moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM054
Policy Title:	Diagnosis Code Requirements - Invalid as Primary		
Section:	Administrative	Subsection:	Diagnosis Codes

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types For dates of service January 1, 2017 and following: ☒ Commercial Group ☒ Commercial Individual ☒ Commercial Self-funded ☒ Commercial Marketplace/Exchange ☒ Short Term For all dates of service: ☒ Medicaid For dates of service October 6, 2009 and following: ☒ Medicare Advantage ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	1/1/2000	Initially Published:	9/15/2016
Last Updated:	9/14/2022	Last Reviewed:	9/14/2022
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		9/14/2022	

Reimbursement Guidelines

A. For all claims:

1. Claims with diagnosis codes listed in the first-listed or primary diagnosis position will be denied if the diagnosis code meets the following criteria:
    a. Manifestation codes
    b. External causes of morbidity
    c. Otherwise have sequence-second coding instructions such as:
        i. "Code first _____"
        ii. "…in diseases classified elsewhere"

B. Inpatient claims:

1. 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.
2. The entire claim will be denied.
3. A corrected claim is needed.

C. The claim will be denied with:

1.

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.)

2.

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.)

D. 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 corrected claim is needed.

1. For contracted, participating providers:
   a. The member may not be balance-billed. The hold-harmless protections apply.
   b. A corrected claim is needed.
2. For non-contracted, out-of-network providers:
   a. On Medicaid plans, the member may not be balance-billed.
   b. On all other plans:
      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.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AHA	=	American Hospital Association
AHIMA	=	American Health Information Management Association
AMA	=	American Medical Association
CCI	=	Correct Coding Initiative (see “NCCI”)
CDC	=	Centers for Disease Control and Prevention
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DHHS	=	Department of Health and Human Services
DMAP	=	Division of Medical Assistance Programs (Medicaid)
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HHS	=	U.S. Department of Health and Human Services
HIPAA	=	Health Insurance Portability and Accountability Act
ICD-10-CM	=	International Classification of Diseases, 10th Revision, Clinical Modification
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka “CCI”)
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.)
UB	=	Uniform Bill
WHO	=	World Health Organization

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"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 principal diagnosis:

An external cause code can never be a principal (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).

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 our 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. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. 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 our 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 our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive 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 *****

Policy History

Date	Summary of Update
9/14/2022	Formatting/Update: Change to new header. Reimbursement guidelines no longer need separate sections by type of business/plan because effective dates by type of business is now specified in the header/scope section. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
9/15/2016	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2000	Original Effective Date (with or without formal documentation). Policy based on ICD-10 coding guidelines & CMS policy on diagnosis codes invalid as primary for specific settings.