Priority Health	BILLING POLICY No. 076
EXCLUDES1	
Date of origin: Feb. 18, 2025	Review dates: None yet recorded

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

ICD-10's Excludes1 criteria details diagnosis codes that shouldn't be reported together because the two codes can't occur at the same time.

An Excludes1 designation for diagnosis codes occurs when the two conditions can't occur together. This means the code flagged for this designation shouldn't be coded at the same time another diagnosis. An Excludes1 note below is listed below a code or category heading, indicating that every code associated with the rule is mutually exclusive, and the two conditions shouldn't be coded together.

EXAMPLE

Below is an example of an Excludes 1 note:

> *M20 Acquired deformities of fingers and toes is at the category level. It is not a complete, reportable code.*

This Excludes1 note states not to report the following conditions and codes alongside any code beginning with M20:

- Acquired absence of fingers and toes (Z89)
- Congenital absence of fingers and toes (Q71.3, Q72.3)
- Congenital deformities and malformations of fingers and toes (Q66, Q68-Q70, Q74)

There is an exception to this rule:

- If the two conditions are truly unrelated, you may code both for the same service.
- The example provided in the coding guidelines is the use of F45.8: Other somatoform disorders with sleep-related teeth grinding (G47.63 Sleep related bruxism). Other somatoform disorders include both teeth grinding and psychogenic dysmenorrhea; however, if the provider documented that the patient has psychogenic dysmenorrhea and also grinds their teeth in their sleep, it would be appropriate to code both F45.8 (dysmenorrhea) and G47.63 (teeth grinding).

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Resources

- Diagnosis Coding: Using the ICD-10-CM
- ICD-10-CM Official Guidelines for Coding and Reporting – Updated Apr. 1, 2024

Related policies

- General Coding billing policy

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made