Outpatient Hospital Inappropriate Primary Diagnosis Codes Policy (CES)

Policy Number: ADMINISTRATIVE 280.1 T0
Effective Date: June 1, 2021

Instructions for Use

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Related Policies
None

Applicable Lines of Business/Products

This policy applies to Oxford Commercial plan membership.

Application

This reimbursement policy applies to services reported using the UB-04 claim form or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network outpatient hospitals and facilities.

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 never be billed as primary on an outpatient hospital (UB-04) claim form or its electronic equivalent.

Reimbursement Guidelines

Oxford will deny claims where an inappropriate diagnosis is in box 67 on a UB-04 claim form or its electronic equivalent. When a code on the Inappropriate Primary Diagnosis List is listed as the primary diagnosis on the claim form, the claim will be denied.

Inappropriate Primary Diagnosis Codes Determination

The following criteria, used to determine codes that are added to the Inappropriate Primary Diagnosis Code 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 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.

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-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.

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)

- 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 Inappropriate Primary Diagnosis Code List for all codes applicable to this policy.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies may apply.

Inappropriate Primary Diagnosis Codes List
A list of ICD-10-CM diagnosis codes that are inappropriate to be used as the primary diagnosis Inappropriate Primary Diagnosis Codes List

Questions and Answers

1	Q:	Does this policy apply to Inpatient Hospital claims?
	A:	No, this policy only applies to outpatient hospital claims. Inpatient hospital claims select the principal diagnosis code based on the Uniform Hospital Discharge Data Set (UHDDS). Inpatient hospital claims report the appropriate ICD-10-CM diagnosis and the ICD-10 PCS procedures codes.

References

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed, and approved by UnitedHealthcare Reimbursement Policy Oversight Committee. [*2020R5015A*]

American Hospital Association (AHA)

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

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

Policy History/Revision Information

Date	Summary of Changes
06/01/2021	• New Reimbursement Policy

Instructions for Use

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.