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 Community Plan reimbursement policies uses 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 Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan 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 Community Plan enrollees.

Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, 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 Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan 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.

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Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid.

This reimbursement policy applies to services reported using the UB-04 Form, the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or their electronic equivalents or their successor forms. This policy applies to all products, all network and non-network providers, including, but not limited to, non-network authorized and percent of charge contract hospitals, ambulatory surgical centers, physicians, and other qualified health care professionals.

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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 Exclusive 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 coding guidelines applicable to this policy.

<u>Inappropriate Primary Diagnosis Codes</u>

For a claim to be eligible for reimbursement, UnitedHealthcare requires the submission of the correct 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.

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Claim Type	Claim Form	Claim Field	Diagnosis List
Outpatient	UB-04	Diagnosis in Box 67 on a UB-04 claim form or its electronical equivalent	Inappropriate Primary 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 Diagnosis Codes list

State Exceptions	
Arizona	Arizona is exempt from all Mutually Exclusive Diagnosis Codes Defined by Excludes 1.
Hawaii	Hawaii Medicaid allows ICD-10 diagnosis code, Z59.41 to be submitted in the primary position when billed with CPT code, S9977.
Idaho	Per State Requirement: Idaho Medicaid allows for Z65.8 to be billed with S9485 and H2011. Idaho is exempt from the Outpatient and Professional Mutually Exclusive Diagnosis Codes Defined by Excludes 1.
Indiana	Indiana is exempt from all Mutually Exclusive Diagnosis Codes Defined by Excludes 1
Kansas	Kansas Medicaid uses a customized, state identified Inappropriate Primary ICD-10 Diagnosis Codes list. (This list is a combination of codes from ICD-10 Inappropriate Primary DX list and the CMS Medicare Unacceptable Principal Diagnosis Code List). Kansas is exempt from all Mutually Exclusive Diagnosis Codes Defined by Excludes 1.
Kentucky	Kentucky is exempt from all Mutually Exclusive Diagnosis Codes Defined by Excludes 1.
Maryland	Maryland is exempt from the Outpatient Facility and Professional Mutually Exclusive Diagnosis Codes Defined by Excludes 1.
Michigan	Per State Requirement: • Michigan Medicaid allows for Z33.1 and Z39.2 to be billed with T1033 and S9445 for Doulas. CPT codes 98960, 989621 & 98962 with modifier CG are excluded from this policy for CHLW providers
Minnesota	Minnesota Medicaid allows for Z33.1 and Z39.1 to be billed with S9445-U4 and 99199-U4
Mississippi	Mississippi is exempt from the Inpatient Mutually Exclusive Diagnosis Codes Defined by Excludes 1
Missouri	Missouri does not require behavioral health diagnosis for 90791 and 90792. The provider should report the most appropriate ICD-10 diagnostic code. Missouri is exempt from the Outpatient Facility and Professional Mutually Exclusive Diagnosis Codes Defined by Excludes 1
Nebraska	Nebraska is exempt from all Mutually Exclusive Diagnosis Codes Defined by Excludes 1.
New Jersey	New Jersey Medicaid allows the following ICD-10 diagnosis codes to be submitted in the primary position when billed with CPT code 3008F: Z68.51, Z68.52, Z68.53, Z68.54 New Jersey Medicaid allows the following ICD-10 diagnosis code, Z59.01 to be submitted in the primary position when billed with CPT code, H0044, T2038, S5165, & T1028. New Jersey Medicaid is exempt from all Mutually Exclusive Diagnosis Codes Defined by Excludes 1.

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	H0044 with modifier U1, U3, U4 and/or U6 can have the following diagnosis codes in the first position: Z59.0, Z59.00, Z59.01, Z59.02, Z59.1, Z59.10, Z59.11, Z59.12, Z59.19, Z59.2, Z59.3, Z59.41, Z59.48, Z59.5, Z59.6, Z59.7, Z59.811, Z59.812, Z59.819, Z59.82, Z59.86, Z59.861, Z59.868, Z59.869, Z59.87, Z59.89, Z59.9. T2038 with modifier U1 and/or U6 can have the following diagnosis codes in the first position: Z59.0, Z59.00, Z59.01, Z59.02, Z59.1, Z59.10, Z59.11, Z59.12, Z59.19, Z59.2, Z59.3, Z59.41, Z59.48, Z59.5, Z59.6, Z59.7, Z59.811, Z59.812, Z59.819, Z59.82, Z59.86, Z59.861, Z59.868, Z59.869, Z59.87, Z59.89, Z59.9. S5165 with modifier U2 and/or U3 can have the following diagnosis codes in the first position: Z59.0, Z59.00, Z59.01, Z59.02, Z59.1, Z59.10, Z59.11, Z59.12, Z59.19, Z59.2, Z59.3, Z59.41, Z59.48, Z59.5, Z59.6, Z59.7, Z59.811, Z59.812, Z59.819, Z59.82, Z59.86, Z59.861, Z59.868, Z59.869, Z59.87, Z59.89, Z59.9.
New Mexico	New Mexico Medicaid allows the following CPT codes 98960, 989621 & 98962 to be submitted with ICD-10 diagnosis codes to be submitted in the primary position: Z55.0, Z55.2, Z55.3, Z55.4, Z55.5, Z55.6, Z55.8, Z56.0, Z56.89, Z56.9, Z58.6, Z58.89, Z59.01, Z59.02, Z59.10, Z59.12, Z59.19, Z59.41, Z59.48, Z59.5, Z59.6, Z59.811, Z59.812, Z59.82, Z59.89, Z60.0, Z60.2, Z60.3, Z60.4, Z60.8
New York	Plan ID NYCDFHP Product ID NYCD NYCDT NYCDB allows Z65.9 to be primary for following CPT codes 90832, 90834, 90837, 90846, 90847, 90849, 90853. NYEPP, NYCDFHP, NYCHP, NYWEL4ME allows Z59.01 and Z59.02 to be billed as primary DX code on a claim. New York is exempt from the Outpatient Facility and Professional Mutually Exclusive Diagnosis Codes Defined by Excludes 1
North Carolina	North Carolina Medicaid Healthy Opportunities Pilot (HOP) services are exempt from this policy.
Ohio	OHIO MMP is excluded from the Outpatient Primary Diagnosis portion of this policy Ohio is exempt from all Mutually Exclusive Diagnosis Codes Defined by Excludes 1.
Rhode Island	Rhode Island Medicaid uses a customized, state identified Inappropriate Primary ICD-10 Diagnosis Codes list which is included in the policy.
Tennessee	Tennessee Medicaid allows ICD-10 diagnosis code S06.2X1S in principal position when billed with any of the following CPT codes: 97151-97158, 0362T and 0373T Tennessee Medicaid allows ICD-10 diagnosis codes Z3A.01, Z3A.19-Z3A.42, Z3A.49, O75.85 and O94 in the principal position when billed with the following CPT code A4670
Texas	Texas Medicaid does not allow the following category to be submitted in the primary or referenced diagnosis: • Diagnosis in the International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3) Texas Medicaid allows for the following ICD-10 diagnosis code to be submitted in the primary position: • Z23 – if immunization is the only service provided during an office visit.
Virginia	Virginia Commonwealth Community Care Plus (CCC Plus) HCBS plan includes H2000 as an HCBS service. HCBS services are exempt from this policy.

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Washington D.C	Washington D.C. is exempt from the Outpatient and Professional Mutually Exclusive Diagnosis Codes Defined by Excludes 1.
Wisconsin	Wisconsin Medicaid allows the following ICD-10 diagnosis codes to be submitted in the primary position when billed with CPT code 3008F: Z68.51, Z68.52, Z68.53, Z68.54. Wisconsin Medicaid allows the following ICD-10 diagnosis codes to be submitted in the primary position when billed with CPT code T1016: Z65.8 or Z65.9.

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: Is there a list of Excludes1 diagnosis codes? A: Providers should refer to the official ICD-10-CM Guidelines for appropriate Excludes1 diagnoses

Attachments	
Inappropriate Primary ICD-10 Diagnosis Codes List	A list of ICD-10-CM diagnosis codes that are inappropriate to be used as the principal/primary diagnosis. This list applies to professional and outpatient facility claims
Rhode Island Medicaid Inappropriate Primary ICD-10 Diagnosis Codes List	A list of ICD-10-CM diagnosis codes that are inappropriate to be used as the primary diagnosis for Rhode Island.
Kansas Medicaid Inappropriate Primary ICD-10 Diagnosis Codes List	Kansas Medicaid uses a customized, state identified Inappropriate Primary ICD-10 Diagnosis Codes list. (This list is a combination of codes from ICD-10 Inappropriate Primary DX list and the CMS Medicare Unacceptable Principal Diagnosis Code List).

Resources
Individual State Medicaid Regulations, Manuals, and Fee Schedules American Hospital Association (AHA)

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

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

History	
7/12/2026	Policy Version Change State Exceptions: Massachusetts removed
6/12/2026	Policy Version Change State Exceptions: Indiana verbiage updated
6/1/2026	Policy Version Change State Exceptions: Updated Texas History Section: Entries prior to 6/1/2024 archived
5/24/2026	Policy Version Change State Exceptions: Updated Wisconsin
4/1/2026	Policy Version Change State Exceptions: Added Maryland, Washington D.C State Exceptions: Updated Arizona, Idaho, Indiana, Kansas, Kentucky, Missouri, Nebraska, New Jersey, New York, Ohio, Texas
2/15/2026	Policy Version Change State Exceptions: Added Idaho State Exceptions: Updated New Jersey
1/11/2026	Policy Version Change State Exceptions: Updated New York
1/1/2026	Policy Version Change State Exceptions: Added Hawaii
11/26/2025	Policy Version Change State Exceptions Updated Tennessee
11/23/2025	Policy Version Change State Exceptions New Jersey verbiage updated
10/12/2025	Policy Version Change Attachments: Kansas Medicaid Inappropriate Primary ICD-10 Diagnosis Codes List updated
10/5/2025	Policy Version Change State Exceptions: New Mexico added
9/21/2025	Policy Version Change State Exceptions: Missouri added Attachments: Inappropriate Primary ICD-10 Diagnosis Codes List Updated
7/13/2025	Policy Version Change State Exceptions California removed
6/15/2025	Policy Version Change Attachments: Kansas Medicaid Inappropriate Primary ICD-10 Diagnosis Codes List updated
5/16/2025	Policy Version Change State Exceptions Added Indiana
3/28/2025	Policy Version Change State Exceptions Updated Texas and Policy overview
11/3/2024	Policy Version Change Attachments: Inappropriate Primary ICD-10 Diagnosis Codes List Updated
10/20/2024	Policy Version Change Attachments: Kansas Medicaid Inappropriate Primary ICD-10 Diagnosis Codes List updated
10/13/2024	Policy Version Change Attachments: Inappropriate Primary ICD-10 Diagnosis Codes List Updated
9/30/2024	Policy Version Change State Exception section: Kansas Updated

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9/22/2024	Policy Version Change Attachments: Inappropriate Primary ICD-10 Diagnosis Codes List Updated
8/1/2024	Policy Version Change State Exceptions Updated
5/1/2024	Policy Implemented by UnitedHealthcare Community Plan
12/12/2023	Policy approved by the Reimbursement Policy Oversight Committee

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