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Revenue Cycle Management

A UPA Billing Office Newsletter

In This Issue

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Waiving Patient Responsibility

Waiving co-pays or balance after insurance can be considered a breach of the practice's insurance contract. UPA insurers contractually require practices seeking reimbursement to make reasonable efforts to collect co-pays from patients. In other words, the practice can't "settle" for receiving only what the insurance company reimburses while not making a good faith effort to collect payment from the patient.

If you routinely waive co-pays for a patient, insurers could pursue general contract damages against you. Additionally, and more significantly, a violation of the terms of the insurance plan can serve as a breach of contract.

Waiving patient copays can be done when the patient demonstrates financial hardship or lack of response to your documented collection efforts.

Providers not wishing to bill the patient can render the service at no cost to the insurance and patient.

Reviewing your current policies and procedures, ensuring they adhere to these standards, will protect you from violating payer contracts.

To review payer specific policies, please refer to their administrative guide.

UnitedHealthcare® Policy Changes

United Healthcare (UHC) will be implementing a few policy changes that we wanted to make you aware of. Please see the fully updates on UHCprovider.com for more details:

Network News | UHCprovider.com

- Excludes 1 coding effective 8/1/24 UHC Community Plan (TennCare) will implement ICD-10 guidelines for Excludes 1 coding. All providers should align to coding with the Excludes 1 guidelines when submitting claims; however, at this time the application of these guidelines is specifically for Inpatient Claims.

- G2211 effective 9/1/24 – For all UHC plans, HCPCS code G2211 will be included within the reimbursement for outpatient E/M services and therefore G2211 is not separately reimbursable.

- X-Ray Interpretation effective 10/1/24 - For all UHC plans, the interpretation (& report) of a radiology service appended with modifier 26 will not be considered for separate reimbursement when reported on the same date of service as an E/M service unless a copy of the radiology report is attached to support separate reimbursement

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- JZ Modifier effective 10/1/24 - UHC Community Plan (TennCare) will align with the CMS requirement that providers and suppliers are required to report the JZ modifier to attest that no amount of drug or biological from a single-dose container or a single-use package was unused or discarded. The use of the JW modifier will continue to be required when submitting claims for any waste from a single-dose container or single-use package.

See CMS list of applicable Drugs & Biologicals HERE: Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy HCPCS Codes (cms.gov)

- Anatomical Modifiers effective 11/1/24 - All UHC plans will require the use of appropriate laterality or anatomical modifiers for surgical procedures that are assigned a bilateral status indicator of 1 on the CMS National Physician Fee Schedule for the claim to be considered for reimbursement. The relevant modifiers include: 50, LC, LD, LM, RC, RI, E1-E4, FA, F1-F9, LT, RT, TA, T1-T9

Reminders of ICD-10 Guidelines for Diagnosis Coding

The provider and/or coder must follow any Includes, Excludes 1 and Excludes 2 notes, and other instructional notes, such as “Code first” and “Use additional code,” listed in the tabular list for the chapter, category, subcategory, and subclassification levels of code selection that direct the coder to use a different or additional code.

Diagnosis Linkage:
Correctly linking and ordering diagnosis codes with procedure codes is an important coding concept that must be applied to ensure accurate reimbursement and medical necessity is supported for the services performed. Code first the ICD-10 for the diagnosis, condition, problem, or other reason for the encounter/visit that is shown in the medical record to be the chief complaint or the primary condition responsible for the services provided.

More than 12 Diagnosis per Claim:
It’s important to note that claim formatting allows up to 4 ICD-10 codes to be linked to each CPT code. A total of 12 ICD-10 codes are submitted per claim. If providers document more than 12 diagnoses to be reported per encounter, then CPT 99499 (unlisted E/M) should be reported for additional diagnosis codes with a $0 charge to ensure all applicable conditions are reported to the payer. This becomes extremely important with risk adjustment payment models when HCC (Hierarchical condition category) diagnoses need reported to maximize reimbursement potential.

Excludes 1 Rule:
Humana and UHC deny claims for Excludes 1 & 2 rules.
An EXCLUDES 1 note means “NOT CODED HERE!” An Excludes 1 note indicates mutually exclusive codes: two conditions that cannot be reported together. An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes 1 note. An Excludes 1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

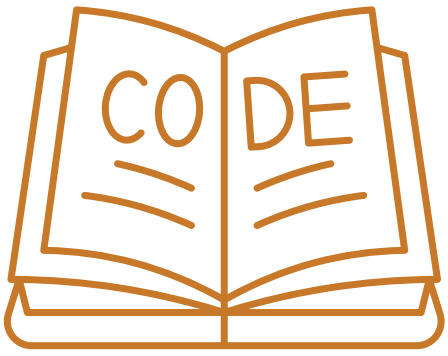
An exception to the Excludes 1 definition is when the two conditions are truly unrelated to each other and can be clearly supported in the documentation. If it is not clear whether the two conditions involving an Excludes 1 note are related or not, query the provider. Review unspecified diagnosis codes, for a more specific code, that may bypass Excludes 1. Reporting two diagnosis codes with Excludes 1 edits may result in a denial and no reimbursement for the performed services. The provider would need to submit supporting documentation to validate the conditions are unrelated. Payer will require an appeal be submitted to consider reimbursement. We are not seeing Humana overturn Excludes 1 appeals.

For example, code F45.8 Other somatoform disorders, has an Excludes 1 note for “sleep related teeth grinding (G47.63)” because “teeth grinding” is an inclusion term under F45.8. Only one of these two codes should be assigned for teeth grinding. However psychogenic dysmenorrhea is also an inclusion term under F45.8, and a patient could have both this condition and sleep-related teeth grinding. In this case, the two conditions are clearly unrelated to each other, so it would be appropriate to report F45.8 and G47.63 together.

Excludes 2 Rule:
Excludes 2 note means “NOT INCLUDED HERE.” An Excludes 2 note indicates that although the excluded condition is not part of the condition it is excluded from, a patient may have both conditions at the same time. Therefore, when an Excludes 2 note appears under a code, it may be acceptable to use both the code and the excluded code together if supported by the medical documentation.

Code First/Use Additional Code:
These instructional notes provide sequencing instruction. They may appear independently of each other or to designate certain etiology/manifestation paired codes. These instructions signal the coder that an additional code should be reported to provide a more complete picture of that diagnosis. In etiology/manifestation coding, ICD-10-CM requires the underlying condition to be sequenced first, followed by the manifestation. In these situations, codes with “In diseases classified elsewhere” in the code description are never permitted as a first-listed or principal diagnosis code and must be sequenced following the underlying condition code.

Code Also:
A “code also” note alerts the coder that more than one code may be required to fully describe the condition. The diagnosis order depends on the circumstances of the encounter. Factors that may determine sequencing include severity and reason for the encounter.



Signs, Symptoms & Unspecified ICD-10 Codes:
Diagnosis codes that describe symptoms and signs, rather than a definitive diagnosis, should only be reported when an established diagnosis has not been made (or confirmed) by the physician. If the provider documents a borderline diagnosis at the time of service, this is treated as a confirmed condition.

While specific diagnosis codes should be reported when they are documented in the medical record, there are instances when signs, symptoms, or unspecified codes are the best choice, but only when sufficient clinical information isn’t known or available.

Unspecified diagnosis codes may result in Excludes 1 or 2 edits, but may also trigger documentation requests, increase denials, etc. Each healthcare encounter should be coded to the highest level of specificity and certainty known for that encounter.

Please be sure that any staff member posting or reviewing charges are aware that tasks may be sent back to the practice to review for proper diagnosis coding, if any of these rules apply. Providers may need to be queried to ensure accurate diagnosis coding is reported and reflected in the supporting documentation. Documentation may be required to escalate or dispute any denied claims related to medical necessity or diagnosis coding rules as clinical indications may be necessary.