University of Michigan Health Plan

PAYMENT REIMBURSEMENT POLICY

Title: PRP-06 Unspecified Diagnosis Codes Reporting

Category: UMHP_PAYMENT REIMBURSEMENT (PR)

Effective Date: 09/30/2024

1.0 Guidelines:

This policy applies to all network and non-network providers, including but not limited to percent of charge contract providers. This policy does not guarantee benefits or solely determine reimbursement. Benefits are determined and/or limited by an individual member's benefit coverage document (COC, SPD, etc.). The Health Plan reserves the right to apply clinical edits to all medical claims through coding software and accuracy of claim submission according to industry billing standards. Clinical edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. The Health Plan may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid through CMS but which are covered by the Health Plan to support covered benefits available through one of the Health Plan's products. Prior approval does not exempt adherence to the following billing requirements. The provider contract terms take precedence if there is a conflict between this policy and the provider contract.

2.0 Description:

Diagnosis codes are used to describe a patient's medical condition(s) documented in the medical record. ICD-10CM Official Coding Guidelines provide instructions and rules put forth by the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS). The NCHS releases an updated code set and guidelines each year, and changes are effective on October 1st of each year.

3.0 Coding and Billing:

The expectation from the Health Plan is that providers document in a manner that is as specific as possible to ensure the best quality information regarding their patient's condition and that ICD-10CM and Procedural Coding are reviewed against the medical record prior to claim submission to ensure accurate reporting.

Specificity

Accurate Coding to the highest specificity is dependent on thorough documentation. ICD-10-CM codes have an alphanumeric structure and should be coded to the highest number of digits available (i.e., highest specificity), as the medical record supports. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth characters, which provide greater detail. A 3-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.

A. Instances when it may be acceptable to use an unspecified diagnosis code are:

1. The patient is in the early course of evaluation, and the provider may not have a complete diagnosis to document.

2. The claim may be from a provider who is not directly involved in diagnosing the patient's condition.

3. The provider seeing the patient may be more of a generalist who cannot define the condition at a level of detail expected by a specialist.
4. There isn't an established code that describes the diagnosis.

B. Instances when it is not acceptable to use an unspecified diagnosis code are:

1. When there is sufficient information to accurately define the patient's condition.

2. The provider can account for basic concepts such as laterality, anatomical locations, trimester of pregnancy, type of diabetes, known complications or comorbidities, description of severity, acuity, or other known parameters.

3. To save time on documentation.

4. Uncertainty if the unspecified code is appropriate for a specific diagnosis (coders should send an inquiry to the rendering physician for clarification in these instances).

Inconsistent Diagnosis

Within the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Manual, there are symbols and code description detail that provides guidance regarding age designations (specific to newborn, pediatric, maternity and adult) and gender. Claims received with a diagnosis code that is inconsistent with the procedure reported may be denied.

Procedure to Diagnosis Mismatch/Incompatibility

Per the Centers for Medicare & Medicaid Services (CMS) an item/service is correctly coded when it meets all the coding guidelines listed in the CMS Healthcare Common Procedure Coding System (HCPCS) guidelines, Local Coverage Determinations (LCDs) or Medicare Administrative Contractor (MAC) articles. Diagnosis(es) reported that do not appropriately correspond to the reported CPT/HCPCS code may result in a denial.

Example: The submitted diagnosis is not reasonable or necessary; diagnosis for CPT/HCPCS code L1844.

HCPCS L1844 - Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated.
ICD-10 J20.2 - Acute bronchitis due to streptococcus

4.0 Documentation Requirements:

A. Complete and thorough documentation is the foundation for proper Coding. Documentation must accurately reflect details such as type of encounter, acute or chronic, location, external causes, etc. Documentation should not be copied and pasted (a.k.a. "cloning") within electronic health records.

B. Documentation needs to be very specific for the following conditions:
- Asthma
- Coma
- Diabetes
- Fractures
- Pregnancy
- Stroke

Terms & Definitions:

ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) A system used by physicians and other health care providers to classify and code all diagnoses, symptoms, and procedures recorded in conjunction with hospital care in the United States. It provides a level of detail that is necessary for diagnostic specificity and morbidity classification in the U.S. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

Unspecified Coding Code assignment that does not fully define critical parameters of the patient's condition that could otherwise be defined given the information available to the provider and the coder.

6.0 Verification of Compliance:

Claims are subject to audit, prepayment, and post-payment to validate compliance with the terms and conditions of this policy.

7.0 References, Citations, Resources & Associated Documents:

CMS National Coverage Determinations (NCDs).
CMS Local Coverage Determinations (LCDs)
https://www.cms.gov/search/cms?keys=ICD-10
UM Health Plan Payment Reimbursement Policy -05 Medical Record Request Standards

8.0 Revision History:

Original Effective Date: 07/02/2020

Next Review Date: 09/30/2025

Revision Date	Reason for Revision
4/21	Annual review; no substantive changes, updated verbiage on the guidelines
01/22	Annual review, approved at CCSC 02-01-2022
12/22	Annual review
10/23	Annual review
7/24	Off-cycle review