Manual: Reimbursement Policy

Policy Title: **Diagnosis Code Requirements - Invalid As Primary**

Section: Administrative

Subsection: Diagnosis Codes

Date of Origin: 1/1/2000 **Policy Number:** RPM054

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

Scope

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

For Commercial claims

Effective for dates of service 1/1/2017 and following:

- All claims:
  Diagnosis codes which are classified as manifestation codes, external causes of morbidity, or otherwise have sequence-second coding instructions such as "code first _____" or "…in diseases classified elsewhere" will not be acceptable in the first-listed or primary diagnosis position. The claim will be denied with:
  - EX code 992 (Primary diagnosis is invalid for this setting. Please resubmit with valid primary diagnosis.)
  - CARC 146 (Diagnosis was invalid for the date(s) of service reported.)
  - RARC MA63 (Missing/incomplete/invalid principal diagnosis.)

- Inpatient claims:
  Diagnosis codes which appear on the CMS list of Unacceptable Principal Diagnosis Codes (as published in each year's CMS "Definitions of Medicare Code Edits" document) will not be acceptable in the first-listed or primary diagnosis position on facility inpatient claims. The claim will be denied with:
  - EX code 992 (Primary diagnosis is invalid for this setting. Please resubmit with valid primary diagnosis.)

- CARC 146 (Diagnosis was invalid for the date(s) of service reported.)
- RARC MA63 (Missing/incomplete/invalid principal diagnosis.)

- These denials 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.

<u>For Medicare Advantage claims</u>

Effective for dates of service 10/06/2009 and following:

- All claims:
  Diagnosis codes which are classified as manifestation codes, external causes of morbidity, or otherwise have sequence-second coding instructions such as "code first _____" or "…in diseases classified elsewhere" will not be acceptable in the first-listed or primary diagnosis position. The claim will be denied with:
  - EX code 992 (Primary diagnosis is invalid for this setting. Please resubmit with valid primary diagnosis.)
  - CARC 146 (Diagnosis was invalid for the date(s) of service reported.)
  - RARC MA63 (Missing/incomplete/invalid principal diagnosis.)

- Inpatient claims:
  Diagnosis codes which are listed on the CMS list of Unacceptable Principal Diagnosis Codes (as published in each year's CMS "Definitions of Medicare Code Edits" document) will not be acceptable in the first-listed or primary diagnosis position on facility inpatient claims. The claim will be denied with:
  - EX code 992 (Primary diagnosis is invalid for this setting. Please resubmit with valid primary diagnosis.)
  - CARC 146 (Diagnosis was invalid for the date(s) of service reported.)
  - RARC MA63 (Missing/incomplete/invalid principal diagnosis.)

<u>For Medicaid/EOCCO claims</u>

Effective for all dates of service:

- Inpatient claims:
  Diagnosis codes which are listed on the CMS list of Unacceptable Principal Diagnosis Codes (as published in each year's CMS "Definitions of Medicare Code Edits" document) will not be

acceptable in the first-listed or primary diagnosis position on facility inpatient claims. The claim will be denied with:

- EX code 992 (Primary diagnosis is invalid for this setting. Please resubmit with valid primary diagnosis.)
- CARC 146 (Diagnosis was invalid for the date(s) of service reported.)
- RARC MA63 (Missing/incomplete/invalid principal diagnosis.)

- All claims:
  - Diagnosis codes which are classified as manifestation codes, external causes of morbidity, or otherwise have sequence-second coding instructions such as "code first _____" or "…in diseases classified elsewhere" will not be acceptable in the first-listed or primary diagnosis position. The claim will be denied with:
    - EX code 992 (Primary diagnosis is invalid for this setting. Please resubmit with valid primary diagnosis.)
    - CARC 146 (Diagnosis was invalid for the date(s) of service reported.)
    - RARC MA63 (Missing/incomplete/invalid principal diagnosis.)

  - Diagnosis codes which are listed on the Oregon DMAP list of Invalid Primary Diagnosis codes (as provided each year by Oregon DMAP) will not be acceptable in the first-listed or primary diagnosis position on any claim. (Note, this list is in addition to the CMS list which applies specifically to Inpatient claims.) The claim will be denied with:
    - EX code 992 (Primary diagnosis is invalid for this setting. Please resubmit with valid primary diagnosis.)
    - CARC 146 (Diagnosis was invalid for the date(s) of service reported.)
    - RARC MA63 (Missing/incomplete/invalid principal diagnosis.)

Background Information

ICD-9-CM and ICD-10-CM coding guidelines include instructions for codes which must be sequenced second to another diagnosis. In these situations, the ICD-10-CM listings for the related codes include cross-referencing instructional notes "code first", "use additional code" and "in diseases classified elsewhere". On all claims in all settings, the codes which are to be sequenced second may not appear in the primary or first-listed diagnosis field. This includes manifestation diagnosis codes, external causes of morbidity diagnosis codes, and certain other diagnosis codes. This requirement is now being applied by the federal government to Moda Health for Encounter Data and other reporting requirements which include Commercial claims.

CMS has defined an additional list of selected codes which CMS considers unacceptable as a principal diagnosis for an inpatient facility claim. These codes describe a circumstance which influences an individual's health status but not a current illness or injury, or codes that are not specific manifestations but may be due to an underlying cause. This CMS requirement is now being applied by the federal government to Moda Health for Encounter Data and other reporting requirements which include Commercial claims.

The Oregon Division of Medical Assistance Programs (DMAP) (aka Oregon Medicaid) has defined an additional list of selected codes which DMAP considers unacceptable as a principal or first-listed diagnosis for all claims.

Each of these lists is updated annually to correspond with the annual update to the diagnosis code set.

Codes, Terms, 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
DMAP	=	Division of Medical Assistance Programs (Medicaid)
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
OHA	=	Oregon Health Authority (Oregon Medicaid)
OHP	=	Oregon Health Plan (Oregon Medicaid)
RPM	=	Reimbursement Policy Manual (e.g. in context of "RPM052" policy number, etc.)
WHO	=	World Health Organization

Coding Guidelines

"Conventions for the ICD-10-CM – Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes):

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation.

Whenever such a combination exists, there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation. …

"Code first" and "Use additional code" notes are also used in sequencing rules for classification for certain codes that are not part of an etiology/manifestation combination." (CMS, et al[1])

"External Causes of Morbidity (V01-Y99) – External cause code can never be a principle diagnosis:

An external cause code can never be a principle (first-listed) diagnosis." (CMS, et al[2])

Cross References

"Diagnosis Code Requirements - Level Of Detail and Number of Characters." Moda Health Reimbursement Policy Manual, RPM053.

References & Resources

1. CMS, NCHS, AHA, & AHIMA. ICD-10-CM Official Guidelines. Section I.A.13.

2. CMS, NCHS, AHA, & AHIMA. ICD-10-CM Official Guidelines. Section I.B.20.a.6).

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.