CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11059	**Date: October 21, 2021**
	Change Request 12471

SUBJECT: April 2022 Update to the Java Medicare Code Editor (MCE) for New Edit 20- Unspecified Code Edit

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement system changes needed to update the Shared System Maintainer (SSM) interface with the Java MCE to accept new MCE Edit 20- Unspecified Code Edit. This CR also provides a mechanism to systematically bypass the new edit when a specific billing note is present in the claim remarks field to indicate the primary reason why laterality could not be determined.

EFFECTIVE DATE: April 1, 2022 - Effective for discharges occurring on or after April 1, 2022.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 4, 2022

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/ 20/ 20.2.1/ Medicare Code Editor (MCE)

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: Unspecified codes exist in the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) classification for circumstances when documentation in the medical record does not provide the level of detail needed to support reporting a more specific code. However, 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.

This Change Request (CR) implements new MCE Edit 20- Unspecified Code Edit. This new edit will be triggered when an unspecified diagnosis code currently designated as either a Complication or Comorbidity (CC) or Major Complication or Comorbidity (MCC), that includes other codes in that code subcategory that further specify the anatomic site, is entered. Medicare contractors may refer to table 6P.3a associated with the FY 2022 Inpatient Prospective Payment System (IPPS)/ Long Term Care Hospital (LTCH) PPS final rule (which is available via the Internet on the CMS website at: http://www.cms.hhs.gov/Medicare/ Medicare-Fee-for-Service-Payment/ AcuteInpatientPPS/index.html) for the list of unspecified diagnosis codes that are subject to this edit. This edit shall signal to the provider 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 medical record 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.

This CR implements a mechanism to bypass the new MCE Edit when a billing note is present in the claim remarks field to indicate the reason why the laterality could not be determined. Specifically, the provider may enter a remark "**UNABLE TO DET LAT 1**" to indicate that the provider is unable to obtain additional information to specify laterality, or remark "**UNABLE TO DET LAT 2**" to indicate that the physician is clinically unable to determine laterality. This action and language will enable the Medicare Administrative Contractor (MAC) to systematically bypass the edit and process the claim accordingly. If there is no language entered into the remarks section as to the availability of additional information to specify laterality and the provider submits the claim for processing, the claim would then be returned to the provider.

B. Policy: No new policy.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility			
		A/B MAC	D M E	Shared-System Maintainers	Other

		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12471.1	The Shared System Maintainer (SSM) shall update the interface to the Java Medicare Code Editor (MCE) in order to receive new MCE Edit 20: **20- Unspecified Code** Unspecified Code edit values: **0** - No Unspecified Edit **1**- Has Unspecified Edit Note: Edit 20 may be returned for the Principal Diagnosis Code and all secondary Diagnosis Codes. This edit is not applicable to the Admitting Diagnosis Code.					X				
12471.1.1	The SSM shall modify the interface to the Java MCE to accept a total of 20 Diagnosis Flags and 20 Procedure Flags, increasing the total byte length of the output string to 1142 bytes.					X				
12471.1.2	Edit 20 will be located at the 15th position within the string of flags for each diagnosis code (Principal and all secondary). FISS shall modify the interface to receive the MCE bit flag for edit 20 in position 81 PIC 99, moving the filler to position 83 PIC x(54).					X				
12471.2	The SSM shall create new reason codes to assign when new MCE edit 20 is returned for the diagnosis code(s) indicated in error in the MCE output record.					X				
12471.3	Medicare contractors shall be aware of the temporary instructions to notify MACs on the 837I that the hospital is unable to obtain medical record documentation from the provider in support of a more specific code to identify laterality, by submitting one of the following remarks in Loop 2300 Billing Note NTE02, or in the remark field on an 11X, 18X or 21X DDE or paper claim: • NTE02= **NTE*ADD*UNABLE TO DET LAT 1~** or claim Remark field = **UNABLE TO DET LAT 1** (This billing note/remark shall be used when the provider is unable to obtain additional documentation to determine laterality.) • NTE02= **NTE*ADD*UNABLE TO DET LAT 2~** or claim Remark field = **UNABLE TO DET LAT 2** (This billing note/remark shall be used when the physician is clinically	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	unable to determine laterality.)									
12471.4	The SSM shall bypass the MCE Edit 20 reason code(s) when one of the billing notes/remarks specified in BR 3 is present on the 837I Loop 2300 Billing Note NTE02 segment, or the remark field on an 11X, 18X, or 21X DDE or paper claim.					X				
12471.5	The Medicare contractor shall set the new reason codes to Return to Provider (RTP).	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12471.6	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Yvette Rivas, yvette.rivas@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

20.2.1 - Medicare Code Editor (MCE)

(Rev.11059; Issued: 10-21-21; Effective: 04-01-22; Implementation: 04-04-22)

A. - General

The MCE edits claims to detect incorrect billing data. In determining the appropriate MS-DRG for a Medicare patient, the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed must be reported accurately to the Grouper program. The logic of the Grouper software assumes that this information is accurate and the Grouper does not make any attempt to edit the data for accuracy. Only where extreme inconsistencies occur in the patient information will a patient not be assigned to a MS-DRG. Therefore, the MCE is used to improve the quality of information given to Grouper.

The MCE addresses three basic types of edits which will support the MS-DRG assignment:

- **Code Edits -** Examines a *claim* for the correct use of diagnosis and procedure codes. They include basic consistency checks on the interrelationship among a patient's age, sex, and diagnoses and procedures *reported.*

- **Coverage Edits -** Examines the type of patient and procedures performed to determine if the services *are* covered.

- **Clinical Edits -** Examines the clinical consistency of the diagnostic and procedural information on the claim to determine if they are clinically reasonable and, therefore, should be paid.

B. - Implementation Requirements

The A/B MAC (A) processes all inpatient Part A discharge/transfer *claims* for both PPS and non-PPS facilities (including waiver States, long-term care hospitals, and excluded units) through the MCE. It processes claims that have been reviewed by the QIO prior to billing through the MCE only for edit types 1, 2, 3, 4, 7, and 12. It does not process the following kinds of *claims* through the MCE:

- Where no Medicare payment is due (amounts reported by value codes 12, 13, 14, 15, or 16 equal or exceed charges).

- Where no Medicare payment is being made. Where partial payment is made, editing is required.

- Where QIO reviewed prior to billing (condition code C1 or C3). It may process these exceptions through the program and ignore development codes or bypass the program.

The MCE software contains multiple versions. The version of the MCE accessed by the program depends upon the patient discharge date entered on the claim.

C. - Bill System/MCE Interface

The A/B MAC (A) installs the MCE online, if possible, so that prepayment edit requirements identified in subsection C can be directed to hospitals without clerical handling.
The MCE needs the following data elements to analyze the *claim*:

- Age;

- Sex;

- Discharge status;

- Diagnosis (25 maximum - principal diagnosis and up to 24 additional diagnoses);

- Procedures (25 maximum); and
- Discharge date.

The MCE provides the A/B MAC (A) an analysis of "errors" on the *claim* as described in subsection D. The A/B MAC (A) develops its own interface program to provide data to MCE and receive data from it.

The MCE Installation Manual describes the installation and operation of the program, including data base formats and locations.

D. - Processing Requirements

The hospital must follow the procedure described below for each error code. For *claims* returned to the provider, the A/B MAC (A) considers the *claim* improperly completed for control and processing time purposes. (See chapter 1.)

NOTE: The following instructions are based on ICD-9-CM diagnosis and procedure codes, *ICD-10-CM and ICD-10-PCS codes.*

1. Invalid Diagnosis or Procedure Code

The MCE checks each diagnosis code, including the admitting diagnosis, and each procedure code against a table of valid diagnosis and procedure codes. An admitting diagnosis, a *principal* diagnosis, and up to *24* additional diagnoses may be reported. Up to *25* total procedure codes may be reported on an inpatient claim. If the recorded code is not in this table, the code is invalid, and the A/B MAC (A) returns the *claim* to the provider.

For a list of valid diagnosis or procedure codes see the "International Classification of Diseases" revision applicable to the date of the inpatient discharge or other service and the "Addendum/Errata" and new codes furnished by the A/B MAC (A). The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure codes before returning the *claim*.

2. External Cause of Injury Code as Principal Diagnosis

External Cause of Injury codes describe the circumstances that caused an injury, not the nature of the injury, and therefore are not recognized by the Grouper program as acceptable principal diagnoses. In ICD-9-CM the external cause of injury diagnosis codes begin with the letter E. In ICD-10-CM the external cause of injury codes begin with the letters V, W, X and Y. For a list of all External cause of injury codes, see *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), and the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).* The hospital must review the medical record and/or face sheet and enter the correct diagnosis before returning the *claim*.

3. Duplicate of *Principal Diagnosis*

Any secondary diagnosis *reported on the claim* that is the same code as the principal diagnosis reported on the claim is identified as a duplicate of the principal *diagnosis.* This is unacceptable because the secondary diagnosis may cause an erroneous assignment to a higher severity *level* MS-DRG. Hospitals may not repeat a diagnosis code. The A/B MAC (A) will delete the duplicate secondary diagnosis and process the *claim*.

4. Age Conflict

The MCE detects inconsistencies between a patient's age and any diagnosis on the patient's record. Examples are:

- A 5-year-old patient with benign prostatic hypertrophy.
- A 78-year-old *who* delivers *a baby*.

In the above cases, the diagnosis is clinically impossible in a patient of the stated age. Therefore, either the diagnosis or age is presumed to be incorrect. Four age code categories are described below.

- A subset of diagnoses is intended only for *"perinatal/newborn." These are diagnoses that occur during the perinatal or newborn period of age 0.*
- Certain diagnoses are considered reasonable only for children between the ages of 0 and 17. These are "Pediatric" diagnoses.
- Diagnoses identified as "Maternity" are coded only for patients between the ages of 9 and 64.
- A subset of diagnoses is considered valid only for patients over the age of 14. These are "Adult" diagnoses. For "Adult" diagnoses the age range is 15 through 124.

The list of diagnoses that are acceptable for each age category can be located in the most current version of the *Definition of Medicare Code Edits manual which is posted at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software*

Prior versions of the manual can be located at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS
and select the final rule for the applicable *Fiscal Year (FY)* from the list on the left. Then select the FY*(CCYY)* Final Rule Data Files, and scroll down to the Definition of Medicare Code Edits *link*.

If the A/B MAC (A) edits online, it will return *claims* for a proper diagnosis or correction of age as applicable. If the A/B MAC (A) edits in batch operations after receipt of the admission query response, it uses the age based on CMS records and returns *claims* that fail this edit. The hospital must review the *Electronic Health Record (EHR), paper medical record,* and/or face sheet and enter the proper diagnosis or patient's age before returning the *claim*.

5. Sex Conflict

The MCE detects inconsistencies between a patient's sex and a diagnosis or procedure on the patient's record. Examples are:

- Male patient with cervical cancer (diagnosis).
- Male patient with a hysterectomy (procedure).

In both instances, the indicated diagnosis or the procedure conflicts with the stated sex of the patient. Therefore, either the patient's diagnosis, procedure or sex is incorrect.

The MCE contains listings of male and female related diagnosis and procedure codes and the corresponding English descriptions. The hospital should review the *EHR, paper medical record,* and/or face sheet and enter the proper sex, diagnosis, and procedure before returning the *claim*.

6. Manifestation Code *as* Principal Diagnosis

A manifestation code describes the manifestation of an underlying disease, not the disease itself, and therefore, cannot be a principal diagnosis. The MCE contains listings of diagnosis codes identified as

manifestation codes. The hospital should review the *EHR, paper medical record,* and/or face sheet and enter the proper diagnosis before returning the *claim*.

7. Nonspecific Principal Diagnosis

Effective October 1, 2007 (FY 2008), the non-specific principal diagnosis edit was discontinued and *is only applicable when processing claims* using MCE version 2.0-23.0 only.

8. Questionable Admission

There are some diagnoses which are not usually sufficient justification for admission to an acute care hospital.

The MCE contains a listing of diagnosis codes identified as "Questionable Admission" when used as principal diagnosis.

The A/B MACs (A) may review on a post-payment basis all questionable admission cases. Where the A/B MAC (A) determines the denial rate is sufficiently high to warrant, it may review the claim before payment.

9. Unacceptable Principal Diagnosis

There are selected codes that describe a circumstance which influences an individual's health status but is not a current illness or injury; therefore, they are unacceptable as a principal diagnosis. For example, the diagnosis code for family history of a certain disease would be an unacceptable principal diagnosis since the patient may not have the disease.

In a few cases, there are codes that are acceptable *as a principal diagnosis* if a secondary diagnosis is coded. If no secondary diagnosis is present the message "requires secondary dx" *will be returned by the MCE.* The A/B MAC (A) may review claims with codes *from* the Unacceptable Principal Diagnosis section and a secondary diagnosis. A/B MACs (A) may choose to review as a principal diagnosis if data analysis deems it a priority.

If codes *from the unacceptable principal diagnosis edit code list* are identified without a secondary diagnosis, the A/B MAC (A) returns the claim to the hospital and requests *that the applicable secondary* diagnosis *be entered.* Also, *any claims* containing other "unacceptable principal diagnosis" codes are returned.

The hospital reviews the *EHR, paper medical record,* and/or face sheet and enters the appropriate principal diagnosis that describes the illness or injury before *resubmitting* the *claim.*

10. Nonspecific O.R. Procedures

Effective October 1, 2007 (FY 2008), the non-specific O.R. procedure edit was discontinued and *is only applicable when processing claims* using MCE version 2.0-23.0 only.

11. Noncovered O.R. Procedures

There are some O.R. procedures for which Medicare does not provide payment.
The A/B MAC (A) will return the *claim* requesting that the non-covered procedure and its associated charges be removed from the claim, Type of Bill (TOB) 11X. If the hospital wishes to receive a Medicare denial, etc., the hospital may submit a non-covered claim, TOB 110, with the non-covered procedure/charges. (For more information on billing non-pay claims, see Chapter 1 of this Manual, Section 60.1.4).

12. Open Biopsy Check

Effective October 1, 2010, the open biopsy check edit was discontinued and *is* only *applicable* when processing *claims using* MCE version 2.0 - 26.*0*.

13. Bilateral Procedure

Effective October 1, 2015, the bilateral procedure edit was discontinued and is only used when processing claims using MCE version 2.0-33.0.

14. Invalid Age

If the hospital reports an age over l24, the A/B MAC (A) requests the hospital *confirm* if it made a *claim* preparation error. If the beneficiary's age is *confirmed to be over l24*, the hospital enters 123.

15. Invalid Sex

A patient's sex is sometimes necessary for appropriate MS-DRG *assignment*. The sex code reported must be either 1 (male) or 2 (female).

16. Invalid Discharge Status

A patient's discharge status is sometimes necessary for appropriate MS-DRG *assignment*. Discharge status must be coded according to the Form CMS-1450 *and UB-04* conventions. See Chapter 25.

17. *Limited Coverage*

For certain procedures whose medical complexity and serious nature incur extraordinary associated costs, Medicare limits coverage to a portion of the cost.

18. Wrong Procedure Performed

Certain external causes of morbidity codes indicate that the wrong procedure was performed.

19. Procedure inconsistent with length of stay *(LOS)*

The following procedure code should only be coded on claims when the respiratory ventilation is provided for greater than four **consecutive** days during the length of stay.

Effective *with discharges on and after* October 1, 2015, ICD-10-PCS code, 5A1955Z - Respiratory Ventilation, Greater than 96 Consecutive Hours

Prior to this date, discharges on and after October 1, 2012, ICD-9-CM procedure code, 96.72, Continuous invasive mechanical ventilation for 96 consecutive hours or more

20. Unspecified Code

Unspecified codes exist for circumstances when documentation in the medical record does not provide the level of detail needed to support reporting a more specific code. However, 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.

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:

Billing Note/Remarks	***Definition***
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.*