AmeriHealth Caritas VIP Care

Inappropriate Diagnosis Coding

Reimbursement Policy ID: RPC.0058.MIDS

Recent review date: 01/2026

Next review date: 06/2026

AmeriHealth Caritas VIP Care reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas VIP Care may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. 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 federal, state, or contractual requirements 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 and Guidelines may apply.

Policy Overview

This policy provides reimbursement guidelines for the correct reporting of the (ICD-10-CM) codes for professional services. Adherence to these guidelines when assigning ICD-10-CM diagnosis code(s) is required under the Health Insurance Portability and Accountability Act (HIPAA). Incorrect coding will result in a claim denial.

Exceptions

N/A

Reimbursement Guidelines

AmeriHealth Caritas VIP Care follows the ICD-10-CM Official Guidelines for Coding and Reporting, which were developed through a collaboration of the Centers for Medicare & Medicaid Services (CMS), the National Center for Health Statistics (NCHS), and the Department of Health and Human Services (DHHS). These guidelines provide clear direction on the coding and sequencing of diagnosis codes.

Diagnosis specificity
In order to be reimbursable, diagnoses must be coded to the highest level of specificity for the condition reported, up to and including 6th and 7th digits if applicable, based upon the degree of clinical detail documented in the medical record for all encounters.

Diagnosis codes which involve laterality must be coded to the highest level of specificity – meaning the 6th digit of the code must be provided to indicate anatomical site. For example, a diagnosis of malignant neoplasm of central portion of the right breast would be coded as C50.111, with the 6th digit representing the right side.

Additionally, the 6th digit in the diagnosis code, representing laterality, must align with the anatomical modifier billed on the ***procedure*** code. For example, if the provider performed a right partial mastectomy to treat the neoplasm, the procedure would need to be billed with the right-laterality modifier in order to be reimbursable.

Claims will be denied when an anatomical procedure modifier conflicts with the diagnosis provided on the claim.

Correct scenario:
19301-RT-partial Mastectomy, right breast C50.111-malignant neoplasm central portion right female breast (In this case, the "RT" modifier in the CPT code matches the 6th-digit "1" in the diagnosis code.)

Incorrect scenario:
19301-RT-partial Mastectomy, right breast C50.119-malignant neoplasm central portion of unspecified female breast (In this case, the "RT" modifier in the CPT code does not have a laterality equivalent in the diagnosis code.)

Invalid Diagnosis Codes
The diagnosis code(s) reported are invalid on the line as they are either an incomplete, a not-active, or a non-existent ICD-10 diagnosis code.

- Incomplete: Diagnosis code reported is not coded to the highest level of specificity based on date of service.
- Not Active: Diagnosis code reported for date of service before its effective date or after the termination date.
- Non-Existent: Diagnosis code reported that has never been a valid ICD-10 diagnosis code.

Deleted Diagnosis Codes
When a claim is submitted with a deleted diagnosis code, it will be validated against the date of service to determine if it was valid at that time. If the code was not valid on the date of service, the claim may be rejected.

Nonspecific Diagnosis codes
Nonspecific diagnosis codes, often ending with "unspecified" or "not otherwise specified" (NOS), are used when the information available isn't detailed enough to assign a more precise diagnosis. Examples include: R69 (Illness, unspecified).

Inappropriate primary diagnosis
AmeriHealth Caritas VIP Care follows ICD-10-CM Official Guidelines. Claims submitted for reimbursement that do not follow the ICD-10-CM official guidelines will not be reimbursed.

According to the ICD-10-CM Official Guidelines, inappropriate primary diagnosis codes include:

- **Code first** "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. For example, a diagnosis of secondary spontaneous pneumothorax (J93.12) has a "Code first" note to code the underlying condition, such as Marfan's Syndrome (Q87.4).
- **Manifestation codes** the underlying disease should be coded first followed by the manifestation code. In most cases the manifestation codes will include the verbiage "in diseases classified elsewhere." For example, central sleep apnea in conditions classified elsewhere (G47.37). ICD-10-CM guidelines state, "Code first underlying condition." In this example, the underlying condition is stroke (I63.9), and therefore it would be coded first. Claims for services received with a manifestation code billed in the primary, first listed, or principal diagnosis position are non-reimbursable.
- **Secondary diagnosis codes** – "Use additional code" indicates that secondary diagnosis code(s) should be used. The secondary diagnosis can never be primary. For example, the diagnosis code for unstable angina (I20.0) has a directive to "use additional code". In this example, the code Z72.0, tobacco abuse would be used as a secondary diagnosis. Claims with a secondary diagnosis code only, are not reimbursed.
- **Sequela codes** A sequela encounter code uses the letter "S" in the 7th position and indicates a late effect that occurs after the acute phase of the injury or illness has passed. When reporting sequela(e), two codes must be reported. The ICD-10-CM guidelines require that the residual should be coded first, followed by the healed illness/injury. For example, painful scar, L90.5 is sequenced first, followed by S92.211S, displaced fracture of body of right calcaneus. A claim received with an ICD-10-CM sequela (7th character "S") code billed as the only diagnosis will not be reimbursed.
- **External cause codes** V, W, X, or Y codes describe the circumstance causing an injury, not the nature of the injury. Claims are not reimbursable when one of these codes is used as the primary diagnosis.
- **Z codes** 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. Per ICD-10-CM guidelines, only the following Z code categories may be used as principal/primary diagnosis:
    - Z00 Encounter for general examination without complaint, suspected or reported diagnosis
    - Except: Z00.6
    - Z01 Encounter for other special examination without complaint, suspected or reported diagnosis
    - Z02 Encounter for administrative examination
    - Z04 Encounter for examination and observation for other reasons
    - Z33.2 Encounter for elective termination of pregnancy
    - Z31.81 Encounter for male factor infertility in female patient
    - Z31.83 Encounter for assisted reproductive fertility procedure cycle
    - Z31.84 Encounter for fertility preservation procedure
    - Z34 Encounter for supervision of normal pregnancy
    - Z39 Encounter for maternal postpartum care and examination
    - Z38 Liveborn infants according to place of birth and type of delivery
    - Z40 Encounter for prophylactic surgery
    - Z42 Encounter for plastic and reconstructive surgery following medical procedure or healed injury
    - Z51.0 Encounter for antineoplastic radiation therapy
    - Z51.1- Encounter for antineoplastic chemotherapy and immunotherapy
    - Z52 Donors of organs and tissues
    - Except: Z52.9, Donor of unspecified organ or tissue
    - Z76.1 Encounter for health supervision and care of foundling

- Z76.2 Encounter for health supervision and care of other healthy infant and child
- Z99.12 Encounter for respirator [ventilator] dependence during power failure

Use of multiple Z codes for the same service will not be reimbursed. If an additional condition is discovered during a routine exam, the additional diagnosis code should be included on the claim for proper reimbursement.

Excludes notes
Within the ICD-10-CM Manual, there are two types of excludes notes.

- Excludes1 indicates “not coded here” which means the diagnosis codes should never be billed together. For example, a congenital form of a disorder cannot occur with an acquired form of a condition.
- Excludes 2 represents “not included here”. It indicates that the condition excluded is not part of the condition represented by the code, but the patient may have both conditions at the same time. Claims that include both the code and the excluded code at the same time may be reimbursable, depending on specific circumstances. For example, a claim that includes both D27.0 benign neoplasm, right ovary and N80.101, endometriosis of the right ovary may be reimbursable, as these are two different conditions.

Definitions

N/A

Edit Sources

I. International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM)
II. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf, p. 41
III. https://www.cms.gov/medicare/coding-billing/icd-10-codes

Attachments

N/A

Associated Policies

N/A

Policy History

09/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas VIP Care from Policy History section
01/2023	Template Revised • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added