UnitedHealthcare Community Plan

Reimbursement Policy
CMS-1500 and UB04
Policy Number 2024R7131A

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 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.

**CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.*

Table of Contents

Application 1
Policy 2
- **Overview** 2
- **Reimbursement Guidelines** 2

Questions and Answers 4
Attachments Error! Bookmark not defined.
Resources 4
History 5

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.

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 coding guidelines applicable to this policy.

Inappropriate Primary Diagnosis Codes

Proprietary information of UnitedHealthcare Community Plan. Copyright 20xx UnitedHealthcare Services, Inc. 2024R7131A

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.

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, Indiana, Kansas, Kentucky, Mississippi, Nebraska, New Jersey, Ohio, Tennessee, Texas	States are exempt from the Inpatient Mutually Inclusive Diagnosis Codes defined by Excludes 1
California	California Medicaid allows the following ICD-10 diagnosis code Z64.0 to be billed in the primary position.
Kansas	Kansas Medicaid uses a customized, state identified Inappropriate Primary ICD-10 Diagnosis Codes list. (This list is a combination codes from ICD-10 Inappropriate Primary DX list and the CMS Medicare Unacceptable Principal Diagnosis Code List).
Massachusetts	Massachusetts is exempt from the Outpatient Primary Diagnosis of this policy.
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 provider.
Minnesota	Minnesota Medicaid allows for Z33.1 and Z39.1 to be billed with S9445-U4 and 99199-U4.
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 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.
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
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

Proprietary information of UnitedHealthcare Community Plan. Copyright 20xx UnitedHealthcare Services, Inc. 2024R7131A

Texas	Texas Medicaid allows the following ICD-10 diagnosis codes to be billed in the primary position: F06.0, F06.1, F06.2, F06.30, F06.31, F06.32, F06.33, F06.34, F06.4, F06.8, F07.0, F07.81, F07.89, F09, F54.
Virginia	Virginia Commonwealth Community Care Plus (CCC Plus) HCBS plan includes H2000 as an HCBS service. HCBS services are exempt from this policy.
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.

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 primary diagnosis.
Kansas 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 Kansas Medicaid.
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.

Resources

Individual State Medicaid Regulations, Manuals, and Fee Schedules

American Hospital Association (AHA)

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

Proprietary information of UnitedHealthcare Community Plan. Copyright 20xx UnitedHealthcare Services, Inc. 2024R7131A

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

History	
5/1/2024	Policy Implemented by UnitedHealthcare Community Plan
12/12/2023	Policy approved by the Reimbursement Policy Oversight Committee

.

Proprietary information of UnitedHealthcare Community Plan. Copyright 20xx UnitedHealthcare Services, Inc. 2024R7131A