ClaimCheck® Provider Training Documentation

Alaska Medicaid claims 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. Changes can occur throughout the year, but a major review is completed annually with possible software upgrades to accommodate changes.

The current 5.0 version of ClaimCheck® will be upgraded to the 8.5 version on November 21, 2008. New edits and guidelines will be implemented in the claims processing system. The changes will include units expansion (see edits 474 and 464) for procedure codes billed with multiple units of service, review of same services billed by multiple providers and invalid procedure code/modifier combinations.

New edits to be applied to claims processing logic after the ClaimCheck® 8.5 upgrade:

Edit 464 – Line added due to units expansion for multiple procedures on a single date of service – If a procedure code is billed with multiple units on a single date of service, the billed line will be split into multiple lines to accommodate processing of one unit per line as appropriate.

Edit 474 – ClaimCheck® has determined multiple results for this procedure billed with multiple units on a single date of service - The billed line will be split into multiple lines to accommodate processing of each unit.

Edit 468 – This procedure code has been paid to another provider for the same date of service (duplicate component billing) – The procedure code is identical to a claim billed for the same patient on the same date of service by another provider (and the procedure code and modifier 26 and/or TC are the same), the service will be denied.

Edit 475 – Adjustments cannot be made to lines added due to units expansion for multiple procedures on a single date of service – Providers must void all related paid claim lines assigned Edit code 464 and rebill if appropriate.

Edit 466 – This procedure code has been paid to another provider for the same date of service (multiple component billing) – The procedure code is identical to a claim billed for the same patient on the same date of service by another provider (and one of the codes has a modifier 26 or TC), the service will be denied.

Edit 471 – Invalid procedure code and modifier combination – If the modifier billed is not valid for the procedure code, the service will be denied.

ClaimCheck® 8.5 New Edit Examples

Edits 474 and 464 – Units Expansion
ClaimCheck® assumes one unit of service per claim line. Most claims systems allow providers to bill multiple services on the same day or allow procedures to be input with a spanned date of service and a quantity to indicate the number of services performed. **Units expansion** is the process whereby lines with multiple units are 'expanded' prior to ClaimCheck® processing, so that each line represents one unit of service.

When providers bill services, the unit field is typically considered a quantity field, although the unit field can represent different values other than the number of times a service is performed. Any service can be billed with multiple units, although it may not be correct to do so from a coding perspective, nor may it be valid to perform the service multiple times from a clinical perspective.

Claim lines affected by units expansion will be denied with Edit 474. The added lines that replace the denied line will be identified with Edit 464.

Procedure Codes **NOT** Subject to Units Expansion

Description	**Code Values/Ranges**
Anesthesia (time values, minutes)	00100 – 01999
Allergy Testing (number of tests)	95004 – 95024, 95028 – 95052
Allergen Immunotherapy (dosage)	95165 – 95180
Ambulance (miles)	A0021 – A0999
Cardiac Event Monitor (time)	93268
Enteral & Parenteral Therapy (units)	B4000 – B9999
Drugs (dosage)	J0120 – J9999, K0119 – K0123, Q9920 – Q9940
Immunology (number of antigens, antibodies)	86000, 86003, 86160, 86161, 86185, 86235, 86255, 86256, 86316, 86403, 86406, 86586
Pathology (# of specimens)	88301 – 88308

Edit 474 – ClaimCheck® has determined multiple results for this procedure billed with multiple units on a single date of service - The billed line will be split into multiple lines (see Edit 464) to accommodate processing of this denied line.

Billed Claim

Procedure Code	From Date	To Date	Units
99201	09/01/2008	09/01/2008	3

Edit 464 – Line added due to units expansion for multiple procedures on a single date of service – If a procedure code is billed with multiple units on a single date of service or spanned over multiple dates of service, the billed line will be split into multiple lines to accommodate processing of one unit per line as appropriate.

Results

Line #	Procedure Code	From Date	To Date	Units	Results
1	99201	09/01/2008	09/01/2008	3	Line denied with Edit 474
2	99201	09/01/2008	09/01/2008	1	Line message 464 added, procedure allowed
3	99201	09/01/2008	09/01/2008	2	Line denied with Edit 436 as duplicate procedures

Edits 474 and 464 Scenario #1:

Mrs. Scott has Alaska Medicaid Coverage. On September 1st she came into Dr. Smith's office as an established patient with the flu. Dr. Smith spent two hours with Mrs. Scott and documented her chart as an "expanded problem focused history and physical exam, with a low complexity medical decision." An 837P is submitted to Alaska Medicaid billing one line item for procedure code 99213 with date of service 09/01/2008 and two units.

Original Billed Claim

Procedure Code	From Date	To Date	Units
99213	09/01/2008	09/01/2008	2

Alaska Medicaid sent a remittance advice to Dr. Smith. ClaimCheck® denied the original claim line for code 474, and created two additional claim lines, one for each unit. Line two paid, with the message code 464. Line three then denied for 436.

Results after ClaimCheck® Processing

Line#	Procedure Code	From Date	To Date	Units
1	99213	09/01/2008	09/01/2008	2
2	99213	09/01/2008	09/01/2008	1
3	99213	09/01/2008	09/01/2008	1

Procedure code 99213 does not allow more than one unit to be billed per date of service. Therefore the claim was processed in the following manner:

Line #1 – Denied for a 474 -*"ClaimCheck® has determined multiple results for this procedure billed with multiple units on a single date of service"*

Line #2 – Paid with edit code message 464 -*"Line added due to units expansion for multiple procedures on a single date of service or spanned date of service"*

Line # 3 - Denied for a *436 - "Procedure rendered more than one time on same date"* (Duplicate of line #2)

Edits 474 and 464 Scenario #2:

Mrs. Denton has Alaska Medicaid coverage. On September 1st she came into Dr. Haley's office and received multiple injections. The claim submitted to Alaska Medicaid is billing one line item for procedure code 62318 with date of service 09/01/2008 and three units.

Original Billed Claim

Procedure Code	From Date	To Date	Units
62318	09/01/2008	09/01/2008	3

Alaska Medicaid sent a remittance advice to Dr. Haley. ClaimCheck® denied the original claim line for code 474, and created three additional claim lines, one for each unit. Line two paid at 100% with the message code 464. Line three paid at 50% with message 972, indicating a multiple surgery payment reduction. Line four then denied for 436.

Results after ClaimCheck® Processing

Line #	Procedure Code	From Date	To Date	Units
1	62318	09/01/2008	09/01/2008	3
2	62318	09/01/2008	09/01/2008	1
3	62318	09/01/2008	09/01/2008	1
4	62318	09/01/2008	09/01/2008	1

Procedure code 62318 does not allow more than 2 units per date of service. Therefore, the claim was processed in the following manner:

Line #1 – Denied for a 474 - *"ClaimCheck® has determined multiple results for this procedure billed with multiple units on a single date of service"*

Line #2 – Paid with edit code message 464 - *"Line added due to units expansion for multiple procedures on a single date of service or spanned date of service"*

Line #3 – Paid with edit code message 972 - *"Multiple Surgery Payment Reduction"*

Line # 4 – Denied for a *436 - "Procedure rendered more than one time on same date"*

Edits 474 and 464 Scenario #3:

Mr. Baker has Alaska Medicaid coverage. On September 1st he sees Dr. Fawcett for dialysis services. A claim is submitted to Alaska Medicaid billing one line item for procedure code 90945 with date of service 09/01/2008 and two units.

Original Billed Claim

Procedure code	From Date	To Date	Units
90945	09/01/2008	09/01/2008	2

Alaska Medicaid sent a remittance advice to Dr. Fawcett. ClaimCheck® denied the original claim line for code 474, and created two additional claim lines, one for each unit. Line two paid, with the message code 464. Line three then denied for 436.

Results after ClaimCheck® Processing

Line #	Procedure Code	From Date	To Date	Units
1	90945	09/01/2008	09/01/2008	2
2	90945	09/01/2008	09/01/2008	1
3	90945	09/01/2008	09/01/2008	1

Procedure code 90945 does not allow more than one unit to be billed per date of service. Therefore the claim was processed in the following manner:

Line #1 – Denied for a 474 - *"ClaimCheck® has determined multiple results for this procedure billed with multiple units on a single date of service"*

Line #2 – Paid with edit code message 464 - *"Line added due to units expansion for multiple procedures on a single date of service or spanned date of service"*

Line # 3 – Denied for a *436 - "Procedure rendered more than one time on same date"* (Duplicate of line #2)

SUMMARY: Claims should be billed correctly with each claim line representing one date of service and only one unit of service, unless the description of the procedure code designates that the code could be for multiple units (i.e. specify number of doses, per hour, each additional 30 minutes, etc.).

Edit 468 – Duplicate Component Billing

This procedure code has been paid to another provider for the same date of service (duplicate component billing) – The procedure code is identical to a claim billed for the same patient on the same date of service by another provider (and the procedure code and modifier 26 and/or TC are the same), the service will be denied.

New Claim Received from Dr. Foster

Procedure Code	From Date	To Date	Units
73550 - TC	09/01/2008	09/01/2008	1

Claim Already Processed from Dr. Martin

Procedure Code	From Date	To Date	Units
73550 - TC	09/01/2008	09/01/2008	1

Results

Procedure Code	From Date	To Date	Units	Results
73550 - TC	09/01/2008	09/01/2008	1	The component of this procedure has been submitted by another provider, this line is denied due to duplicate component billing with Edit 468.

SUMMARY: Radiology services can be billed with a modifier to indicate the charge is for the professional (modifier 26) or technical (modifier TC) component of the service. Dr. Martin had already billed for the technical component of the radiology service when the claim from Dr. Foster was received. Therefore, Dr. Foster's claim was denied as a duplicate. If Dr. Foster meant to bill for the professional component, a corrected claim would be required using modifier 26.

Edit 466 - This procedure code has been paid to another provider for the same date of service (multiple component billing) – The procedure code is identical to a claim billed for the same patient on the same date of service by another provider (and one of the codes has a modifier 26 or TC). The service will be denied, as Alaska Medicaid does not pay for duplicate services.

Edit 466 Scenario:

Mrs. Scott has Alaska Medicaid Coverage. On September 1st she came into Dr. Smith's office with a fractured femur. Dr. Smith does a radiological exam, with two views of the femur, and documents Mrs. Scott's chart. An 837P is submitted to Alaska Medicaid billing one line item for procedure code 73500 and modifier 26 with date of service 09/01/2008 and one unit. The claim was processed and paid by Alaska Medicaid.

Claim Sent in by Provider "Dr. Smith" (Already Processed)

Procedure	From Date	To Date	Units
73550 – 26	09/01/2008	09/01/2008	1

One month later, on 10/01/2008, Mrs. Scott goes to Dr. John's office for a second opinion. Dr. John also does a radiological exam with two views of the femur. An 837P is submitted to Alaska Medicaid, billing 73500 x 1 unit, but the date is incorrectly entered as 09/01/2008.

Claim Sent in by Provider "Dr. John" (New)

Procedure Code	From Date	To Date	Units
73550	09/01/2008 (incorrect date of service)	09/01/2008	1

Alaska Medicaid sent an RA to Dr. Johns' office indicating that Medicaid has denied the claim for 466- *"This procedure code has been paid to another provider for the same date of service (multiple component billing)"*. To correct the error, the date was corrected and rebilled.

Corrected Claim Sent in by Provider "Dr. John": Results after ClaimCheck® Processing.

Procedure code	From Date	To Date	Units
73550	10/01/2008	10/01/2008	1

SUMMARY: Verify that dates of service are correct prior to submitting claims. Radiology services billed without a modifier indicate the charge is for the professional and technical components. Dr. John's claim for the incorrect date of service was denied because Dr. Smith had already been paid for the professional component. However, since the date of service was corrected, Dr. John was allowed to bill for the service, including both the professional and technical components.

Edit 471 – Invalid procedure code and modifier combination – If the modifier billed is not valid for the procedure code, the service will be denied.

Edit 471 Scenario:

Beth has Alaska Medicaid coverage. She comes into Dr. Potts office on September 1st, with a cold. Dr. Potts spent a one hour with Beth and listed it in her chart as an "expanded problem focused history and physical exam, with a low complexity medical decision." An 837P is submitted to Alaska Medicaid, billing one line item for procedure code "99213" x 1 unit with a modifier 26, date of service 09/01/2008.

Original Billed Claim

Procedure Code	From Date	To Date	Units
99213 – 26	09/01/2008	09/01/2008	1

Alaska Medicaid then sent a RA to Dr. Pott's office indicating that the claim was denied for reason 471, *"Invalid procedure code and modifier combination"*. This is due to the modifier 26 not being appropriate for procedure code 99213. The claim was resubmitted with the inappropriate modifier removed and was subsequently paid.

Results after ClaimCheck® Processing

Procedure Code	From Date	To Date	Units
99213	09/01/2008	09/01/2008	1

SUMMARY: Verify the appropriateness of the modifier relationship to the procedure code prior to claims submission. Modifier descriptions and information can be located in the Current Procedural Terminology (CPT) and Health Care Procedure Coding System manuals. Additional information can be located in the provider billing manuals, appendix E or F.

ClaimCheck® Report Changes

ClaimCheck® Report Changes will display the units of service and any lines added due to unit expansion. Additional status codes have been added for the new edits. A listing of the Status Codes and their corresponding MMIS Edit Codes are on the following page. An example of the new format and the status codes are as follows:

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        CPD092                          ALASKA MEDICAID MANAGEMENT INFORMATION SYSTEM                    REPORT NO: CP-O-150-2
  RUN: 09/25/08 11:10:17                   DEPARTMENT OF HEALTH AND SOCIAL SERVICES                        PAGE :          1
CYCLE: 09/25/08                                      C L A I M C H E C K

                                          C L A I M S   A U D I T   R E P O R T


ACCOUNT:   AKM              PROVIDER   XX1234
-------------------------------------------------------------------------------------------------------------------------------
          DOS      PROC CODE    CODE DESCRIPTION                DX    UNITS    $ AMOUNT      HX      STS CDE        ICN
        ---------  ---------    ---------------------------   ------  -----    --------      --      -------

RECIP#: 1234567891       PT SEX: M     AGE:   0  RECIP NAME  JOHN DOE         REND PROV MDXXXX
                                                  DIAG 1: 71886   DIAG 2: 72769   DIAG 3:         DIAG 4:
        01/01/07    27405-RT                                 71886       2        0.00                SPL   7XXX415007801
                    27405   RT HAS BEEN DENIED DUE TO MULTIPLE RESULTS
                    27405-RT     REPAIR OF KNEE LIGAMENT        71886       1      950.00                    7XXX415007802
                    27405-RT     REPAIR OF KNEE LIGAMENT        71886       1      950.00                MDO   7XXX415007803
                    27405 RT  CAN ONLY BE DONE 01 TIMES ON A SINGLE DATE, DUPLICATES DENIED

RECIP#: 1234567891       PT SEX: F     AGE:   0  RECIP NAME  JANE DOE         REND PROV MDXXXX
                                                  DIAG 1: 4659    DIAG 2: 78607   DIAG 3:         DIAG 4:
        04/04/07    99213        OFFICE/OUTPATIENT VISIT, EST   4659        1      128.00                VIS   7XXX217502901
                    99213     VISIT NOT INDICATED FOR REIMBURSEMENT  WITH 11450
                    11450        REMOVAL, SWEAT GLAND LESION    1021        1      128.00     HIST               7XXX217502901
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The first claim on the report is for John Doe. The provider billed procedure code 27405-RT with 2 units. ClaimCheck® applied the status code SPL due to units expansion and the line is denied (Edit 474). The result is 2 added lines to replace the denied line (Edit 464). The first line is approved and the second line is denied with status code MDO as the service can only be done one time on a single date of service (Edit 436).

The second claim on the report is for Jane Doe. The provider billed for an office visit, however, there is a history claim (indicated with HIST in the HX column) from the provider that billed a surgical procedure on the same date of service. Procedure code 99213 is denied with status code VIS (Edit 435) as the visit is not indicated for separate reimbursement on the same date of service as a surgical procedure.

ClaimCheck® Status Code Definitions and MMIS Edits Table

Status Code	DESCRIPTION	Existing / New	MMIS Edit Current/History
BCD	IS A BILATERAL CODE, DUPLICATES DENIED (added to existing Edit 436)	N	436
DCB	EVALUATE FOR POSSIBLE DUPLICATE COMPONENT BILLING	N	468
DUP	IS A DUPLICATE PROCEDURE CODE, REVIEW DOCUMENTATION	E	428
INC	IS INCIDENTAL TO	E	434/454
IOS	INTENSITY OF SERVICE	N	450
MAL	CAN ONLY BE DONE X TIMES IN A PERSON S LIFETIME, DUPLICATES DENIED (added to existing Edit 436)	N	436
ME	IS MUTUALLY EXCLUSIVE TO	E	437/457
MCB	EVALUATE FOR POSSIBLE MULTIPLE COMPONENT BILLING	N	466
MDO	CAN ONLY BE DONE X TIMES ON A SINGLE DATE, DUPLICATES DENIED (added to existing Edit 436)	N	436
MPR	PAYMENT REDUCED DUE TO MULTIPLE PROCEDURE REDUCTION (added to existing Edit 972)	N	972
NVF	EXCEEDS New Visit Frequency AND IS REPLACED WITH ESTABLISHED VISIT	E	413/463
PRE	CODE A IS WITHIN THE X DAY PRE OP RANGE FOR B	E	441/461
PST	CODE A IS WITHIN THE X DAY POST OP RANGE FOR B	E	442/462
REB	IS REBUNDLED TO	E	433/453
SPL	HAS BEEN DENIED DUE TO MULTIPLE RESULTS	N	474
UBD	INCLUDES UNILATERAL OR BILATERAL PERFORMANCE, DUPLICATES DENIED (added to existing Edit 436)	N	436
UD0	MODIFIER NOT APPROPRIATE FOR PROCEDURE	N	471
UXP	LINE ADDED DUE TO UNITS EXPANSION	N	464
VIS	VISIT NOT INDICATED FOR REIMBURSEMENT WITH	E	435/455