Manual: Reimbursement Policy

Policy Title: **Diagnosis Code Requirements - Level of Detail, Number of Characters, and Laterality**

Section: Administrative

Subsection: Diagnosis Codes

Date of Origin: 1/1/2000 **Policy Number:** RPM053

Last Updated: 10/13/2021 **Last Reviewed:** 10/13/2021

Scope

For dates of service in 2016 and prior, this policy applies to Medicare Advantage and Medicaid claims only.

For dates of service January 1, 2017 and following, this policy applies to all claims. This includes Medicare Advantage, Summit Health, Medicaid, and Commercial claims.

Reimbursement Guidelines

A. Number of characters (Incomplete or Complete diagnosis codes)

1. Diagnosis codes are to be used and reported at their highest number of characters available.

2. ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6, or 7 alpha-numeric characters. A diagnosis code is invalid or incomplete if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.

3. If any diagnosis code submitted on the claim is not a valid, complete diagnosis code for the date(s) of service on the claim, the entire claim will be denied.
    a. The claim will be denied regardless of the order or position of the incomplete/invalid diagnosis code.
    b. The denial will be to provider responsibility. This is due to a billing error which needs to be corrected.
        i. For contracted, participating providers –
        The member may not be balance-billed. The hold-harmless protections apply.

ii. For non-contracted, out-of-network providers –

There is no contractual hold-harmless protection for the member. However, the billing error needs to be corrected. To correct the diagnosis denial and access any available out-of-network benefits under the member's plan, all diagnosis codes must be complete and valid. A corrected claim is needed.

c. The denial explanation code will be:

Type	Code	Definition or wording
EX	85M	One or more diagnosis codes on this claim requires more digits to be complete. Please resubmit the claim with a more specific diagnosis.
CARC	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
RARC	M81	You are required to code to the highest level of specificity.

4. Steps to Remedy the Denial

   a. If the claim is denied with explanation code 85M, every diagnosis code on the claim must be reviewed by the billing office for accuracy and completeness against the current list of valid ICD-10-CM codes for the date of service.

   b. Diagnosis codes with typos in any character position could result in the diagnosis code not matching the list of valid and complete diagnosis codes for the date(s) of service on the claim. If this occurs, the typo will also result in this denial message of incomplete code requiring more digits, even if the invalid diagnosis code is a full seven characters.

   c. Ensure that the corrected claim is submitted with the proper information to indicate a corrected claim.

      i. Use resubmission code "7" for claim frequency type in box 22 of the CMS1500 claim form or electronic equivalent.

      ii. List the denied claim number in the "orig ref #" portion of box 22.

B. Laterality Must Be Specific

1. Diagnosis codes are to be used and reported with specific laterality.

   a. Effective for claims processed July 1, 2021 and following (including claim adjustments), diagnosis codes with unspecified laterality are not accepted for processing.

   b. Provider notification letters were sent, see Appendix.

2. ICD-10-CM diagnosis codes include many diagnosis codes that indicate laterality (right, left, unilateral, bilateral).

3. The diagnosis codes on the claim need to accurately reflect the laterality of the condition and the services.

a. The ICD-10 coding guidelines and instructions state, "Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient's condition at the time of that particular encounter." (CMS, et al[2])

b. When services are being rendered (aka the time of the patient encounter mentioned in the ICD-10 guidelines), the provider knows whether they are treating the right side, the left side, or both sides of any condition that involves laterality.

   i. This laterality information must be documented in the medical record.

   ii. If the medical record does not state which side or sides the condition affects, the coding team needs to send a query back to the physician to obtain a signed and dated addendum entry into the chart to provide that missing information before the diagnosis code is assigned and the claim is submitted. The ICD-10-CM guidelines for laterality provide instructions for this situation. (CMS, et al[3])

4. When any diagnosis submitted on the claim (primary or secondary) is an unspecified laterality diagnosis code, the entire claim will be denied.

   a. The claim will be denied regardless of the order or position of the unspecified laterality diagnosis code.

   b. The denial will be to provider responsibility. This is due to a billing error which needs to be corrected.

      i. For contracted, participating providers –

      The member may not be balance-billed. The hold-harmless protections apply.

      ii. For non-contracted, out-of-network providers –

      There is no contractual hold-harmless protection for the member. However, the billing error needs to be corrected. To correct the diagnosis denial and access any available out-of-network benefits under the member's plan, all diagnosis codes must be specific about laterality. A corrected claim is needed.

   c. The denial explanation code will be:

Type	Code	Definition or wording
EX	w82	Unspecified laterality diagnosis is not accepted; corrected claim required.
CARC	16	Claim/service lacks information or has submission/billing error(s).
RARC	N769	A lateral diagnosis is required.

5. Steps to Remedy the Denial

   a. If the claim is denied with explanation code w82, every diagnosis code on the claim must be reviewed by the billing office for unspecified laterality.

   b. Review the medical record documentation to determine the appropriate laterality.

      i. If the original medical record inquiry will not support a diagnosis code with specific laterality, an amended visit note cannot be used to support changing coding for

reimbursement purposes. (Moda[4]) In this case, a sign and symptom diagnosis code may need to be selected for the corrected claim.

ii. If necessary, query the provider to clarify the meaning of the medical record entry and/or the appropriate sign and symptom diagnosis code to select.

c. Select the appropriate diagnosis code(s) with specific laterality for the condition. If both sides are involved:

i. Some conditions will require two diagnosis codes to be assigned, one for the left and one for the right.

ii. Other conditions have a bilateral diagnosis code available.

d. Ensure that the corrected claim is submitted with the proper information to indicate a corrected claim.

i. Use resubmission code "7" for claim frequency type in box 22 of the CMS1500 claim form or electronic equivalent.

ii. List the denied claim number in the "orig ref #" portion of box 22.

6. To prevent denials for unspecified laterality:

Best practice is that only diagnosis codes with laterality specified ("right," "left," or "bilateral") be included in any quick-pick, drop-down, or pop-up diagnosis code choice lists used.

a. When the provider is selecting diagnosis codes at the time of the encounter documentation, the provider knows which side or sides are affected by the condition. An unspecified laterality diagnosis code option is not appropriate to offer.

b. When the coding team is preparing the claim for submission, if the medical record does not indicate whether right, left, or both sides were involved or affected, query the provider before submitting the claim; do not select an unspecified laterality diagnosis code.

C. Laterality of Diagnosis Codes and Procedure Codes/Modifiers Must Match

1. Modifiers which indicate laterality must agree with the laterality of all diagnosis codes on the line item.

2. Line items with a diagnosis code indicating laterality will deny when submitted with a modifier indicating a conflicting laterality. For example:

a. CPT 24685-LT submitted with diagnosis code S52.021C will deny because this is a diagnosis code for a fracture of the right ulna. Modifier LT for the left side of the body does not agree with a diagnosis for the right side of the body. Either the modifier or the diagnosis code needs to be corrected on this line item.

b. CPT 69436-RT submitted with diagnosis code H71.12 (Cholesteatoma of tympanum, left ear) will deny because modifier RT for the right side of the body does not agree with a diagnosis for the left side of the body. Either the modifier or the diagnosis code needs to be corrected on this line item.

3. The denial explanation code will be:

Type	Code	Definition or wording
EX	t62	The diagnosis code and modifier are inappropriate.
CARC	11	The diagnosis is inconsistent with the procedure.
RARC	none	n/a

4. Steps to Remedy the Denial
    a. If the claim is denied with explanation code t62, review the medical record documentation to determine the appropriate laterality.
    b. Determine whether the modifier or the diagnosis code needs to be corrected to match the correct laterality documented in the medical record.
    c. Ensure that the corrected claim is submitted with the proper information to indicate a corrected claim.
        i. Use resubmission code "7" for claim frequency type in box 22 of the CMS1500 claim form or electronic equivalent.
        ii. List the denied claim number in the "orig ref #" portion of box 22.

Codes and Definitions

Acronyms Defined

Acronym		Definition
AHA	=	American Hospital Association
AHIMA	=	American Health Information Management Association
AMA	=	American Medical Association
CCI	=	Correct Coding Initiative (see "NCCI")
CDC	=	Centers for Disease Control and Prevention
CMS	=	Centers for Medicare and Medicaid Services
DHHS	=	Department of Health and Human Services
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HHS	=	U.S. Department of Health and Human Services
HIPAA	=	Health Insurance Portability and Accountability Act
ICD-10-CM	=	International Classification of Diseases, 10th Revision, Clinical Modification
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)

Acronym		Definition
NCCI	=	National Correct Coding Initiative (aka "CCI")
NCHS	=	National Center for Health Statistics
RPM	=	Reimbursement Policy Manual (e.g. in context of "RPM052" policy number, etc.)
UB	=	Uniform Bill
WHO	=	World Health Organization

Coding Guidelines

"Level of Detail in Coding

Diagnosis codes are to be used and reported at their highest number of characters available.

ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6, or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth characters which provide greater detail.

A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable." (CMS, et al[1])

"Use of Sign/Symptom/Unspecified Codes

Sign/symptom and "unspecified" codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. ... Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient's condition at the time of that particular encounter. ..." (CMS, et al[2])

When laterality is not documented by the patient's provider, code assignment for the affected side may be based on medical record documentation from other clinicians. If there is conflicting medical record documentation regarding the affected side, the patient's attending provider should be queried for clarification. Codes for "unspecified" side should rarely be used, such as when the documentation in the record is insufficient to determine the affected side and it is not possible to obtain clarification. (CMS, et al[3])

Cross References

A. “Diagnosis Code Requirements - Invalid As Primary.” Moda Health Reimbursement Policy Manual, RPM054.

B. “Medical Records Documentation Standards.” Moda Health Reimbursement Policy Manual, RPM039.

References & Resources

1. CMS, NCHS, AHA, & AHIMA. “Level of Detail in Coding.” ICD-10-CM Official Guidelines. Section I.B.2.

2. CMS, NCHS, AHA, & AHIMA. “Use of Sign/Symptom/Unspecified Codes.” ICD-10-CM Official Guidelines. Section I.B.18.

3. CMS, NCHS, AHA, & AHIMA. “Laterality.” ICD-10-CM Official Guidelines, October 2021 update. Section I.B.13.

4. Moda Health. “Records Considered for Review.” Moda Health Reimbursement Policy Manual, RPM039, Section L.1.b.

Background Information

The Centers for Medicare and Medicaid Services (CMS) has for many years required all diagnosis codes to be billed to the highest number of characters or digits available. CMS rejects a claim as unprocessable if it contains an incomplete or invalid diagnosis code. This requirement is now being applied by the federal government to Moda Health for Encounter Data and other reporting requirements which include Commercial claims.

This requirement is based upon correct coding rules in the ICD-10-CM General Coding Guidelines.

Moda Health also requires that diagnosis codes are specific regarding laterality and that the modifiers and diagnosis codes on a line item are consistent regarding which laterality applies to the services. This requirement is based upon correct coding rules.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document Moda Health’s payment guidelines for those services covered by a member’s medical benefit plan. Healthcare providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Moda Health Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes.

Providers are expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between the Moda Health Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and Moda Health Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; Moda Health strives to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Appendix

April 30, 2021

«Prov_Group_Name»
ATTN: Billing/Office Manager
«PRAD_ADDR1» «PRAD_ADDR2»
«PRAD_CITY», «PRAD_STATE» «PRAD_ZIP»

Dear Billing/Office Manager,

Moda Health medical claims processing includes the use of clinical edits that follow CMS/Medicare coding guidelines, as well as other industry standard guidelines (including but not limited to AMA, CPT, HCPCS) for the appropriate adjudication of claims.

In an effort to reduce healthcare waste and billing errors, Moda Health will be standardizing clinical editing and reimbursement policies to more closely follow CMS for all lines of business, and enhancing the way clinical editing is applied to professional and facility claims.

Effective with processing dates of July 1, 2021 and after (regardless of the date of service), Moda Health will be broadly implementing the following clinical edits for all our lines of business (or as noted below):

340B Drug Discount Program-Acquired Drugs and Biologicals (Modifiers JG & TB) – Commercial claims for OEBB and PEBB members billed by participating and non-participating providers without using the appropriate modifier, JG or TB, will be denied. We expect your claims to comply with the following CMS requirements by including the necessary modifiers for proper reimbursement:

- Line items meeting all the following requirements will be denied if not submitted with modifier JG:
  - Claims for OEBB and PEBB plans.
  - Submitted by a hospital that is eligible for the 340B program.
  - Line item for a drug that is eligible for the 340B program (procedure code has status indicator K on the OPPS fee schedule for the date of service).

A corrected claim with the required modifier will be needed to resolve the denial. More information can be found on reimbursement policy RPM063.

Laterality – Claims billed with a diagnosis code of unspecified laterality will deny. Corrected claims would be required to identify which laterality (or both, as applicable) was affected.

Age Inconsistencies – Some diagnosis codes contain references to age. Professional and DME claims billed with inappropriate diagnosis to age relations will be denied. In some cases, a denial will occur because there is another diagnosis code available that specifically applies to the patient's age and should be reported instead. Corrected claims will be required.

CMS Rate Sheets for Critical Access Hospitals (CAH) and Rural Health Clinics (RHC) – Facilities with CAH and/or RHC designations receive periodic (but no less than annual) updates to their CMS rate sheets based on filed cost reports. These rate sheets determine reimbursement for covered services and are critical to be provided in a timely manner from the facility. Claims with rate sheets received more than twelve months prior will deny with CARC 164 (Attached/other documentation referenced on the claim was not received in a timely fashion).

NDC requirement for Nutrition – Moda has identified billing inconsistencies for parenteral and enteral nutrition (PEN) products. To ensure appropriate pricing applies we are requiring the following when submitting claims for these items: In addition to billing HCPCS codes B4100 – B5200, B9998, and B9999, please include NDC numbers when available. If an NDC number is not available, send a copy of the invoice showing the purchase price with the claim.

As we continue to focus on our commitment of more closely aligning our policies with CMS guidelines and being transparent with our provider partners, we'd like to thank you for your continued efforts of following correct coding and billing practices.

To view a complete list of Moda's reimbursement policies, please visit www.modahealth.com/medical/policies_reimburse.shtml.

Questions?

We're here to help. Just email medical@modahealth.com or call us toll-free at 877-605-3229.

Sincerely,

Moda Health Medical Provider Relations team