will be made for one DRG for the combined stay.

- A planned readmission is considered a readmission due to scheduling problems for either the facility or the physician, or a readmission for physician or patient convenience.

- A premature discharge may be considered when signs and symptoms of an acute process are documented but not addressed during the first admission, and/or treatment was initiated but not monitored, evaluated, and/or completed prior to discharge.

- Readmissions that occur as a result of a patient leaving against medical advice (AMA) will be exempt from the readmission policy. These cases may be reviewed to determine if AMA was the proper discharge status on the first admission. For cases in which discharge status of AMA is deemed inappropriate, the readmission policy will become applicable.

---

**Webinars**

**National Provider Identifier (NPI) Overview**

Get It. Share It. Use It!

The Blue Cross Blue Shield of North Dakota (BCBSND) NPI Implementation team would like to offer a webinar for all providers who have questions regarding their NPI. Some of the topics that will be discussed include:

- What is the NPI?
- Who is required to get it?
- What are the deadlines for obtaining NPIs?
- How do I get an NPI?
- When do I use it?
- Who do I notify when I receive my NPI?
- What are subparts?
Transfer Audit

General Description
The Transfer Audit reviews all hospital claims for appropriate transfer/discharge status.

Objective
The purpose of the Transfer Audit is to ensure fair and equitable utilization 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. Blue Cross Blue Shield of North Dakota (BCBSND) is committed to ensuring that our claims database represents correct DRGs and payment amounts.

- Review the claims for a member that have a discharge and readmit on the same or the following day.
- Review institutional claims and corresponding medical records for appropriate use of discharge disposition code.
- Inform provider of audit findings.
- Inform the provider of the appropriate use of discharge disposition code following published definitions in the Federal Register and Uniform Hospital Discharge Data Set (UHDDS).

Process
1. Inpatient acute care claims selected for review have a discharge date from one provider and an admit date to another provider within 1 day.

2. Resources that may be used include the medical record from each claim, the Federal Register and UHDDS definitions.
   - Based on the Federal Register and UHDDS definitions, the discharge status code 02 should be utilized in any instance where the patient’s care was not completed at the first facility and is transferred to another acute care facility for continuation of care. The means of transport, whether by private vehicle or ambulance, should not be a consideration when assigning the appropriate discharge status code.
   - BCBSND will accept patient status code 66 and handle it like patient status code 02 (Transferred to another short-term hospital). BCBSND does not recognize Medicare CAH status for payment purposes. Therefore, reimbursement will be affected and a transfer payment applied.
   - BCBSND will review claims submitted with status code 70. BCBSND will return any claims if another patient status code was more appropriate per the code list and claims should be resubmitted.

3. The BCBSND Medical Director provides input for cases where unusual circumstances are found.

4. The results of the audit finding are provided to the facility who transferred the patient. BCBSND provides individual case summaries and the rationale used in making a change recommendation when disagreement with the original claim submission occurs.
5. Notification for all departments at the facility regarding a Transfer Audit adverse determination on a DRG Validation claim will be sent to the Utilization Review Department. It will be the responsibility of the Utilization Review Department at each facility to forward the information to the Business Office. Any actions that will be taken for each claim should be discussed and coordinated between the two departments.

6. If an inappropriate discharge status code is found during the course of the DRG Validation Coding Audit, notification will be sent to the Medical Records Department contact person along with other communications for that quarter’s audit.

7. The providers have 45 days following this notification to request reconsiderations. The DRG Validation Audit Program Reconsideration Process is available to providers and consists of two levels of reconsideration.

8. Reference the Rebilling chapter regarding resubmissions.
HealthCare News Articles

The following page is a copy of the HealthCare News article that pertains to the Readmission Audit. Articles regarding the DRG Validation Program will periodically appear in future HealthCare News Bulletins.

- June 2006 - Revised Patient Status Code - Institutional
- February 2008 - Revised and New Patient Status Code - Institutional
Coding and Billing

Administration for Vaccines Supplied by North Dakota Department of Health

North Dakota State law limits the amount that can be charged for the administration of a vaccine supplied by the North Dakota Department of Health (NDDoH).

Modifier SL identifies immunizations given with vaccines supplied by the NDDoH. Modifier SL must be submitted with the proper vaccine CPT® code (90476 - 90749) for the vaccine administered. The corresponding charge should represent the administration of the immunization only. Charges should NOT be submitted for the vaccine itself since it is supplied by the state free of charge to the provider. Reimbursement for services submitted with modifier SL will be the lesser of:

- charges; or
- the maximum amount allowed by the State of North Dakota

Since the administration for vaccines supplied by the NDDoH is submitted using the vaccine CPT® codes (90476-90749) with the SL modifier, providers should NOT bill for administration of vaccines under the immunization administration for vaccines/toxoids CPT® codes (90465 - 90474). Blue Cross Blue Shield of North Dakota will return claims for correction that have two lines for administration of one vaccine.

The following is an example of how to correctly bill for DtaP provided by the NDDoH for a child under age 7:

<table>
<thead>
<tr>
<th>CPT® codes</th>
<th>Definition</th>
<th>Modifier</th>
<th>Charge for Administration only</th>
</tr>
</thead>
<tbody>
<tr>
<td>90700</td>
<td>DtaP, &lt;age 7, IM</td>
<td>SL</td>
<td>$X.XX</td>
</tr>
</tbody>
</table>

Revised Patient Status Code - Institutional

Effective Date: Discharges on or after January 1, 2006

A patient status code is reported on institutional claims in Form Locator 22. Medicare implemented a new patient status code 66 to use when patients are transferred to a Critical Access Hospital (CAH). Previously there was no specific code available and providers typically used patient status 01 (Discharged to home or self-care), 05 (Discharged/transferred to another type of institution not defined elsewhere in this code list) or some other code.

Blue Cross Blue Shield of North Dakota (BCBSND) will accept patient status code 66 and handle it like patient status code 02 (Transferred to another short-term hospital). BCBSND does not recognize Medicare CAH status for payment purposes. Therefore, reimbursement will be affected and a transfer payment applied.

BCBSND will review claims submitted with status code 05 and will handle as patient status code 02 if the transfer was to a Medicare defined children’s or cancer hospital. BCBSND does not recognize children’s or cancer hospitals as PPS exempt. Therefore, reimbursement will be affected and a transfer payment applied. Under the transfer methodology, the transferring hospital will receive a per diem amount, calculated by dividing the DRG rate by the average length of stay, for each day up to the full DRG rate.

Patient Status - Form Locator 22

05 Discharged/transferred to another type of institution not defined elsewhere in this code list

Usage Note:
Cancer hospitals excluded from Medicare PPS and children’s hospitals are examples of such other types of institutions.

66 Discharged/transferred to a Critical Access Hospital (CAH).
*See specific Level II HCPCS listed in HealthCare News #289 that will not be included in the surgical allowance when billed on 0278.

**See specific Level II HCPCS listed in HealthCare News #289 that will not be included in the surgical allowance when billed on 0636.

Codes that are considered surgical should be submitted on the same claim for the same stay. Units must always be one (1). Modifiers should be used if different sites need to be identified; however, surgical procedures performed bilaterally must be submitted as two separate line items to receive the correct reimbursement. Modifier 50 may be appended to one of the lines but a bilateral procedure cannot be billed as only one line with modifier 50. Use of modifier 73 (discontinued procedure prior to anesthesia) will result in a 50 percent reduction to the fee schedule amount for the procedure.

The presence of a code on the listing of surgical procedures does not indicate coverage. Any medical policies and benefits continue to apply.

## Coding and Billing

### Revised and New Patient Status Code - Institutional

**Update to HealthCare News #269**

**Effective Date: Discharges on or after April 1, 2008**

The National Uniform Billing Committee (NUBC) has redefined patient status code 05 and created a new patient status code 70. A patient status code is reported on institutional claims in Form Locator 17 of the UB-04 claim form. Changes and updates are in bold.

Patient status code 05 has been redefined to indicate a discharge/transfer to a designated cancer center or children’s hospital. Previously, this status code also included transfers to another type of institution not defined elsewhere in the code list. Prior to 2008, Blue Cross Blue Shield of North Dakota (BCBSND) reviewed all claims with patient status 05 to determine if the transfer was to a Medicare-defined children’s hospital, cancer center or other type of institution such as a chemical dependency residential treatment center. A transfer payment applied if the transfer was to a children’s hospital or cancer center. A transfer payment was not applied if the transfer was to an institution not defined in the code list. **BCBSND will no longer review claims submitted with patient status 05 and will always apply a transfer payment. Providers should always submit the appropriate patient status code.**

Patient status code 70 has been created to indicate discharges/transfers to another type of institution not defined elsewhere in the code list. **BCBSND will accept the new patient status code and will review claims submitted with patient status code 70.** Reimbursement will be the full DRG rate if the new code is used appropriately. BCBSND will return any claims if another patient status code was more appropriate per the code list and claims should be resubmitted. Example: It would be appropriate to use status code 70 for a transfer to an inpatient chemical dependency unit or a residential treatment center.

**Patient Status - Form Locator 17**

- Status Code 05 - Discharge/transfer to a designated cancer center or children’s hospital
- Status Code 70 - Discharge/transfer to another type of health care institution not defined elsewhere in the code list
Catastrophic Audit

General Description
The Catastrophic Audit reviews inpatient claims reimbursed by outlier payment status or percentage of charges to identify incorrect billing practices, appropriate level of care, and variation in charges from provider to provider. This audit will be performed on an as-needed basis.

Objective
The purpose of the Catastrophic Audit is to ensure fair and equitable utilization 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. Blue Cross Blue Shield of North Dakota (BCBSND) is committed to ensuring that our claims database represents correct DRGs and payment amounts.

- Select claims that are reimbursed by outlier payment status or percentage of charges.
- Review the itemized bill and corresponding medical record for appropriate billing.
- Identify inconsistencies and potential billing errors, and seek clarification from the provider.

Process
1. All paid claims for the quarter are run through an edit process.
2. Claims that meet outlier status or were paid on a percentage of charges methodology are selected by a Registered Nurse for review.
3. Resources utilized for this audit include the medical record, a detailed itemization of hospital charges report and InterQual Level of Care Criteria.
4. The BCBSND Medical Director, the Reimbursement staff and Medical Review and Audit staff are involved in the review process.
5. When inconsistencies and potential billing errors are identified, clarification is obtained from the provider.
6. Results of audit findings are provided to all facilities upon review of the claim. BCBSND provides individual case summaries and the rationale used in making the decision.
7. The providers have 45 days following this notification to request reconsiderations. The DRG Validation Audit Program Reconsideration Process is available to providers and consists of two levels of reconsideration.
8. Reference the Rebilling chapter regarding resubmissions.
Reconsideration Process

The reconsideration process is a process for providers to request reconsideration on the claim decisions made in the DRG Validation Audit Program. The DRG Validation Audit Program Reconsideration Process applies only to the DRG Validation Audit Program.

First Level of Reconsideration

The provider must send a written request via certified mail with any additional information and the rationale for the request within 45 days of certified receipt date of the DRG notification letter. The request will be reviewed by a coding professional or a registered nurse. If following this review the conclusion remains adverse, a medical doctor will review the case and make the final determination. Blue Cross Blue Shield of North Dakota (BCBSND) will respond to the provider within 45 days of the certified receipt date of the request with a determination. This level of reconsideration will determine if medical documentation and treatment provided supports the rationale for allowing the claim as originally submitted.

Second Level of Reconsideration

The provider must send a written request via certified mail with any additional information within 45 days of the certified receipt date of BCBSND first level reconsideration response. A physician consultant, with the same or similar specialty as the health care provider, will review the request. BCBSND will respond to the provider with a determination within 45 days of certified receipt date of the request. This is the final level of reconsideration for issues related to DRG Validation with BCBSND.

At the conclusion of the Level II reconsideration, an administrative assessment will be performed to determine if the BCBSND Reconsideration Process was conducted appropriately.

Independent External Review

A health care provider may request an independent external review as outlined in HealthCare News 314. This external review may be requested only after exhausting all of the DRG Validation Program’s reconsideration processes.
Guidelines for Requesting a Reconsideration:

- Send a written request via certified mail.
- Send the request to:
  VP Clinical Excellence and Quality
  Health Network Innovation
  Blue Cross Blue Shield of North Dakota
  4510 13th Avenue S
  Fargo, ND 58121

- The written request and the medical record information must be received within the 45-day time frame.
- Submit any additional information and the rationale for the request.
- Focus on the pertinent medical information.
- Submit medical documentation not previously provided.

If the attending physician and/or Medical Director wishes to discuss a claim with the BCBSND Medical Director, the appropriate time is after the first level reconsideration has taken place and the provider has received the response letter from BCBSND. After an inquiry, if a disagreement remains regarding the proposed determination, the provider may request reconsideration to the second level by submitting additional information.
HealthCare News Articles

The following pages are copies of HealthCare News articles that pertain to the Reconsideration Process. Articles regarding the DRG Validation Program will periodically appear in future HealthCare News Bulletins.

- December 2009 – Independent External Review Process
- April 2012 – Reconsideration Process
**Independent External Review Process**

A provider may request an independent external review to determine if medical care provided was medically necessary and appropriate to the claim as submitted by the healthcare provider and reviewed by BCBSND. An independent external review may be requested only after exhausting BCBSND’s provider appeal process. BCBSND has contracted with North Dakota Health Care Review, Inc. (NDHCRI) to conduct independent external reviews. BCBSND will provide the medical information and medical policies used in the provider inquiry and appeal process.

The determination from NDHCRI will be the final decision and will be communicated in writing to BCBSND. BCBSND will provide written notification of the determination to the provider within 60 days from the receipt date of the completed request form.

North Dakota Century Code, Section 26.1-36-44 states, “Costs associated with the independent external review are the responsibility of the nonprevailing party.” Therefore, the nonprevailing party is responsible for payment of the $750 review fee after the final determination has been made.

To request a review, complete and submit the Request for Independent External Review form to BCBSND within 60 days following the final BCBSND appeal determination. This form can be found at www.THORConnect.org, Provider Services, Forms.

The Independent External Review process does not apply to the following and requests will be returned to the provider:

- Benefit plan exclusions
- Self-funded employee benefit plans
- Federal Employee Program (FEP).

---

**Coding and Billing**

**Outpatient and Inpatient Consults – Professional**

*Effective for services on or after January 1, 2010*

To ease billing requirements for providers, and in lieu of the 2010 RVU changes, BCBSND will follow CMS’s billing change related to consult codes. Effective for services on or after January 1, 2010, BCBSND will not accept CPT® codes 99241 – 99245 and 99251 – 99255. The appropriate office visit or hospital care code must be submitted. The new and established patient rules will apply in the same manner.

According to the Federal Register, November 25, 2009, Final Rule for the Physician Fee Schedule, CMS will no longer allow physicians to submit claims using the American Medical Association’s CPT® codes that identify Office or Other Outpatient Consultation (99241 – 99245) and/or Inpatient Consultations (99251 – 99255). These codes remain valid codes but will not be accepted by CMS. Providers have been instructed to use other appropriate E&M codes such as the new/established office visit codes and initial/subsequent hospital care codes to report these services. The Relative Value Units (RVUs) for the work component of these E&M codes, as well as the surgical global package, have been adjusted to reflect their use in replacing consults.

Modifier AI (Principle physician of record) has been created for use by the admitting physician of record for hospital inpatient and nursing facility admissions. This will distinguish the admitting physician from other physicians who provide specialty care when billing inpatient hospital care codes. When a specialty physician sees a patient for the first time as a “consult,” an initial hospital care code is used regardless of when the “consult” occurs during the stay. Unless the specialty physician has admitted the patient, modifier AI should not be used in this situation. Additional visits by the specialty physician must be billed as subsequent hospital care.

**Office or Other Outpatient Consultations**

(CPT® codes 99241 – 99245)

These office or outpatient consultations should be submitted using the new or established patient office or other outpatient visit codes identified by CPT® codes 99201 – 99215. The consultation codes will be non-covered as provider liable with instructions to resubmit using one of the above office visit codes.

**Inpatient Consultations (CPT® codes 99251 – 99255)**

The first time a physician sees a patient in “consult,” an initial hospital care code may be billed regardless of when the visit occurs during an inpatient stay. There may be multiple initial hospital care codes on the admit date or other date depending on the physician(s) who assesses the patient in “consult.” However, there should never be more than one initial hospital care code per physician. Subsequent visits to the patient must be billed using subsequent care codes. Inpatient consultation codes will be non-covered as provider liable with instructions to resubmit using one of the inpatient or nursing facility day care codes.

The admitting physician must append modifier AI to the initial hospital or nursing facility care code to identify the admitting physician of record. There should only be one initial hospital or nursing facility care code with modifier AI. Any additional codes with this modifier will be non-covered as a duplicate service.

We will continue to monitor CMS guidelines for additional information related to the change in coding of consults.
DRG Validation

Reconsideration Process

The reconsideration process is a process for providers to request reconsideration on the claim decisions made in the DRG Validation Audit Program. This reconsideration process applies only to the DRG Validation Audit Program and is available online at www.THORConnect.org, Provider Services, Billing & Reimbursement, DRG Validation Program.

First Level of Reconsideration

The provider must send a written request via certified mail with any additional information and the rationale for the request within 45 days of certified receipt date of the DRG notification letter. The request will be reviewed by a coding professional or a registered nurse. If following this review the conclusion remains adverse, a medical doctor will review the case and make the final determination. Blue Cross Blue Shield of North Dakota (BCBSND) will respond to the provider within 45 days of the certified receipt date of the request with a determination. This level of reconsideration will determine if medical documentation and treatment provided supports the rationale for allowing the claim as originally submitted.

Second Level of Reconsideration

The provider must send a written request via certified mail with any additional information within 45 days of the certified receipt date of BCBSND first level reconsideration response. A physician consultant, with the same or similar specialty as the health care provider, will review the request. BCBSND will respond to the provider with a determination within 45 days of the certified receipt date of the request. This is the final level of reconsideration for issues related to DRG Validation with BCBSND. At the conclusion of the Level II reconsideration, an administrative assessment will be performed to determine if the BCBSND Reconsideration Process was conducted appropriately.

Independent External Review

A health care provider may request an independent external review as outlined in HealthCare News 314. This external review may be requested only after exhausting all of the DRG Validation Program’s reconsideration processes.

Guidelines for Requesting a Reconsideration:

- Send a written request via certified mail.
- Send the request to:
  Director, Medical Quality
  Medical Management
  Blue Cross Blue Shield of North Dakota
  4510 13th Avenue S
  Fargo, ND 58121
- The written request and the medical record information must be received within the 45-day time frame.
- Submit any additional information and the rationale for the request.
- Focus on the pertinent medical information.
- Submit medical documentation not previously provided.

If the attending physician and/or Medical Director wishes to discuss a claim with the BCBSND Medical Director, the appropriate time is after the first level reconsideration has taken place and the provider has received the response letter from BCBSND. After an inquiry, if a disagreement remains regarding the proposed determination, the provider may request reconsideration to the second level by submitting additional information.

Coding Counts

Therapeutic Phlebotomy

CPT® code 99195 (Phlebotomy, therapeutic [separate procedure]) in the Medicine section represents a therapeutic phlebotomy. This procedure is often used in the treatment of polycythemia vera to reduce the hematocrit value and red blood cell mass. Therapeutic phlebotomies are used in the treatment of other diseases as well.

Although obtaining a blood specimen is also referred to as phlebotomy, this code is not reported for the acquisition of blood specimens for laboratory services.
Rebilling Process

Coding Audit

After the reconsideration process is completed, Blue Cross Blue Shield of North Dakota (BCBSND) performs a refund on cases where a DRG discrepancy was identified. The provider needs to resubmit these claims with the appropriate codes to receive reimbursement.

Level of Care Audit

As of January 1, 2005, claims are reviewed prior to payment. Providers are notified via certified mail with instructions how to resubmit the claim for reimbursement.

Readmission Audit

After the reconsideration process is completed, and the determination is to combine two hospital admissions, BCBSND performs a refund of the paid admission. It is the policy of BCBSND to deduct the amount of any refund from future payments due you by BCBSND. Information relevant to this deduction is included in the Blue Cross Hospital Deduction report the provider receives after the deduction is made.

When multiple claims are to be combined, the provider is instructed to make the necessary changes and resubmit as one claim.

Transfer Audit

After the reconsideration process is completed, BCBSND performs a refund on any paid claims and instructs the facility to resubmit the claim with the correct discharge status.

If the claim has not been paid, the provider will be instructed to resubmit the claim with the appropriate discharge status code.

Catastrophic Audit

After the reconsideration process is completed, BCBSND performs a refund on claims that need adjustment.

The provider needs to resubmit this claim with the appropriate billing instructions and codes to receive reimbursement.
Communication Document Examples

The following pages contain example copies of communication to Health Care Providers pertinent to Coding, Level of Care, Readmission, and Transfer Audits. For easier reference, the page number has been included in parentheses after each type of document.

Coding Audit Letters
- Mail In Request (11.1.2)
- On-site Review Request (11.1.3)
- Agreement (11.1.4)
- Disagreement (11.1.5)
- Claims Adjustment Form (11.1.6)

Level of Care Audit Letters
- Mail In Request (11.1.7)
- Utilization Review Department Disagreement - Medical (11.1.8)
- Utilization Review Department Disagreement - Surgical (11.1.9)

Readmission Audit Letters
- Utilization Review Department Disagreement (11.1.10)

Transfer Audit Letters
- Utilization Review Department Disagreement (11.1.11)

Reconsideration Letters
- Level of Care Audit Agreement (11.1.12)
- Level of Care Audit Disagreement - Medical/Surgical (11.1.13)
- Level of Care Audit Agreement (11.1.14)
- Level of Care Audit Disagreement - Medical/Surgical (11.1.15)
Date

Medical Record Contact
Hospital
Address

Dear Ms. XXXXXX:

The enclosed list of records has been selected for review under the Blue Cross Blue Shield of North Dakota (BCBSND) DRG Validation Audit Program for 3rd Quarter 2012.

These records should be submitted to BCBSND within 30 days of receipt of this request. The following documentation from each chart is being requested from your Health Information Department so we may verify the services reimbursed are properly supported by documentation in the medical record:

<table>
<thead>
<tr>
<th>Face Sheet</th>
<th>Physician Queries</th>
<th>Pathology Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graphic/Vital Sign Record</td>
<td>Discharge Summary</td>
<td>Consultations</td>
</tr>
<tr>
<td>Radiology Reports</td>
<td>Intake and Output Record</td>
<td>Respiratory Therapy</td>
</tr>
<tr>
<td>Emergency Room Records</td>
<td>Operative Reports</td>
<td>Nurses’ Notes</td>
</tr>
<tr>
<td>History and Physical Exam</td>
<td>Anesthesia Reports</td>
<td>Medication Lists</td>
</tr>
<tr>
<td>Physician Orders</td>
<td>OB Delivery Records</td>
<td>Coding Summary Sheet</td>
</tr>
<tr>
<td>Physician Progress Notes</td>
<td>Laboratory Reports</td>
<td></td>
</tr>
</tbody>
</table>

Please send the above health information with a copy of this letter to:

Reimbursement Coding Coordinator
Health Network Innovation
Blue Cross Blue Shield of North Dakota
4510 13th Ave S
Fargo, ND 58121-0001

Chart copies will be reimbursed at a rate of $6.00 per chart. Invoices should be sent to Attn: Utilization Review Examiner, Health Network Innovation, Blue Cross Blue Shield of North Dakota, 4510 - 13th Avenue S, Fargo, ND 58121.

Thank you in advance for your cooperation.
Date

Medical Record Contact
Hospital
Address

Dear Ms. XXXXXX:

The enclosed list of records has been selected for review under the Blue Cross Blue Shield of North Dakota (BCBSND) DRG Validation Audit Program for 3rd Quarter 2012. Review of the medical record will verify the services reimbursed are properly supported by documentation in the medical record.

These records should be available February 19, 20, 21 and 22, 2013 for one Coding Reviewer. If, for some reason, the review must be postponed or cancelled, BCBSND will notify you in advance and reschedule. All reviews conducted at your facility will be conducted in a manner to maintain confidentiality. At the conclusion of the review, you will have the opportunity to meet and discuss preliminary findings. All final DRG recommendations will be returned to your facility in a separate report.

Please have available a private work area with access to phone and electrical lines for laptop hookup.

Chart copies, if requested, will be reimbursed at a rate of $6.00 per chart. Invoices should be sent to Attn: Utilization Review Examiner, Health Network Innovation, Blue Cross Blue Shield of North Dakota, 4510 - 13th Avenue S, Fargo, ND 58121.

Thank you in advance for your cooperation.
Date

Medical Record Contact
Hospital
Address

**RE: 3rd Quarter 2012 Coding Audit**

Dear Ms. XXXXXX:

The attached claims have been reviewed as part of the Blue Cross Blue Shield of North Dakota DRG Validation Audit Program. The claims were subject to a **coding review**.

It has been determined that these claims were appropriate as submitted by your facility for reimbursement. This notice is for informational purposes and **no further action is required**.

Any questions regarding the DRG Validation Coding Audit or the Reconsideration Process should be directed to the Reimbursement Coding Coordinator at (701) XXX-XXXX.
Date

Medical Record Contact
Hospital
Address

**RE: 3rd Quarter 2012 Coding Audit**
Inpatient Claim for XXXXXXXXXX, Benefit Plan XXXXXXXXXX
Dates of Service: MM/DD/YYYY – MM/DD/YYYY

Dear Ms. XXXXXX:

The above referenced claim was reviewed as part of the Blue Cross Blue Shield of North Dakota (BCBSND) DRG Validation Audit Program. The claim was subject to a **coding review**.

BCBSND disagrees with the claim as submitted. Please see the enclosed claim adjustment form for specific details.

It has been determined that a refund is due to BCBSND for this admission. It is the policy of BCBSND to deduct the amount of any refund from future payments due you by BCBSND. Information relevant to this deduction will be included in the Blue Cross Hospital Deduction report you receive after the deduction is made. **You will need to resubmit this claim with the recommended corrections to receive payment.**

If you disagree with this determination, you may request reconsideration by following the enclosed Reconsideration Process enclosure. If you agree with the proposed change and would like to expedite the process, please notify the Reimbursement Coding Coordinator in writing that you agree with the recommended change. Following this notification, the claim can be resubmitted for reimbursement and the Reconsideration Process timeframe of 45 days will be waived.

Any questions regarding the DRG Validation Coding Audit or the Reconsideration Process should be directed to the Reimbursement Coding Coordinator at (701) XXX-XXXX.
Blue Cross Blue Shield of North Dakota
DRG Coding Audit Claim Adjustment

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Quarter:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case #:</td>
<td>Contract:</td>
</tr>
<tr>
<td>Last Name:</td>
<td>Admit Date:</td>
</tr>
<tr>
<td>First Name:</td>
<td>Discharge Date:</td>
</tr>
<tr>
<td>Birth Date:</td>
<td>Medical Record #:</td>
</tr>
<tr>
<td>Original Diag Code: 5849</td>
<td>New Diag Code: 99681</td>
</tr>
<tr>
<td>Diag Codes:</td>
<td>Codes:</td>
</tr>
<tr>
<td>99681</td>
<td>5849</td>
</tr>
<tr>
<td>2765</td>
<td>2765</td>
</tr>
<tr>
<td>4732</td>
<td>4732</td>
</tr>
<tr>
<td>28521</td>
<td>28521</td>
</tr>
<tr>
<td>25080</td>
<td>25080</td>
</tr>
<tr>
<td>7580</td>
<td>7580</td>
</tr>
<tr>
<td>5880</td>
<td>5880</td>
</tr>
<tr>
<td>4019</td>
<td>4019</td>
</tr>
<tr>
<td>E878</td>
<td></td>
</tr>
<tr>
<td>Proc Codes:</td>
<td>Codes:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Original DRG Code: 316  
New DRG Code: 331

Summary Comment

Disagree with principal diagnosis code selection. The patient has acute and chronic renal failure, status post kidney transplant. Coding Clinic 3rd Quarter 1998 advises “code 996.81, Complications of a transplanted organ, Kidney, is the correct principal diagnosis. Code 586, Renal failure, unspecified, should be assigned as a secondary diagnosis.” Coding Clinic 3rd Quarter 2001 also advises “Codes from subcategory 996.8, Complications of transplanted organ, are assigned when the recipient is rejecting the transplanted organ or there are other complications or diseases of the transplanted organ.” Acute and chronic renal failure would both be considered complications or diseases of the transplanted organ. Recommend 996.81 as the principal diagnosis code.
BEGIN REPORT: PROV NUMBER: PROV NAME:

MEDICAL RECORDS
NAME OF HOSPITAL
ADDRESS
CITY ST ZIP

DATE
CLAIM NUMBER

ADMISSION OF PATIENT NAME ON DATE OF SERVICE CASE NO. ######
BENEFIT PLAN NO. ######################## DATE OF BIRTH ####-####-

TO ASSIST IN THE REVIEW OF THE ABOVE CLAIM, MAY WE HAVE A
PHOTOSTATIC COPY OR TRANSCRIPT OF THE FOLLOWING:

ENTIRE CHART FOR REVIEW FOR THE DRG VALIDATION PROGRAM

THANKS FOR YOUR HELP.

INSTITUTIONAL CLAIMS DEPARTMENT
1-800-368-2312; OR (701) 282-1090

CLAIM NUMBER
Date

RE: Patient Name:  
Date of Birth:  
Benefit Plan Number:  
Dates of Service:  
Patient Account #:  

Dear Utilization Review Department –

We reviewed the above referenced claim as part of the Blue Cross Blue Shield of North Dakota (BCBSND) Diagnosis Related Group (DRG) Validation Audit Program. The claim was subject to a level of care review.

BCBSND disagrees with the claim as submitted and is recommending this claim be resubmitted as observation status, based on the following:

You will need to advise your business office of our determination and have them resubmit this claim as an observation claim. If you have questions or need clarification regarding the determination, you may call 1-701-282-1449 or 1-701-282-1942 and speak to a DRG nurse reviewer. This call does not replace the formal Reconsideration Process. If you disagree with this determination, you may still request reconsideration by following the Reconsideration Process as noted in the DRG Validation Audit Program Provider Reference Manual. This manual is available online at www.BCBSND.com, Provider Services, Billing & Reimbursement, DRG Validation Program.

InterQual Acute Level of Care Criteria provides support for determining the appropriateness of an acute hospital admission utilizing a condition-specific focus. InterQual Level of Care Criteria is a nationally recognized review tool used when making a decision about level of care, along with common medical practice across the state and Medical Director input.

Any further questions regarding this claim or the Reconsideration Process should be sent in writing to Cindy Cameron, Team Leader Medical Review, Health Network Innovation, Blue Cross Blue Shield of North Dakota, 4510 13 Avenue South, Fargo, ND 58121.

Sincerely,

Cindy Cameron RN  
Team Leader Clinical Excellence & Quality  
Health Network Innovation Division – BCBSND
Date

RE: Patient Name:  
Date of Birth:  
Benefit Plan Number:  
Dates of Service:  
Patient Account #:  

Dear Utilization Review Department – : 

We reviewed the above referenced claim as part of the Blue Cross Blue Shield of North Dakota (BCBSND) Diagnosis Related Group (DRG) Validation Audit Program. The claim was subject to a level of care review.

BCBSND disagrees with the claim as submitted and is recommending this claim be resubmitted as outpatient, based on the following:

You will need to advise your business office of our determination and have them resubmit this claim as an outpatient claim. If you have questions or need clarification regarding the determination, you may call 1-701-282-1449 or 1-701-282-1942 and speak to a DRG nurse reviewer. This call does not replace the formal Reconsideration Process. If you disagree with this determination, you may still request reconsideration by following the Reconsideration Process as noted in the DRG Validation Audit Program Provider Reference Manual. This manual is available online at www.BCBSND.com, Provider Services, Billing & Reimbursement, DRG Validation Program.

InterQual Acute Level of Care Criteria provides support for determining the appropriateness of an acute hospital admission utilizing a condition-specific focus. InterQual Level of Care Criteria is a nationally recognized review tool used when making a decision about level of care, along with common medical practice across the state and Medical Director input.

Any further questions regarding this claim or the Reconsideration Process should be sent in writing to Cindy Cameron, Team Leader Medical Review, Health Network Innovation, Blue Cross Blue Shield of North Dakota, 4510 13 Avenue South, Fargo, ND 58121.

Sincerely,

Cindy Cameron RN  
Team Leader Clinical Excellence & Quality  
Health Network Innovation Division – BCBSND
Date

RE:Patient Name:
Date of Birth:
Benefit Plan Number:
Dates of Service:
Patient Account #:

Dear Utilization Review Department –:

We reviewed the above referenced claim as part of the Blue Cross Blue Shield of North Dakota (BCBSND) Diagnosis Related Group (DRG) Validation Audit Program. The claim was subject to a readmission review.

BCBSND disagrees with this claim as submitted. We are recommending combining this stay with date of service , with patient account number based on the following:

You will need to advise your business office of our determination and have them resubmit this claim as one combined stay. If you have questions or need clarification regarding the determination, you may call 1-701-282-1449 or 1-701-282-1942 and speak to a DRG nurse reviewer. This call does not replace the formal Reconsideration Process. If you disagree with this determination, you may still request reconsideration by following the Reconsideration Process as noted in the DRG Validation Audit Program Provider Reference Manual. This manual is available online at www.BCBSND.com, Provider Services,

Billing & Reimbursement, DRG Validation Program.

Any further questions regarding this claim or the Reconsideration Process should be sent in writing to Cindy Cameron, Team Leader Medical Review, Health Innovation Network, Blue Cross Blue Shield of North Dakota, 4510 13 Avenue South, Fargo, ND 58121.

Sincerely,

Cindy Cameron RN
Team Leader Clinical Excellence & Quality
Health Network Innovation Division – BCBSND
Date

RE: Patient Name:
   Date of Birth:
   Benefit Plan Number:
   Dates of Service:
   Patient Account #:

Dear Utilization Review Department -

We have reviewed the above referenced claim as part of the Blue Cross Blue Shield of North Dakota (BCBSND) Diagnosis Related Group (DRG) Validation Audit Program. The claim was subject to a transfer review.

BCBSND disagrees with the claim as submitted as this patient was transferred to another facility. We are recommending this claim be resubmitted with the appropriate discharge status code of  .

You will need to advise your business office of our determination and have them resubmit this claim with corrected transfer code. If you have questions or need clarification regarding the determination, you may call 1-701-282-1449 or 1-701-282-1942 and speak to a DRG nurse reviewer. This call does not replace the formal Reconsideration Process. If you disagree with this determination, you may still request reconsideration by following the Reconsideration Process as noted in the DRG Validation Audit Program Provider Reference Manual. This manual is available online at www.BCBSND.com, Provider Services, Billing & Reimbursement, DRG Validation Program.

Any further questions regarding this claim or the Reconsideration Process should be sent in writing to Cindy Cameron, Team Leader Medical Review, Health Network Innovation, Blue Cross Blue Shield of North Dakota, 4510 13 Avenue South, Fargo, ND 58121.

Sincerely,

Cindy Cameron RN
Team Leader Clinical Excellence & Quality
Health Network Innovation Division – BCBSND
Date

(Provider Name)
(Facility)
(Address)
(City, State, Zip)

RE: Patient Name:
   Date of Birth:
   Benefit Plan Number:
   Dates of Service:
   Patient Account #:

Dear (Last Name):

We received and reviewed your reconsideration concerning the proposed adjustment of reimbursement for the above referenced inpatient stay. After careful reconsideration of all available information, it is our determination to allow this claim to be reimbursed at an inpatient level of care.

The Diagnosis Related Group (DRG) Validation staff reviewed this case. Our findings are as follows: This is appropriate for inpatient in this case.

InterQual Acute Level of Care Criteria provides support for determining the appropriateness of an acute hospital admission utilizing a condition-specific focus. InterQual Level of Care Criteria is a nationally recognized review tool used when making a decision about level of care, along with common medical practice across the state and Medical Director input.

You do not need to resubmit the claim, as we will process your original claim as submitted.

Sincerely,

Cindy Cameron RN
Team Leader Clinical Excellence & Quality
Health Network Innovation Division – BCBSND
Date

(Provider Name)
(Facility)
(Address)
(City, State, Zip)

RE: Patient Name:
Date of Birth:
Benefit Plan Number:
Dates of Service:
Patient Account #:

Dear (Last Name):

We received and reviewed your reconsideration concerning the proposed adjustment of reimbursement for the above referenced inpatient stay. After careful reconsideration of all available information, it is our determination to uphold the decision that this claim is reimbursed at an observation level of care.

The Diagnosis Related Group (DRG) Validation staff, including the Medical Director, reviewed this case. Our findings are as follows:

InterQual Acute Level of Care Criteria provides support for determining the appropriateness of an acute hospital admission utilizing a condition-specific focus. InterQual Level of Care Criteria is a nationally recognized review tool used when making a decision about level of care, along with common medical practice across the state and Medical Director input.

You will need to advise your business office of our determination and have them resubmit this claim as an claim. If you disagree with this determination, you may request reconsideration by following the Reconsideration Process as noted in the DRG Validation Audit Program Provider Reference Manual. This manual is available online at www.BCBSND.com, Provider Services, Billing & Reimbursement, DRG Validation Program.

Any questions regarding this claim or the Reconsideration Process should be sent in writing to Cindy Cameron, Team Leader Medical Review, Health Network Innovation, Blue Cross Blue Shield of North Dakota, 4510 13th Avenue South, Fargo, ND 58121.

Sincerely,

Cindy Cameron RN
Team Leader Clinical Excellence & Quality
Health Network Innovation Division – BCBSND
Date

(Provider Name)
(Facility)
(Address)
(City, State, Zip)

RE:  Patient Name:
     Date of Birth:
     Benefit Plan Number:
     Dates of Service:
     Patient Account #:

Dear (Last Name):

An outside Consulting Physician reviewed this reconsideration request and concluded that this admission is appropriate for inpatient level of care.

At the conclusion of the Second Level Reconsideration process, an administrative assessment was performed to determine if the BCBSND Reconsideration Process was conducted appropriately. This is the final level of reconsideration for issues related to Diagnosis Related Group (DRG) Validation. Please refer to Chapter 9 of the Provider Reference Manual provided by the DRG Validation Audit Program for further reference.

You do not need to resubmit the claim, as we will process your original claim as submitted.

Sincerely,

Cindy Cameron RN
Team Leader Clinical Excellence & Quality
Health Network Innovation Division – BCBSND
Date

(Provider Name)
(Facility)
(Address)
(City, State, Zip)

RE: Patient Name:  
Date of Birth:  
Benefit Plan Number:  
Dates of Service:  
Patient Account #:  

Dear (Last Name):

An outside Consulting Physician reviewed this reconsideration request and concluded that this admission is appropriate for [level of care].

Rationale provided by the Consultant for this decision includes:

At the conclusion of the Second Level Reconsideration process, an administrative assessment was performed to determine if the Blue Cross Blue Shield of North Dakota Reconsideration Process was conducted appropriately. This is the final level of reconsideration for issues related to Diagnosis Related Group (DRG) Validation. Please refer to Chapter 9 of the Provider Reference Manual provided by the DRG Validation Audit Program for further reference.

You will need to advise your business office of our determination and have them resubmit this claim as an observation status.

Sincerely,

Cindy Cameron RN  
Team Leader Clinical Excellence & Quality  
Health Network Innovation Division – BCBSND
Provider Reference Manual Update Letters

The following pages contain copies of the Explanation of Updates letter included in annual updates to the DRG Validation Audit Program Provider Reference Manual.

- January 2010
- January 2011
- March 2012
January 2010

TO: Utilization Management Departments/Health Information Departments of all participating Blue Cross Blue Shield of North Dakota (BCBSND) hospital providers.


This manual was first distributed to your departments in August 2003. All changes to the manual are updated on the Blue Cross Blue Shield of North Dakota web site (www.bcbsnd.com). To access the manual online, log onto the BCBSND web site, select THORconnect.org which is within the Providers section and then select Provider Service. The manual is located within Billing and Reimbursement.

Statistical Updates

We have provided charts that detail statistics regarding reviews conducted by the DRG Validation Program staff from 2008. These charts include:

- The number of claims paid by the plan (Coding Audit)
- The number of claims by total admissions (Level of Care, Readmission/Transfer)
- The number of claims reviewed by the Program
- The number of claims where the Program disagreed with the claim as submitted
- The number of claims appealed
- The number of appeals reversed

In the 2008 Level of Care and Readmit/Transfer Audits, the average percent of all acute inpatient claims reviewed was 5.9 percent. BCBSND disagreed with an average of 1.5 percent of the total acute inpatient claims received by BCBSND. The facilities appealed an average of 28.6 percent of the claims on which BCBSND disagreed. BCBSND reversed an average of 24.7 percent of the claims appealed.

In the 2008 Coding Audit, the average percentage of all acute inpatient claims reviewed was 11.8 percent. BCBSND disagreed with an average of 1.9 percent of the total acute inpatient claims paid by BCBSND. The facilities appealed an average of 12.3 percent of the claims on which BCBSND disagreed. BCBSND reversed an average of 31.1 percent of claims appealed.

Included in the larger facility packets are enclosures that reflect facility specific information regarding the Program audits.
We hope all of the 2010 updates to the DRG Provider Reference Manual provide a useful resource for your facility in understanding the DRG Validation Program conducted by Blue Cross Blue Shield of North Dakota. Should you have any questions regarding the DRG Validation Program, please contact Carman Bercier, the Manager of BlueCard Operations & Claims Review.

Sincerely,

Senior Vice President
Claims Administration & Member Services

Senior Vice President/
Chief Medical Officer
Medical Management

Manager
BlueCard Operations & Claims Review
*Beginning January 1, 2005, the audit process was changed from post claim payment to pre claim payment.

<table>
<thead>
<tr>
<th>Claim Numbers</th>
<th>1st Qtr. 08</th>
<th>2nd Qtr. 08</th>
<th>3rd Qtr. 08</th>
<th>4th Qtr. 08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Paid By Admit Date</td>
<td>6,499</td>
<td>6,489</td>
<td>6,251</td>
<td>6,293</td>
</tr>
<tr>
<td>Reviewed Claims</td>
<td>377</td>
<td>443</td>
<td>417</td>
<td>274</td>
</tr>
<tr>
<td>Disagrees</td>
<td>112</td>
<td>127</td>
<td>94</td>
<td>61</td>
</tr>
<tr>
<td>Appealed</td>
<td>20</td>
<td>42</td>
<td>32</td>
<td>19</td>
</tr>
<tr>
<td>Reversed</td>
<td>4</td>
<td>11</td>
<td>8</td>
<td>5</td>
</tr>
</tbody>
</table>
DRG Validation Program
Coding Audits
All Facilities

- Paid Claims: 6,255 (1st Qtr. 08), 6,357 (2nd Qtr. 08), 6,395 (3rd Qtr. 08), 5,946 (4th Qtr. 08)
- Reviewed Claims: 738, 743, 744, 739
- Disagrees: 121, 146, 117, 110
- Appealed: 9, 20, 14, 18
- Reversed: 5, 4, 6, 4
TO: Utilization Management Departments and Health Information Departments of all participating Blue Cross Blue Shield of North Dakota (BCBSND) hospital providers


This manual was first distributed to your departments in August 2003. All changes to the manual are updated on the BCBSND web site (www.bcbsnd.com). To access the manual online, enter the BCBSND web site, select THORconnect.org which is within the Providers section and then select Provider Services. The manual is located within Billing and Reimbursement.

**Statistical Updates**

We have provided charts that detail statistics regarding reviews conducted by the DRG Validation Program staff from 2009. These charts include:

- The number of claims paid by the plan (Coding Audit)
- The number of claims by total admissions (Level of Care, Readmission/Transfer)
- The number of claims reviewed by the Program
- The number of claims where the Program disagreed with the claim as submitted
- The number of reconsiderations requested
- The number of reconsiderations reversed

In the 2009 Level of Care and Readmission/Transfer Audits, the average percent of all acute inpatient claims reviewed was 5.1 percent. BCBSND disagreed with an average of 1.5 percent of the total acute inpatient claims received by BCBSND. The facilities requested reconsiderations on an average of 9.9 percent of the claims on which BCBSND disagreed. BCBSND reversed an average of 47.4 percent of the claims reconsidered.

In the 2009 Coding Audit, the average percentage of all acute inpatient claims reviewed was 11.6 percent. BCBSND disagreed with an average of 2.1 percent of the total acute inpatient claims paid by BCBSND. The facilities requested reconsiderations on an average of 11.6 percent of the claims on which BCBSND disagreed. BCBSND reversed an average of 32.2 percent of claims reconsidered.

Included in the larger facility packets are enclosures that reflect facility specific information regarding the Program audits.
We hope all of the 2011 updates to the DRG Provider Reference Manual provide a useful resource for your facility in understanding the DRG Validation Program conducted by BCBSND. Should you have any questions regarding the DRG Validation Program, please contact Jami Berger, AVP of Medical Quality.

Sincerely,

David Hanekom M.D., F.A.C.P., C.M.P.E.  
Chief Medical Officer  
Medical Management  

Jami Berger B.S.N., R.N., M.B.A.  
Assistant Vice President  
of Medical Quality  
Medical Management
*Beginning January 1, 2005, the audit process was changed from post claim payment to pre claim payment.
March 2012

Dear BCBSND Provider:

As a member of a Utilization Management Department or Health Information Department of a participating Blue Cross Blue Shield of North Dakota (BCBSND) hospital provider, we are writing to inform you about 2012 Updates to the Diagnosis Related Group (DRG) Validation Provider Reference Manual.

Enclosed in this mailing are statistical and communication updates to the DRG Validation Program. Please note no criteria updates have been made to the DRG reference manual at this time. Any future revisions or updates will be communicated in a separate mailing.

Statistical Updates

We have provided charts that detail statistics regarding reviews conducted by the DRG Validation Program staff from 2010. These charts include:

- The number of claims paid by the plan (Coding Audit)
- The number of claims by total admissions (Level of Care, Readmission/Transfer)
- The number of claims reviewed by the program
- The number of claims in which the program disagreed with the claim as submitted
- The number of reconsiderations requested
- The number of reconsiderations reversed

In the 2010 Level of Care and Readmit/Transfer Audits, the average percentage of all acute inpatient claims reviewed was 5.7 percent. BCBSND disagreed with an average of 1.7 percent of the total acute inpatient claims received by BCBSND. The facilities requested reconsiderations on an average of 15.8 percent of the claims which BCBSND disagreed. BCBSND reversed an average of 42.2 percent of the claims reconsidered.

In the 2010 Coding Audit, the average percentage of acute inpatient claims reviewed was 12.4 percent. BCBSND disagreed with an average of 2.2 percent of the total acute inpatient claims paid by BCBSND. The facilities requested reconsiderations on an average of 17.1 percent of the claims which BCBSND disagreed. BCBSND reversed an average of 27.9 percent of the claims reconsidered.

Included in the larger facility packets are enclosures that reflect facility specific information regarding the Program audits.
Communication Update

We will continue to send certified communication letters regarding Level of Care, Readmission or Transfer reviews to the facility’s Utilization Review Department regarding determinations. **Please note, as of April 2, 2012, we will no longer be including a Business Office copy.** It will be the responsibility of the Utilization Review Department at each facility to forward the information to the Business Office.

We will continue to send certified communication letters regarding Coding reviews to the facility’s Medical Records Department.

This manual was first distributed to your departments in August 2003. All changes to the manual are updated on the BCBDND website at www.bcbsnd.com. To access the manual online, enter the BCBSND website, select THORconnect.org which is within the Providers section and then select Provider Services. The manual is located within Billing and Reimbursement.

If you have any questions regarding the DRG Validation Program, please contact Jami Berger, Director of Quality Management.

Sincerely,

Eunah Fischer M.D.  
Interim Chief Medical Officer  
Medical Management

Jami Berger B.S.N., R.N., M.B.A.  
Director Medical Quality  
Medical Management