WISCONSIN MEDICAID UPDATE

FEBRUARY 10, 1995

UPDATE 95-4

TO:
Physicians
Physician Assistants
Nurse Practitioners
Podiatrists
Dental Surgeons
Independent Laboratories
Radiology Providers

Enhanced Procedure Code Review During Claims Processing - Effective For Dates of Service on and After April 1, 1995

Automated Procedure Coding Review Enhances Efficiency of Claims Processing

To enhance the efficiency and consistency of claims processing, Wisconsin Medicaid has directed the fiscal agent to incorporate an automated procedure coding review software known as GMIS ClaimCheck® into the Medicaid claims processing system, effective for dates of service on and after April 1, 1995. The basic GMIS ClaimCheck® software package was specifically customized to assure consistency with existing Wisconsin Medicaid policy. Insurance companies and other state Medicaid programs use similar software.

This enhanced claims processing system reflects and monitors current Medicaid reimbursement policy. The enhancement incorporates both Wisconsin Medicaid policy and coding generally consistent with the American Medical Association Physician's Current Procedure Terminology(CPT) publication.

Providers Affected by the Enhanced Procedure Code Review

Claims submitted by the following providers are subject to this enhanced review:

- physicians (including lab and radiology)
- dental surgeons
- nurse practitioners
- physician assistants
- podiatrists
- independent laboratories
- radiology providers

Physician claims for anesthesia (type of service 7), AODA/mental health services, and claims from other providers not listed above are not reviewed by this system enhancement.

Informational Meetings about the Enhanced Procedure Code Review

EDS and the Bureau of Health Care

Financing are jointly sponsoring half-day informational meetings on this enhanced procedure code review process. The dates are:

- March 13 -Madison Holiday Inn Southeast
- March 17 -Green Bay Holiday Inn City Centre
- March 20 -Pewaukee County Inn
- March 21- Eau Claire Midway Motor Lodge
- March 22-Stevens Point Holiday Inn

Attached is detailed information concerning these sessions, including times and specific locations.

Benefits of the Enhanced Procedure Code Review Process

There are several benefits from this enhancement:

- claims may process quicker because certain coding errors are corrected while a claim is being processed.
- information specific to the procedure code assignment appears on the Remittance and Status reports. This allows providers to know specifically which claim details are affected by the review.
- claims payment for multiple and/or complex procedures is more consistent.
- enhancement does not change Wisconsin Medicaid policy. Billing requirements have not changed.

However, since the enhancement more effectively identifies claims that are inconsistent with Wisconsin Medicaid billing requirements, some providers may receive less reimbursement for procedures if they are billed in the same manner as prior to implementation of the enhancement.

Description of the Enhanced Procedure Code Review Process

The enhancement uses software that reviews claims for consistency with Wisconsin Medicaid policies, CPT coding conventions, and generally accepted reimbursement concepts. This type of software is used nationally. It has been customized to reflect Wisconsin Medicaid reimbursement policies.

Only CPT codes are reviewed. HCPCS codes (i.e., "A" or "J" codes) are not reviewed. Providers should continue to use all currently allowable modifiers, and type and place of service codes.

Claims submitted to the fiscal agent are reviewed for several categories of billing inconsistencies and errors, with respect to CPT codes. These include unbundling of procedure codes, separate billing for integral or incidental procedures and billing mutually exclusive codes.

The review affects claims in any of the following ways:

a. the claim may pass through unchanged.

b. The procedure codes may be re-bundled into one or more appropriate codes.

c. One or more of the codes may be denied as incidental/integral or mutually exclusive. The remaining code(s) continue processing.

Pricing is still based on Wisconsin Medicaid methods of reimbursement and

maximum allowable fees.

What The Enhanced Procedure Code Review Detects and Does

The enhancement identifies the following categories of billing inconsistencies:

1. Unbundling (Code Splitting)
Unbundling occurs when two or more CPT codes are used to describe a procedure when a single, more comprehensive code (i.e., a global fee) is more appropriate. For example, lab tests billed separately are rebundled into the single, most appropriate panel. Similarly, endoscopy codes are rebundled into the single most comprehensive code. The review may also rebundle billed codes into a new code which did not appear on the original claim.

Based on a claim review for unbundling, the fiscal agent considers for reimbursement only that single, most appropriate code when unbundling is detected.

Billed amounts for codes are also totalled. For example, if three procedures billed at $20, $30 and $25, respectively, are rebundled into a single procedure code, the system calculates the billed amount for that rebundled code at $75. However, the provider is reimbursed up to the maximum allowable fee for that procedure code.

2. Integral/Incidental Procedures
Integral procedures are those performed as part of a more complex primary procedure. They require few additional physician resources. For example, when a recipient undergoes a transurethral incision of the prostate (procedure code 52450) and a cystourethroscopy (procedure code 52000), the cystourethroscopy is considered integral to the performance of the prostate procedure.

Incidental procedures are those performed at the same time as a more complex primary procedure. They require few additional physician resources and are generally not considered necessary to the performance of the primary procedure. For example, a wedge biopsy of the liver (procedure code 47100) is incidental to the removal of the small intestine (procedure code 44120).

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

3. Mutually Exclusive
Mutually exclusive procedures are those that cannot be performed on a single recipient at the same operative session or are different code descriptions of the same type of procedures. For example, a vaginal hysterectomy (procedure code 58620) and an abdominal hysterectomy (procedure code 58150) are mutually exclusive - either one or the other, but not both, procedures are performed.

When two or more procedures are considered mutually exclusive, the fiscal agent considers for reimbursement only the code with the highest billed usual and customary charge.

4. Age/Sex Edits
Wisconsin Medicaid is upgrading its ability to identify age/sex procedure code conflicts, based on current Wisconsin Medicaid age/sex limitations. This results in more stringent claim reviews when a provider bills a procedure code inappropriate for the recipient's age or sex.

5. Duplicates
Wisconsin Medicaid is upgrading its ability to identify inappropriate billing of duplicate and multiple procedures. This

results in more stringent review of duplicate billing errors.

Periodic Review of Previously Submitted Claims

Periodically, the claims processing system reviews claims history to identify related procedures that have been separately billed for services rendered by the same performing provider to the same recipient on the same date. These claims are reviewed for appropriate coding to detect unbundling, mutual exclusivity, incidentals/integrals.

If an inconsistency is found during the periodic review, the claims are adjusted. Your Remittance and Status report indicates the affected claims and the action taken on the affected details of the claims.

For example, assume the following claims were submitted for services provided by the same provider to the same recipient on the same date of service:

Submission Date	Service Date	Code & Description
April 18, 1995	April 2, 1995	84436 Thyroxine, total
June 14, 1995	April 2, 1995	84479 Triiodothyronine

The periodic review finds that procedure 84436 and procedure 84479 should be rebundled into procedure code 80091 (thyroid panel). The review recoups the payments for 84436 and 84779 and pays for the rebundled code 80091.

How to Read the Remittance and Status Report

Providers receive a specific Explanation of Benefits (EOB) message for denied details. The Remittance and Status report shows the procedures affected by the review; whether they were rebundled, considered incidental or integral, mutually exclusive, or whether a more appropriate code was substituted. Attachment 2 shows detailed examples of a Remittance and Status report.

Impact on Prior Authorization and Second Surgical Opinions

Prior authorization and second surgical opinion requirements are unchanged as a result of this enhanced review capability.

Procedure to Follow If You Have Questions Why Particular Details on A Claim Were Denied

Follow these procedures If uncertain about why particular details on a claim were denied by the fiscal agent:

1. review the Remittance and Status report.

2. review the claim you submitted.

3. consult CPT publications for proper coding instructions.

4. consult the Wisconsin Medicaid Provider Handbook (Part A), the applicable Wisconsin Medicaid provider-specific handbooks, other appropriate handbooks and bulletins, and Wisconsin Medicaid Updates for current policy and billing instructions.

5. contact the fiscal agent for further information or explanation

Requesting Adjustments

Providers may request an adjustment to a paid claim by submitting an adjustment form with supporting documentation that explains why the enhanced procedure code review coding logic should not be

followed. Documentation may include operative reports, descriptions of special circumstances, or other information that justifies overruling the denial. Indicate "medical consultant review requested" on the adjustment form. Please refer to Appendices 27 and 27a of Part A of the Wisconsin Medicaid Provider Handbook for information on filing adjustments.

ATTACHMENT 1

Impact of Coding Review Logic on Medicaid Reimbursement- Specific Examples

Note: This list is illustrative, rather than all-inclusive. For further information, consult your CPT publication and/or WMAP Provider Handbook.

Medical Procedure Review

1. ***Evaluation and Management Services***
   No impact at this time.

2. ***Casting and Strapping***
   No impact at this time.

3. ***Specimen Handling***
   No impact at this time.

4. ***Supplies***
   No impact at this time.

5. ***Pre and Post-Op Auditing***
   No impact at this time.

Surgical Reviews

1. ***Separate Procedures***
   Codes listed as separate procedures in CPT, when performed as an integral part of a total larger procedure for the same date of service, is included in the global payment for the larger procedure. If performed alone, they can be separately reimbursed.

   Example:
   Procedure Code 42842 (Extensive throat surgery)
   Procedure Code 42870 (Excision of lingual tonsil, separate procedure)

   Procedure Code 42870 is incidental to procedure code 42842; only procedure code 42842 is considered for reimbursement If procedure code 42870 were billed alone, it is considered for reimbursement.

2. ***EKGs During Surgery***
   EKG monitoring during surgery requiring continual cardiac monitoring is considered integral to the surgical procedure and included in the global surgical fee when billed by the surgeon.

3. ***Topical Nerve Block/Injection***
   The injection is included in the global fee for the surgical procedure.

   Example:
   Procedure Code 11770 (Excision of pilonidal cyst)
   Procedure Code 64450 (Injection of anesthetic agent, other peripheral nerve)

The review considers procedure code 64450 incidental to procedure code 11770; only procedure code 11770 is considered for reimbursement.

4. ***Exploratory Procedures***
When an exploratory procedure is billed with a surgical procedure, only the surgical procedure is reimbursed. If performed alone, the exploratory procedure is separately reimbursed. Wisconsin Medicaid may consider the diagnostic procedure incidental to the surgical procedure or may rebundle it into the larger procedure.

Example 1:
Procedure Code 49200 (Removal of abdominal lesion)
Procedure Code 49000 (Exploration of abdomen)

Procedure Code 49000 is incidental to 49200.

Example 2:
Procedure Code 45385 (Colonoscopy, lesion removal)
Procedure Code 45378 (Colonoscopy, diagnostic)

Procedure code 45378 is rebundled into the more comprehensive procedure code 45385.

5. ***Biopsies***
Biopsies are considered an integral part of many surgical procedures. They are not separately reimbursable. Biopsy codes are rebundled into a larger, more comprehensive code, or treated as incidental to the major surgical procedure.

Example:
Procedure Code 44120 (Removal of small intestine)
Procedure Code 47100 (Wedge biopsy of liver)

Procedure Code 47100 is incidental to procedure code 44120.

6. ***Wound Repairs***
Multiple wound repairs in the same repair category are rebundled into a single code based on the combined length of the wounds.

Example:
Four separate superficial wound repairs, each 2.2 cm. long each, (each procedure code 12001) are rebundled into the single code procedure 12004 (7.6 to 12.5 cm)

7. ***Excision of Skin Lesions***
Certain skin lesion removals are treated as incidental to the major surgical procedures. Other lesions requiring more than simple closure may be reimbursed separately.

Example 1:
Procedure Code 11400 (Excision of benign lesion, 0.5 cm or less)
Procedure Code 11401 (Excision of benign lesion, 0.6 to 1.0 cm)

Both anatomically related lesion excisions are processed separately.

Example 2:
Procedure Code 31360 (Removal of larynx)
Procedure Code 11400 (Removal of benign lesion)

Procedure code 11400 is incidental to the broader procedure code 31360.

8. ***Excisions and Repairs of Major Lesions***
Separate reimbursement of major lesion repairs is allowed unless the procedures are incidental to major tissue transfer or rearrangement. If the procedure is incidental, it is included in the global payment of the major procedure.

9. ***Musculoskeletal Procedures***
Multiple procedures on the same site are treated as mutually exclusive; only the procedure code with the highest charge is considered for reimbursement.

Example:
Procedure Code 25620 (Open treatment of distal radial fracture) billed at $750.00
Procedure Code 25600 (Closed treatment of distal radial fracture) billed at $200.00

The two procedures are considered mutually exclusive; only procedure code 25620 is considered for reimbursement.

10. ***Diskectomy/Vertebral Corpectomy***
The two procedures are mutually exclusive; only the procedure with the highest billed amount is considered for reimbursement.

Example:
Procedure Code 63081 (Removal of vertebral body) billed at $2,000
Procedure Code 63075 (Neck spine disk surgery) billed at $2,900

The two procedures are mutually exclusive; only procedure 63075 is considered for reimbursement.

11. ***Knee Arthroscopy***
Knee arthroscopy is included in the global payment of a more comprehensive surgical procedure, unless the arthroscopy is performed for diagnostic purposes only. Then, separate processing of the procedure code is allowed. When two approaches (arthroscopic and open) are required, both may be considered for reimbursement.

Example 1:
Procedure Code 29879 (Arthroscopy, Chondroplasty)
Procedure Code 29870 (Diagnostic Arthroscopy)

Procedure code 29870 is rebundled into procedure code 29879.

Example 2:
Procedure Code 29880 (Meniscectomy)
Procedure Code 29877 (Arthroscopy, Chondroplasty)

Procedure code 29877 is considered incidental to the broader procedure code 29880.

Example 3:
Procedure Code 27405 (Collateral repair of torn ligament)
Procedure Code 29888 (Arthroscopically aided cruciate ligament repair)

Both codes are considered for reimbursement.

12. Nasal Endoscopy

Diagnostic endoscopy is treated as integral to the performance of a surgical endoscopy; only the surgical procedure on the same date of service is considered for reimbursement.

Example:
Procedure Code 31235 (Nasal/sinus endoscopy with sphenoid sinusoscopy)
Procedure Code 31020 (Sinusotomy, maxillary; intranasal)

Procedure code 31235 is incidental to the broader surgical procedure code 31020.

13. Cardiac Catheterization

Cardiac catheterization codes may be integral or mutually exclusive to other cardiac procedures. Payment for catheter codes is allowed in conjunction with an injection code and supervisory code.

Example 1:
Procedure Code 93526 (Combined right and left catheterization)
Procedure Code 92993 (Atrial septectomy or septostomy, blade method, includes cardiac catheterization)

Procedure code 93526 is integral to the performance of procedure code 92993.

Example 2:
Procedure Code 93526 (Combined right and left catheterization)
Procedure Code 93545 (Injection procedure during catheterization for angiography)
Procedure Code 93555 (Imaging supervision, interpretation, and report)

All three codes are considered for reimbursement.

Laboratory Procedures Review

1. ***Automated Multichannel Lab Panels***

The review rebundles individual lab codes into the single code that covers the total number of tests that are typically performed using automated multi-channel equipment.

Example:
Procedure Code 84295 (sodium, blood)
Procedure Code 84132 (potassium, blood)
Procedure Code 82435 (chlorides, blood)

The three separate codes rebundle into procedure code 80003 (three clinical lab tests).

2. ***Laboratory Panels***
Tests that normally constitute a panel are rebundled into the code describing that panel. The tests are rebundled only when all components of that panel are billed separately. If all components of a panel are not performed, each is conisdered for reimbursement separately.

Example:
Procedure Code 84436 (Thyroxine, total)
Procedure Code 84479 (Triiodothyronine, resin uptake)

The two procedures are rebundled into procedure code 80091 (Thyroid panel). If only procedure code 84436 is billed, it is considered for reimbursement separately.

3. ***Laboratory Pathology***
Specimen removal and surgeon gross analysis of the specimen are incidental to the major surgery and included in the global surgical code.

NEW INFORMATION ON THE REMITTANCE AND STATUS REPORT

REMITTANCE AND STATUS REPORT

EDS - Fiscal Agent For the Wisconsin Medical Assistance Program
6406 Bridge Road
Madison, WI. 53784

Voice Response 800/947-3544 608/221-4247
Policy/Billing 800/947-9627 608/221-9883
Eligibility 608/221-9254

I.M. Billing
1 W. Williams
Anytown, WI 55555

PROVIDER NUMBER 87654321 REPORT SEQ NUMBER R/S NUMBER 1234567 DATE 04/23/95 PAGE 3

PATIENT NAME/ID NUMBER / SERVICE DATES FROM TO	UNDS	PERF PROV/ RX NUMBER	MEDICAL RECORD NO / DAYS QTY	TS	PROC/ACCOM/ DRUG CDE/M1 M2	ACCOUNTING NO / CLAIM NUMBER / PROCEDURE/ACCOMODATION/DRUG DESCRIPTION	TOTAL BILLED	TOTAL ALLOWED	OTHER DEDUCTED CHARGES	COPAY	PAID AMOUNT	EOB CODES
RECIPIENT IM/1234567890			123REC			209895XXXXXXXXX						
040295 040295		12345678	1	002	63081	VERTEBRAL CORPECTOMY (VER	2000 00	00		00	00 00	942
942 PROCEDURE DENIED AS MUTUALLY EXCLUSIVE TO 63075 PROCESSED ON THIS CLAIM.												
040295 040295		12345678	1	002	63075	DISKECTOMY, ANTER, DECOM	2900 00	162365		00 3 00	162065	12
						CLAIM TOTAL	4900 00	162365		00 3 00	162065	
RECIPIENT IM/1234567890			123REC			209895XXXXXXXXX						
040595 040595		12345678	1	002	44120	ENTERECTOMY, RESECTION OF	950 00	87241		00 3 00	86941	12
040595 040595		12345678	1	002	47100	BIOPSY OF LIVER, WEDGE (S	375 00	00		00	00 00	943
943 PROCEDURE DENIED AS INCIDENTAL/INTEGRAL TO 44120 PROCESSED ON THIS CLAIM.												
						CLAIM TOTAL	1325 00	87241		00 3 00	86941	
RECIPIENT IM/1234567890			123REC			209895XXXXXXXXX						
040695 040695		12345678	1	002	29879	ABRASION ARTHROPLASTY(INC	1225 00	70338		00 3 00	70038	12
040695 040695		12345678	1	002	29870	ARTHROSCOPY/ KNEE/ DIAGNO	00	00		00	00 00	941
941 PROCEDURE IS REBUNDLED TO 29879 PROCESSED ON THIS CLAIM.												
						CLAIM TOTAL	1225 00	70338		00 3 00	70038	

The dollar amounts indicated are for illustrative purposes only.

REMITTANCE AND STATUS REPORT

EDS - Fiscal Agent For the Wisconsin Medical Assistance Program
6406 Bridge Road
Madison, WI. 53784

Voice Response 800/947-3544 608/221-4247
Policy/Billing 800/947-9627 608/221-9883
Eligibility 608/221-9254

I.M. Billing
1 W. Williams
Anytown, WI 55555

PROVIDER NUMBER 87654321 REPORT SEQ NUMBER 6 DATE 04/23/95 R/S NUMBER PAGE 4

PATIENT NAME/ID NUMBER / SERVICE DATES FROM TO / UNITS / PERF PROV/RX NUMBER	MEDICAL RECORD NO / DAYS QTY	TYPE OF SERVICE	PROC/ACCOM/DRUG CDE/M1 M2	ACCOUNTING NO / CLAIM NUMBER / PROCEDURE/ACCOMODATION/DRUG DESCRIPTION	TOTAL BILLED	TOTAL ALLOWED	OTHER DEDUCTED CHARGES	COPAY	PAID AMOUNT	EOB CODES
RECIPIENT IM/1234567890	123REC			209895XXXXXXXXX						
040795 040795 12345678	1	005	84295	SODIUM; SERUM	00	00	00	00	00	941
941 PROCEDURE IS REBUNDLED TO 80003 PROCESSED ON THIS CLAIM.										
040795 040795 12345678	1	005	84132	POTASSIUM, SERUM	00	00	00	00	00	941
941 PROCEDURE IS REBUNDLED TO 80003 PROCESSED ON THIS CLAIM.										
040795 040795 12345678	1	005	82435	CHLORIDE; BLOOD	00	00	00	00	00	941
941 PROCEDURE IS REBUNDLED TO 80003 PROCESSED ON THIS CLAIM.										
040795 040795 12345678	1	005	80003	THREE CLINICAL CHEM TESTS	22	00 11	24	00 1	00 10	24 12
				CLAIM TOTAL	22	00 11	24	00 1	00 10	24

The dollar amounts indicated are for illustrative purposes only.