Inpatient Unacceptable Principal Diagnosis Policy, 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 reimbursement policies 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's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare 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 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 due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations. UnitedHealthcare 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 UB04 claim form or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network inpatient facilities, including, but not limited to, non-network authorized and percent of charge contract facilities.

UnitedHealthcare Commercial
This Reimbursement Policy applies to all UnitedHealthcare Commercial benefit plans.

UnitedHealthcare Individual Exchange
This Reimbursement Policy applies to all Individual Exchange benefit plans.

Policy

Overview

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 (HHS), 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 not be billed as the principal diagnosis on an inpatient hospital (UB04) claim form or its electronic equivalent.

Reimbursement Guidelines

UnitedHealthcare will deny claims when a code on the Unacceptable Principal ICD-10-CM Diagnosis List is submitted as a principal diagnosis in box 67 on a UB-04 claim form or its electronical equivalent. UnitedHealthcare will also deny claims when a code on the Principal Diagnosis Requiring Secondary Diagnosis List is submitted as a principal diagnosis in box 67 without the appropriate secondary diagnosis.

Principal Diagnosis Requiring Secondary Diagnosis List

Z51.89

Unacceptable Principal Diagnosis Codes Determination

The following criteria, used to determine codes that are added to the Unacceptable Principal 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
• A manifestation code describes the manifestation of an underlying disease, not the disease itself, and therefore, cannot be reported as first-listed or principal diagnosis.
• 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, if known.

Sequela codes
• Coding of sequela generally requires two codes sequenced with the condition or nature of the sequela first and the sequela code second. Exceptions 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 example 1st. T54.2X1A, 2nd D61.2.
Except toxic effect in a pregnant patient, Example: (1st) O9A.213, (2nd) T50.6X1A.

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, Example: (1st) T67.01XA, (2nd) R65.10.
• Severe sepsis requires a code for the underlying systemic infection be sequenced first, followed by a code from category R65.2, Severe sepsis, Example: (1st) A41.9, (2nd) R65.20.

Burns and corrosions of external body surfaces specified by site, or those confined to eye and internal organs (Category T20-T28)
• 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. Example: (1st) T51.91XA, (2nd) T26.91XA, (3rd) T32.10.

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):
These codes may be designated as primary diagnosis, secondary diagnosis or may be either. If the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting designates one of these codes as secondary only, it should only be reported as secondary and an appropriate primary diagnosis included in the first position. The following codes are secondary diagnosis only codes:
• Codes Z15.03-Z15.09, Z15.81, Z15.89, Genetic susceptibility to malignant neoplasms and other disease. These codes should only be reported as secondary diagnoses.
• Category Z16, Resistance to antimicrobial drugs. Sequence the infection code first.
• Category Z17, Estrogen receptor status. Sequence the malignant neoplasm of breast code first.
• Category Z19, Hormone sensitivity malignancy status. Sequence the malignant neoplasm code first.
• Code Z33.1, Pregnant state. 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 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.
• Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances. These codes should only be reported as secondary diagnoses.
• Category Z68, Body Mass Index (BMI). The BMI codes should only be reported as secondary diagnoses.
• Category Z91.12, Patient's intentional underdosing of medication regimen. Sequence the underdosing of medication (T36-T50) first.
• Category Z91.13, Patient's unintentional underdosing of medication regimen. Sequence the underdosing of medication (T36-T50) first.
• Code Z91.83, Wandering in diseases classified elsewhere. Sequence the underlying disorder first.
• Code Z92.82, Status post administration of tPA in a different facility within the last 24 hours prior to admission to current facility. Sequence the condition requiring tPA first.

Refer to the Unacceptable Principal Diagnosis Code List for all codes applicable to this policy.

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:** Does this policy apply to Outpatient Hospital claims? **A:** No, this policy only applies to Inpatient hospital claims. Inpatient hospital claims select the principal diagnosis code based on the Uniform Hospital Discharge Data Set (UHDDS).
2	**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.
3	**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.

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
DRG 998 Diagnosis List	A list of DRG 998 Diagnosis codes that are Unacceptable to be used as the Principal diagnosis

Resources
American Hospital Association (AHA) 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	
4/14/2024	Policy Version Change Updated application section Policy List Change: Unacceptable Principal ICD10 Diagnosis Codes List Entries prior to 8/28/2022 archived

4/1/2024	**Template Update**
	• Transferred content to shared policy template that applies to both UnitedHealthcare Commercial and Individual Exchange benefit plans.
	• Updated Application section to indicate this Reimbursement Policy applies to:
	  ○ All UnitedHealthcare Commercial benefit plans
	  ○ All Individual Exchange benefit plans

9/24/2023	Policy Version Change Policy List Change: Unacceptable Principal ICD10 Diagnosis Codes List
4/16/2023	Policy Version Change Policy List Change: Unacceptable Principal ICD10 Diagnosis Codes List, DRG 998 Diagnosis List Logo Updated
1/1/2023	Policy Version Change Policy List Change: Unacceptable Principal ICD10 Diagnosis Codes List
8/28/2022	Policy Version Change Policy List Change: Unacceptable Principal ICD10 Diagnosis Codes List
8/1/2021	Policy implemented by UnitedHealthcare Employer & Individual
4/20/2021	Policy approved by the Reimbursement Policy Oversight Committee

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