ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus, Wisconsin Medicaid
To: Ambulance Providers, Ambulatory Surgery Centers, Anesthesiologist Assistants, AODA Counselors, Audiologists, Case Management Providers, Certified Registered Nurse Anesthetists, Chiropractors, Community Care Organizations, Community Support Programs, Comprehensive Community Services Providers, Crisis Intervention Providers, Day Treatment Providers, Dentists, Family Planning Clinics, Federally Qualified Health Centers, HealthCheck Providers, HealthCheck "Other Service" Providers, Hearing Instrument Specialists, Independent Labs, Individual Medical Supply Providers, Master's Level Psychotherapists, Medical Equipment Vendors, Mental Health/Substance Abuse Clinics, Narcotic Treatment Services Providers, Nurse Midwives, Nurse Practitioners, Nursing Homes, Occupational Therapists, Opticians, Optometrists, Pharmacies, Physical Therapists, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Portable X-ray Providers, Prenatal Care Coordination Providers, Psychologists, Rehabilitation Agencies, Rural Health Clinics, School-Based Services Providers, Specialized Medical Vehicle Providers, Speech & Hearing Clinics, Speech-Language Pathologists, Specialized Medical Vehicle Providers, Therapy Groups, HMOs and Other Managed Care Programs

Expanded Review by ClaimCheck

This *ForwardHealth Update* gives information about changes to the ClaimCheck process, including the addition of ClaimCheck features and the expansion of the use of ClaimCheck software to all providers billing on the 1500 Health Insurance Claim Form and the 837 Health Care Claim: Professional transaction.

Information in this *Update* applies to providers who render services to Wisconsin Medicaid and BadgerCare Plus members.

ClaimCheck Expansion

ForwardHealth will continue to monitor claims for compliance with reimbursement policy using an automated procedure coding review software known as McKesson ClaimCheck®. ClaimCheck reviews claims submitted for billing inconsistencies and errors during claims processing. Insurance companies, Medicare, and other state Medicaid programs use similar software.

Wisconsin Medicaid currently uses ClaimCheck early in the claims process, which gives providers a comprehensive list of denials generated by the claim.

Following implementation, ForwardHealth will use ClaimCheck at a later point during claims processing. As a result, ClaimCheck will not review claims that have been denied for general billing errors, such as an invalid member identification number or an invalid or missing provider number. Providers will need to correct the general billing error and resubmit the claim, at which point ClaimCheck will review the claim.

Currently, Wisconsin Medicaid is using an older version of ClaimCheck and monitors a smaller set of procedure codes, provider types, and policy areas. Following implementation of ForwardHealth interChange, the most current version of ClaimCheck will be used and ClaimCheck will be expanded to do the following:

- Expand the review to include both *Current Procedural Terminology* (CPT) procedure codes and modifiers *and* Healthcare Common Procedure Coding System (HCPCS) procedure codes and modifiers. Currently only CPT codes are monitored.

- Expand to include all claims submitted on the 1500 Health Insurance Claim Form or the 837 Health Care Claim: Professional for all providers. Currently, only a limited number of provider types are monitored.
- Expand to review current claims against claims previously submitted. Overpayments discovered may be recovered. Currently, ClaimCheck reviews only the individual claim for inconsistencies.

Explanation of benefit codes specific to the ClaimCheck review will appear on a provider's paper Remittance Advice and electronic 835 Health Care Claim Payment/Advice transactions.

The expansion of ClaimCheck will not change Medicaid or BadgerCare Plus policy on covered services but will monitor compliance with policy more closely and reimburse providers appropriately.

Areas Monitored by ClaimCheck

Currently, ClaimCheck monitors only for unbundling (code splitting), incidental/integral procedures, and mutually exclusive procedures. After implementation of ForwardHealth interChange, ClaimCheck will monitor claims for the following situations:

- Unbundled procedures.
- Incidental/integral procedures.
- Mutually exclusive procedures.
- Medical visit billing errors.
- Preoperative and postoperative billing errors.
- Age-related billing errors.
- Cosmetic procedures.
- Gender-related billing errors.
- Medically obsolete procedures.
- Assistant surgeon billing errors.
- Modifier-related billing errors.
- Bilateral and duplicative procedures.

Unbundled Procedures

Unbundling occurs when two or more procedure codes are used to describe a procedure that may be better described by a single, more comprehensive procedure code. ClaimCheck considers the single, most appropriate procedure code for reimbursement when unbundling is detected.

If certain procedure codes are submitted, ClaimCheck rebundles them into the single most appropriate procedure code. For example, if a provider submits a claim with procedure codes 12035 (Layer of closure of wounds, 12.6 cm to 20.0 cm) and 12036 (Layer closure of wounds, 20.1 cm to 30.0 cm), ClaimCheck rebundles them to procedure code 12037 (Layer closure of wounds over 30.0 cm).

ClaimCheck will also total billed amounts for individual procedures. For example, if the provider bills three procedures at $20, $30, and $25, ClaimCheck rebundles them into a single procedure code, adds the three amounts, and calculates the billed amount for that rebundled code at $75. Then, ForwardHealth reimburses the provider either the lesser of the billed amounts or the maximum allowable fee for that rebundled procedure code.

Incidental/Integral Procedures

Incidental procedures are those procedures performed at the same time as a more complex primary procedure. These require few additional provider resources and are generally not considered necessary to the performance of the primary procedure. For example, the removal of an asymptomatic appendix is considered an incidental procedure when done during hysterectomy surgery.

Integral procedures are those procedures performed as part of a more complex primary procedure. For example, when a member undergoes a transurethral incision of the prostate, the cystourethroscopy (procedure code 52000) is considered integral to the performance of the prostate procedure and would be denied.

When a procedure is either incidental or integral to a major procedure, ClaimCheck considers only the *primary* procedure for reimbursement.

Mutually Exclusive Procedures

Mutually exclusive procedures are procedures that would not be performed on a single member on the same day or that use different codes to describe the same type of procedure.

For example, procedure code 58260 (Vaginal hysterectomy, for uterus 250 g or less)and procedure code 58150 (Total abdominal hysterectomy [corpus and cervix], with or without removal of tube[s], with or without removal of ovary[s]) are mutually exclusive — either one or the other, but not both procedures, is performed.

When two or more procedures are mutually exclusive, ForwardHealth considers for reimbursement the procedure code with the highest provider-billed amount and denies the other code.

Medical Visit Billing Errors

Medical visit billing errors occur if evaluation and management (E&M) services are reported separately when a substantial diagnostic or therapeutic procedure is performed. Under Centers for Medicare and Medicaid Services (CMS) guidelines, most E&M procedures are not allowed to be reported separately when a substantial diagnostic or therapeutic procedure is performed.

Medical visit edits monitor services included in CPT procedure ranges 92002-92019, 99024 (postoperative follow-up), 99026-99058 (special services), 99201-99456 (E&M codes) and HCPCS codes S0620, S0621 (routine ophthalmological examinations).

ClaimCheck monitors medical visits based on the type of E&M service (i.e., initial or new patient; or follow-up or established patient services) and the complexity (i.e., major or minor) of the accompanying procedure.

For example, if a provider submits procedures 22630 (Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace [other than for decompression], single interspace; lumbar) and 99221 (Initial hospital care, per day), ClaimCheck denies procedure 99221 as a visit when submitted with procedure 22630 with the same date of service (DOS). Procedure code 22630 is a major procedure with a 90-day global surgical period.

Preoperative and Postoperative Billing Errors

Preoperative and Postoperative billing errors occur when E&M services are billed with surgical procedures during their preoperative and postoperative periods. ClaimCheck bases the preoperative and postoperative periods on designations in the CMS National Physician Fee Schedule.

For example, if a provider submits procedure code 99212 (Office or outpatient visit for the evaluation and management of an established patient) with a DOS of 11/02/08 and procedure 27750 (Closed treatment of tibial shaft fracture [with or without fibular fracture]; without manipulation) with a DOS of 11/03/08, ClaimCheck will deny procedure code 99212 as a preoperative visit because it is submitted with a DOS one day prior to the DOS for procedure code 27750.

Age-Related Billing Errors

Age-related billing errors occur when a provider bills an age-specific procedure to a patient whose age is outside the designated age range.

For example, if a provider bills procedure code 43831 (Gastrostomy, open; neonatal, for feeding) for a 45 year-old patient, ClaimCheck will deny the procedure based on the fact that the patient does not meet the age criteria for a neonatal procedure.

Cosmetic Procedures

Surgical procedures that are performed without a medically indicated purpose are considered to be cosmetic procedures. Most of these procedures are requested by the member merely to improve physical appearance.

Gender-Related Billing Errors

Gender-related billing errors occur when a provider submits a gender-specific procedure for a patient of the opposite sex.

For example, if a provider submits procedure code 58150 (Total abdominal hysterectomy [corpus and cervix], with or without removal of tube[s], with or without removal of ovary[s]) for a male, ClaimCheck will deny the procedure based on the fact that procedure code 58150 is a female gender-specific procedure.

Medically Obsolete Procedures

Obsolete procedures are procedures that are no longer performed under prevailing medical standards. Procedures designated as obsolete are denied.

Assistant Surgeon Billing Errors

ClaimCheck development and maintenance of assistant surgeon values includes two designations, *always* and *never*. ClaimCheck uses the American College of Surgeons (ACS) as its primary source for determining assistant surgeon designations.

For example, if a provider bills procedure code 10040 (Acne surgery [eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules]) with modifier -80 (assistant surgeon), ClaimCheck determines that the procedure does not require an assistant surgeon and denies the procedure code.

Modifier Billing Errors

ClaimCheck accepts all CPT and HCPCS modifiers and performs procedure to modifier validity checks to determine if a procedure code is valid with a specific modifier.

Bilateral and Duplicative Procedures

ClaimCheck has identified five types of duplicate procedure billing errors that encompass duplicate procedures submitted with the same DOS. The five types of duplicative billing errors are as follows:

- If the description of the procedure code contains the word, "bilateral," the procedure can be performed only once on a single DOS.
- When the description of the procedure code contains the phrase, "unilateral/bilateral," the procedure can be performed only once on a single DOS.
- When the description of the procedure specifies "unilateral" and there is another procedure in which the description specifies "bilateral" performance of the same procedure, the unilateral procedure cannot be submitted more than once on a single DOS.

  When the description of one procedure specifies a "single" procedure and the description of a second procedure specifies "multiple" procedures, the "single" procedure cannot be submitted more than once on a single DOS.
- When procedures that may be performed a specified number of times on a single DOS reach the maximum number of times, then additional submissions of the procedure are not recommended for reimbursement.
- When a CPT or HCPCS procedure is billed more than once on a single DOS but the CPT or HCPCS procedure is not normally billed in duplicate, the second procedure is denied.

Payments Denied as a Result of the ClaimCheck Review

Providers should take the following steps if they are uncertain about why particular services on a claim were denied:

- Review ForwardHealth remittance information for the specific reason for the denial.
- Review the claim submitted to ensure all information is accurate and complete.
- Consult current CPT and HCPCS publications to make sure proper coding instructions were followed.
- Consult current ForwardHealth publications to make sure current policy and billing instructions were followed.
- Call Provider Services for further information or explanation.

If a provider disagrees with ClaimCheck's determination, the provider may resubmit the claim with supporting documentation to Provider Service Written Correspondence. If the original claim is in an allowed status, the provider may submit an Adjustment/Reconsideration Request, F-13046 (10/08), with supporting documentation and the words, "medical consultant review requested" written on the form, to Provider Services Written Correspondence.

Information Regarding Managed Care

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis. For managed care policy, contact the appropriate managed care organization. HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *dhs.wisconsin.gov/forwardhealth/*.

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