MEDICAID REIMBURSEMENT POLICY

Inappropriate Diagnosis Code

Active

Section: General Coding
Policy Number: 081
Effective Date: 08/05/24

Description

This policy addresses the specificity and sequencing of diagnosis codes submitted on professional (837P) and outpatient facility claims (837I).

Policy Statement

Blue Cross and Blue Shield of Minnesota (Blue Cross) follows the rules and guidelines for diagnosis code assignment and sequencing published in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and the ICD-10-CM Official Guidelines for Coding and Reporting. Claims that have been submitted with inappropriately coded or sequenced diagnosis codes will be rejected and will need to be corrected and resubmitted.

Specificity

Diagnosis codes should be assigned to the highest level of specificity supported by medical record documentation. In addition, the full number of characters for an ICD-10-CM code, which varies between 3 and 7, must be assigned. Codes with three characters represent the heading of a category of codes, which may be further subdivided to the fourth-seventh character level for additional specificity. A code is considered invalid if it has not been coded to the full number of characters required for that code.

Laterality

If a code indicates laterality, Blue Cross requires specification of whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided in ICD-10-CM and the condition is bilateral, separate diagnosis codes for both the left and right sides should be assigned. If the patient's provider does not document laterality, the provider should be queried. If necessary, medical record documentation from other qualified healthcare practitioners involved in the care of the patient should be used.

Excludes Notes

The excludes notes in ICD-10-CM must be followed to ensure accurate code assignment. An Excludes 1 note means, "Not coded here" and indicates that two conditions cannot occur together, such as a congenital and an acquired form of the same condition.
An Excludes 2 note means "Not included here" and indicates that the condition excluded is not part of the condition represented by the code. Both codes may be used together when appropriate.

Sequencing

Examples of guidelines that must be followed to ensure appropriately sequenced diagnosis codes include, but are not limited to the following:

Manifestation Codes: Certain conditions have both an underlying etiology and multiple body system manifestations. The underlying condition must be sequenced first followed by the manifestation code.

Code First: "Code first" notes are included under manifestation codes and under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a "code first" note and an underlying condition is present, the underlying condition should be sequenced first.

Secondary Diagnosis Codes: Certain conditions may require more than one code to fully describe a condition. The secondary code should not be sequenced first.

Sequela Codes: A sequela is the residual effect after the acute phase of an illness or injury has terminated (example: scar formation resulting from a burn). Coding of sequela generally requires two codes sequenced in the following order: the condition or nature of the sequela is sequenced first. The sequela code is sequenced second.

External Causes of Morbidity (V, W, X, Y codes): The external causes of morbidity codes should never be sequenced first. External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies.

Factors influencing Health Status and Contact with Health Services (Z codes): Certain categories of Z codes cannot be submitted as a first-listed code and should only be assigned as additional diagnoses. Examples include history (of), outcome of delivery and BMI codes.

The ICD-10-CM manual and the ICD-10-CM Official Guidelines for Coding and Reporting should be referenced for complete instructions and guidelines.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier: N/A
ICD-10 Diagnosis: GC-081 Inappropriate Diagnosis Code List
ICD-10 Procedure: N/A
CPT/HCPCS: N/A
Revenue Codes: N/A

Resources

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
ICD-10-CM Official Guidelines for Coding and Reporting

Policy History

05/28/2024	Initial Committee Approval