healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	ICD-10-CM Excludes1 Notes		
Policy Number:	PO-RE-090v1		
Effective Date:	04/01/2024	**Last Approval Date:**	02/07/2024

I. Policy Description

Effective 04/01/2024, Healthfirst expects the ICD-10-CM Excludes1 Notes policy in accordance with the ICD-10-CM coding guidelines and the Medicare Claims Processing Manual governed by the Centers for Medicare and Medicaid Services (CMS) to be followed. This policy aims to ensure accurate and appropriate coding practices by adhering to the Excludes1 Notes, as defined by the ICD-10-CM guidelines. The Excludes1 Notes indicate that certain codes should never be used together as they represent mutually exclusive conditions that cannot occur simultaneously.

The below information applies to the following lines of business.

- Child Health Plus
- Small/Individual Group (Commercial Plan)
- Essential Plan
- Medicaid Managed Care
- Medicare PPO
- Integrated Benefits Dual Connection Plan
- Health & Recovery Plan (HARP)
- Medicare Advantage
- Medicaid Advantage Plus/MAP (Complete Care)
- Qualified Health Plan (QHP)
- Managed Long Term Care Partial Capitation Plan (MLTCP)
- Senior Health Plan (SHP)- Coverage based on benefit plan.

Reimbursement Guidelines

Excludes1 Notes indicate medical conditions that cannot coexist, such as congenital versus acquired form of the same condition. Since a patient cannot have both forms simultaneously, a claim must be correctly coded with only one version of the ICDs. It is important to ensure that the codes used on claims reflect the mutually exclusive nature of these conditions.

To find the Excludes1 Notes, refer to the relevant section heading or specific ICD-10-CM code. When the note appears after a section heading, it applies to all codes within that section.

In ICD-10-CM, when a category includes an Excludes1 note, it outlines what codes should NOT be billed together. Examples of this code scenario would include but are not limited to the following:

1. Example of Excludes1 (related conditions)

B06 Rubella [German measles]

Excludes 1: congenital rubella (P35.0)

- Code being excluded is never used with this code
- The two conditions cannot occur together

2. Example of Excludes1 (unrelated conditions)

G47.63 Sleep related bruxism (teeth grinding)

Excludes 1: other somatoform disorders (F45.8)

- Psychogenic dysmenorrhea is an inclusion term under F45.8 but can be coded with G47.63 because the two conditions are unrelated

Adjudication and Appeal Process

1. Healthcare providers submitting claims for reimbursement must accurately assign codes based on the ICD-10-CM classification and adhere to the Excludes1 notes provided within the coding guidelines.

2. If a claim is submitted with codes that violate the Excludes1 notes, Healthfirst asks that the claim be resubmitted adhering to Excludes1 guidelines.

3. Corrected claim 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***.

It is the responsibility of healthcare providers to ensure that accurate and appropriate codes are assigned based on the Excludes1 notes. Healthcare providers should refer to the official ICD-10-CM coding guidelines and instructions for accurate coding guidance.

II. Applicable Codes

Code	Description	Comment
N/A	N/A	

III. Definitions

Term	Meaning

Type 1 Excludes note	A type 1 Excludes note is a pure excludes note. It means “NOT CODED HERE!” An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

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

MS: CD-10-CM Features Excludes1 Notes

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 amounts that Healthfirst or the member owes the provider.