Claim Coding Accuracy Reminders

To maximize the number of first-pass pay claims, your staff should review the accuracy of their procedure and diagnosis coding. Following are some general DO’s and DON’Ts to consider.

A. CPT and ICD-9 coding should be at the highest specificity possible. In other words, “Unlisted Procedure” codes should ONLY be used when no SPECIFIC code is available.

B. There needs to be a correlation between the level of service provided, diagnosis code and procedure code.

Example:    RIGHT
            99213 – Expanded Office Visit
            382.9 – Acute Otitis Media

            WRONG
            99215 – Comprehensive Office Visit
            382.9 – Acute Otitis Media

C. The procedure code must correlate with the patient’s age/sex.

Example:    RIGHT
            54152 - Circumcision, except newborn
            Patient is a 40-year-old male.

            WRONG
            54150 – Circumcision, newborn
            Patient is a 40-year-old male.

Example:    RIGHT
            84153 - Prostate Specific Antigen (PSA)
            Patient is a 40-year-old male.

            WRONG
            84153 – Prostate Specific Antigen (PSA)
            Patient is a 40-year-old female.
D. There needs to be a correlation between the procedure and diagnosis codes used.

Example:

\[
\begin{array}{ll}
\text{RIGHT} & \text{WRONG} \\
70551 – \text{MRI of brain} & 70551 – \text{MRI of brain} \\
346.90 – \text{Migraine headache} & 780.6 – \text{fever}
\end{array}
\]

Below is a list of procedure codes which do NOT have specific diagnosis requirements.

<table>
<thead>
<tr>
<th>36000</th>
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<th>84443</th>
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</table>

E. Type of Service (TOS) codes, or modifiers, need to be used on claims for these services:

- Assistant Surgery
- Anesthesia
- Home Medical Equipment
- Ambulatory Surgery Center
- Radiation Therapy
- X-ray Services
- Laboratory Services

F. The place of service and CPT procedure code must match.

Example:

\[
\begin{array}{ll}
\text{RIGHT} & \text{WRONG} \\
99213 – \text{Expanded Office Visit} & 99213 – \text{Expanded Office Visit} \\
\text{Place of service: 11 Office} & \text{Place of service: 21 Inpatient Hospital}
\end{array}
\]

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G. **Effective September 9, 1999,** AMA CPT anatomical modifiers will be required for all applicable procedures.

**Example:** 66821 - YAG laser
The left or right eye should be indicated by using the LT or RT modifier.

Following are the acceptable anatomical modifiers.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Modifier</th>
<th>Description</th>
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<tbody>
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<td>E1</td>
<td>Upper Left Eyelid</td>
<td>RC</td>
<td>Right Coronary Artery</td>
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<tr>
<td>E2</td>
<td>Lower Left Eyelid</td>
<td>LC</td>
<td>Left Circumflex Coronary Artery</td>
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<tr>
<td>E3</td>
<td>Upper Right Eyelid</td>
<td>LD</td>
<td>Left Anterior Descending Coronary Artery</td>
</tr>
<tr>
<td>E4</td>
<td>Lower Right Eyelid</td>
<td>TA</td>
<td>Left Foot, Great Toe</td>
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<tr>
<td>FA</td>
<td>Left Hand, Thumb</td>
<td>T1</td>
<td>Left Foot, Second Digit</td>
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<tr>
<td>F1</td>
<td>Left Hand, Second Digit</td>
<td>T2</td>
<td>Left Foot, Third Digit</td>
</tr>
<tr>
<td>F2</td>
<td>Left Hand, Third Digit</td>
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<td>Left Foot, Fourth Digit</td>
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<td>Left Hand, Fourth Digit</td>
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<td>Left Hand, Fifth Digit</td>
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<td>Right Foot, Great Toe</td>
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<td>Right Hand, Thumb</td>
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<td>Right Foot, Second Digit</td>
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<td>T8</td>
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<td>F8</td>
<td>Right Hand, Fourth Digit</td>
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<td>F9</td>
<td>Right Hand, Fifth Digit</td>
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<td>Right Side</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LT</td>
<td>Left Side</td>
</tr>
</tbody>
</table>

**59** Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services. Modifier ‘-59’ is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, **different site** or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier ‘-59’.

H. The time span on dates of service and units must match. **Effective September 9, 1999,** claims will be returned when the units do NOT match the dates of service.

**Example:**

**RIGHT**
99232 - Subsequent hospital care
Dates of service: 10/01/99 – 10/04/99
Units: 004

**WRONG**
99232 - Subsequent hospital care
Dates of service: 10/01/99 – 10/04/99
Units: 005

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I. The number of units must correlate with the nomenclature of the CPT code used.

**Example:**

**RIGHT**

90918 - ESRD related services per full month  
Dates of service: 09/01/99 – 09/30/99  
Units: 001

**WRONG**

90918 - ESRD related services per full month  
Dates of service: 09/01/99 – 09/30/99  
Units: 030

To minimize the number of claims returned, which causes delays in claims processing and payment, we encourage you to have your staff attend coding seminars. A new schedule of upcoming Blue Shield workshops will be mailed in a future Blue Shield Report newsletter. In the meantime, contact your Professional Relations Representative for assistance with your coding questions.

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**Electronic Remittance Advice Format Changes**

By October 1, 1999, the electronic Remittance Advices will have the capability of reporting two (2) Remark/Reason Codes per service line item. Currently, this field is formatted to accept only one (1) code.

The Remittance Advice ‘reason’ code value will be presented in the Electronic Remittance Notice ‘formats’ supported by EMS as follows:

1. In versions 002.00 and 002.01 of the NSF ERN structure, the three (3) digit ‘reason’ code value will be presented at the service line level of field 20 of the 451 record in positions 153 through 155.

2. In the 3B.00 and 4B.00 implementations of the V3051 835 transaction, the three (3) digit ‘reason’ code value will be presented at the service line level in an occurrence of the REF segment in the SVC loop. The REF segment, with ‘TD’ as the REF01 Qualifier Code value and ‘XXX’ representing the ‘reason’ code value, will be structured as follows: REF*TD*XXX~

In order for you to utilize this new automated ERN posting process, you will need to contact your system software vendor and ask that the necessary programming changes be completed before October 1st.