

Inappropriate Primary Diagnosis Codes Policy, Professional for Louisiana

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 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
<p>This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.</p> <p>This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.</p>

Policy
<p>Overview</p> <p>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. Utilizing the ICD-10-CM Official Guidelines for Coding and Reporting, this policy identifies diagnosis codes, which should never be billed as primary on a CMS-1500 claim form or its electronic equivalent.</p>
<p>Reimbursement Guidelines</p> <p>UnitedHealthcare Community Plan will deny claims where an inappropriate diagnosis is pointed to or linked as primary in box 24E on a CMS-1500 claim form or its electronic equivalent. When a code on the Inappropriate Primary Diagnosis List is pointed to or linked as the primary diagnosis on the claim form, the associated claim line(s) will be denied.</p>
<p>Inappropriate Primary Diagnosis Codes Determination</p>
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The following criteria, used to determine codes that are added to the Inappropriate Primary Diagnosis Codes list, are sourced to the Official ICD-10-CM Guidelines for Coding and Reporting, which govern the use of specific codes:

Manifestation codes

- Manifestation codes cannot be reported as first-listed or principal diagnoses. In most cases the manifestation codes will include the verbiage, “in diseases classified elsewhere.”

“Code first” notes when not a manifestation code

- “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 which is caused by an underlying condition, the underlying condition is to be sequenced first.

Sequela codes

- Coding of sequela generally requires two codes sequenced with the condition or nature of the sequela first and the sequela code second. An exception to this guideline are those instances where the code for the sequela is followed by a manifestation code identified in the tabular list and title, or the sequela code has been expanded at the fourth, fifth or sixth characters to include the manifestation(s).

Malignant neoplasm associated with transplanted organ

- A malignant neoplasm of a transplanted organ should be coded as a transplant complication. Assign first the appropriate code for complications of transplanted organs and tissue (category T86), followed by code C80.2, Malignant neoplasm associated with transplanted organ.

Conditions due to external or toxic agents

- For any conditions which have been caused by external or toxic agents, assign first the appropriate code for the external or toxic agent (category T51-T65), followed by the condition.

Gout (Category M1A - M10)

- For lead-induced gout and lead-induced chronic gout, code first toxic effects of lead and its compounds (Category T56.0).
- For gout and chronic gout due to renal impairment, code first associated renal disease.
- For other secondary gout and other secondary chronic gout, code first associated condition.

Symptoms and signs specifically associated with systemic inflammation and infection (Category R65)

- When systemic inflammatory response syndrome (SIRS) is present with a noninfectious condition and no subsequent infection is present, assign first the appropriate code for the underlying condition, followed by a code from Category R65.1, SIRS of non-infectious origin.
- Severe sepsis requires a code for the underlying systemic infection be sequenced first, followed by a code from category R65.2, Severe sepsis.

Burns and corrosions of external body surfaces specified by site, or those confined to eye and internal organs (Category T20-28)

- For corrosion burns of external body surfaces specified by site or those confined to eye and internal organs, assign first the appropriate code for the chemical and intent (Category T51-T65), followed by the corrosion burn code. Non-corrosion burns may be sequenced first.

Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances (Category T36-T50)

- For adverse effects of drugs, medicaments and biological substances, assign first the appropriate code for the nature of the adverse effect, followed by the appropriate code for the adverse effect of the drug (Category T36-T50).
- Codes for underdosing (Category T36-T50) should never be assigned as principal or first-listed diagnosis codes.
- Codes for poisoning (Category T36-T50) may be sequenced first.

External causes of morbidity (Category V00-Y99)

- The external cause of morbidity codes should never be sequenced as the first-listed or principal diagnosis, as they are intended only to provide data for injury research and evaluation of injury prevention strategies.

Factors influencing health status (Category of codes beginning with Z)

- Category Z16, Resistance to antimicrobial drugs. Sequence the infection code first.
- Category Z3A, Weeks of gestation. Sequence first complications of pregnancy, childbirth, and the puerperium (O00-O9A), followed by a code from Category Z3A to identify the specific week of the pregnancy.
- Code Z33.1. This code is a secondary code only for use when the pregnancy is in no way complicating the reason for visit. Otherwise, a code from the obstetric chapter is required
- Category Z37, Outcome of Delivery. The outcome of delivery (Category Z37) should be included on all maternal delivery records and it is always sequenced as a secondary code.
- Category Z68, Body Mass Index (BMI). The BMI codes should only be reported as secondary diagnoses.

Refer to the Inappropriate Primary Diagnosis Code List for codes applicable to this policy.

Questions and Answers

1	<p>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?</p> <p>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.</p>
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Attachments

<p><u>Inappropriate Primary ICD-10 Diagnosis Codes List</u></p>	<p>A list of ICD-10-CM diagnosis codes to be used on or after date of service October 1, 2015.</p>
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Resources

- Individual state Medicaid regulations, manuals & fee schedules
- American Medical Association, *Current Procedural Terminology (CPT®) Professional Edition* and associated publications and services
- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- Centers for Disease Control and Prevention, *International Classification of Diseases, 10th Revision, Clinical Modification*

History

8/7/2022	<p>Policy Version Change Attachments: Inappropriate Primary ICD-10 Diagnosis Codes List updated History Section: Entries prior to 8/7/2020 archived</p>
2/15/2021	<p>Removed reference to other state exceptions.</p>
9/1/2014	<p>Policy implemented by UnitedHealthcare Community & State</p>