Diagnosis Code Requirements - Level of Detail, Number of Characters, Laterality, and Site

Last Updated: 11/12/2025 **Last Reviewed:** 11/12/2025 **Originally Effective:** 1/1/2000

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a **Policy #: RPM053**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** All

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.
      iii. It is important that performing providers (e.g., laboratories, radiology, DME providers, etcetera) review incoming orders and actively query the ordering provider as needed when an incomplete diagnosis code is listed on the incoming order.
   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.
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." [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. [3]
4. For Medicaid claims:
    a. Effective for claims processed July 1, 2021 and following (including claim adjustments), diagnosis codes with unspecified laterality are not accepted for processing. Any diagnosis submitted (in any position on the claim) with an unspecified laterality diagnosis code, will cause a denial.
    b. Provider notification letters were sent, see Appendix.
    c. Scope of denial:
        i. For Professional CMS1500 claims, the diagnosis codes are analyzed at the line level.
        ii. For Facility CMS1450 claims, the diagnosis codes are analyzed at the claim level.
    d. The denial will occur regardless of the order or position of the unspecified laterality diagnosis code.
    e. 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.

iii. It is important that performing providers (e.g., laboratories, radiology, DME providers, etcetera) review incoming orders and actively query the ordering provider as needed when a diagnosis code with unspecified laterality is listed on the incoming order.

5. 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.

6. Steps to Remedy the Denial
   a. When a denial with explanation code w82 occurs, 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.[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.

7. 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.
   a. For example:
      i. 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.

ii. 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.

b. Special considerations for breast cancer:

i. When a patient has breast cancer on one side, some services clinically must be performed on the opposite side of the body. For example, the placement of a central venous access line or port.

ii. Please note that procedure codes such as 36557 or 36561 do not require the use of modifier LT or RT.

iii. If modifiers LT or RT are appended to such procedure codes when not needed, the laterality of the breast cancer diagnosis will conflict with the laterality of the modifier, and the line item will deny.

iv. To avoid this denial, omit the modifier RT or LT on the procedure code; it is not needed.

v. If a modifier is used and a denial occurs, a corrected claim is needed to resolve the denial. An appeal letter will not result in the clinical edit being removed.

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.

D. Non-Lateral Sites Must Be Specific

1. Diagnosis codes are to be used and reported with specific body sites. Diagnosis codes with unspecified site are not accepted for processing.

2. ICD-10-CM diagnosis codes include many diagnosis codes that indicate non-lateral body sites (e.g., spinal regions, abdominal quadrants, muscles of various locations).

3. The diagnosis codes on the claim need to accurately reflect the site or location 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.” [2]

b. When services are being rendered (aka the time of the patient encounter mentioned in the ICD-10 guidelines), the provider knows the location of any condition that involves sites or locations, with very rare possible exceptions.
   i. This site and location information must be documented in the medical record.
   ii. If the medical record does not state which site or location 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; these guidelines apply to non-lateral body sites as well. [3]

4. When any diagnosis submitted (in any position on the claim) is an unspecified site diagnosis code, a denial will occur.
   a. Scope of denial:
      i. For Professional CMS1500 claims, the diagnosis codes are analyzed at the line level.
      ii. For Facility CMS1450 claims, the diagnosis codes are analyzed at the claim level.
   b. The denial will occur regardless of the order or position of the unspecified site diagnosis code.
   c. 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 body site. A corrected claim is needed.
      iii. It is important that performing providers (e.g., laboratories, radiology, DME providers, etcetera) review incoming orders and actively query the ordering provider as needed when a diagnosis code with unspecified site is listed on the incoming order.
   d. The denial explanation code will be:

Type	Code	Definition or wording
EX	z29	Unspecified laterality or unspecified site diagnosis is not accepted in any position; corrected claim with more specific diagnosis required.
CARC	16	Claim/service lacks information or has submission/billing error(s).
RARC	M76	Missing/incomplete/invalid diagnosis or condition.

5. Steps to Remedy the Denial
   a. When a denial with explanation code z29 occurs, every diagnosis code on the claim must be reviewed by the billing office for unspecified site.
   b. Review the medical record documentation to determine the appropriate site.
      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. [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 site for the condition. If multiple sites are involved, multiple diagnosis codes will likely need to be assigned, unless a code is available indicating multiple sites.

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 site:
   Best practice is that only diagnosis codes with specified sites 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 site(s) or region(s) are affected by the condition. An unspecified site diagnosis code option is not appropriate to offer in a quick-pick menu.
   b. When the coding team is preparing the claim for submission, if the medical record does not indicate the body site or location involved or affected, query the provider before submitting the claim; do not select an unspecified site diagnosis code.

Definitions

Acronyms/Abbreviations

Acronym	Definition
AHA	American Hospital Association
AHIMA	American Health Information Management Association
AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
NCHS	National Center for Health Statistics
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Diagnosis Code Requirements - Invalid As Primary." Moda Health Reimbursement Policy Manual, RPM054.
C. "Medical Records Documentation Standards." Moda Health Reimbursement Policy Manual, RPM039.

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.

Policy History

Reminder: 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 current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
11/12/2025	Clarification of laterality mismatch denials in certain breast cancer situations; how to avoid or resolve denials. Coding Guidelines & Sources section retired; see Resources for information. Background Information section retired. Important Statement section retired; info in Related Policy RPM001. History section info added to 9/19/2022 entry. Acronyms & Resources updated. Formatting updates. No policy changes.
9/11/2024	Diagnosis laterality denials will now only apply to Medicaid claims.
8/14/2024	Formatting updates. No policy changes.
10/11/2023	Policy Name: "Site" added to title for clarity. Clarified performing providers are responsible to ensure diagnosis codes on incoming orders are complete and are specific to laterality and that unspecified site diagnosis codes will create denials.
1/11/2023	Clarified unspecified laterality diagnosis in any position will cause a denial. Formatting updates. No policy changes.
9/19/2022	Clarified to query the provider to resolve unspecified diagnosis code before submitting claim. Policy History section added; entries prior to 2022 omitted (in archive storage). Idaho added to Scope. Acronyms updated. Formatting updates. No policy changes.
9/15/2016	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2000	Original Effective Date (with or without formal documentation). Policy based on CMS policy for level of detail required for diagnosis codes (complete versus incomplete codes).

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