Unspecified Codes in the Inpatient Setting

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In the event of a conflict, federal and state guidelines, as applicable, as well as the member's benefit plan document supersede the information in this policy. Additionally, to the extent there are any conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval.

Overview

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) classification includes unspecified codes for circumstances when documentation in the medical record does not provide the level of detail needed to support reporting a more specific code. According to CMS, in the inpatient setting, there should generally be very limited and rare circumstances for which the laterality (right, left, bilateral) of a condition is unable to be documented and reported.

Policy

The edit identifies when unspecified diagnosis codes are reported as a principal or secondary diagnosis based on the Medicare Code Editor (MCE).

Per CMS Transmittal R11059CP, April 2022 Update to the Java Medicare Code Editor (MCE), "Effective April 1, 2022, the Unspecified Code edit will be triggered for certain unspecified diagnoses codes currently designated as either a Complication or Comorbidity (CC) or Major Complication or Comorbidity (MCC), that include other codes available in that code subcategory that further specify the anatomic site, when entered on the claim. This edit message indicates that a more specific code is available to report. It is the provider's responsibility to determine if a more specific code from that subcategory is available in the medical record documentation by a clinical provider.

If, upon review, additional information to identify the laterality from the available EHR or paper medical record, or documentation by any other clinical provider is unable to be obtained or there is documentation in the record that the physician is clinically unable to determine the laterality because of the nature of the disease/condition, then the provider must enter that information into the remarks section.

The provider should submit the billing note/remarks that best identifies the primary reason why specificity could not be determined."

Definition of the billing note/remarks to be added to the claim:

- UNABLE TO DET LAT 1 - Provider is unable to obtain additional information to specify laterality.
- UNABLE TO DET LAT 2 - Physician is clinically unable to determine laterality.

Documentation History

Type	Date	Action
Effective Date	4/1/2022	New Policy
Revised Date	4/19/2022	Updated links

References

Government Agencies

https://www.cms.gov/files/document/r11059cp.pdf