PROVIDER QUICK TIPS #113

CHANGES TO DIAGNOSIS CODE EDITS

In preparation for the ANSI X12 version 5010 implementation, effective with claims submitted on or after October 17, 2011, the Department of Human Services will begin denying claims when the diagnosis code is not on file for the date of service. While ANSI X12 version 5010 implementation pertains only to the submission of electronic claims, the requirement for a valid diagnosis will also pertain to the submission of paper claims. An invalid diagnosis code is defined as a diagnosis code that has not been coded to the full number of digits required for that code. For example, diabetes mellitus without mention of complication is reported as 2500 but a 5th digit is required to determine the sub-classification for the type of diabetes. This code must be reported with a 5th digit from 0-3 (e.g. 25003). If the 5th digit is not included, the claim will deny because it contained an invalid diagnosis code. Providers should refer to their ICD-9 CM reference manual and use the code set that is valid for the date of service. This change applies to all claim types that currently require a diagnosis code be submitted. Please remember to submit claims with the appropriate diagnosis code format required for your particular claim type.

Thank you for your service to our Medical Assistance recipients.
We value your participation.
Check the department's website often: www.dhs.pa.gov

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DEPARTMENT OF HUMAN SERVICES