healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Appropriate Use of Manifestation Diagnosis Codes		
Policy Number:	PO-RE-137v1		
Effective Date:	01/01/2025	**Last Approval Date:**	07/21/2025

I. Policy Description

Healthfirst is committed to ensuring accurate and compliant claims submission through the correct use of diagnosis coding, specifically emphasizing the appropriate application of Manifestation Codes. This policy outlines the guidelines and best practices for the correct utilization of manifestation codes in accordance with ICD-10-CM coding standards.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Medicare Advantage
- Personal Wellness Plan (PWP)/Health & Recovery (HARP)
- Qualified Health Plan (QHP)
- Essential Plan (EP)
- Managed Long Term Care Plan (MLTCP – Senior Health Partners)
- Medicaid Advantage Plus/MAP (CompleteCare)
- Medicare PPO

Definition of Manifestation Codes

Manifestation codes are ICD-10-CM diagnosis codes that describe the specific signs, symptoms, or manifestations resulting from an underlying disease or condition. These codes are used to specify how an underlying disease presents or affects the patient but do not represent the underlying disease itself. Manifestation codes are identified by blue highlights in the ICD-10-CM Manual and are intended to be used in conjunction with the code for the underlying condition.

Reimbursement Guidelines

To ensure proper coding and reimbursement, the following guidelines must be adhered to when using manifestation codes:

Use of Manifestation Codes:

- Manifestation codes may not be used as primary diagnosis for billing purposes. The codes describe the manifestation of an underlying disease, not the disease itself. They should be used as a secondary diagnosis only.
- Do not report a manifestation code as the only diagnosis on a claim.
- Do not report a manifestation code as the first-listed or principal diagnosis.
- Always code the underlying disease first before assigning any manifestation codes.
- Accurate documentation supporting the underlying disease and its manifestation(s) is essential.

Coding Instructions:

- Follow the ICD-10-CM Manual instructions, which specify that manifestation codes are backed by blue highlights.
- In the Alphabetic Index, manifestation codes are listed as secondary codes in slanted brackets, with the underlying disease code listed first.
- Look for the “Code first underlying disease” instructional note accompanying the underlying disease codes.
- For conditions with both etiology and manifestation, the etiology code will have a “use additional code” note, and the manifestation code will have a “code first” note.

Example:

D64.9 -Anemia
Code first underlying disease, such as:
N18-Chronic Kidney Disease
D64.9 is not accepted as a primary diagnosis because instruction requires the underlying condition be coded first.

Claims Submissions:

- Ensure the underlying disease is coded first.
- Include relevant manifestation codes only as secondary diagnosis.
- Avoid using “in diseases classified elsewhere” codes as the first or principal diagnosis; these should always be used in conjunction with an underlying condition.

Adjudication and Appeal Process

1. Claims containing improper use of manifestation codes, such as reporting solely manifestation codes or mis ordering diagnosis codes, will be subject to review and potential denial.

2. Providers must review the ICD-10-CM Manual and adhere to coding guidelines to prevent claim denials.

3. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

4. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.

5. Reimbursement is subject to member eligibility, program coverage, and medical necessity at the time the service is provided.

6. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

For any questions or further clarification regarding this policy, providers are encouraged to reach out to their designated contact within our organization.

II. Applicable Codes

Code	Description	Comment

III. Definitions

Term	Meaning
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Current Procedural Terminology © American Medical Association. All rights reserved.

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

FY2022 April1 update ICD-10-CM Guidelines

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amount that Healthfirst or the member owes the provider.