Coding Tips and Billing Reminders—Fall 2024

CHPW would like providers to be aware of several coding tips and billing reminders.

Coding Tips

These coding guidelines apply for all CHPW lines of business: Medicaid, Medicare Advantage, and Individual and Family Cascade Select.

Acute Myocardial Infarction (AMI)

A heart attack (myocardial infarction or MI) is a serious medical emergency in which the supply of blood to the heart is suddenly blocked, usually by a blood clot. The American College of Cardiology and the American Heart Association classify acute myocardial infarction (MI) into five types. When there is no information regarding the type of MI, type 1 is the default.

In ICD-10-CM, MIs are coded as initial and subsequent, utilizing a four-week rule. The terms initial and subsequent are used to indicate the timing of the acute MIs in relation to each other. The “INCLUDES” note under I21 states the category includes myocardial infarction specified as acute or with a stated duration of 4 weeks (28 days) or less from onset. This gives the indication for a “4-week rule.” Notice that it also clarifies the time frame as from onset, not discharge from the hospital, etc. The “INCLUDES” note under I22 states the category includes acute myocardial infarction occurring within four weeks (28 days) of a previous acute myocardial infarction, regardless of site. When a code from category I22 is assigned, there should also be a code from category I21 assigned to designate the initial myocardial infarction site. Also, there is a code for old myocardial infarction, I25.2. There is not, however, a code subcategory for chronic. The guidelines state that the acute code categories I21 and I22 may be reported for the 28-day duration as long as the patient requires continued care. If the patient requires continued care for the myocardial infarction after the 28-day period, then the aftercare codes must be used instead as ICD-10-CM does not contain codes for chronic myocardial infarction. Providers should document the timeline of the MI in the medical record using the number of days or weeks in order to report the condition appropriately. Notations such as “recent” or “several weeks” are considered vague.

References:

- ICD-10-CM Coding Guidelines Section I.C.9.e.1
- ICD-10-CM Coding Guidelines Section I.C.9.e.4
- ICD-10-CM Coding Guidelines Section I.C.9.b

Cerebrovascular Accident (CVA)

A cerebrovascular accident, also known as a stroke, is a serious life-threatening medical condition that happens when the blood supply to part of the brain is cut off. When blood flow to an area of the brain stops, oxygen and nutrients cannot get to that area of the brain, and brain cells begin to die, resulting in permanent damage. Strokes are a medical emergency and urgent treatment is essential in an acute care setting. To report CVA, refer to diagnosis code category I63.xx, Cerebral infarction 4th and 5th digits identify location and cause. Acute stroke (ICD-10-CM category I63) codes should not be coded from an outpatient setting since confirmation of the diagnosis should be determined by diagnostic studies, such as brain CT or brain MRI, which would be ordered in an emergency room or inpatient setting.

When a patient has a stroke, a code from subcategory R29.7 reports the National Institutes of Health Stroke Scale score which identifies the patient's neurological status and the severity of the stroke. The stroke scale codes are reported secondarily to an acute stroke code (category I63).

Following discharge from the acute care setting, report any sequelae (late effects) related to the CVA as I69.3xx, Sequelae of cerebral infarction; the 5th and 6th digits identify the nature of the late effect. In the absence of a sequela, report code Z86.73, Personal history of transient ischemic attack (TIA) and CVA without residual deficits.

References:

- ICD-10-CM Coding Guidelines Section I.C.18.i
- ICD-10-CM Coding Guidelines Section I.C.9.d
- AHA Coding Clinic – ICD-10 Published 10/6/2010

Modifier 25

Definition: Modifier 25 - Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service. This and other modifier definitions can be found in the CPTI book.

Modifier 25 should be appended to an E/M service when the provider renders an E/M to the patient on the same day as another service or minor procedure. The provider work dedicated to the E/M service must go beyond what is normally provided with the same-day procedure and documentation should clearly reflect that. Modifier 25 submissions require a minimum of two codes. During coding audits, CHPW found claims where modifier 25 was misused that resulted in denial.

Following are some examples of inappropriate use of this modifier:

- Modifier 25 appended to claims when an E/M visit was the only service reported
- Modifier 25 appended when there is no CCI edit requiring a modifier
- E/M billed with modifier 25 with imaging codes only (example: EKG)
- E/M billed with modifier 25 with labs only
- E/M billed with modifier 25 with genetic testing codes
- 99211 billed with modifier 25 is not a separately identifiable service
- Modifier 25 appended to a surgical procedure instead of E/M
- E/M code billed with modifier 25 along with major surgery code (90 days global) on same day. In this case modifier 57 should be used when appropriate.
- Modifier 25 used on claims when modifier 24 is appropriate. The same physician or physician within the same practice and subspecialty of physician that performed the major surgical procedure is billing an E/M code within the 90 days after the procedure.

Also, when the same physician bills an E/M within 10 days after the minor procedure they performed.

- Modifier 55 should be billed instead of billing an E/M with modifier 25 to break the surgical package.

References:

- CPT 2024 Professional Edition Codebook, Appendix A
- Reporting CPT Modifier 25 - CPT Assistant 2023
- Reporting CPT Modifier 25 (ama-assn.org)
- 25 - JF Part B - Noridian (noridianmedicare.com)
- NCCI for Medicare | CMS

Reporting Multiple Deliveries

Reporting twin or multiple deliveries, when the global obstetrical care is provided by the same physician or physician group, can be tricky and confusing. Here are some coding tips:

- If a patient is having twins, both vaginally, then code 59400 or 59610 would be billed for twin A, and 59409 or 59612 would be billed with modifier 51 for twin B.
- If both twins are delivered via cesarean delivery, then ***only*** code 59510 should be reported. No additional payment will be made by CHPW for additional babies.
- If twin A is delivered vaginally and twin B is delivered by cesarean then report global code 59510 or 59618, for the cesarean delivery, and 59409 or 59612, for the vaginal delivery with the modifier 51 appended. Modifier 59 (Distinct procedural service) is not appropriate to use in this case. Both CPT® and the American College of Obstetricians and Gynecologists (ACOG) recommend using modifier 51 (Multiple procedures) for the second delivery.
- The appropriate diagnosis code for multiple gestations should be indicated in all above scenarios.

References:

- CPT Assistant 8/1/2022 Maternity Care-Conception to Delivery
- American College of Obstetricians and Gynecologists
- Physician-Related Services/Health Care Professional Services billing guide

---

Billing Reminders

Hypertension—All Lines of Business

Based on ICD-10-CM Coding Guideline Section I.C.9, a ***combination code*** should be used for Hypertension with Hearth Disease (Category I11), for Hypertensive Chronic Kidney Disease

(Category I12) and for Hypertensive Heart and Chronic Kidney Disease (Category I13). I10 Essential (primary) hypertension should not be coded separately with I11, I12 or I13.

Coding hypertension with CKD and CHF should be as follows:

- I11.0 Hypertension with CHF
- I11.9 Hypertensive Heart Disease **without** CHF
- I12.9 Hypertension with CKD
- I12.0 Hypertension with stage 5 CKD or ESRD
- I13.0 Hypertension with CHF with CKD stage 1-4
- I13.1 Hypertensive Heart with CKD stage 1-4 without heart failure
- I10 cannot be billed with any of these diagnoses (dx): I11x,I12x,I13x, R03.0,O13x,O14x
- R03.0 cannot be billed with any of these dx: I10-I16x
- I11 and I12 family cannot be billed together because combination code I13 exists and should be billed instead.

ICD-10 Coding Update

Please review the [ICD-10-CM Official Guidelines for Coding and Reporting FY 2023 -- UPDATED April 1, 2023 (October 1, 2022 - September 30, 2023)] for more information.

Pain Management Procedures—Apple Health

The following CPT codes should not be billed with modifiers 59, XE, XS, XP, or XU. The CPT® codes listed below with an asterisk (*) are limited to two during the postoperative period while the enrollee is admitted to the hospital. Refer to the [Physician-Related Services/Health Care Professional Services billing guide] for more information.

11981*	20610	62282*	62355*	64402*
11982*	20612	62284	62360*	64405*
11983*	27096	62290	62361*	64408*
20526*	61790*	62291	62362*	64410*
20550	62264*	62320*	62365*	64412*
20551	62270	62322*	63650*	64413*
20552	62272	62324*	63655*	64415*
20553	62273*	62326*	63685*	64416*
20600	62280*	62350*	63688*	64417*
20605	62281	62351	64400	64418
64420*	64450*	64530*	64595*	64681*
64421*	64479*	64553*	64600*	64802*
64425*	64480*	64555*	64605*	64804*
64430*	64483*	64561*	64610*	64809*
64435*	64484*	64565*	64612*	64818
64445*	64505*	64575*	64616*	36400
64446*	64508*	64580*	64617*	36420
64447*	64510*	64581*	64620*	36425
64448*	64517*	64585*	64630*	36555

64449	64520	64590	64680	36566
36568 36580 36584 36589 36600 36620 36625 36660 62263 62287	63600 76000 76496 77001 77002 77003 93503 95970 95990			

Prolonged Services—All Lines of Business

Prolonged services billing requirements are different based on the line of business and/or the code billed. Below are a few code requirements to be aware of.

For **Apple Health**, the HCA covers:

- Up to three hours per client, per diagnosis, per day.
- Following CMS guidelines for HCPCS codes G0316, G0317, G0318, and G2212. Providers must follow coding rules.
- Refer to the [Physician-Related Services/Health Care Professional Services billing guide]() for more information.

For **Medicare Advantage and Individual and Family Cascade Select**, code G2211:

- Can be reported ***in addition to*** Office and Outpatient (O/O) E/M codes 99202-99205 and 99211-99215. This code ***may not be reported as standalone***; it must be reported with one of these specified O/O E/M visit codes.
- Is ***not payable*** with O/O E/M codes 99202-99205 and 99211-99215 codes ***with modifier 25***.

Swing Bed Claims—Apple Health

CHPW updated our claims system in July 2024 to reject claims if the IB 837 INST (inbound electronic institutional claim) file does not have a date of service (DOS) segment at the detail level (DTP*472; date time period and actual date of service) for specific bill types/place of service, including swing beds in skilled nursing facilities.

Per Washington State Health Care Authority (HCA) guidelines:

- The Line DOS is required on INST claim forms for*:
  - Nursing home claims
  - Swing bed claims
  - All outpatient services
- The HCA does not require the Line DOS when the services are **inpatient**.

- Nursing Home claims and swing bed claims can be designated either inpatient or outpatient services. While Medicare designates them as inpatient, the HCA has always designated theirs as outpatient.

***Note:** The HCA does not differentiate between Critical Access Hospitals who bill for swing bed claims any differently than nursing facilities who bill for swing beds claims. Both are considered outpatient, and both must list the DOS at the header and each service line.
If a skilled nursing institutional claim in the IB 837 has more than 1 Service Line, each line must have the DTP*472 segment for Loop 2400.

HCA Billing Guide Update
The Nursing Home billing guide has been updated effective October 1, 2024 to clarify that DOS is required at both the header and line levels. The billing guide is anticipated to be updated for November 1, 2024 to specifically address swing beds.

Questions
Contact Provider.Relations@chpw.org