



## ClaimCheck® Phase One

EDS is pleased to announce the launch of *ClaimCheck*® Phase One beginning with claims processed on November 8, 2004. This claims evaluation software will benefit providers through greater standardization, minimal medical review of claims, and faster, more clinically precise and consistent adjudication. EDS will implement *ClaimCheck*® in two phases. Our implementation program reflects an in-depth knowledge of the Vermont Medicaid program and is guided by the experience of integrating similar McKesson software into Medicaid programs in Oklahoma, Wisconsin, and Mississippi.

*ClaimCheck*® is a highly flexible system that can be tailored to the unique needs of the Vermont Medicaid program. It will be used to adjudicate the following claim types:

- M** – HCFA – Physician Claims
- O** – Outpatient – Laboratory and Radiology Only
- X** – Outpatient Cross Overs – Laboratory and Radiology Only
- Y** – HCFA – Physician Cross Over
- P** – Vision Claims

In Phase One, the following edits/audits will be activated:

- **Gender Replacement** - When a gender specific code is billed under the wrong gender, *ClaimCheck*® will deny the procedure code originally billed and add a new code to support the correct gender.
- **Age Replacement** – When an age specific code is billed for a recipient who is not of that age, *ClaimCheck*® will deny the originally billed procedure code and add a new code to support the appropriate age.
- **New Visit Frequency Replacement** – This edit validates correct billing for the new-established visit. The edit will only work when the patient is already an established patient and a new visit code is billed. *ClaimCheck*® will deny the new visit code and replace it with the appropriate established level of care code. *ClaimCheck*® will not edit in reverse from established to new. A code replacement may result from a claim previously processed in history. The replacement code will appear on the current remittance advice (RA).
- **Mutually Exclusive** –Mutually exclusive is a reimbursement edit based on a combination of third party reimbursement policies, CCI, CMS and other non-clinically based resources. This edit is activated when *ClaimCheck*® identifies two or more codes that are not usually performed on the same patient on the same date of service. *ClaimCheck*® will validate against correct coding rules from the

scenarios listed below and process for payment the code with the highest complexity. The other procedure(s) will be denied as mutually exclusive.

This edit reviews:

- Limited/complete
- Partial/total
- Single/multiple
- Unilateral/bilateral
- Initial/subsequent
- Simple/complex
- Superficial/deep
- With/without

A code may be denied due to a previously processed claim in history. The replacement code will appear on your RA. This is a new system feature. Previously, our system did not edit for mutually exclusive coding combinations.

Effective with claims *received* on December 6, 2004, you must append modifier 25 in accordance with correct coding guidelines when billing E&M services. Any claim processed without modifier 25 appended will be denied as mutually exclusive. Modifier 25 has already been listed as appropriate for these codes and can now be used with submitted claims.

*ClaimCheck*® will also affect RAs. Paper RAs will show an additional detail line when a service has been denied and a replacement code has been added. The additional detail line will reference the ICN that contains the replacement code.

The 835 Electronic RA will be modified to support the replacement information by utilizing the SVC06 and SVC07 elements. Starting with paid date of November 5, 2004, the following change will be implemented: we will report the revenue code (in SVC04) and the HCPCS procedure code (in SVC01) when *both* are present in an Institutional claim detail. (Previously, in this circumstance, the revenue code appeared in SVC01). If *just* the revenue code is present on the detail, it will continue to appear in SVC01.

Providers can also expect to see new EOB messages on their RAs. These should be familiar to providers, as other local payors use the same EOB messages.

Services that have received a PA (Prior Authorization) or a GA (General Assistance) voucher will be reviewed by *ClaimCheck*®.

EDS Provider Services anticipates a temporary increase in provider inquiries concerning *ClaimCheck*®. If you have a question regarding an individual claim please call Provider Services at 802-878-7871 or (in state) 800-925-1706. If you have a question about *ClaimCheck*® policy or disagree with a *ClaimCheck*® action and have supporting documentation pertaining to your complaint please email us at [ClaimCheckcommunications@eds.com](mailto:ClaimCheckcommunications@eds.com).

The implementation of Phase Two is scheduled for a future date. As with Phase One, providers will be notified prior to the implementation of Phase Two.

Please help us keep our *ClaimCheck*® distribution list current by contacting EDS at [ClaimCheckcommunications@eds.com](mailto:ClaimCheckcommunications@eds.com) if there is a specific contact person who should receive future *ClaimCheck*® communications.



## ClaimCheck® Phase Two

The Office of Vermont Health Access and EDS are pleased to announce the launch of *ClaimCheck®* Phase II beginning with claims processed on August 15, 2005. This claims evaluation software will benefit providers through greater standardization, automation of medical claim review, and faster, more clinically precise and consistent adjudication.

Last September, we announced that *ClaimCheck®* would be implemented in two phases. Phase I was successfully implemented in November, 2004. To ensure that all provider concerns and suggestions are considered and disruption to provider operations is minimized, we have revised the implementation plan to four phases. Phases III and IV will be announced at a later date.

*ClaimCheck®* is a highly flexible system that can be tailored to the unique needs of the Vermont Medicaid program. It will be used to adjudicate the following claim types:

- M – HCFA – Professional Claims
- O – Outpatient – Laboratory and Radiology Only
- X – Outpatient Cross Overs – Laboratory and Radiology Only
- Y – HCFA – Professional Cross Over
- P – Vision Claims

In Phase Two, the following edits/audits will be activated:

- **Incidental** – A claim will be considered incidental when the same provider, on the same date of service, performs certain procedures commonly performed in conjunction with other procedures. *ClaimCheck®* considers these a component of the overall service provided. An incidental procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.
- **Pre-Post Op Care** – The surgical global period as assigned by CMS will be used to determine whether office or hospital visits should be considered as part of that surgical procedure. This is a change in Medicaid policy, *ClaimCheck®* considers payment for these services to be inclusive in the reimbursement of the surgical procedure. The criteria for determining a Pre-Post op procedure is same provider, and a procedure performed within the defined pre/post op time frame as determined by CMS.

Minor and major surgical procedures are defined as:

- Minor – 0 day pre-op, 0 or 10 post-op
- Major – 1 day pre-op, 90 day post op

● **Assistant Not Allowed** - When a procedure is submitted with an assistant surgeon modifier, *ClaimCheck*® will determine whether that procedure always or never requires an assistant surgeon. The American College of Surgeons (ACS) is the source used for the assistant surgeon designations. The ACS developed these designations using clinical guidelines vs. statistical measures. If the code/modifier combination alone does not warrant the medical necessity of an assist, a denial will result.

● **Cosmetic Procedure** - A number of surgical procedures may be performed without a medically-indicated purpose, and *ClaimCheck*® will consider them cosmetic in nature. This edit links surgical procedure with diagnosis. A report will be created of suspect claims and documentation may be requested for post payment audit.

With the implementation of the above edits, providers can expect to see changes in reimbursement policy of some code combinations that may have been reimbursed in the past. The major changes have been identified and are listed below:

**36410, 36415, 36416, G0001** – The collection of a blood specimen is an inherent part of performing a specific laboratory test and will be denied as incidental when both the collection and performance of the test are accomplished by the same site/facility.

**81000, 81002, 81003** – Urine tests, as a basic evaluative tool of the practitioner, are sometimes considered to be an integral component of the overall service provided. This may result in an incidental denial.

**A4550** – Surgical Trays, in accordance with Medicare policy, will be denied as incidental. Payment for surgical trays is included in the payment for the service to which they are incident.

**90780, 90781** - Intravenous therapy is standard practice during most surgical and therapeutic procedures. It is commonly used to assist with the hydration of a patient and to provide an access route for the administration of medications and thus is considered clinically integral to the successful performance of the primary procedure or anesthesia service. This logic is supported by CMS and NCCI guidelines.

The following modifiers are now allowed and can be used with claims submitted immediately.

- **24** – “Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period”

- **59** – “Distinct Procedural Service”

You must follow correct coding guidelines when billing with modifiers 24 and 59. Documentation must support the use of these modifiers. **Providers are encouraged to submit these claims electronically as we will not be requiring documentation up front to support the use of modifiers 24 and 59.** Please note that post-payment auditing will randomly and routinely be performed. If your claim is subject to such review, you will be asked to provide documentation. Adjustments to payment may result if documentation is insufficient.

Change to Modifier 51 - In the past, modifier 51 was only to be submitted on secondary surgical procedures where prior authorization was required. This is no longer the case. Modifier 51 is to be used as defined in CPT under correct coding guidelines.

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As with Phase I, services that have received a PA (prior authorization) or a GA (general assistance) voucher will not be reviewed by *ClaimCheck*®.

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