

Medi-Cal ICD-10 Diagnosis Code Requirements

Medi-Cal policy states that providers may not submit the following nonspecific diagnosis codes when billing for laboratory procedures:

ICD-10 CM Diagnosis Code	ICD-10 CM Diagnosis Code Description	ICD-10 CM Diagnosis Code	ICD-10 CM Diagnosis Code Description
Z00.00	Encounter for general adult medical examination without abnormal findings	Z01.10	Encounter for examination of ears and hearing without abnormal findings
Z00.5	Encounter for examination of potential donor of organ and tissue	Z01.89	Encounter for other specified special examinations
Z00.6	Encounter for examination for normal comparison and control in clinical research program	Z02.1	Encounter for pre-employment examination
Z00.8	Encounter for other general examination	Z02.3	Encounter for examination for recruitment to armed forces
Z01.00	Encounter for examination of eyes and vision without abnormal findings		

There are some exceptions regarding the CPT-4 codes for HIV testing: 86701-86703, 87389, 87390 and 87806. These CPT-4 codes may be billed with any ICD-10-CM diagnosis code. For additional exceptions, see the Medi-Cal manual.

In addition, certain laboratory procedures require specific ICD-10-CM diagnosis codes. This information is communicated in separate Quest Diagnostics Client Bulletins as well as in the Medi-Cal Provider Manual. For additional information and exceptions on Medi-Cal's nonspecific diagnosis policy, visit www.medi-cal.ca.gov

We depend on our clients to provide us with the patient's complete insurance information and valid ICD-10-CM diagnosis codes.

We will be requesting from you a specific ICD-10-CM code(s) if one is not provided on the laboratory requisition.

If you have any questions, please contact your Quest Diagnostics sales representative.

Disclaimer: The CPT codes provided are based on AMA guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed. Diagnoses must always be documented in the patient's medical record.

The ultimate responsibility belongs to the ordering physician to correctly assign the patient's diagnosis based on the patient's history, symptoms and medical conditions.