

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

Providers are responsible for submission of accurate claims requests. This reimbursement policy is intended to ensure that you are reimbursed based on the code that correctly describes the procedure performed. This and other reimbursement policies may use CPT, CMS or other coding methodologies from time to time. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

Coding methodology, clinical rationale, industry-standard reimbursement logic, regulatory issues, business issues and other input is considered in developing reimbursement policy.

This information is intended to serve as a resource regarding the reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly we may use reasonable discretion in interpreting and applying this policy to services being delivered in a particular case. Further, the policy does not cover all issues related to reimbursement for services rendered to enrollees as legislative mandates, the provider contract documents, and the enrollee's benefit coverage documents, may supplement or in some cases supersede this policy. Finally, systems logic or set up may prevent the loading of this policy onto different claims platforms in exactly the same way; however, we strive to minimize these variations.

ACN Group Inc. (OptumHealth Physical Health), may modify this policy from time to time by publishing a new version of the policy on its Website; however, the information presented in this policy is believed to be accurate and current as of the date of publication.

ICD-9-CM Policy

Type	Reimbursement
Number	0053

Approved by	Approval Date
Reimbursement and Technology Committee Quality Improvement Committee	August 9, 2007 October 11, 2007

Description

This policy describes OptumHealth Physical Health position on provider use of standard code set, ICD-9-CM (The International Classification of Diseases, Ninth Revision, Clinical Modification).

Audience

Targeted Population	This policy applies to all products, all network and non-network practitioners. This includes non-network authorized, percent of charge contract, and flat rate/per diem contract practitioners.* <i>*Fee schedule/provider contract/client contract may supersede</i>
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Policy

<p>Policy Statement</p>	<p>In accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA), OptumHealth Physical Health requires an ICD-9-CM identifier on all claim encounter forms.</p> <p>Practitioners should assign an ICD-9-CM code that provides the highest degree of accuracy and completeness. ICD-9-CM is composed of codes with 3, 4, or 5 digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater specificity. A three-digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit sub classifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code.</p> <p>Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider. ICD-9-CM Symptoms, Signs, and Ill-defined conditions, e.g. 700 series codes, contain many codes used to describe symptoms.</p>
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Edit Sources

OptumHealth Physical Health sources its reimbursement and coding policy to methodologies used and recognized by third party authorities. The sources used to determine reimbursement and coding policy are:

Current Procedural Terminology book (CPT) from the American Medical Association (AMA)

Centers for Medicare and Medicaid (CMS) National Coverage Policy and current Centers for Medicare and Medicaid (CMS) Policy Manual(s) <http://www.cms.hhs.gov>

ChiroCode DeskBook, 18th ed., 2010. <http://www.chirocode.com>

Background Summary

HIPAA applies to several different types of organizations commonly referred to as “covered entities”. The law applies directly to three groups of “covered entities.”

- Health Care Providers: Any provider of medical or other health services, or supplies, who transmit health information in connection with a transaction for which standard requirements have been adopted.
- Health Plans: Any individual or group plan that provides or pays the cost of health care.
- Health Care Clearinghouses: A public or private entity that transforms health care transactions from one form to another.

Transactions are activities involving the transfer of health care information for specific purposes. Under HIPAA, covered entities engaging in identified transactions must use the same code sets and identifiers. Standard transactions include but are not limited to

claims and encounter information, payment and remittance advice, and claims status and inquiry.

Code sets are the codes used to identify specific diagnosis and clinical procedures on claims and encounter forms. CPT-4 and ICD-9 codes are examples of code sets for procedure and diagnosis coding.

Definitions

ICD-9-CM	The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures. ICD-9-CM is used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office encounters.
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References and Resources

- References**
1. Practice Management Information Corporation, *ICD.9-CM, International Classification of Diseases, 9th Revision, Clinical Modification, seventh edition, 2008.*
 2. The National Center for Health Statistics, *ICD-9-CM Official Guidelines for Coding and Reporting*, April 1, 2005.

History/Updates

Approval date	Revision History: 10/9/08, 2/26/09, 4/8/10
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