PCHP Reimbursement Policy		
Topic: ICD-10 First Billed Diagnosis	Policy Number: PCHP.RI.007	Policy Section: Clinical
Last Modification Date:	Effective Date: 5/15/2025	

Policy Disclaimer:

Please ensure adherence to correct billing and submission protocols. Utilize industry-standard compliant codes when submitting claims. Services should be coded using Current Procedure Terminology® (CPT), Healthcare Common Procedure Coding System (HCPCS), and/or revenue codes. These codes specify the services or procedures rendered and must be fully substantiated in the medical record or office notes upon billing. Our reimbursement policies apply uniformly to both participating and non-participating professional providers and facilities, unless stated otherwise.

Failure to comply with appropriate coding/billing guidelines or current reimbursement policies may result in actions by PCHP, including claim rejection or denial, claim payment recovery/recoupment, or reimbursement adjustment to accurately reflect the services provided.

These reimbursement policies are designed to support you in submitting accurate claims and to clarify the criteria for reimbursement if PCHP covers the service under the member's benefit plan; however, coverage determination for items such as, but not limited to service, procedure, item, do not guarantee reimbursement. All billed services must align with authorization and medical necessity guidelines.

These reimbursement policies may be overridden by mandates in provider contracts, state or federal regulations, or Centers for Medicare & Medicaid Services (CMS) requirements. PCHP strives to implement policy changes promptly; any delays may necessitate recoupment of claims payment to the effective date as outlined in the policy. We reserve the right to periodically review and update these policies as needed, with the most current version available on our website upon any revisions.

Policy:

Certain diagnosis codes in ICD-10-CM are not accepted as a principal or first listed diagnosis. Coding conventions defined in the ICD-10 manual describe these scenarios. The term “principal diagnosis” is used on inpatient facility claims and “first listed diagnosis” is used on outpatient and professional claims. The term “primary diagnosis” will be used in this document to refer to either.

Certain conditions have both an underlying etiology and multiple body system manifestations. Coding conventions require the condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a “code first” note with the manifestation code and a “use additional code” note with the etiology code in ICD-10. In most cases, the manifestation code will have “in diseases classified elsewhere” in the code title.

Example:

• L62 – Nail disorders in diseases classified elsewhere Code first underlying disease, such as, Pachydermoperiostosis (M89.4). L62 is not accepted as a primary diagnosis because instructions require the underlying condition to be coded first.

In addition to the ICD-10 manifestation designation, CMS identifies manifestation codes for the Outpatient Code Editor. The CMS manifestation codes may not appear as primary diagnoses on outpatient hospital claims. CMS updates this list quarterly.

Sequelae of Injuries:

The residual or late effect of an injury generally requires two codes. The primary diagnosis must describe the nature of the sequela. The secondary diagnosis describes the original injury and usually has an "S" in the 7th position to indicate sequela. (Sequela of cerebrovascular disease is an exception.)

Example:

• Treatment of ankle instability following a sprain: M24.271 - Disorder of ligament, right ankle

• S93.411S - Sprain of calcaneofibular lig., right ankle, sequela

S93.411S is not accepted as a primary diagnosis because instructions require the residual condition be coded first.

Multiple Coding for a Single Condition:

There are some single conditions that require more than one code. Coding instructions in the ICD-10 manual clearly indicate which must be coded first.

Examples:

• K52.1 - Toxic gastroenteritis and colitis - Code first (T51-T65) to identify toxic agent

• Z16. - Resistance to anti-microbial drugs- Code first the infection

External Causes of Morbidity:

ICD-10 codes in the range V00-Y99 are not accepted as the primary or first listed diagnosis as they describe the cause of the morbidity, not the condition itself.

References:

This policy has been developed through consideration of the following:

- CMS, Department of Health and Human Services, Texas Health and Human Services and all applicable agencies, National Correct Coding Initiative, ICD-10 Classification.

Policy History:

Description	Date
Policy Created	May 9, 2024
Policy Approved	January 30, 2025


Parkland
Community Health Plan