Network Notification

Date: February 10, 2010 **Number: OH-P-2010-05**

To: All Ohio PCP, Specialty Providers

From: CareSource

Subject: Top Claim Denials

As part of our ongoing commitment to timely and clearly articulated communication of policy or process changes, the information listed below supplements current policies to include those listed in the CareSource Provider Manual.

As announced in our October 12, 2009 letter (OH-P-204) sent to our Provider Network and our *Code Editing Guidelines on Professional Claims* document (OH-P-215) included in our Fall 2009 Provider Mailpak, CareSource continues to be committed to industry standard claim adjudication practices. Consistent with these practices, we updated our claims processing edits in November 2009 to help make it easier for you to work with us. Concurrent with this update, we launched enhanced claims functionality on our secure Provider Portal located on our website, caresource.com. The new functionality provides more detailed claim line edit descriptions. All of the edits enhanced or implemented in November 2009 are applied to professional claims submitted on a CMS 1500 form.

Recently, we identified the top five reasons for code editing denials. These include:

- **Not a Primary Diagnosis Code** – This edit identifies ICD-9 diagnosis codes that are not allowed for reporting alone or as a primary diagnosis. Claims submitted with these ICD codes will be denied and must be resubmitted as a corrected claim with a valid Primary Diagnosis Code within timely filing guidelines.

  Example: Two common diagnosis codes seen in this edit are V22.2 (pregnant state, incidental) and V58.69 (Long-term (current) use of other medications). In the ICD-9-CM publication, these codes have a symbol SDx. This symbol identifies V codes that can only be used as a secondary diagnosis.

- **Invalid Diagnosis** – Diagnosis code is invalid for date of service or does not exist.

Examples of invalid diagnosis are 075.0 and 311.00. Information regarding coordination and maintenance of ICD-9 diagnosis codes can be found in the introduction of the ICD-9-CM publication.

- **Unbundled Code (CCI Edit**) -- This edit compares CPT codes reported for the same date of service to find procedures that should not be submitted together. Unbundling is the act of billing CPT codes which are components of other CPT codes. Unbundling can either be incidental (procedures which are not essential to complete the procedure) or mutually exclusive (related procedures). Depending on the particular code combination, CareSource may deny one or more of the related codes. There are three unbundling edits used by CareSource including (U) = Unbundling, (I) = Incidental, and (E) Exclusive.

  Example includes 69210 (Removal impacted cerumen) has a relationship with 69200 (Removal foreign body from external auditory canal; without general anesthesia). Also, Procedure codes 11721 (debridement of the nail) and 11056 (pairing or cutting of benign lesion) have a relationship.

- **Daily Frequency Exceeded** -- This edit is based on CPT and HCPCS code descriptions, along with CMS and industry standards, that define maximum billable units per procedure. If a claim line contains units that exceed these limits, CareSource will only allow the appropriate unit values associated with that code.

  Examples include: 10040 (acne surgery) which has a daily max of 1; 92065 (orthoptic treatment) *which has a daily max of 1, and 33916* (surgery on a great vessel) which has a daily max of 1.

- **Non-Specific Diagnosis Codes** – When selecting diagnosis codes, select the code that provides the most detail.

  Two common diagnosis codes seen in this edit are 250 (diabetes mellitus) and 493 (asthma). In the ICD-9-CM book, these codes have a symbol $\surd 4^{th}$. There are also codes that have the symbol $\surd 5^{th}$. These symbols indicate that the code requires a fourth or fifth digit.

If you have any questions about the information in this Network Notification, please contact Provider Services at 1-800-488-0134.