Scope

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

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

Reimbursement Guidelines

A. For Commercial claims

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

1. All claims:
   a. Diagnosis codes which are classified as the following, or will not be acceptable in the first-listed or primary diagnosis position:
      i. Manifestation codes
      ii. External causes of morbidity
      iii. Otherwise have sequence-second coding instructions such as:
          1) “Code first _____”
          2) “...in diseases classified elsewhere”

   b. The claim will be denied with:
      i. 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.)
ii.
- **EX code z60** (A non-primary diagnosis code was submitted as the primary diagnosis code.)
- **CARC 16** (Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.)
- **RARC MA63** (Missing/incomplete/invalid principal diagnosis.)

2. Inpatient claims:
   a. 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.
   b. The claim will be denied with:
      i. **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.)
      ii. **EX code z60** (A non-primary diagnosis code was submitted as the primary diagnosis code.)
         **CARC 16** (Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.)
         **RARC MA63** (Missing/incomplete/invalid principal diagnosis.)

3. Financial responsibility for denied claims:
   These denials are provider responsibility. Do not balance-bill the member. The denial is due to a billing error.
   a. For contracted, participating providers –
      i. The member may not be balance-billed. The hold-harmless protections apply.
      ii. A corrected claim is needed.
   b. For non-contracted, out-of-network providers –
      i. 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.
      ii. A corrected claim is needed.
B. For Medicare Advantage claims

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

1. All claims:
   a. Diagnosis codes which are classified as the following, or will not be acceptable in the first-listed or primary diagnosis position:
      i. Manifestation codes
      ii. External causes of morbidity
      iii. Otherwise have sequence-second coding instructions such as:
         1) “Code first _____”
         2) “…in diseases classified elsewhere”
   b. The claim will be denied with:
      i. 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.)
      ii. EX code z60  (A non-primary diagnosis code was submitted as the primary diagnosis code.)
         CARC 16  (Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.)
         RARC MA63  (Missing/incomplete/invalid principal diagnosis.)

2. Inpatient claims:
   a. 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.
   b. The claim will be denied with:
      i. 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.)
      ii. EX code z60  (A non-primary diagnosis code was submitted as the primary diagnosis code.)
         CARC 16  (Claim/service lacks information or has submission/billing error(s)
3. Financial responsibility for denied claims:
   a. These denials are provider responsibility. Do not balance-bill the member. The denial is due
to a billing error.
   b. A corrected claim is needed.

C. For Medicaid claims

Effective for all dates of service:

1. All claims:
   a. Diagnosis codes which are classified as the following, or will not be acceptable in the first-
      listed or primary diagnosis position:
      i. Manifestation codes
      ii. External causes of morbidity
      iii. Otherwise have sequence-second coding instructions such as:
          1) “Code first _____”
          2) “…in diseases classified elsewhere”
      iv. Listed on the Oregon DMAP list of Invalid Primary Diagnosis codes (as provided each
          year by Oregon DMAP). Note, this list is in addition to the CMS list which applies
          specifically to Inpatient claims.
   
   b. The claim will be denied with:
      i. 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.)
      
      ii. EX code z60 (A non-primary diagnosis code was submitted as the primary
          diagnosis code.)
      CARC 16 (Claim/service lacks information or has submission/billing error(s)
          which is needed for adjudication.)
      RARC MA63 (Missing/incomplete/invalid principal diagnosis.)
2. Inpatient claims:

   a. 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.

   b. The claim will be denied with:

      i.  
         - 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.)

      ii. 
         - EX code z60  (A non-primary diagnosis code was submitted as the primary diagnosis code.)
         - CARC 16  (Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.)
         - RARC MA63  (Missing/incomplete/invalid principal diagnosis.)

3. Financial responsibility for denied claims:

   a. These denials are provider responsibility. Do not balance-bill the member. The denial is due to a billing error.

   b. A corrected claim is needed.

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**Codes, Terms, and Definitions**

**Acronyms Defined**

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<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AHA</td>
<td>American Hospital Association</td>
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<td>AHIMA</td>
<td>American Health Information Management Association</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<td>AMA</td>
<td>American Medical Association</td>
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<tr>
<td>CCI</td>
<td>Correct Coding Initiative (see “NCCI”)</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
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<td>DHHS</td>
<td>Department of Health and Human Services</td>
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<tr>
<td>Acronym</td>
<td>Definition</td>
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<td>DMAP</td>
<td>Division of Medical Assistance Programs (Medicaid)</td>
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<td>DRG</td>
<td>Diagnosis Related Group (also known as/see also MS DRG)</td>
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<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System (acronym often pronounced as &quot;hick picks&quot;)</td>
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<tr>
<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
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<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
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<td>ICD-10-CM</td>
<td>International Classification of Diseases, 10th Revision, Clinical Modification</td>
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<tr>
<td>MS DRG</td>
<td>Medicare Severity Diagnosis Related Group (also known as/see also DRG)</td>
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<tr>
<td>NCCI</td>
<td>National Correct Coding Initiative (aka “CCI”)</td>
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<td>NCHS</td>
<td>National Center for Health Statistics</td>
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<td>OHA</td>
<td>Oregon Health Authority (Oregon Medicaid)</td>
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<td>OHP</td>
<td>Oregon Health Plan (Oregon Medicaid)</td>
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<td>RPM</td>
<td>Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)</td>
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<td>UB</td>
<td>Uniform Bill</td>
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<td>WHO</td>
<td>World Health Organization</td>
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**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 al1)

“External Causes of Morbidity (V01-Y99) – External cause code can never be a principal diagnosis:
An external cause code can never be a principal (first-listed) diagnosis.” (CMS, et al2)
Cross References


References & Resources


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.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document Moda Health’s payment guidelines for those services covered by a member’s medical benefit plan. Healthcare providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Moda Health Reimbursement Policy is not intended to impact care decisions or medical practice.
Providers are responsible for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Providers are expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims are to 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] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member’s medical benefit plan. Should there be any conflicts between the Moda Health Reimbursement Policy and the member’s medical benefit plan, the member’s medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider’s agreement, and Moda Health Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; Moda Health strives to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****