

## Coding Clues



### **2005 ICD-9-CM Codes – Be Ready by October 1, 2004**

According to HIPAA law, there will not be a 90-day code grace period for transitioning to the new ICD-9-CM 2005 codes for Medicare claims. This means that the 2005 ICD-9-CM code sets must be used for services provided on or after October 1, 2004. The changes for 2005 are extensive:

- 171 new diagnosis codes
- 203 revised diagnosis codes
- 25 invalid diagnosis codes

### **2005 CPT and HCPCS Codes - Effective January 1, 2005**

There will be no 90-day grace period for CPT and HCPCS code revisions in January either. This change is due to the HIPAA Transaction and Code Set Rule requiring all code sets to be valid at the time that the service is provided.

### **Place of Service (POS) - Mistakes Can Be Costly and Cause High Denials**

In a rule change that became effective on April 1, CMS is requiring the physical address where the service was performed, to be listed in Box 32 of the 1500 form. The rule change applies to paper and electronic claims.

The requirement is to list where the service was performed including the name, address and zip code in Box 32. The only exception is for a service performed in a patient's home (POS 12).

One carrier reports that as many as 30% of claims received daily are rejected because the address is not being listed correctly. In fact, incorrect or missing POS codes are often cited among the top 10 reasons claims are denied.

Be careful when selecting the POS code to bill E/M services that are not performed in the office setting. E/M codes are grouped according to place of service (eg, office, inpatient, ed, nursing facility, etc.). For example: Outpatient codes 99201-99215, new and

established, are used for office visits but also for encounters in other outpatient settings such as outpatient clinics and in some cases the emergency department, but not for inpatients or patients in observation, skilled nursing home patients or patients at home.

A complete list of POS codes can be found in the front of the CPT manual in most professional and expert editions.

**NOTE:** For practices with multiple locations, a PO Box cannot be used as the service location. To cue your data entry staff to list the correct address on the claim:

- Create a separate superbill for each location you bill from.
- Or list all locations on the superbill and circle the location where the service was performed.

### **Denials – Steps To Consider Before Writing the Claim Off**

- Step 1: Directly speak with the supervisor of each carrier representative you talk with on the phone during the initial denial inquiry.
- Step 2: In a letter, appeal the denial and ask the carrier for the basis of the denial, in writing. A review by a physician of the same specialty can be requested when appropriate.
- Step 3: If there are recurring issues and you are unable to obtain a written basis of denial, ask for assistance from the Carrier Advisory Committee (CAC) representative within the physician's specialty society.
- Step 4: In writing, document the steps you have taken and your carrier's responses (or lack thereof) and send as a complaint to your carrier's regional office.

It may also be helpful to contact your carrier medical director. They won't help track particular claims but can be an excellent resource for policy questions. But use your carrier medical director prudently, for example the medical director is the appropriate person to contact when a particular diagnosis code should be added to the local medical review policies (LMRP) or when a particular code is routinely being denied improperly by the carrier.

### **National Survey Reveals Priorities For Parents During Pediatric Visits**

In the survey parents responded to a comprehensive set of questions about well-child visits and related questions about the home to promote their child's development. To view the survey and results go to:

<http://www.aap.org/advocacy/releases/junesurvey.htm>