Inappropriate Diagnosis Codes

Reimbursement Policy ID: RPC.0058.2100

Recent review date: 10/2023

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AmeriHealth Caritas Louisiana reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas Louisiana may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including but not limited to Current Procedural Terminology (CPT®), the Healthcare Common Procedure Coding System (HCPCS), and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM). Other factors that may affect payment include but are not limited to medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other policies. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all healthcare services billed on CMS-1500 forms or its electronic equivalent and, when specified, billed on UB-04 forms or its electronic equivalent.

Policy Overview

This policy provides reimbursement guidelines for the correct reporting of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes for professional services. Adherence to these guidelines when assigning ICD-10 diagnosis code(s) is required under the Health Insurance Portability and Accountability Act (HIPAA). Incorrect coding will result in a claim denial.

Exceptions

N/A

Reimbursement Guidelines

AmeriHealth Caritas Louisiana follows the ICD-10-CM Official Guidelines for Coding and Reporting, developed through a collaboration of the Centers for Medicare & Medicaid Services (CMS), the National Center for Health Statistics (NCHS), and the Department of Health and Human Services (DHHS), which provides a clear direction on the coding and sequencing of diagnosis codes.

Diagnosis Specificity
In order to be reimbursable, diagnoses must be coded to the highest level of specificity for the condition reported, up to and including the 6th and 7th digits if applicable, based upon the degree of clinical detail documented in the medical record for all encounters.

Diagnosis codes that involve laterality must be coded to the highest level of specificity – meaning the 6th digit of the code must be provided to indicate the anatomical site. For example, a diagnosis of malignant neoplasm of the central portion of the right breast would be coded as C50.111, with the 6th digit representing the right side.

Additionally, the 6th digit in the diagnosis code, representing laterality, must align with the anatomical modifier billed on the *procedure* code. For example, if the provider performed a right partial mastectomy to treat the neoplasm, the procedure would need to be billed with the right-laterality modifier in order to be reimbursable.

Claims will be denied when an anatomical procedure modifier conflicts with the diagnosis provided on the claim.

Correct scenario:
19301-RT-partial Mastectomy, right breast C50.111-malignant neoplasm central portion right female breast (In this case, the “RT” modifier in the CPT code matches the 6th-digit “1” in the diagnosis code.)

Incorrect scenario:
19301-RT-partial Mastectomy, right breast C50.119-malignant neoplasm central portion of unspecified female breast (In this case, the “RT” modifier in the CPT code does not have a laterality equivalent in the diagnosis code.)

Inappropriate Primary Diagnosis
AmeriHealth Caritas Louisiana follows ICD-10-CM Official Guidelines. Claims submitted for reimbursement that do not follow the ICD-10-CM official guidelines will not be reimbursed.

According to the ICD-10-CM Official Guidelines, inappropriate primary diagnosis codes include:

- Code First - “Code first” notes occur with certain codes that are not specifically manifestation codes but may be due to an underlying cause. When a “code first” note is present that is caused by an underlying condition, the underlying condition is to be sequenced first, if known. For example, a diagnosis of secondary spontaneous pneumothorax (J93.12) has a “code first” note to code the underlying condition, such as Marfan’s Syndrome (Q87.4).
- Manifestation codes – The underlying disease should be coded first followed by the manifestation code. In most cases, the manifestation codes will include the verbiage, “in diseases classified elsewhere.” For example, central sleep apnea in conditions classified elsewhere (G47.37). ICD-10-CM guidelines state “Code first underlying condition” In this example, the underlying condition is stroke (I63.9), and therefore it would be coded first. Claims for services received with a manifestation code billed in the primary, first listed, or principal diagnosis position are non-reimbursable.
- Secondary Diagnosis codes – “Use additional code” indicates that secondary diagnosis code(s) should be used. The secondary diagnosis can never be primary. For example, the diagnosis code for unstable angina, I20.0, has a directive to “use additional code”. In this example, the code Z72.0, tobacco abuse would be used as a secondary diagnosis. Claims with a secondary diagnosis code only, are not reimbursed.
- Sequela codes - A sequela encounter code uses the letter “S” in the 7th position and indicates a late effect that occurs after the acute phase of the injury or illness has passed. When reporting sequela(e) two codes must be reported. The ICD-10-CM guidelines require that the residual should be coded first, followed by the healed illness/injury. For example, a painful scar, L90.5, is sequenced first followed by S92.211S, a displaced fracture of the body of the right calcaneus. A claim received with an ICD-10-CM sequela (7th character "S") code billed as the only diagnosis will not be reimbursed.

- External cause codes - V, W, X or Y codes describe the circumstance causing an injury, not the nature of the injury. Claims are not reimbursable when one of these codes is used as the primary diagnosis.

Excludes Notes

Within the ICD-10-CM Manual, there are two types of "Excludes" notes.

- Excludes1 indicates "not coded here" which means the diagnosis codes should never be billed together. For example, a congenital form of a disorder cannot occur with an acquired form of a condition.
- Excludes2 represents "not included here". It indicates that the condition excluded is not part of the condition represented by the code, but the patient may have both conditions at the same time. Claims that include both the code and the excluded code at the same time may be reimbursable, depending on specific circumstances. For example, a claim that includes both D27.0 benign neoplasm, rt ovary, and N80.101, endometriosis of the right ovary may be reimbursable, as these are two different conditions

Definitions

N/A

Edit Sources

I. *International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM)*
II. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf, p. 41
III. https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines-updated-02012022.pdf

Attachments

N/A

Associated Policies

N/A

Policy History

10/10/2023	Reimbursement Policy Committee Approval
08/25/2023	Removal of Policy Implemented by AmeriHealth Caritas from Policy History section
01/10/2023	Template Revised Revised preamble Removal of Applicable Claim Types table Coding section renamed to Reimbursement Guidelines Added Associated Policies section
	Precedes Act 319