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 a conflict, federal and state guidelines, as applicable, and the member's benefit plans supersede the information in this policy. Also, to the extent of 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. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) includes unspecified codes for situations where medical record documentation does not provide enough detail to support a more specific code. According to CMS, in the inpatient setting, it is generally expected that there will be rare instances when the laterality (right, left, bilateral) of a condition cannot be documented and reported.

Per CMS Transmittal R11059CP (April 2022 update to the Java Medicare Code Editor), effective April 1, 2022, the Unspecified Code edit will be triggered for certain unspecified diagnosis codes designated as either a Complication or Comorbidity (CC) or Major Complication or Comorbidity (MCC) when more specific codes are available in the same subcategory. This edit is intended to ensure that the most specific diagnosis code possible is reported.

It is the provider's responsibility to determine whether a more specific code exists within the subcategory based on available medical record documentation by a clinical provider. If laterality cannot be determined after reviewing the EHR, paper records, or documentation from other clinical providers—and there is documentation that the physician is clinically unable to determine laterality due to the nature of the condition—this information must be included in the remarks section of the claim.

Reimbursement Guidelines

When laterality cannot be determined, the provider should submit a billing note/remark that clearly identifies the reason specificity could not be established. Acceptable remark codes include:

- **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.

Claims submitted without appropriate specificity or required remarks may be subject to edits, denials, or return for correction under the Medicare Code Editor (MCE) rules.

Supplemental Information

Definitions

Term	Definition
CMS	The Centers for Medicare & Medicaid Services

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Effective Date	04/01/2022	New Policy
Revised Date	04/19/2022	Updated links
Revised Date	12/13/2024	Updated Template
Revised Date	08/08/2025	Updated Template; created Reimbursement Guidance section; updated links

References

References This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

Reference	Link
CMS	Medicare Learning Network (MLN), April 2022 Update to the Java Medicare Code Editor (MCE) for New Edit 20 – Unspecified Code Edit

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*