ACUPUNCTURE Today


BILLING INSURANCE

# Diagnosis Denials: "Excludes 1" Notes

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*Question*: I am typically paid by insurance with no problems and most often code lower back pain. However, I have had a slew of denials recently, with the denial indicating my diagnosis is incorrectly coded per the ICD-10 guidelines. What should I do?

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This same question has been asked numerous times in the past year by members of our AAC Insurance Information Network, with members stating that their claims are being denied for this reason. There are several potential explanations for the denials; let's go from the least to most likely.

Incomplete Diagnosis

There can be a few issues causing the denials; the simplest, but least likely is you are using an incomplete diagnosis. Lower back pain was updated in October 2021; there are now three new codes and instead of the lower back pain code being four characters in length, M54.5, it has been updated to include greater specificity: M54.50, M54.51 and M54.59. If you are using the outdated code, the simple fix would be to use one of the new codes.

If it is a Medicare claim, whether Medicare Part B or traditional Medicare, or Medicare Advantage Part C, those plans only accept M54.51 for vertebrogenic back pain or M54.59 for other low back pain. This means for patients with those plans, if you are using M54.50, it will be rejected.

Improper Use of Codes


However, I am assuming you are already aware of these changes, so they are not the likely culprits in your recent denials. Instead, it may be that codes billed with low back are causing the claim to be denied because they are considered "excludes." Excludes for ICD-10 is a set of rules whereby certain codes cannot be used on the same claim.

The excludes of greatest concern are called "Excludes 1," which strictly forbid a combination of codes on the same claim. Spinal pain is an example of a code that cannot be combined with certain other codes. Based on your statement, I would see this as the culprit.

Lower back pain and any spine pain code at any level may not be coded when there is a diagnosis of a disc condition to the spine. I see this come up often on acupuncture billing when the patient has been diagnosed with a disc injury and the acupuncture provider diagnoses pain *in addition* to the disc code. When that is done, the claim will automatically be denied, as spinal pain with the disc code is considered an Excludes 1 and cannot be on the same claim.

In simplest terms, there is no need to indicate pain when you have a disc issue, as pain is essentially inherent. "Pain" should be used when there is no more definitive diagnosis to indicate what is causing the pain. I have seen this most often when care is a referral, and the referring provider has indicated a disc code, but the acupuncture provider adds pain. That additional pain code will be the reason for the denial. *You do not need to indicate pain for a region when you have already indicated an injury, such as a sprain or strain*.

You may code disc alone or pain alone of the spine, but never in combination. If there is a disc diagnosis, that would be the most appropriate code, as it gives further delineation and specificity of the condition, and provides a clearer picture of a care plan than simply pain.

*Note:* While this is true for most plans, the exception in acupuncture claims is with Aetna, which does not accept disc diagnosis for acupuncture, Therefore, your claim should use a pain code

instead of a disc code.

Excludes for Spinal Pain

Here is a list of excludes for spinal pain codes to help assure that you do not use this combination of codes on a claim. Note that for thoracic and lumbar spine pain, it also includes sprains and strains.

- *Neck pain M54.2* cannot be combined with any disc codes in the M50 series.
- *Thoracic spine pain M54.6* cannot be combined with any disc codes in the M51 series, nor sprains of the thoracic S23 range and lumbar sprain S33.
- *Lumbar spine pain M54.50, M54.5 and M54.59* cannot be combined with any disc codes M51 series; or a strain of lumbar S39 series and sciatica with lower back pain M54.40-M54.42.

Excludes 1 Notes

Excludes 1 diagnoses are the ones to avoid in that they cannot never be combined and will lead to denial. It means "Not coded here!" An Excludes 1 note indicates that the code excluded should never be used at the same time as the code above the Excludes 1 note.

These Excludes 1 notes can be found throughout the ICD-10 CM codebook, either at the beginning of a code block that pertains to all codes in that block, or on the specific code itself. It indicates when two conditions cannot occur together or are mutually exclusive (i.e., not coded here). The excluded code identified in the Excludes 1 note shouldn't be used at the same time as the code or code range listed *above* the Excludes 1 note.

This edit isn't a denial of medical necessity or invalid codes, but an edit that enforces correct coding guidelines as established by ICD-10 CM official coding guidelines. Simply make the correction and send in the corrected claim.

*Note:* If you have a code that has an "Excludes 2" note, this indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes 2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

Other Considerations

While these are the most common and likely will fix your issue, there are others to be aware of to avoid similar denials on acupuncture claims. Do not combine codes that are muscle in origin on the same claim. For example, if you code myalgia, fibromyalgia, myositis, or muscle spasm, do not combine any of these; use only one.

Similar problems occur with spinal nerve conditions such as radiculopathy, neuritis and nerve plexus disorders; the codes cannot be combined. For example, you would never code cervical radiculopathy M54.12 with cervicobrachial syndrome M53.1; it would be one or the other.

Most important for any acupuncture claim is making sure you are using a diagnosis that is correct for the patient's condition, but also payable. That means ensuring it is not being combined with a code that will disallow the claim from being accepted for payment.

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*Editor's Note*: Have a billing question? Submit it to Sam via email at sam@hjrossnetwork.com. Submission is acknowledgment that your question may be the subject of a future column.

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