Coding Guidance for HIV Clinical Practices: Diagnosis Coding for HIV Patients

This module discusses diagnosis coding used by medical practices when treating patients with HIV. Diagnosis coding establishes the medical necessity for a service, and can be the cause for denials, depending on payer edits.

This module will guide medical practices in diagnosis coding for fee-for-service patients, but will emphasize risk adjusted diagnosis coding. Medical practices that are part of Accountable Care Organizations or that have risk-based contracts with payers need to give the payer an accurate picture of the acuity of their patient population. The practice does this through accurate diagnosis coding on claim forms.

HIV Medicine Association
1300 Wilson Blvd., Suite 300
Arlington, VA 22209
www.hivma.org
(703) 299-1215
info@hivma.org
@hivma

Prepared for the HIV Medicine Association by Betsy Nicoletti
April 2018

Physician claims in a fee-for-service world:

In fee-for-service reimbursement, physician payment is based on the fee associated with the CPT/HCPCS code. The diagnosis shows medical necessity, and may be the cause of denials.

Physicians use CPT or HCPCS codes to tell the payer what was done (lab test, office visit) and modifiers to describe special circumstances (separate procedure done on day of office visit).

Providers use diagnosis codes to tell the payer:

- The reason the service was performed.
- The medical necessity of the service.

The payer uses the diagnosis code to determine coverage and medical necessity.

In fee-for-service medicine:

Diagnosis coding establishes medical necessity, and may be the reason for a denial, particularly for diagnostic tests or procedures. Services with national or local coverage policies often have specific diagnosis codes that are required for payment.

In risk based contracts or shared savings programs:

Payers assess the acuity of a panel of patients, and use that acuity along with age/gender distribution, cost, quality and outcomes, to provide incentive payments or decrease payments at the end of a contract year.

What should physicians and other practitioners do?

Document underlying medical problems that require or affect treatment — **even if you are not treating the problem at this visit**. The patient presents with new onset cough. After taking the history and exam, the physician diagnosis GERD. However, the patient is HIV positive, and the differential diagnosis included infectious diseases related to HIV. Include HIV status on the claim form. *Specific examples provided later in the guide.*

This guide will provide specifics about selecting diagnosis codes in medical practices as our payment models change.

.

WHY DID YOU DO IT ?

PAYER POLICIES

NCDS / LCDS
PRIVATE PAYER POLICIES

- INDICATE COVERED INDICATIONS FOR SERVICE
- MAY HAVE FREQUENCY LIMITS
- MAY REQUIRE CONSERVATIVE TREATMENT FIRST

MEDICAL NECESSITY

ICD-10-CM CODE ESTABLISHED THE MEDICAL NECESSITY FOR THE SERVICE

RISK BASED CONTRACTS / SHARED SAVINGS

MAY ADJUST PAYMENT AFTER CONTRACT YEAR BASED ON

- ACUITY
- COST
- QUALITY
- PATIENT SATISFACTION
- RE-ADMISSIONS

Coding and Reporting Guidelines for diagnosis coding:

1. Use the ICD-10-CM codes that describe the patient's diagnosis, symptom, complaint, condition, or problem.
2. Use the ICD-10-CM code that is chiefly responsible for the item or service provided.
3. Assign codes to the highest level of specificity.
4. Do not code suspected diagnoses in the outpatient setting. Code only the diagnosis symptom, complaint, condition, or problem reported. Medical records, not claim forms, should reflect that the services were provided for "rule out" purposes.
5. Code a chronic condition as often as applicable to the patient's treatment.
6. Code all documented conditions, which coexist at the time of the visit that require or affect patient care or treatment. (Do not code conditions which no longer exist).

Assessment versus past medical history

Conditions that are listed in past medical history or in the problem list, but are not considered at the time of the encounter **are not added** to the claim form.

Conditions that are addressed at the visit, that are listed in the assessment/impression section of the note **are added** to the claim form and submitted to the insurance company.

Third-party insurers assess the diagnosis codes submitted in the course of a contract or calendar year. Accurately reporting the severity of patients' conditions affects end of year savings or fee decreases. *Consider reporting these at an annual visit, if addressed.*

Key Points

- Report chronic conditions annually—the slate is wiped clean.
- For chronic conditions with a complication or manifestation, use those codes.
- Add status codes.
- Document and report co-morbid conditions if treated or if they affect treatment being provided.

Common diagnosis codes

The following charts list codes and categories of codes that carry a risk adjustment score. (HCC weight).

	Code	HCC Category	HCC Weight
Human immunodeficiency virus [HIV] disease (AIDS)	B20	1	0.312
Asymptomatic human immunodeficiency virus [HIV] infection status	Z21	1	0.312

	Code	HCC Category	HCC Weight
Chronic viral hepatitis B with delta-agent	B18.0	29	0.165
Chronic viral hepatitis B without delta-agent	B18.1	29	0.165
Chronic viral hepatitis C	B18.2	29	0.165
Other chronic viral hepatitis	B18.8	29	0.165
Chronic viral hepatitis, unspecified	B18.9	29	0.165

Both B20 and Z21 carry the same HCC risk score/weight.

Following ICD-10 guidelines, a patient with HIV status without symptoms is coded with Z21, positive HIV status. Some doctors and non-physician practitioners would prefer to use B20. According to ICD-10, B20 is used when the patient has confirmed AIDS. According to these guidelines, if a patient has or has had an HIV related condition, use B20 AIDS. If the patient has a positive HIV status, without symptoms or related conditions, use Z21. **Both carry the same risk adjustment score**.

Report co-morbid conditions that are treated or that affect treatment
Medical practices "report" diagnoses by submitting the diagnosis on a health insurance claim form sent to the payer for payment of a service or procedure.

Key Points

- **Major depressive disorder**: Use a specific code in category F32 or F33
- **Diabetes:** If the patient has a complication or manifestation of diabetes, such as nephropathy, use the code with the manifestation
- **Neoplasms**: Report malignant neoplasm if the patient has evidence of the disease or is receiving treatment for the disease. If neither of those are present, use personal history of malignant neoplasm codes.
- **Infectious diseases**: Document other infectious diseases and submit the diagnosis codes for them on the claim form when the patient is treated.
- **Substance abuse**: Report substance abuse codes if documented at the time of a visit.

Frequently reported ICD-10 codes that do <u>not</u> risk adjust	**Related conditions that do risk adjust: use if accurate (EXAMPLES)**
F10.10 Alcohol abuse uncomplicated F10.9 Alcohol use unspecified	F10.- Alcohol abuse, dependence, use with complications — most of these risks adjust
F11.10 Opioid abuse uncomplicated F11.90 Opioid use uncomplicated	F11.- Opioid abuse, dependence, use with complications — most of these risks adjust F11.20 Opioid dependence, uncomplicated does risk adjust
F12.10 Cannabis abuse uncomplicated F12.90 Cannabis use uncomplicated	F12.- Cannabis abuse, dependence, use with complications — most of these risks adjust
F14.10 Cocaine abuse uncomplicated F14.90 Cocaine use, uncomplicated	F14.- Cocaine abuse, dependence, use with complications — most of these risks adjust
E66.9 Obesity unspecified	E66.01 Morbid (severe) obesity due to excess calories E66.2 Morbid (severe) obesity with alveolar hypoventilation BMI 40 and over (use code in category Z68) BMI 35 and over in patients with chronic conditions is considered morbid obesity. Use E66.01

Don’t forget status codes:

Factors influencing health status and contact with health services

- Attention to/or status of artificial opening status, such as colostomy, ileostomy
- Acquired absence of toes or feet
- Aftercare for/or status of heart, lung or liver transplant or bone marrow transplant
- BMI ≥ 40
- BMI ≥ 35 is considered morbid obesity in a patient with chronic illnesses (E66.01)
- Renal dialysis status
- Dependence on ventilator status
- HIV positive
- Long term, current use of insulin