A Closer Look: Documentation and Coding for Behavioral Disorders

In this month’s issue of Blue Review, we are taking a closer look at behavioral health disorders. Behavioral health disorders are usually categorized by intense alterations in thinking, mood and/or behavior over time and can be difficult to diagnose as they are often accompanied by multiple and similar symptoms. While the Diagnostic and Statistical Manual of Mental Disorders (DSM-5®) is used to assess and diagnose the patient, the ICD-9-CM coding system is required for reimbursement.

It is critical for coding staff to understand mental illness terms as many terms are closely related. If there is ambiguity in the meaning of a term or title description, best practice for coding staff may be to query the provider for clarification.

GENERAL DOCUMENTATION TIPS

To obtain an accurate and complete picture of a patient’s health status, clinical documentation should include the following information:

- Reason for encounter and medical history
- Prior diagnostic test results
- Assessment, clinical impression and diagnosis
- Plan for care
- Date, name and credentials of clinician
- Reason for diagnostic and ancillary services
- Health risk factors (e.g., alcohol and drug use, diet, sleep patterns)

SCHIZOPHRENIC DISORDERS

Schizophrenic disorders are characterized by disturbances in thought, mood, sense of self; bizarre, purposeless behavior, repetitious activity, or inactivity. Clinical documentation should include the type and clinical status of the disorder which is required for selection of the appropriate diagnosis code. ICD-9 requires a fourth digit to identify the type of schizophrenic disorder and a fifth digit to specify the clinical status. The clinical status is noted as Subchronic, Chronic, Subchronic with Acute Exacerbation, Chronic with Acute Exacerbation, and in Remission. Listed below are ICD-9 codes associated with Schizophrenic disorders:

- 295.0x Schizophrenic Disorders
- 295.1x Disorganized Type
- 295.2x Catatonic Type
- 295.3x Paranoid Type
- 295.4x Schizoaffective Disorder

In ICD-10, schizophrenia has two categories: F20 schizophrenic disorders and F21 schizotypal disorders. Schizotypal disorders are characterized as personality disorders in which a person has trouble with relationships and disturbances in thought patterns, appearance and behavior. The F20 category requires a fourth digit to identify the schizophrenia type.

Sub-category F20.8, other schizophrenia, requires a fifth digit to further define the condition. Code F20.81, schizoaffective disorder, is borderline schizophrenia disorder, not present for the full time required to diagnose schizophrenia; code F20.89, other schizophrenia, classifies all other schizophrenia types not identified by a fourth digit, for example, cenesthopathic schizophrenia or simple schizophrenia.

- F20.0 Paranoid Schizophrenia
- F20.1 Disorganized Schizophrenia
- F20.2 Catatonic Schizophrenia
- F20.3 Undifferentiated Schizophrenia
- F20.4x Schizophreniform Disorder
- F20.5 Residual Schizophrenia
- F20.6x Residual Type
- F20.7x Schizoaffective Type
- F20.8x Other Schizophrenia
- F20.9x Unspecified Schizophrenia

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A Closer Look: Documentation and Coding for Behavioral Disorders

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**EPISODIC MOOD DISORDERS**

Bipolar Disorders and Major Depressive Disorder (MDD) are considered episodic mood disorders. Episodic mood disorders are conditions categorized by periods of depression, sometimes alternating with periods of elevated mood. Bipolar disorder includes mania and depression while major depressive disorder is a stand-alone diagnosis. A required fourth digit in ICD-9 identifies the episodic mood disorder type and the episode.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>296.0x</td>
<td>Bipolar Disorder, single manic episode</td>
</tr>
<tr>
<td>296.1x</td>
<td>Manic Disorder, recurrent episode (bipolar disorder)</td>
</tr>
<tr>
<td>296.2x</td>
<td>Major Depressive Disorder, single episode</td>
</tr>
<tr>
<td>296.3x</td>
<td>Major Depressive Disorder, recurrent episode</td>
</tr>
<tr>
<td>296.5x</td>
<td>Bipolar I Disorder, most recent episode (or current) manic</td>
</tr>
<tr>
<td>296.6x</td>
<td>Bipolar I Disorder, most recent episode (or current) depressed</td>
</tr>
<tr>
<td>296.7x</td>
<td>Bipolar I Disorder, most recent episode (or current) unspecified</td>
</tr>
</tbody>
</table>

The fifth-digit classification identifies the severity or the clinical status. If the episode is recent or current, the severity is noted; otherwise, the fifth digit indicates the current clinical status.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Unspecified</td>
</tr>
<tr>
<td>1</td>
<td>Mild</td>
</tr>
<tr>
<td>2</td>
<td>Moderate</td>
</tr>
<tr>
<td>3</td>
<td>Severe without psychotic behavior</td>
</tr>
<tr>
<td>4</td>
<td>Severe with psychotic behavior</td>
</tr>
<tr>
<td>5</td>
<td>In partial remission or unspecified remission</td>
</tr>
<tr>
<td>6</td>
<td>Full Remission</td>
</tr>
</tbody>
</table>

Documentation for depression requires a specific level of detail because there are two types: situational and chemical. Situational depression arises from life circumstances that impact the individual such as a traumatic event or death in the family. Chemical depression is caused by chemical abnormalities in the brain and is treated mainly with drugs. Based on the medical record documentation, situational depression codes to ICD-9 code 311 and major depressive disorder codes to either 296.2x or 296.3x.

However, in ICD-10 there is no distinction between depression not otherwise specified (NOS) and major depressive disorder. Both descriptive titles fall under one ICD-10 code, F32.9. ICD-10 has six categories for episodic mood disorders:

- F30 Manic Episode
- F31 Bipolar Disorder
- F32 Major Depressive Disorder, Single Episode
- F33 Major Depressive Disorder, Recurrent
- F34 Persistent mood (affective) disorders
- F39 Unspecified mood (affective) disorder

The fourth digit in ICD-10 further specifies symptoms associated with the current episode. The fifth digit identifies the severity or the clinical status.

**DELUSIONAL DISORDERS**

Delusional disorders are characterized by the presence of non-bizarre delusions which may persist for at least one month. In ICD-9, the required fourth digit identifies the type of delusional disorder and there is no fifth-digit assignment.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>297.0</td>
<td>Paranoid State, simple</td>
</tr>
<tr>
<td>297.1</td>
<td>Delusional Disorder</td>
</tr>
<tr>
<td>297.2</td>
<td>Paraphrenia</td>
</tr>
<tr>
<td>297.3</td>
<td>Shared Psychotic Disorder</td>
</tr>
<tr>
<td>297.8</td>
<td>Other Specified Paranoid States</td>
</tr>
<tr>
<td>297.9</td>
<td>Unspecified Paranoid State</td>
</tr>
</tbody>
</table>

In ICD-10, delusional disorders are under one category (F22) and there is no fourth- or fifth-digit assignment. Shared psychotic disorder does not fall under the delusional disorder category; rather it has its own category, F24.

**References**

1. International Classification of Diseases, 9th edition, Clinical Modification

DSM and DSM-5 are registered trademarks of the American Psychiatric Association.

Note: This material is provided for informational purposes only and is not an endorsement of any particular site or resource. The owners/operators of each website are solely responsible for the content on their respective websites. This material is for educational purposes only and is not intended to be a definitive source for what codes should be used for, any particular disease, treatment or services. Health care providers are instructed to submit claims using the most appropriate code based upon the medical record documentation, coding guidelines and reference materials.
Medicare Crossover Claim Submission Reminder

As referenced in the March 2014 issue of Blue Review, Blue Cross and Blue Shield Plans have been using the Centers for Medicare & Medicaid Services (CMS) crossover process to receive Medicare primary claims since January 2006. The CMS crossover process routes Medicare Supplemental claims (Medigap and Medicare Supplemental) directly from Medicare to BCBSIL so that providers do not need to also submit the claim to BCBSIL. Over the years, this Medicare crossover process has helped increase efficiency by requiring only one claim submission, reducing duplicate submissions, improving payment accuracy, and increasing member and provider satisfaction.

Although the above process has been in existence for over eight years, providers have continued to submit the claim to both Medicare and BCBSIL resulting in duplicate claims. These duplicate claims result in additional, unnecessary work and possible inaccurate claims processing, which in turn has a negative impact on providers, members and Plans.

When the Home Plan receives a Medicare Primary claim before it is crossed over, it may be incorrectly paid based on an estimated Explanation of Medicare Benefits (EOMB). Provider payment should be calculated based on the actual EOMB. Members are also impacted when providers submit duplicate claims. When the Home Plan uses an estimated EOMB, they may incorrectly calculate member cost sharing.

In an effort to improve the Medicare crossover administrative process, all providers are instructed to follow new rules concerning Medicare secondary claim submission. CMS requires that when a Medicare claim has been crossed over, providers are to wait 30 calendar days from the initial Medicare remittance date before submitting the claim to BCBSIL.

BCBSIL will reject provider-submitted claims when Medicare is considered primary, including those with Medicare-exhausted benefits that have crossed over, if they are received within 30 calendar days of the initial remittance date or with no Medicare remittance date. It is expected that this modification will help address duplicate claim submissions.

For additional information, including answers to frequently asked questions, look for the extended article in the News and Updates section of our website at bcbsil.com/provider.

Fighting Health Care Fraud, One Call at a Time

Each year, our Fraud Hotline receives thousands of calls reporting possible health care fraud and abuse. The BCBSIL Special Investigations Department (SID) actively reviews every call to determine if the information presented meets guidelines for fraud and abuse.

If there is a question of fraud, preliminary interviews and field audits may be conducted to determine if fraud was intentionally committed. If SID concludes that there was no act of fraud, the case may be referred to the appropriate business area, which may offer guidance to resolve the issue.

There are cases in which hotline reports have led to recovery efforts for inappropriate payment of claims and reimbursements or to law enforcement for criminal prosecution. Some of the most egregious cases leading to criminal prosecutions have stemmed from hotline calls.

The evidence is clear: Each call or report can make a difference in the fight against fraud and abuse. Health care fraud affects all of us, so please report your suspicions of fraud to the SID. The following resources are available 24 hours a day, seven days a week for reporting suspected fraud and abuse:

**Phone**
Call the BCBSIL Fraud Hotline: 877-272-9741. (All calls are confidential and may be made anonymously.)

**Online**
Visit the Fraud and Abuse page in the Education and Reference Center section of our website at bcbsil.com/provider where you will find more information and a link to file a report online.

**U.S. Mail**
Report fraud by mailing your correspondence to SID at: BCBSIL, Attn: Special Investigations Department, 300 East Randolph Street, 35th Floor, Chicago, IL 60601.
Meet Your Ancillary Provider Network Consultant (PNC)

BCBSIL contracts with more than 2,000 independent ancillary providers in Illinois and Northwest Indiana. Our Ancillary PNC focuses specifically on the services provided by Skilled Nursing Facilities, Home Health Agencies, Hospice, Home Infusion Therapy, Durable Medical Equipment suppliers, Orthotics and Prosthetics, Dialysis Centers and Private Duty Nursing agencies.

The following Ancillary PNC is available to meet with you and your staff regarding BCBSIL policies and procedures, billing and contractual issues:

- Elaine Williams, 312-653-4305

You may also direct your requests and inquiries to our general email box at ancillarynetworks@bcbsil.com, or leave a message at 312-653-4820.

Professional PNC Assignments (Revised April 2014)

Our PNCs serve as the liaison between BCBSIL and our independently contracted professional provider community, developing and maintaining cooperative working relationships with professional providers in our network throughout Illinois and Northwest Indiana.

If you are an ancillary provider (DME, home infusion therapy, skilled nursing facility, home health, hospice, orthotics/prosthetics, dialysis, private duty nursing), your PNC is Elaine Williams. She can be reached at 312-653-4305 or ancillarynetworks@bcbsil.com.

To find your Professional PNC, refer to this Illinois county map. PNCs for professional providers in Cook and DuPage Counties (Codes 16 and 22) are assigned by either Chicago ZIP code or city, as listed below. This information is also available in the Education and Reference Center section of our website at bcbsil.com/provider.

ILLINOIS TERRITORY BREAKDOWN BY COUNTY CODE

Northern (8, 43, 49, 81, 89, and 98) – Gina Plescia
Southern (2, 3, 12, 13, 14, 15, 17, 18, 24, 25, 26, 28, 30, 33, 35, 39, 40, 41, 44, 51, 60, 61, 64, 67, 73, 76, 77, 79, 80, 82, 83, 84, 87, 91, 93, 95, 96, 97 and 100) – Teresa Trumbley
West-Central (1, 5, 7, 9, 11, 29, 31, 34, 36, 42, 55, 59, 63, 65, 66, 68, 69, 75, 85, 86 and 94) – Roy Pyers
East-Central (10, 20, 21, 23, 27, 38, 53, 54, 57, 58, 70, 72, 74, 90, 92 and 102) – Amanda Williams
North Metro (4, 6, 19, 37, 45, 47, 48, 50, 52, 56, 62, 71, 78, 88 and 101) – Cathy Dismuke
South Metro (32, 46 and 99) – Adam Kwiecien

Northwest Indiana – Kathleen Barry

Cook County (16) – See below for Cook and DuPage County Breakdown
DuPage County (22) – See below for Cook and DuPage County Breakdown

COOK AND DUPAGE COUNTY BREAKDOWN BY CITY AND ZIP CODE

Adam Kwiecien – City: Lemont
Ana Hernandez – ZIP Codes: 60601, 60602, 60603, 60604, 60605, 60606, 60607, 60610, 60611, 60612, 60614, 60616, 60622, 60634
Cathy Dismuke – Cities: Addison, Bartlett, Bloomingdale, Hanover Park, Hillsiburg, Medinah, Roselle, Streamwood, Wayne
Gina Plescia – Cities: Arlington Heights, Elk Grove Village, Hoffman Estates, Schaumburg
Kathleen Barry – Cities: Aurora, Burr Ridge, Calumet City, Chicago Heights, Darien, Dolton, Flossmoor, Ford Heights, Glen Ellyn, Glendale Heights, Glenwood, Homewood, Lansing, Lisle, Lynwood, Matteson, Naperville, Olympia Fields, Park Forest, Richton Park, Riverdale, Sauk Village, South Holland, Steger, Summit, Thornton, Warrenville, Willowbrook, Woodridge
Tyrone Sturgis – City: Evanston; ZIP Codes: 60608, 60609, 60613, 60615, 60617, 60618, 60619, 60620, 60621, 60623, 60624, 60625, 60626, 60627, 60628, 60629, 60630, 60631, 60632, 60633, 60635, 60636, 60637, 60638, 60639, 60640, 60641, 60642, 60643, 60644, 60646, 60647, 60648, 60649, 60650, 60651, 60652, 60653, 60654, 60655, 60656, 60657, 60658, 60659, 60660, 60661, 60666, 60668, 60669, 60670, 60673, 60674, 60675, 60676, 60677, 60678, 60680, 60681, 60686, 60689, 60690, 60693, 60694, 60695, 60696

VISIT OUR WEBSITE AT BCBSIL.COM/PROVIDER
PHARMACY PROGRAM UPDATES

Pharmacy Program Changes Effective April 1, 2014

STANDARD FORMULARY CHANGES
Based on the availability of new prescription medications and Prime National Pharmacy and Therapeutics Committee review of changes in the pharmaceuticals market, some revisions were made to the standard BCBSIL formulary effective April 1, 2014.

Brand Medications Added to the Formulary, Effective April 1, 2014

<table>
<thead>
<tr>
<th>Formulary Brand*</th>
<th>Drug Class/Condition Used For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opsumit</td>
<td>Pulmonary Hypertension</td>
</tr>
<tr>
<td>Valchlor</td>
<td>Topical Treatment of Cancer</td>
</tr>
</tbody>
</table>

Brand Medication Moved to a Higher Out-of-pocket Payment Level, Effective April 1, 2014

Non-Formulary Brand* | Condition Used For | Generic Formulary Alternative(s)* | Formulary Brand Alternative(s)* |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Solaraze</td>
<td>Actinic Keratosis</td>
<td>fluorouracil cream, imiquimod cream</td>
<td>Carac, Zyclara</td>
</tr>
</tbody>
</table>

*This list is not inclusive. Other medications may be available in this drug class.

STANDARD FORMULARY DISPENSING LIMIT CHANGES
BCBSIL’s standard prescription drug benefit program includes coverage limits on certain medications and drug categories. Dispensing limits are based on U.S. FDA-approved dosage regimens and product labeling.

Effective April 1, 2014, dispensing limits were added/modified for the following drugs:

<table>
<thead>
<tr>
<th>Drug Class and Medication*</th>
<th>Dispensing Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotics</td>
<td></td>
</tr>
<tr>
<td>Alinia tabs (nitazoxanide)</td>
<td>6 tabs/30 days</td>
</tr>
<tr>
<td>Zithromax tabs (azithromycin)</td>
<td>60 tabs/180 days</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Invokana tabs (canagliflozin)</td>
<td>30 tabs/30 days</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td></td>
</tr>
<tr>
<td>Tecfidera Starter Kit (dimethyl fumarate)</td>
<td>60 caps/180 days</td>
</tr>
<tr>
<td>Tecfidera 120 mg caps (dimethyl fumarate)</td>
<td>14 caps/180 days</td>
</tr>
</tbody>
</table>

Targeted mailings were sent to members affected by formulary changes and dispensing limits per our usual process of notifying members prior to implementation of formulary changes that may be impacted.

For the most up-to-date formulary and list of drug dispensing limits, visit the Pharmacy Programs section of our website at bcbsil.com/provider.

*Third-party brand names are the property of their respective owners

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are instructed to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member’s certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.
Modifications 26 and TC:

Modifiers 26 and TC: According to the CPT codebook, Modifier 26 denotes professional services for lab and radiological services. Modifier TC denotes technical component for lab and radiological services. These modifiers should be used in conjunction with the appropriate lab and radiological procedures only.

Note:

When a physician or professional provider performs both the technical and professional service for a lab or radiological procedure, the provider must submit the total service on one line and bill it as global, rather than submitting each service individually.

This material is for educational purposes only and is not intended to be a definitive guide for coding claims. Health care providers are instructed to submit claims using the most appropriate code based on the CPT codebook and other established industry standard guidelines and reference materials.
IN THE KNOW

Claims Processing Update

In previous issues of Blue Review, BCBSIL notified you that we will begin accepting partial batches, rejecting only individual claims that do not meet HIPAA compliance standards. Partial batches are a group of claims submitted where one or more claims may be rejected and all other claims will be processed. These enhancements will be effective in April 2014.

When you transmit ANSI 5010 837 professional or institutional claim file(s), BCBSIL will forward all valid and successful claims for processing and adjudication. Our payer response reports will indicate which claims were rejected so that those claims may be corrected and resubmitted as appropriate. The entire batch of claims should not be resubmitted, as this will result in duplicate claims within the adjudication process.

If you use a billing service or clearinghouse to submit claims on your behalf, please be sure they are aware of this information.

If you have any questions about this notice, please contact our Electronic Commerce Center at 800-746-4614 for further assistance.