PCHP Reimbursement Policy		
Topic: Unlisted Codes in an Inpatient Setting	Policy Number: PCHP.RI.022	Policy Section: Administration
Last Modification Date:	Effective Date: 5/15/2025	

Policy Disclaimer:

Please ensure adherence to correct billing and submission protocols. Utilize industry-standard, compliant codes when submitting claims. Services should be coded using Current Procedure Terminology® (CPT), Healthcare Common Procedure Coding System (HCPCS), and/or revenue codes. These codes specify the services or procedures rendered and must be fully substantiated in the medical record or office notes upon billing. Our reimbursement policies apply uniformly to both participating and non-participating professional providers and facilities, unless stated otherwise.

Failure to comply with appropriate coding/billing guidelines or current reimbursement policies may result in actions by PCHP, including claim rejection or denial, claim payment recovery/recoupment, or reimbursement adjustment to accurately reflect the services provided.

These reimbursement policies are designed to support you in submitting accurate claims and to clarify the criteria for reimbursement if PCHP covers the service under the member's benefit plan; however, coverage determination for items such as, but not limited to service, procedure, item, do not guarantee reimbursement. All billed services must align with authorization and medical necessity guidelines.

These reimbursement policies may be overridden by mandates in provider contracts, state or federal regulations, or Centers for Medicare & Medicaid Services (CMS) requirements. PCHP strives to implement policy changes promptly; any delays may necessitate recoupment of claims payment to the effective date as outlined in the policy. We reserve the right to periodically review and update these policies as needed, with the most current version available on our website upon any revisions.

Policy:

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. 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.

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.

References:

This policy has been developed through consideration of the following:

- CMS, Department of Health and Human Services, Texas Health and Human Services and all applicable agencies, National Correct Coding Initiative.
- https://www.cms.gov/files/document/r11059cp.pdf

Policy History:

Description	Date
Policy Created	May 9, 2024
Policy Approved	January 30, 2025