

# Diagnosis Coding Payment Policy

## Applicability

This Policy applies to the following Fallon Health products:

- Fallon Medicare Plus
- MassHealth ACO
- NaviCare HMO SNP
- Summit Eldercare PACE
- Fallon Health Weinberg PACE
- Community Care

## Policy

Fallon Health requires diagnosis codes submitted on professional (CMS-1500/837P) and facility (UB-04/837I) claims to be valid, complete, and sequenced in accordance with the ICD-10-CM Official Guidelines for Coding and Reporting and any applicable CMS or industry standard coding rules. Claims that do not include appropriate diagnosis coding and sequencing may be denied or adjusted.

## Reimbursement

Covered services are defined by the member's benefit plan documents. Reimbursement is contingent upon submission of accurate claims, including appropriate ICD-10-CM diagnosis coding and sequencing. When an inappropriate diagnosis is reported as primary for a professional claim line, Fallon Health may deny the affected line(s). When an unacceptable principal diagnosis is reported for a facility claim, Fallon Health may deny the claim.

## Referral/notification/prior authorization requirements

No referral, notification, or prior authorization requirements are specific to this policy. Standard product and benefit requirements apply.

Refer to the member's benefit plan documents and Fallon Health administrative policies for general authorization requirements.

## Billing/coding guidelines

All claims for services should be submitted using industry standard forms or HIPAA standard electronic formats and must include diagnosis codes that are valid, complete, and appropriately sequenced.

- Manifestation codes may not be reported as first-listed/principal diagnosis.
- "Code first" notes must be followed.
- Sequela generally require two codes, with the residual condition sequenced first and sequela second.
- Do not report mutually exclusive diagnosis codes together when an ICD-10-CM Excludes 1 note applies.
- Some ICD-10-CM codes include laterality (left, right, or bilateral).
  - Laterality must be specified. Do not bill unspecified laterality codes.
  - Do not bill conflicting laterality codes from the same subcategory for the same service.

## Claim form diagnosis field requirements

Claim type	Claim form	Diagnosis field requirement
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Inpatient facility	UB-04/837I	Report the correct principal diagnosis in the principal diagnosis field (UB-04 Box 67 or electronic equivalent).
Outpatient facility	UB-04/837I	Report a diagnosis appropriate to support the primary reason for the encounter in the diagnosis field (UB-04 Box 67 or electronic equivalent).
Professional	CMS-1500/837P	Link the appropriate primary diagnosis to each claim line (CMS-1500 Box 24E diagnosis pointer or electronic equivalent).

### References

- ICD-10-CM Official Guidelines for Coding and Reporting (CMS/NCHS/DHHS)
- Centers for Medicare & Medicaid Services (CMS) manuals and publications
- Centers for Disease Control and Prevention (CDC), International Classification of Diseases, Tenth Revision, Clinical Modification

### Place of service

This policy applies to services provided in any and all settings.

### Policy history

Origination date: 7/1/2026  
 Previous revision date(s):

*The criteria listed above apply to Fallon Health Plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for The Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of The Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.*