UnitedHealthcare® Medicare Advantage
Reimbursement Policy
CMS 1500
UB04
Policy Number 2025R9064A

# Diagnosis Code Requirement Policy, Professional and Facility

***IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY***

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

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 Medicare Advantage reimbursement policies 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 UB04 forms (CMS 1450) and to those billed on CMS 1500 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 resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage 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 Medicare Advantage 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 facility 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 Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Facilities can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.



** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.

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## Application

This reimbursement policy applies to all Medicare Advantage products and for network provider services reported using the UB04 and CMS 1500 form or its electronic equivalent or its successor form.

## 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

United Healthcare 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, 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.

**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 | Unacceptable Principal ICD-10-CM Diagnosis Codes 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 |

| Definitions | |
|---|---|
| Excludes1 | It means “NOT CODED HERE!” An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. |
| Primary Diagnosis | Primary diagnosis is the diagnosis to which the majority of the resources were applied. |
| Principal Diagnosis | The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.” |

| Questions and Answers | |
|---|---|
| 1 | **Q:** Is it appropriate to bill Q21.0 congenital malformations of cardiac septa with I51.0 acquired cardiac septal defect?<br>**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?<br>**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?<br>**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. |

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| 4 | **Q:** Is there a list of Excludes1 diagnosis codes?<br>**A:** Providers should refer to the official ICD-10-CM Guidelines for appropriate Excludes1 diagnoses. |

## Resources

www.cms.gov

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

Centers for Medicare and Medicaid Services - Acute Inpatient PPS, MS-DRG Classification and Software, Definition of Medicare Code Edits

Centers for Medicare & Medicaid Services - FY 2022 IPPS Final Rule Home Page | CMS- Federal Register - Section d: Unacceptable Principal Diagnosis Edit

Definitions of Medicare Code Edits V39.1 - Definitions of Medicare Code Edits- Section 9 Unacceptable Primary diagnosis

Integrated Outpatient Code Editor (I/OCE)

## History

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|---|---|
| 5/1/2025 | Policy Version Change<br>Resource Section: Updated |
| 7/12/2024 | Policy Version Change |
| 5/1/2024 | Policy Implemented by UnitedHealthcare Medicare Advantage |