PAYMENT REIMBURSEMENT POLICY

Title: PRP-06 Unspecified Diagnosis Codes

Category: PHP_PAYMENT REIMBURSEMENT POLICIES (PRP)

Effective Date: 12/28/2022

Physicians Health Plan
PHP Insurance Company
PHP Service Company

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:

The expectation from the Health Plan is that providers document in a manner that is specific as possible to assure the best quality information regarding their patient's condition when coding ICD-10-CM. "Unspecified" is defined as coding that does not fully define important parameters of the patient's condition that could otherwise be defined given the information available to the provider and the coder. Unspecified coding can be vague and not appropriate when there is information available that would allow for greater specificity. Unspecified ICD-10-CM codes should only be selected when there isn't an established code that describes the diagnosis. Claims submitted with unspecified diagnosis regarding laterality, anatomical locations, trimester of pregnancy, type of diabetes, known complications or comorbidities, severity acuity may be denied.

3.0 Terms & Definitions:

ICD-10-CM. A catalog of diagnosis codes used by medical professionals for medical coding and reporting in health care settings. The Centers for Medicare and Medicaid Services (CMS) maintain the catalog in the U.S., releasing yearly updates.

4.0 Coding and Billing:

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).

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 the diagnosis of the patient's condition.

3. The provider seeing the patient may be more of a generalist who is not able to define the condition at a level of detail expected by a specialist.

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).

5.0 Documentation Requirements:

A. Complete and thorough documentation is the foundation for proper coding. Documentation must clearly 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:

1. Asthma.
2. Coma.
3. Diabetes.
4. Fractures.
5. Pregnancy.
6. Stroke.

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)
PHP Payment Reimbursement Policy -05 Medical Record Request Standards

8.0 Revision History:

Original Effective Date: 07/02/2020

Next Review Date: 12/28/2023

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