Diagnosis Code Requirement Policy, Professional and Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare® Commercial and Individual Exchange Reimbursement Policy® Commercial and Individual Exchange Reimbursement Policy may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare® Commercial and Individual Exchange Reimbursement Policy® Commercial and Individual Exchange Reimbursement Policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare® Commercial and Individual Exchange Reimbursement Policy may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare® Commercial and Individual Exchange Reimbursement Policy enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare® Commercial and Individual Exchange Reimbursement Policy due to programming or other constraints; however, UnitedHealthcare® Commercial and Individual Exchange Reimbursement Policy strives to minimize these variations.

UnitedHealthcare® Commercial and Individual Exchange Reimbursement Policy may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

Application

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500), UB04 claim form or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians and other qualified health care professionals, outpatient facility claims, Ambulatory Surgical Centers (ASC), Outpatient Surgical Centers (OSC), including, but not limited to, non-network authorized and percent of charge contract physicians, other qualified health care professionals or facilities.

Policy

Overview

This policy addresses reimbursement guidelines for reporting appropriate ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) diagnosis on an Inpatient and Outpatient Facility UB04 claim form or Professional CMS-1500 claim form or its electronic equivalent.

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting, developed through a collaboration of The Centers for Medicare and Medicaid Services (CMS), the National Center for Health Statistics (NCHS), and the Department of Health and Human Services (DHHS), provides clear direction on the coding and sequencing of diagnosis codes.

Reimbursement Guidelines

UnitedHealthcare aligns with the official ICD-10-CM Guidelines for Coding and Reporting, and requires the appropriate diagnosis be submitted on a claim and coded in accordance with the guidelines to be considered for reimbursement. Examples of these guidelines include, but are not limited to the following:

- **Manifestation codes that describe the manifestation of an underlying disease, not the disease itself. Therefore, it cannot be reported as first listed or principal diagnosis.**
- **"Code first" notes occur with certain codes that are not manifestation codes but may be due to an underlying cause. When present, the underlying condition is sequenced first, if known.**
- **Sequela coding generally requires two codes: the condition or nature of the sequela first, and the sequela code second. Exceptions to this guideline are instances where the sequela code is followed by a manifestation code, or the sequela code has been expanded to include the manifestation(s).**
- **Code malignant neoplasm of a transplanted organ as a transplant complication. Assign the appropriate code for complications of transplanted organs and tissue (category T86) first, followed by code C80.2.**
- **For conditions caused by external or toxic agents, assign the appropriate code for the agent first (category T51-T65), followed by the condition code. For toxic effects in a pregnant patient, assign the code for the toxic effect first, followed by the code for the pregnancy.**
- **Principal Diagnosis requiring a secondary diagnosis be submitted. For Example, code Z51.89.**
- **External causes of morbidity codes (V00-Y99) describe how the injury/health condition occurred, (traffic accident, fall, etc) and the intent of the injury/health condition (intentional/unintentional). Therefore, these codes should not be used as principal diagnosis.**
- **Factors that influence health status (Category of codes beginning with Z) describe the reason for the encounter. Certain Z codes may only be used as first listed or principal diagnosis. Other Z codes may only be listed as a secondary code based on the circumstances of the encounter.**
- **Sepsis, Severe Sepsis, and Septic Shock (Category R65)**
- **Mutually Inclusive Diagnosis Codes defined by Exclude1. An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note.**

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting should be consulted for the detailed descriptions of all diagnosis guidelines applicable to this policy.

Unacceptable Principal or Inappropriate Primary Diagnosis Codes

For a claim to be eligible for reimbursement, UnitedHealthcare requires the submission of the correct principal or primary diagnosis code in the appropriate location on the Claim Form. The table provided below delineates the proper allocation of the diagnosis code, in conjunction with the reference list, to provide guidance for the submission of the appropriate diagnosis code.

Claim Type	Claim Form	Claim Field	Diagnosis List
Inpatient	UB-04	Principal diagnosis in Box 67 on a UB-04 claim form or electronical equivalent	1. Unacceptable Principal ICD-10-CM Diagnosis Codes List 2. DRG 998 Diagnosis List
Outpatient	UB-04	Diagnosis in Box 67 on a UB-04 claim form or its electronical equivalent	Inappropriate Primary ICD-10-CM Diagnosis Codes List
Professional	CMS-1500	Diagnosis pointed to or linked as primary in box 24E (Diagnosis Pointer) on a CMS-1500 claim form or its electronic	Inappropriate Primary ICD-10-CM Diagnosis Codes List

MS-DRG Classification
MS-DRG No. 998 MS-DRG 998 represents a discharge reporting a principal diagnosis that is invalid as a principal diagnosis. Examples include a diagnosis of diabetes mellitus or an infection of the genitourinary tract during pregnancy, both unspecified as to episode of care. These diagnoses may be valid, but they are not sufficient to determine the principal diagnosis for MS-DRG assignment purposes.

Questions and Answers	
1	**Q:** Is it appropriate to bill Q21.0 congenital malformations of cardiac septa with I51.0 acquired cardiac septal defect? **A:** No. A congenital form and an acquired form of the same condition cannot be reported together. Excludes1 Guidelines ensure the highest specificity that most accurately represents the members health condition through correct diagnosis coding.
2	**Q:** When an inappropriate diagnosis code is pointed to or linked as primary in box 24E on a CMS-1500 claim form or its electronic equivalent and there is more than one claim line, will the entire claim be denied? **A:** No. Only the claim line(s) associated with the diagnosis code inappropriately reported as primary in box 24E will be denied by this policy.
3	**Q:** When an inappropriate principal diagnosis code is submitted as the principal diagnosis in Box 67 of the UB-04 claim form or its electronic equivalent will the entire claim be denied? **A:** Yes. Inappropriately reporting diagnosis codes that are not found on the principal diagnosis list as the principal reason for admission in box 67 of the UB-04 claim form will result in the entire claim being denied by this policy.
4	**Q:** What does Hospital Diagnosis Related Groups (DRGs) mean? **A:** DRGs categorize patients by their diagnoses and the associated costs while treating them. Hospital DRGs are divided into two types: (1) Medical DRGs, which don't reflect operating room procedures, and (2) Surgical DRGs.
5	**Q:** What is the relationship between the Hospital DRG Codes and ICD-10-CM? **A:** The ICD-10-CM is a morbidity classification published by the National Center for Health Statistics under authorization of the World Health Organization for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO). ICD-10-CM codes are used to determine DRG. The DRG determines the single payment the hospital will receive for treating the patient, not for each X-ray image, room supply, syringe, swab, or pill, but single cost that covers the entire care episode.
6	**Q:** Is there a list of Excludes1 diagnosis codes? **A:** Providers should refer to the official ICD-10-CM Guidelines for appropriate Excludes1 diagnoses.

Attachments	
Unacceptable Principal ICD-10-CM Diagnosis Codes List	A list of ICD-10-CM diagnosis codes that are unacceptable to be used as the principal diagnosis This list applies to inpatient claims submitted on a UB04 claim form.

DRG 998 Diagnosis list	A list of DRG 998 Diagnosis codes that are unacceptable to be used as the principal diagnosis. This list applies to inpatient claims submitted on a UB04 claim form.
UnitedHealthcare Inappropriate Primary ICD-10-CM Diagnosis Codes List	A list of ICD-10-CM diagnosis codes that are inappropriate to be used as the primary diagnosis. This list applies to both outpatient UB04 and professional 1500 submitted claims.

Resources

American Hospital Association (AHA)

Centers for Medicare and Medicaid Services, CMS Manual System and other publications and services

Centers for Disease Control and Prevention, International Classification of Diseases, 10th Revision, Clinical Modification

History

5/1/2024	Policy implemented by UnitedHealthcare® Commercial and Individual Exchange
12/12/2023	Policy approved by the Reimbursement Policy Oversight Committee

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