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DIAGNOSIS VALIDITY & CODING GUIDELINES

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Description

Diagnosis (ICD-10-CM) codes are alphanumeric codes with three to seven characters, and are used to describe a clinical picture. Diagnosis codes should be coded to the **highest level of specificity appropriate for the condition**, based upon the degree of clinical detail known at the time of the encounter. Diagnosis codes are routinely updated and revised by the National Center for Health Statistics (NCHS) under authorization of the World Health Organization (WHO).

Policy

Blue Cross Blue Shield North Carolina (Blue Cross NC) follows ICD-10-CM diagnosis coding guidelines according to the criteria outlined in this policy.

Reimbursement Guidelines

Diagnoses not coded to the highest level of specificity may cause a claim line or entire claim to deny.

Diagnosis codes used prior to their effective date or after their termination date, may cause a claim line or entire claim to deny.

External causes of morbidity codes begin with the letter V-Y. These codes provide additional details on injuries or health conditions. V-Y codes are not intended to be the primary diagnosis nor the sole diagnosis on a claim. Therefore, claims received with a V-Y code as a sole diagnosis or a V-Y code in the primary position will deny.

Manifestation codes are codes that describe the manifestations or symptoms of a disease and not the disease itself. Per the ICD-10-CM Manual, manifestation codes should not be the sole diagnosis on a claim. Additionally, the underlying disease shall be coded first and not the manifestation. Therefore, claims received with a manifestation code as a sole diagnosis or a manifestation code in the primary position will deny.

ICD-10-CM guidelines indicate that secondary diagnoses code shall be used to represent a secondary diagnosis. Secondary diagnosis codes shall not be used to represent a primary diagnosis. Therefore, claims submitted with a secondary diagnosis as a sole diagnosis or in the primary position will deny.

Factors Influencing Health Status and Contact with Health Services are represented as “Z” codes. These codes provide details on the reason for presenting for healthcare services, including but not limited to encounters for routine exams. Depending upon the reason for the encounter, they may be primary or secondary codes. An additional diagnosis code should be used if a diagnosis or condition is discovered during a routine exam. This additional diagnosis code will need to be included on the claim.

There are specific Z codes for procedures and treatment not carried out. These are represented within the following categories: Z28 and Z53. Immunizations, treatment, and procedures will not be reimbursed when they are not carried out when indicated with only a diagnosis from category Z28 or Z53.

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ICD-10-CM codes that indicate a sequela are coded with the 7th character of "S". Sequela diagnoses are not to be billed in the primary position. Guidelines advise to code the condition or nature of the sequela first. Therefore, claims submitted with a sequala diagnosis as a sole diagnosis or in the primary position will deny.

Antineoplastic chemotherapy and immunotherapy encounters must also include a diagnosis code specifying the current disease or injury. Claims submitted without the diagnosis code indicating the current disease will be denied.

Within the ICD-10-CM Manual guidelines, there are mutually exclusive code pairs which are defined with an Excludes 1 note. Claim lines including mutually exclusive codes will be denied.

ICD-10-CM laterality guidelines are enforced and must be followed. Claims lines will be denied when an anatomical modifier conflicts with the diagnosis provided on the claim. Additionally, claim lines with conflicting diagnoses or diagnoses combinations will be denied.

Blue Cross NC utilizes the Outpatient Prospective Payment System's (OPPS) Unacceptable Principal ICD-10-CM Diagnosis list for facility claims. All services billed with one of these diagnosis codes will not be eligible for reimbursement.

Correct diagnostic coding within ICD-10-CM should follow current year ICD-10-CM Official Guidelines for Coding and Reporting.

Rationale

Blue Cross NC aligns with correct coding guidelines as produced by governing bodies, such as CMS and WHO. It is the expectation of Blue Cross NC that providers also follow the ICD-10-CM coding guidelines as part of correct coding. Failure to do so may result in claim denial.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross NC web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Related policy

Bundling Guidelines

Consistency Guidelines

References

American Medical Association, Current Procedural Terminology (CPT®)

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

Centers for Medicare & Medicaid Services, CMS Manual System, and Medicare Claims Processing Manual 100-04

Healthcare Common Procedure Coding System

BlueCross BlueShield of North Carolina

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Medicare Reimbursement Policy

History

6/1/2022	New policy developed. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022**. (eel)

Application

These reimbursement requirements apply to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services.

This policy relates only to the services or supplies described herein. Please refer to the Member's Evidence of Coverage (EOC) for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.

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