VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

Standard Operating Procedure

Title: Unspecified Diagnosis Code

Issuance Date: April 26, 2023

(Must be reviewed annually)

Applicable Regulations, Guidelines, and AHS Policy:

None

Purpose:

There may be instances in which a non-covered unspecified diagnosis code may be billed. In those cases, providers may request a review of certain claims payments to the State's fiscal agent with documentation. The fiscal agent will submit the request to the DVHA Clinical Operations Unit. for review. Unspecified diagnosis codes will be reviewed for laterality.

Procedure:

DVHA's Coding Team and Clinical Operations Unit reviews the ICD-10-CM diagnosis code restrictions in the claims adjudication system as part of the Quarterly Code Process. The use of ICD-10-CM Diagnosis Codes could cause a claim to deny for two primary reasons:

- The ICD-10-CM Diagnosis Code is not allowed as the Primary Diagnosis on the claim. These diagnosis codes are often unspecified and will not be accepted on claims in the primary diagnosis position but may be appropriate to report in a secondary position.
- The ICD-10-CM Diagnosis Code is not allowed to be reported to Vermont Medicaid due to a lack of specificity related to laterality. These diagnosis codes have a choice for left, right, bilateral, and unspecified. However, the unspecified code will not be accepted on claims in any diagnosis position. The provider should choose the most specific code outlined in the medical record. If the most specific code is not outlined in the medical record, the fiscal agent educates the provider to specify laterality in the medical record and follow best coding practices.

Code coverage determinations by the Department of Vermont Health Access are final and no further review will be completed.

Claims Payments

DVHA will review claims submission inquiries when related to the following circumstances:

- Improper payments or non-payments - claims that paid differently than expected.
- Coding errors - place of service, modifiers, diagnosis, and provider type/specialty

A Reconsideration Request for such a review must be made within 90 calendar days of the original authorization decision. Requests made after 90 days will be returned with no action taken. The request for review must be filed on the Reconsideration Request form. All issues regarding providers' objection(s) to the findings must be documented. The request must incorporate a brief background of the case and rationale for alternative decision. Requests will be reviewed by a qualified member of the DVHA when all information related to the claim is submitted. For the unspecified diagnosis codes in question, the reviewer is the DVHA Clinical Operations Unit Coder. Upon receipt of the request and all supporting information, the DVHA will review all information received. The DVHA may consider additional information, either verbal or written, from the provider or others, for clarification. DVHA will issue a written decision to the provider of its review decision or notify the provider that an extension is needed within 30 calendar days of receipt of the request for review. There is no additional review or reconsideration after the written decision on the review. This decision is final.

If the determination warrants a financial impact to DVHA, the PBR process will be initiated by the DVHA Clinical Operations Unit Coder.

Revision History:

Date	Summary of Revisions
1/3/2022	New SOP
2/8/22	Edits based on 2/7/22 meeting with SMEs
3/24/2022	OMU review, updated to ADA template.
4/26/2023	Review, minor edits.

Table 1 Revision History