November 10, 2008

ClaimCheck®

ClaimCheck® Upgrade Includes New Edits

Medical Assistance claims processed by the State of Alaska's Fiscal Agent go through a series of edits using a software product called ClaimCheck. This software follows Current Procedural Terminology (CPT) guidelines of the American Medical Association and health care industry standards. Each year the logic used to audit claims is updated to accommodate legislative changes, legal determinations, and administrative program changes.

This year, the annual software audit and update process includes new edits and guidelines. These upgrades are currently being tested and will begin appearing on your remittance advice reports in November, 2008. The changes will include units expansion to allow for evaluation of procedure codes billed with multiple units of service, review of same laboratory and radiology services billed by multiple providers for the same patient and date of service and audit for invalid procedure code and modifier combinations.

New edits to be applied to claims processing logic after the upgrade are as follows:

Edit 464 – Line added due to units expansion for multiple procedures on a single date of service.

Edit 466 - Multiple Component Billing - This procedure code has been paid to another provider for the same patient and date of service. (Total service vs. technical (modifier TC) or professional service (modifier 26) component)

Edit 468 – Duplicate Component Billing - This procedure code has been paid to another provider for the same patient and date of service. (Total service vs. total service, Technical service component vs. technical service component (TC modifier), professional service component vs. professional service component (modifier 26))

Edit 471 – Invalid procedure code and modifier combination.

Edit 474 Multi-unit procedure code on a single claim line (does not apply to all procedure codes). Lines will be added to the document to replace this denied line (see Edit 464).

Edit 475 –EOB Edit 464 claim lines cannot be adjusted. A claim void and subsequent rebill is required to make changes to these lines.

The ClaimCheck® reports you receive with your remittance advice will have a new format to accommodate the new editing processes. There will also be new abbreviations that reflect the outcome of claims processing. Future training programs will address these changes. Watch for upcoming in-depth instructional materials and examples that will aid you in understanding the new process.

Additional information regarding basic ClaimCheck edits can be located in Appendix E or F of the provider billing manuals.