Manual: Reimbursement Policy

Policy Title: **Diagnosis Code Requirements - Level Of Detail and Number of Characters**

Section: Administrative

Subsection: Diagnosis Codes

Date of Origin: 1/1/2000 **Policy Number:** RPM053

Last Updated: 11/3/2017 **Last Reviewed:** 12/12/2018

Scope

For dates of service in 2016 and prior, this policy applies to Medicare Advantage and Medicaid claims only.

For dates of service January 1, 2017 and following, this policy applies to all claims. This includes Medicare Advantage, Medicaid, and Commercial lines of business.

Reimbursement Guidelines

Diagnosis codes are to be used and reported at their highest number of characters available.

ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6, or 7 alpha-numeric characters. A diagnosis code is invalid or incomplete if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.

If any diagnosis code submitted on the claim is not a valid, complete diagnosis code for the date(s) of service on the claim, the entire claim will be denied.

- The claim will be denied regardless of the order or position of the incomplete/invalid diagnosis code.
- The denial will be to provider responsibility. This is due to a billing error which needs to be corrected.
    - For contracted, participating providers –
      The member may not be balance-billed. The hold-harmless protections apply.
    - For non-contracted, out-of-network providers –
      There is no contractual hold-harmless protection for the member. However, the billing error needs to be corrected. In order to process the claim to access any available out-of-network benefits under the member's plan, all diagnosis codes must be complete and valid. A corrected claim is needed.
- The denial explanation code will be:

- 85M (One or more diagnosis codes on this claim requires more digits to be complete. Please resubmit the claim with a more specific diagnosis.)
- CARC = 16 (Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.)
- RARC = M81 (You are required to code to the highest level of specificity.)

Steps to Remedy the Denial

- If the claim is denied with explanation code 85M, every diagnosis code on the claim must be reviewed by the billing office for accuracy and completeness against the current list of valid ICD-10-CM codes for the date of service.
- Diagnosis codes with typos in any character position could result in the diagnosis code not matching the list of valid and complete diagnosis codes for the date(s) of service on the claim. If this occurs, the typo will also result in this denial message of incomplete code requiring more digits, even if the invalid diagnosis code is a full seven characters.
- A corrected claim is needed.

Background Information

The Centers for Medicare and Medicaid Services (CMS) has for many years required all diagnosis codes to be billed to the highest number of characters or digits available. CMS rejects a claim as unprocessable if it contains an incomplete or invalid diagnosis code. This requirement is now being applied by the federal government to Moda Health for Encounter Data and other reporting requirements which include Commercial claims.

This requirement is based upon correct coding rules in the ICD-10-CM General Coding Guidelines.

Codes and Definitions

Acronyms Defined

Acronym		Definition
AHA	=	American Hospital Association
AHIMA	=	American Health Information Management Association
CDC	=	Centers for Disease Control and Prevention
CMS	=	Centers for Medicare and Medicaid Services
DHHS	=	Department of Health and Human Services
HHS	=	U.S. Department of Health and Human Services
ICD-10-CM	=	International Classification of Diseases, 10th Revision, Clinical Modification
NCHS	=	National Center for Health Statistics

Acronym		Definition
RPM	=	Reimbursement Policy Manual (e.g. in context of "RPM052" policy number, etc.)
WHO	=	World Health Organization

Coding Guidelines

"Level of Detail in Coding

Diagnosis codes are to be used and reported at their highest number of characters available.

ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6, or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth characters which provide greater detail.

A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable." (CMS, et al[1])

Cross References

"Diagnosis Code Requirements - Invalid As Primary." Moda Health Reimbursement Policy Manual, RPM054.

References & Resources

1. CMS, NCHS, AHA, & AHIMA. ICD-10-CM Official Guidelines. Section B.2.

IMPORTANT STATEMENT

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS,

DRG guidelines, CMS' National Correct Coding Initiative (CCI/NCCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.