

# Coding Policy

## Diagnosis Coding

CODING POLICY NUMBER: 2

<b>Effective Date:</b> 6/1/2026	POLICY STATEMENT.....	1
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**SCOPE:** Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”). **The full Company portfolio of current coding policies is available online and can be [accessed here](#).**

### POLICY APPLICATION

- Providence Health Plan Participating Providers
- Non-Participating Practitioners
- Commercial
- Medicaid/Oregon Health Plan
- Medicare

\*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Coding policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

### POLICY STATEMENT

I. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes are used to report symptoms, illnesses, injuries, or other circumstances which influence an individual’s health status.

- II. Company aligns with the ICD-10-CM Official Guidelines for Coding and Reporting by the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), which provides clear direction on the proper reporting and sequencing of diagnosis codes.
- III. Coding edits are developed to promote the accuracy and efficiency of claims processing and reporting. Examples of diagnosis code related edits include, but are not limited to:
  - A. Noncompliance with official guidelines
  - B. Misuse of unspecified codes
  - C. Inconsistencies between code sets

## PROCEDURE

### GENERAL GUIDELINES

Diagnoses code abstraction must adhere to established Company and ICD-10-CM Official Guidelines for Coding. All codes submitted must be supported by the clinical documentation and reportable for the date of service. See Coding Policy 01.0 (General Coding Policy) for additional information.

#### Invalid Codes

All diagnosis codes submitted must be valid for the date of service and must be reported at the highest level of specificity available. A diagnosis code is invalid or incomplete if it has not been coded to the full number of characters required for that code, including placeholders and the 7th character, if applicable. Claims submitted with truncated, ineffective, or invalid diagnosis codes will be denied.

#### Sequencing

Some diagnosis codes may be reported only as principle or first-listed diagnoses, while certain others may be billed only as secondary or subsequent diagnoses. Incorrect sequencing of diagnosis codes may result in claim or service denials. Providers should refer to the ICD-10-CM Official Guidelines and the “Definitions of Medicare Code Edits” published annually by CMS for detailed guidance.

Examples when special attention to sequencing rules must be observed include, but are not limited to:

- **Manifestation codes** (typically identified by a code description including “in diseases classified elsewhere” or a “code first...” instructional note) describe the complications of an underlying disease and cannot be reported as the primary diagnosis. They must be sequenced after the etiology (the underlying disease or “use additional...”) code.

- **External Causes of Morbidity codes** are supplemental codes describing the circumstances (how, where, why, etc.) causing an injury, not the nature of the injury itself. The appropriate injury code must be sequenced before any external cause codes.
- **Sequelae codes** are used to indicate that a previous injury or illness directly caused a late effect. The condition or nature of the sequela (i.e. the resulting existing condition) is sequenced first, followed by the sequela code (i.e. the original injury code with 7<sup>th</sup> character “S”).
- **Secondary-Only codes** are supplemental codes intended to provide additional context – such as a patient’s BMI, coma scale, NIHSS, underimmunization status, genetic susceptibility, incidental pregnancy, personal or family history, or social determinants of health – and must accompany a primary diagnosis that reflects the reason for the encounter.
- **Unacceptable Principal Diagnoses** are codes that describe a circumstance which influences an individual’s health status but not a current illness or injury, or codes that are not specific manifestations but may be due to an underlying cause. These codes are considered unacceptable as a principal diagnosis on inpatient facility claims.
- **Z Codes That May Only be Principal/First-Listed Diagnosis** can only be reported as a secondary diagnosis (rather than a primary diagnosis) when there are multiple encounters on the same day and the medical records for the encounters are combined.

#### **Excludes1 Notes**

Excludes1 notes signify that the excluded code should never be reported at the same time as the code above the note. A type 1 Excludes note is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition. If clinical documentation clearly supports the presence of both conditions, available ICD-10 options must be assessed to identify a more accurate or comprehensive code that resolves the exclusion conflict.

To ensure accurate and compliant billing, Company does not allow services to be billed with diagnosis codes that are mutually exclusive when submitted for the same member, by the same provider, on the same date of service. In cases where the documentation adequately supports that the two conditions are unrelated, services may be reimbursed accordingly.

#### **UNSPECIFIED CODES**

Only codes that accurately reflect the highest level of specificity known at the time of service shall be reported. When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code. Use of codes that describe signs and symptoms is permitted when a related definitive diagnosis has not been established by the provider.

#### **Laterality**

Some ICD-10-CM codes specify laterality, indicating whether a condition affects the left, right, or both sides of the body. If no bilateral code exists and the condition is present on both sides, assign separate codes for the left and right sides.

Laterality can be determined from documentation by other clinicians (e.g., nurses, EMTs) if not noted by the provider. Use of “unspecified” laterality codes should be exceedingly rare; only when the documentation is insufficient to determine the affected side(s) and it is not possible to obtain clarification via query.

Providers must know whether a patient’s condition affects the right, left, or both sides to properly manage, evaluate, assess or treat them. Effective for dates of service on or after August 4, 2025, claims including “unspecified” laterality diagnosis codes in the first or second positions at either the claim or charge level will be denied.

## CODE CONSISTENCY

All reported claims data must reflect a consistent and medically plausible clinical picture. Discrepancies between submitted diagnosis codes and other claims elements (e.g. member demographics, CPT codes, HCPCS codes, modifiers) may result in delayed or denied reimbursement. Company utilizes coding edits to validate submitted codes against available data.

Examples of inconsistencies to avoid include, but are not limited to:

- **Anatomical Conflict** – The diagnosis code does not align with the procedure code(s) and/or modifier(s) billed. This includes inconsistencies in laterality or anatomical site.  
*Examples:*
  - Diagnosis of right eye cataract reported with a modifier indicating cataract extraction performed on the left eye.
  - Diagnosis of humeral fracture reported with the CPT code for ulnar fracture reduction.
- **Age Conflict** – The diagnosis is not appropriate for the patient’s age.  
*Examples:*
  - Diagnosis of “fussy infant” on services for a 90-year-old patient.
  - Diagnosis of age-related osteoporosis on a claim for a newborn.
- **Incorrect Application of 7<sup>th</sup> Characters** – Diagnosis codes that require a 7<sup>th</sup> character (e.g. injuries, fractures, obstetric episodes) must include the correct character.  
*Example:*
  - Reporting a 7<sup>th</sup> character “A” (active treatment) for a patient receiving physical therapy after surgical repair of a torn ligament, where “D” (recovery care) would be appropriate.
- **Diagnostic vs Preventive Service Conflict** – Preventive services must be billed with the appropriate screening or well-exam diagnosis codes. Problem-focused services must be supported by diagnosis codes that reflect the condition being evaluated or treated.  
*Example:*

- An office visit for abdominal pain billed with the diagnosis code for a general adult medical examination without abnormal findings.

## **CROSS REFERENCES**

- Coding Policy 01.0 (General Coding Policy)

## **REFERENCES**

1. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Official Guidelines for Coding and Reporting
2. Centers for Medicare & Medicaid Services ([cms.gov](https://www.cms.gov))
3. American Hospital Association ([aha.gov](https://www.aha.gov))

## **POLICY REVISION HISTORY**

<b>Date</b>	<b>Revision Summary</b>
8/2025	New Policy
05/2026	Annual review. No changes