CareSource | NETWORK Notification

Notice Date: August 21, 2026
To: Ohio Medicaid Providers
From: CareSource
Subject: Inpatient Code Specificity-Additional Information

Summary
This information is to provide additional guidance and impact for the Inpatient Code Specificity excerpt from the Network Notification currently posted.

6. Inpatient Code Specificity

> **ICD-10-CM Official Guidelines for Coding and Reporting**
> "Codes are to be assigned to the highest level of specificity. Unspecified codes are to be reported only when there is no greater specificity that can be applied based on available documentation."

CMS Transmittal R11059CP

> "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."

The Unspecified Code guidance focuses on inpatient facility claims and evaluates a diagnosis code list of approximately 3,500 codes. The intent of the edit is to identify situations where an unspecified diagnosis code has been reported even though more specific diagnosis code options are available within the same ICD-10-CM code category.

Inpatient facility claims containing a principal or other diagnosis code designated as unspecified when more specific diagnosis codes are available within the same ICD-10-CM code category to identify the anatomic site and/or laterality.

This edit evaluates diagnosis codes reported on the claim and identifies unspecified codes when additional clinical specificity may be available based on the medical record documentation.

Providers should report diagnosis codes to the highest level of specificity supported by the medical record. The use of unspecified diagnosis codes may not accurately reflect the documented condition when a more detailed code is available.

Examples of unspecified diagnosis codes include S22.39XA (fracture of one rib, unspecified side), S77.00XA (crushing injury of unspecified hip), and S72.90XA (fracture of unspecified femur). Similar scenarios may exist across numerous diagnosis categories where greater specificity can be reported regarding laterality, anatomical location, severity, encounter type, or other clinical characteristics.

The edit is intended to address coding opportunities where additional specificity is available and supported by documentation, helping to improve coding accuracy and consistency across inpatient claims.

Questions?
If you have questions, please contact CareSource Provider Services at 1-800-488-0134, available Monday through Friday, 7 a.m. to 8 p.m., Eastern Time (ET).

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