ICD-CM Reimbursement Policy					
Policy Number	0053	**Annual Approval Date**	04/2024	**Approved By**	Optum Reimbursement and Technology Committee Optum Quality and Improvement Committee

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. Optum reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. 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 only as a general reference resource regarding Optum's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to Client enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

**CPT® is a registered trademark of the American Medical Association*

Application

This policy applies to all products, all network and non-network rehabilitation providers. This includes non-network authorized, and percent of charge contract providers.

Fee schedule/provider contract/client contract may supersede

Policy

Overview

Optum's policy is to allow reimbursement for claims submitted with a standard and valid diagnosis code, as found in applicable code set ICD-CM (The International Classification of Diseases, Clinical Modification).

The purpose of this policy is to ensure that Optum reimburses for services that are billed and documented, without reimbursing for billing submission or data entry errors or for non-documented services.

Reimbursement Guidelines

In accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA), Optum requires a valid ICD-10 identifier on all claim encounter forms.

Practitioners should assign an ICD-10 code that provides the highest degree of accuracy and completeness. A code is invalid if it has not been coded to the full number of digits required for that code.

Background Information

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 and ICD-10 codes are examples of code sets for procedure and diagnosis coding.

Resources

- American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services
- Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- Centers for Medicare and Medicaid Services
- ICD-CM

History / Updates

10/11/2007	New
10/2008	Annual review and update
02/2009	Annual review and update
04/2010	Annual review and update
04/2011	Annual review and update
04/2012	Annual review and update
04/2013	Annual review and update
04/2014	Annual review and update
04/2015	Annual review and update
04/2016	Annual review and update
04/2017	Annual review and update, Changed ICD-CM references to ICD-10 where ICD-CM was placeholder during transition to ICD-10 coding requirement.
04/2018	Annual review and update
04/2019	Annual review and update
04/2020	Annual review and update
04/2021	Annual review and update
05/2022	Annual review and update
04/2023	Annual review and update

04/2024	Annual review and update