LOUISIANA
Department of HEALTH and HOSPITALS

UNISYS

# Louisiana Medicaid

# ClaimCheck®
# &
# Clear Claim Connection™
# Orientation

# April 27-29, 2010

# Revision Log

- July 2012 – Page 13 – Bullet added regarding LT/RT and -50 modifiers

# ClaimCheck® & Clear Claim Connection™ Project Overview

Louisiana Medicaid is pleased to announce the implementation of ClaimCheck® and Clear Claim Connection™.

**ClaimCheck®**

ClaimCheck® is an automated procedure code editing system that will supplement the current MMIS claims processing system for professional services in a variety of outpatient settings. This product monitors and evaluates billing information and coding accuracy with edits based on widely accepted industry practices, coding guidelines and specialty standards.

**Clear Claim Connection™**

Clear Claim Connection™, a provider reference tool, is a web-based application that enables providers to access the editing rules and clinical rationale for the ClaimCheck edits.

# Statement of Implementation

- Effective with processing date May 17, 2010; regardless of the service date(s).
- The implementation will affect professional provider claims with services rendered in various settings and includes claims billed on the CMS 1500 or electronically in the 837P format and the KM3 or billed electronically in the 837P format with K3 segment.
- When implemented, claims will process through both MMIS edits as well as ClaimCheck edits.
- Claims denied as the result of a ClaimCheck edit will be clearly identified on the RA as a ClaimCheck denial.

# ClaimCheck Edit Overview

**Areas affected by ClaimCheck implementation are:**

- Assistant Surgeon and Assistant at Surgery
- Medical Visit Billing
- New Visit Frequency
- Global Surgery – Pre and Post Op
- Rebundling
- Mutually Exclusive Procedures
- Incidental Procedures
- Site Specific Modifiers
- Multiple Surgery Reduction
- Modifiers

# Assistant Surgeon & Assistant at Surgery

- ClaimCheck uses the American College of Surgeons (ACS) as its primary source for determining assistant surgeon designations. This rationale is based on the fact that the ACS determines these designations using clinical necessity guidelines.

- A procedure code to modifier validity check is performed to determine if a procedure code is valid with an 80/AS modifier.

- Certified Nurse Midwives acting as an Assistant at Surgery are identified by the AS modifier.

- If the procedure code does not require an assistant surgeon, the provider will receive EOB message:

  558-Assistant Surgeon invalid for this procedure/ClaimCheck

- Using ClaimCheck clinical guidelines, some procedure codes not currently reimbursed may now be reimbursable and some procedure codes currently reimbursed may no longer be reimbursable.

- A list of procedure codes reimbursable with the 80/AS modifiers is forthcoming at www.lamedicaid.com**.**

# Medical Visit Billing

- Consistent with CMS guidelines, ClaimCheck does not allow the separate reporting of most Evaluation and Management (E&M) services when a substantial diagnostic or therapeutic procedure is performed.

- Providers will receive EOB message:

  592 – E & M Code not payable same day-current claim/ClaimCheck

  593 – E & M Code not payable same day-history claim/ClaimCheck

# New Visit Frequency

"New Patient" Evaluation & Management Code Frequency:

- Consistent with CPT guidelines, a new patient is one who has not received any professional services from the physician or another physician of the same specialty, who belongs to the same group practice, within the past three years.

  Exception: When identifying the "initial" pre-natal visit of each new pregnancy.

- Providers are encouraged to verify specialty/sub-specialty designations.

# Global Surgery-Pre and Post Operative

- Pre/post operative editing will deny E&M services that are reported with surgical procedures during their associated pre/post operative periods. This editing is generally based on values designated in the CMS National Physician Fee Schedule.

- ClaimCheck will produce a pre/post operative edit denying E&M services that are reported with surgical procedures during their associated pre/post operative periods.

- Providers will receive EOB messages:

585-Procedure denied in pre-op period current claim/ClaimCheck.

586-Procedure denied in pre-op period history claim/ClaimCheck.

587-History procedure voided due to pre-op period of current claim/ClaimCheck.

588-Procedure denied in post-op period current claim/ClaimCheck.

589-Procedure denied in post-op period history claim/ClaimCheck.

591-History procedure voided due to post-op period of current claim/ClaimCheck.

Providers can view the National Physician Fee Schedule and the specific GSP period for each procedure code at www.cms.hhs.gov/physician feeschedule.com.

# Rebundling

- Procedure rebundling occurs when two or more procedures are used to report a service when a single, more comprehensive procedure code exists that more accurately represents the service performed by the provider.
- Occasionally, the correct procedure code that most accurately represents the service is not present on the claim. In these instances, ClaimCheck adds the procedure code to the claim document as a new line.
- ClaimCheck will deny the claim lines billed by the provider with EOB message:

  547-Procedure rebundled due to current claim information/ClaimCheck

  548-Procedure rebundled due to history claim information/ClaimCheck

- The system will generate a new claim line under the same Internal Control Number (ICN) with the correct rebundled procedure code.
- Providers will see the system generated claim line with the rebundled code processed on the RA with EOB message:

  546-Claim added as a result of ClaimCheck rebundling.

# Mutually Exclusive Procedures

- Mutually exclusive edits are developed between procedures based on the following CPT description verbiage:

| | |
|---|---|
| limited/complete | partial/total |
| single/multiple | unilateral/bilateral |
| initial/subsequent | simple/complex |
| superficial/deep | with/without |

- Procedures that represent overlapping services or accomplish the same result are considered mutually exclusive.
- Mutually exclusive edits consist of combinations of procedures that differ in technique or approach but lead to the same outcome.
- Providers will see the following EOB messages:

579- Procedure mutually exclusive to another current procedure/ClaimCheck

582- Procedure mutually exclusive to a procedure that has already paid/ClaimCheck

583- History procedure voided, mutually exclusive to current claim/ClaimCheck

# Incidental Procedure

- 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.

- Provider will receive EOB message:

  567-Procedure incidental to a procedure on current claim/ClaimCheck

  573-Procedure incidental to a procedure in history/ClaimCheck

# Site Specific Modifiers

- Site specific modifiers may be used on appropriate CPT codes to accurately document the anatomic site where procedures are performed.
- "LT" or "RT" may be used when services are performed on either the left or the right side. Providers should not use these modifiers instead of the "50" modifier (bilateral procedure) unless directed to do so.
- When billing a site specific modifier in addition to other modifiers for an applicable procedure code, the site specific modifier should be reported in the first position on the claim.
- A procedure code to modifier validity check is performed to determine if a procedure code is valid with the site specific modifier billed.

  The claim will receive EOB message:

  933- Invalid procedure code-modifier combination/ClaimCheck

  921- Units do not match site-specific modifier/ClaimCheck

# Site Specific Modifiers

The list of site-specific modifier is as follows:

| | |
|---|---|
| LT | Left side |
| RT | Right side |
| E1 | Upper left, eyelid |
| E2 | Lower left, eyelid |
| E3 | Upper right, eyelid |
| E4 | Lower right, eyelid |
| LC | Left circumflex, coronary artery |
| LD | Left anterior descending coronary artery |
| RC | Right coronary artery |
| TA | Left foot, great toe |
| T1 | Left foot, second digit |
| T2 | Left foot, third digit |
| T3 | Left foot, fourth digit |
| T4 | Left foot, fifth digit |
| FA | Left hand, thumb |
| F1 | Left hand, second digit |
| F2 | Left hand, third digit |
| F3 | Left hand, fourth digit |
| F4 | Left hand, fifth digit |
| F5 | Right hand, thumb |
| F6 | Right hand, second digit |
| F7 | Right hand, third digit |
| F8 | Right hand, fourth digit |
| F9 | Right hand, fifth digit |
| T5 | Right foot, great toe |
| T6 | Right foot, second digit |
| T7 | Right foot, third digit |
| T8 | Right foot, fourth digit |
| T9 | Right foot, fifth digit |

# Multiple Surgery Reduction

- When more than one surgical procedure is performed on the date of service, the 50/51 modifiers must be appended appropriately for claims to process correctly and prevent denials. Certain procedure codes are exempt due to their status as “add-on” codes or “modifier-51 exempt codes.

- Multiple Surgery Reduction is the general industry term applied to the practice of paying decreasing pay percentages for multiple surgeries performed during the same surgical session.

- Providers will receive EOB messages:

    934- Modifier 50/51 is required/ClaimCheck

    938- Modifier 50/51 is invalid/ClaimCheck

# Modifiers

- Louisiana Medicaid will begin accepting additional nationally recognized modifiers as a result of the ClaimCheck implementation.

- ClaimCheck performs procedure to modifier validity checks to determine if a procedure code is valid with a specific modifier.

** Improper use of these modifiers to maximize reimbursement will subject the provider to administrative sanctions and/or possible exclusion from the Louisiana Medicaid Program.

  Documentation in the provider's record must clinically substantiate the usage of modifiers.

  Ongoing evaluation of providers' usage of modifiers is anticipated.

- Although DHH initially indicated addition of modifiers would be effective with date of service, the decision has been made to implement these changes effective with processing date of May 17,2010 in order to maintain consistency.

# Modifiers

- Some of the modifiers that will be acceptable include:

  **24**-Unrelated evaluation and management service by the same physician during a post-op period.

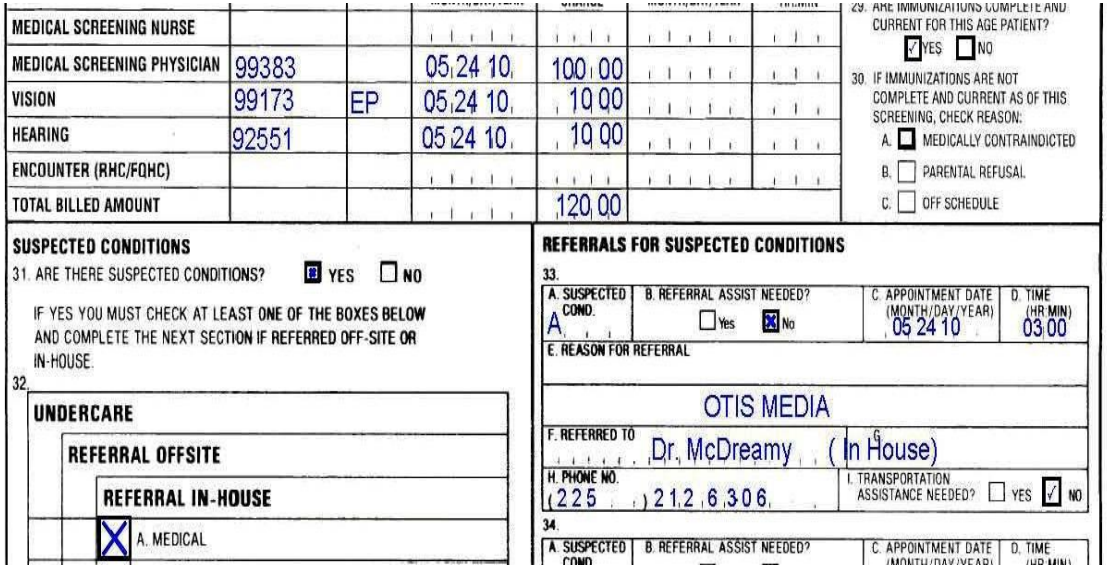
  **25**-Significant, separately identifiable evaluation and management service by the same physician on the same day
  of a procedure.

  **57**-Evaluation and management service that resulted in the initial decision to perform the surgery.

  **59**-To indicate that a distinct procedural service was performed; separate from other services rendered on the same day by the same provider.

  **79**-An unrelated procedure or services by the same physician during the post-operative period.

**In this example; a Kidmed screening has been performed, a suspected condition has been found and referred in-house.**



| | | | | | | |
|---|---|---|---|---|---|---|
| MEDICAL SCREENING NURSE | | | | | | |
| MEDICAL SCREENING PHYSICIAN | 99383 | | 05 24 10 | 100 00 | | |
| VISION | 99173 | EP | 05 24 10 | 10 00 | | |
| HEARING | 92551 | | 05 24 10 | 10 00 | | |
| ENCOUNTER (RHC/FQHC) | | | | | | |
| TOTAL BILLED AMOUNT | | | | 120 00 | | |

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT? [✓] YES [ ] NO

30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
A. [ ] MEDICALLY CONTRAINDICTED
B. [ ] PARENTAL REFUSAL
C. [ ] OFF SCHEDULE

**SUSPECTED CONDITIONS**

31. ARE THERE SUSPECTED CONDITIONS? [■] YES [ ] NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.
UNDERCARE
REFERRAL OFFSITE
REFERRAL IN-HOUSE
[X] A. MEDICAL

**REFERRALS FOR SUSPECTED CONDITIONS**

33.

| A. SUSPECTED COND. | B. REFERRAL ASSIST NEEDED? | C. APPOINTMENT DATE (MONTH/DAY/YEAR) | D. TIME (HR:MIN) |
|---|---|---|---|
| A | [ ] Yes [X] No | 05 24 10 | 03:00 |

E. REASON FOR REFERRAL: OTIS MEDIA

F. REFERRED TO: Dr. McDreamy (In House)

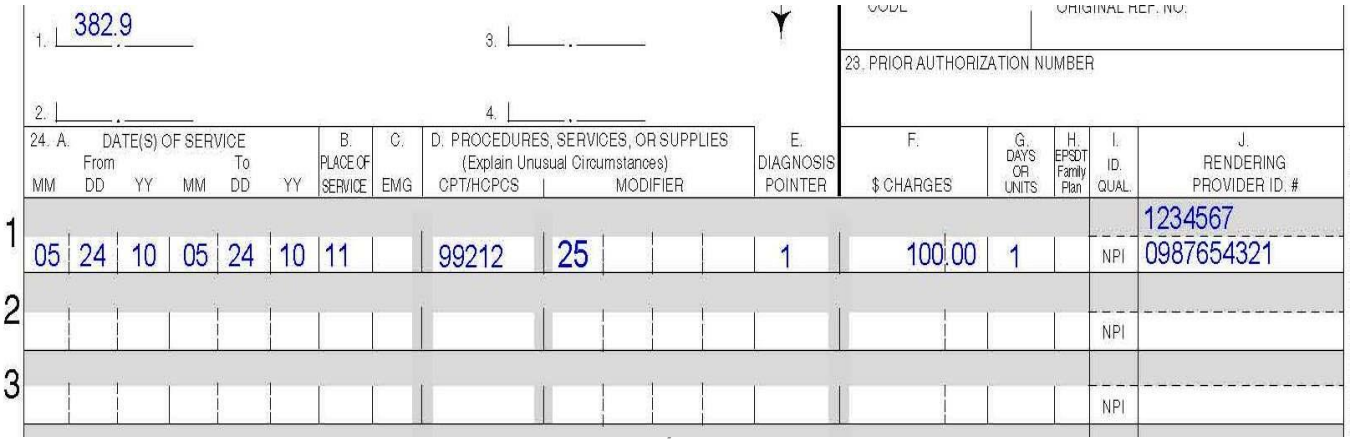
H. PHONE NO.: (225) 212 6306

I. TRANSPORTATION ASSISTANCE NEEDED? [ ] YES [✓] NO

34. A. SUSPECTED COND. | B. REFERRAL ASSIST NEEDED? | C. APPOINTMENT DATE | D. TIME

**When a suspected condition is identified during the screening and is diagnosed/treated by the screening provider during the same visit, no office visit higher than a 99212 may be billed.**

****The 99212 will be appended with modifier 25. ****



1. 382.9 3. 2. 4.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | | | | | | 1234567 |
| 1 | 05 | 24 | 10 | 05 | 24 | 10 | 11 | | 99212 | 25 | 1 | 100.00 | 1 | | NPI | 0987654321 |
| 2 | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | NPI | |

# Remittance Advice Updates

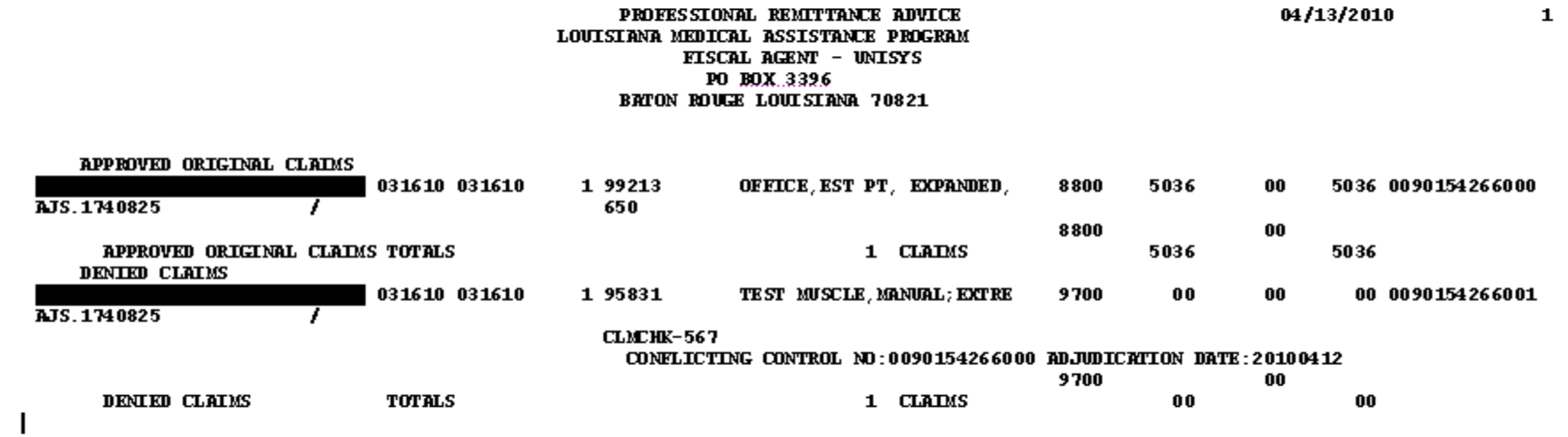
- Following the implementation of ClaimCheck, additional information will be added to **both paper and electronic (835)** remittance advices to assist providers in identifying ClaimCheck edits.

- ClaimCheck edits (CLMCHK) are identified in bold letters directly underneath the claim line.

- The EOB message codes are identified by a three digit number (i.e. 558) located directly to the side of the CLMCHK indicator.

- The Error Code translation page will identify the EOB message that correlates with the specific three digit number and will also provide the definition of CLMCHK.

The remittance advice will clearly identify a ClaimCheck.



PROFESSIONAL REMITTANCE ADVICE 04/13/2010 1
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

APPROVED ORIGINAL CLAIMS

[redacted] 031610 031610 1 99213 OFFICE,EST PT, EXPANDED, 8800 5036 00 5036 0090154266000
AJS.1740825 / 650

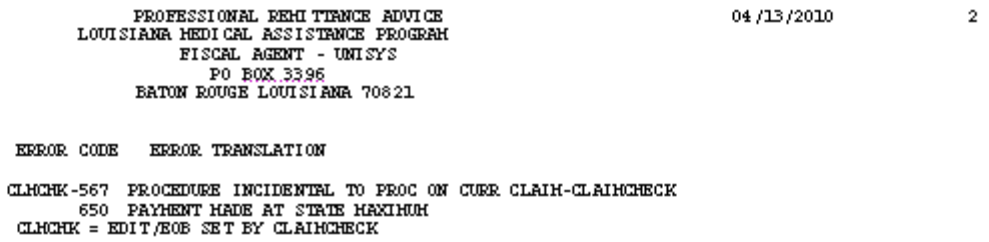
8800 00
APPROVED ORIGINAL CLAIMS TOTALS 1 CLAIMS 5036 5036

DENIED CLAIMS

[redacted] 031610 031610 1 95831 TEST MUSCLE,MANUAL;EXTRE 9700 00 00 00 0090154266001
AJS.1740825 /

CLMCHK-567
CONFLICTING CONTROL NO:0090154266000 ADJUDICATION DATE:20100412
9700 00
DENIED CLAIMS TOTALS 1 CLAIMS 00 00

A ClaimCheck edit will be clearly identified on the error code translation page of the remittance advice.



PROFESSIONAL REMITTANCE ADVICE 04/13/2010 2
LOUISIANA MEDICAL ASSISTANCE PROGRAM
FISCAL AGENT - UNISYS
PO BOX 3396
BATON ROUGE LOUISIANA 70821

ERROR CODE ERROR TRANSLATION

CLMCHK-567 PROCEDURE INCIDENTAL TO PROC ON CURR CLAIM-CLAIMCHECK
650 PAYMENT MADE AT STATE MAXIMUM
CLMCHK = EDIT/EOB SET BY CLAIMCHECK

# Clear Claim Connection™

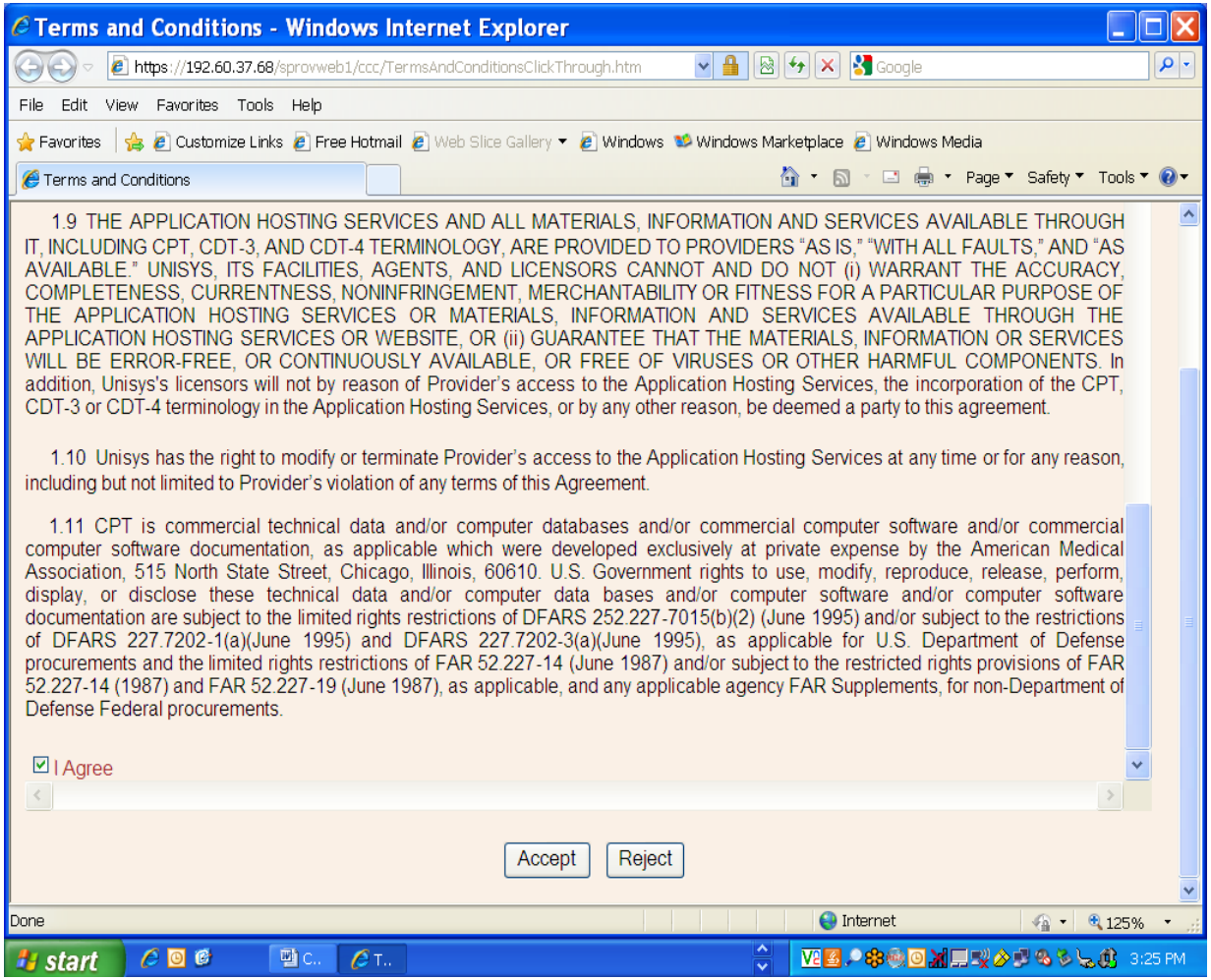
- Clear Claim Connection is an automated web application that allows providers to review claim payment polices, rules and clinical rationale used in the processing claims.
- Clear Claim Connection is carrier/payor specific, and Louisiana Medicaid may not use the same rationale as other carriers. For LA Medicaid, access the application through www.lamedicaid.com.
- Clear Claim Connection does not guarantee recipient Medicaid eligibility or payment of claims. This application is a tool to assist providers with the understanding of clinical rationale for applying certain ClaimCheck edits to claims being adjudicated.
- Log into Clear Claim Connection with the attending provider number and applicable logon and password.
- When inquiring about multiple units of a procedure code using Clear Claim Connection, a separate line must be entered for each unit.
- A maximum of 10 claim lines is accepted per claim review application. If greater than 10 lines must submit separate inquiries grouped by date of service.
- Clear Claim Connection is a provider assistance tool; claim audit results do not override Louisiana Medicaid policy.


Clear Claim Connection is accessed through the secure provider application area of lamedicaid.com.

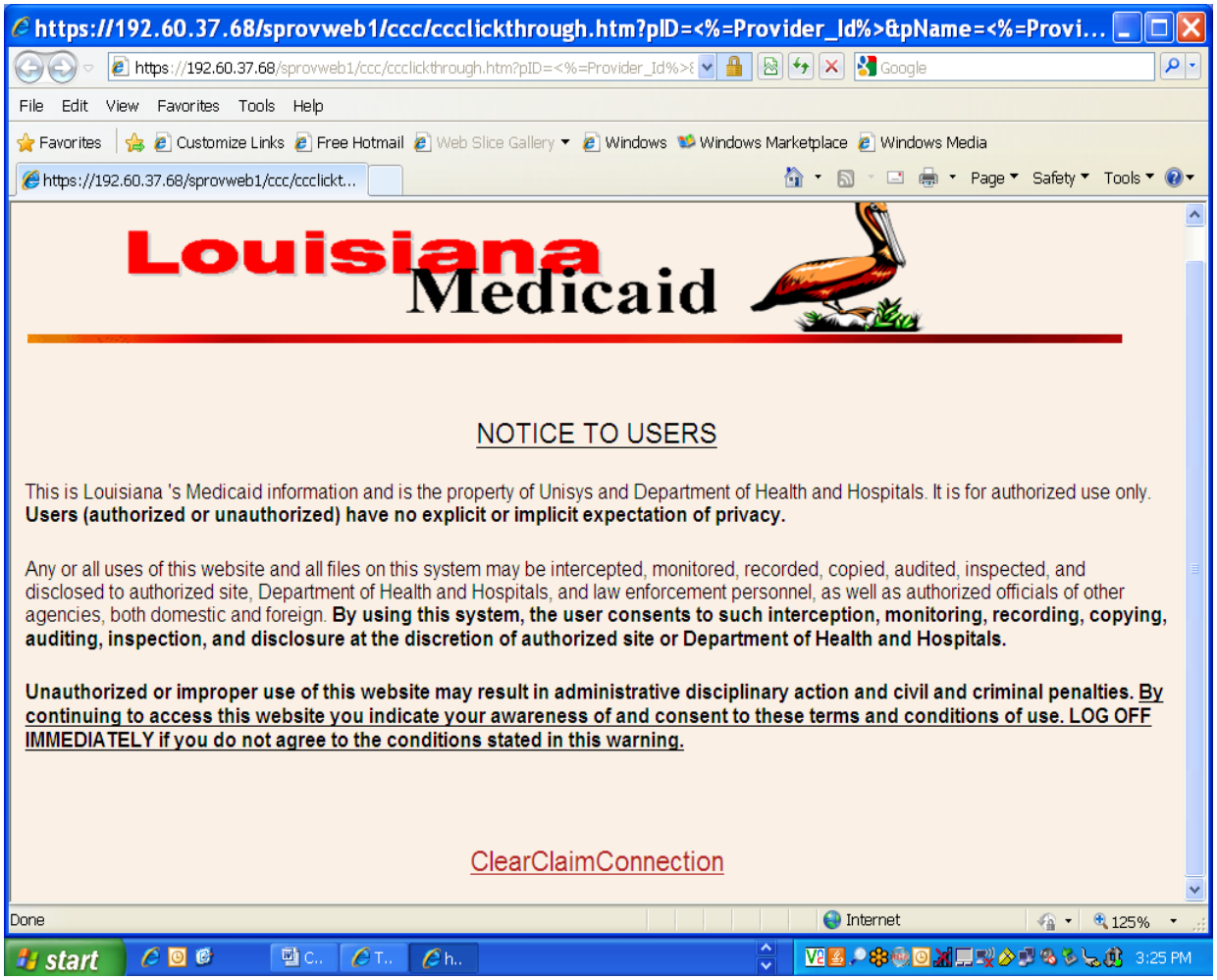

Providers will enter the attending provider number.


Providers enter their applicable logon ID and Password.

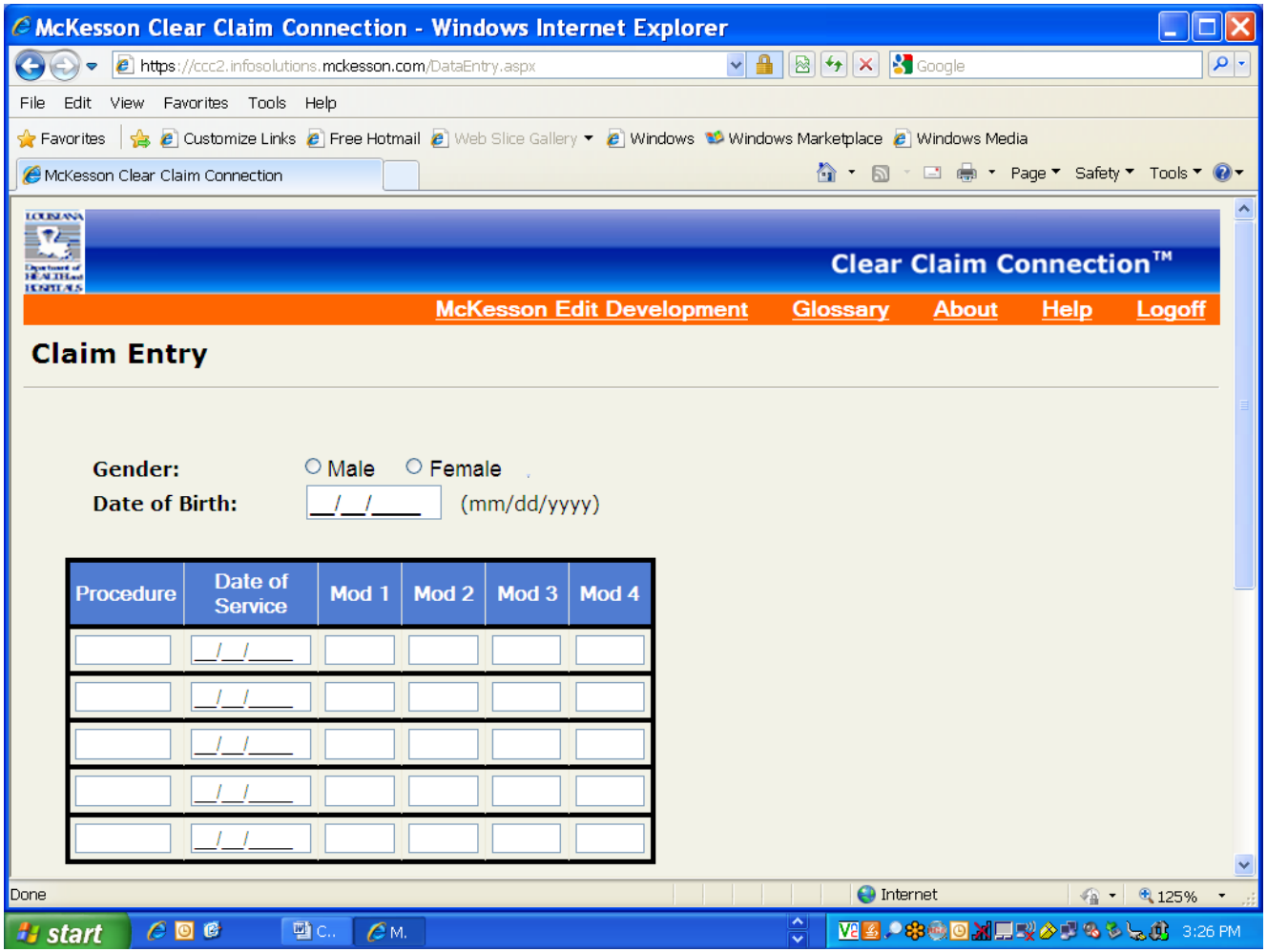

Providers click on the Clear Claim Connection link available on the list of provider applications.




Providers must scroll to read the disclaimer and indicate "I Agree", then "Accept or Reject" on the terms & conditions.

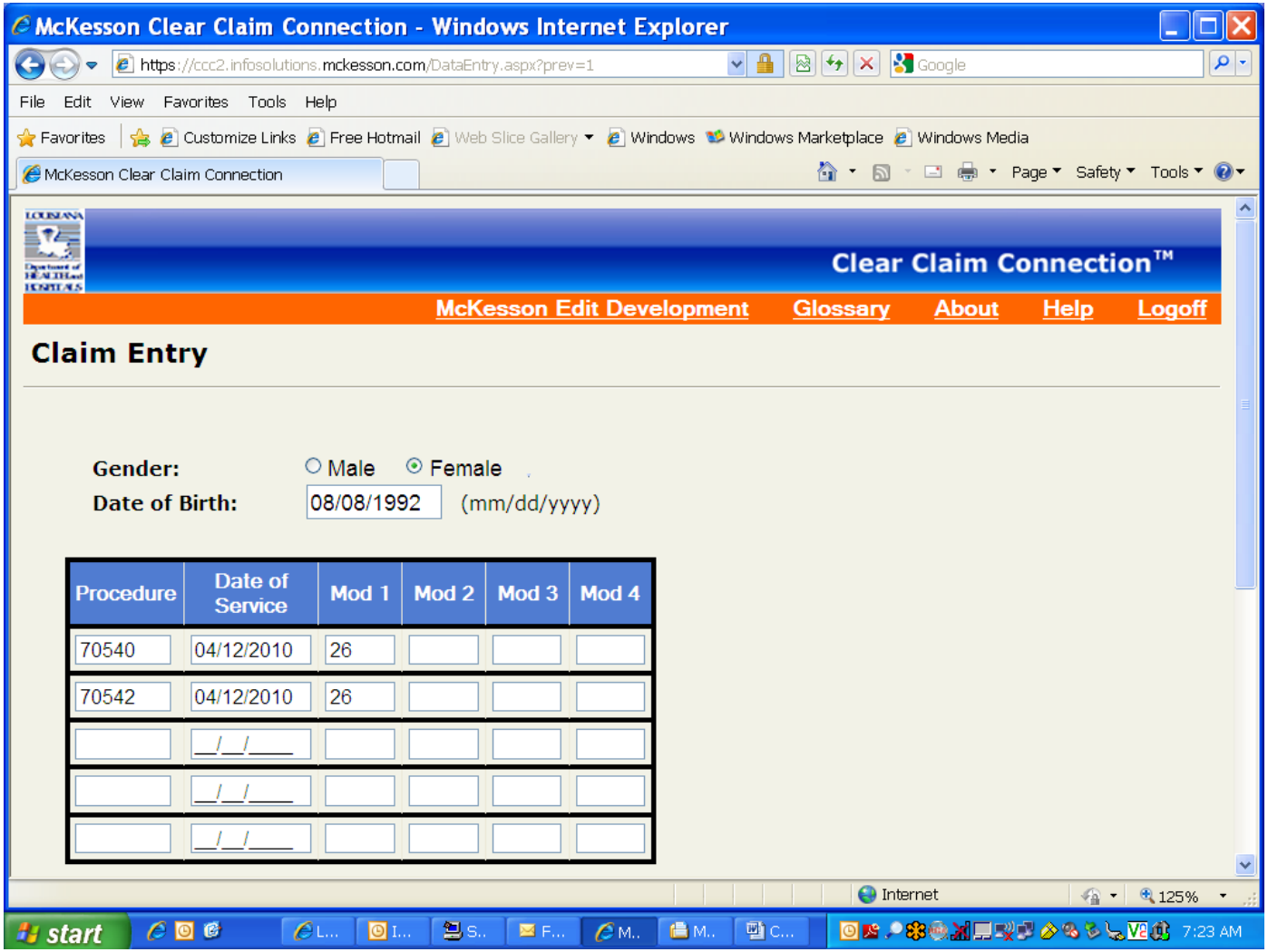



Enter through the Clear Claim Connection portal.




At the claim entry page, enter gender and birth date of recipient. Enter the procedure code, date of service and any applicable modifiers.

Enter up to 10 claim lines per claim edit review. If claim data is greater than 10 lines, submit separate inquiries and group the same date of service on the same inquiry screen.

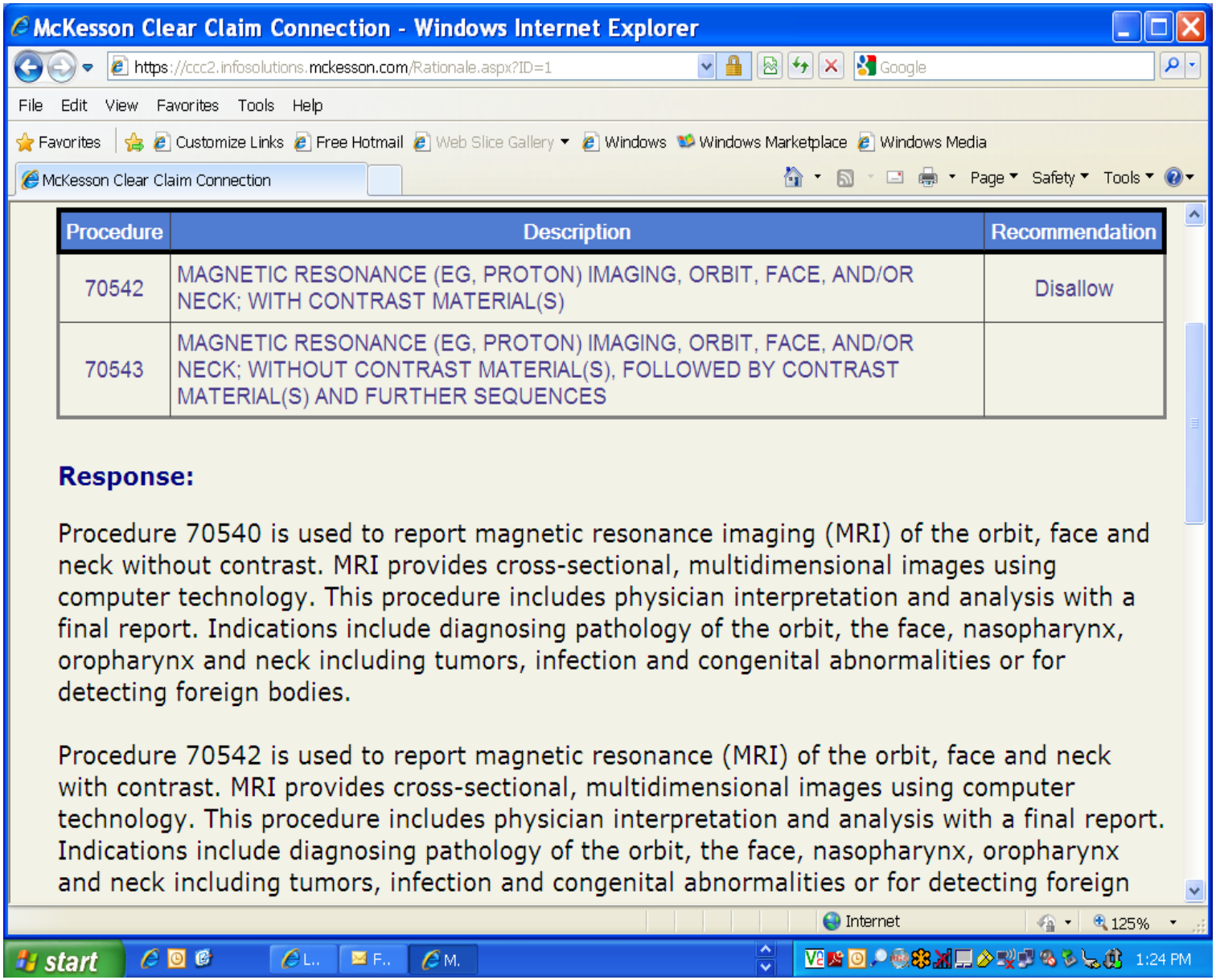


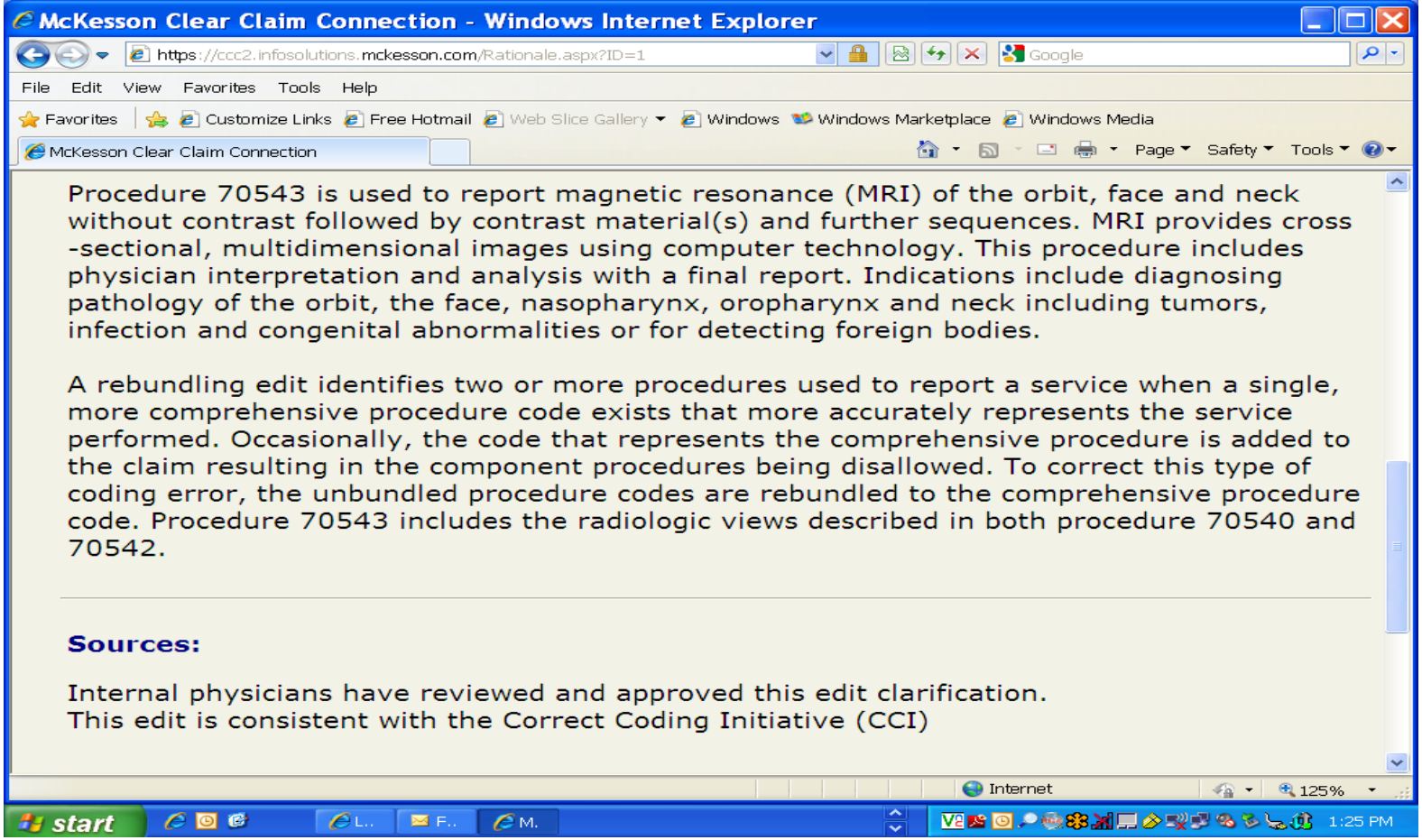

Gender related information is entered.
Date of birth information is entered.
Claim information is entered as submitted on claim form.


Clear Claim Connection will edit information entered and provide results.

In this example, Clear Claim Connection is indicating that the two claim lines that were billed will deny and will be rebundled with procedure code 70543 paying.

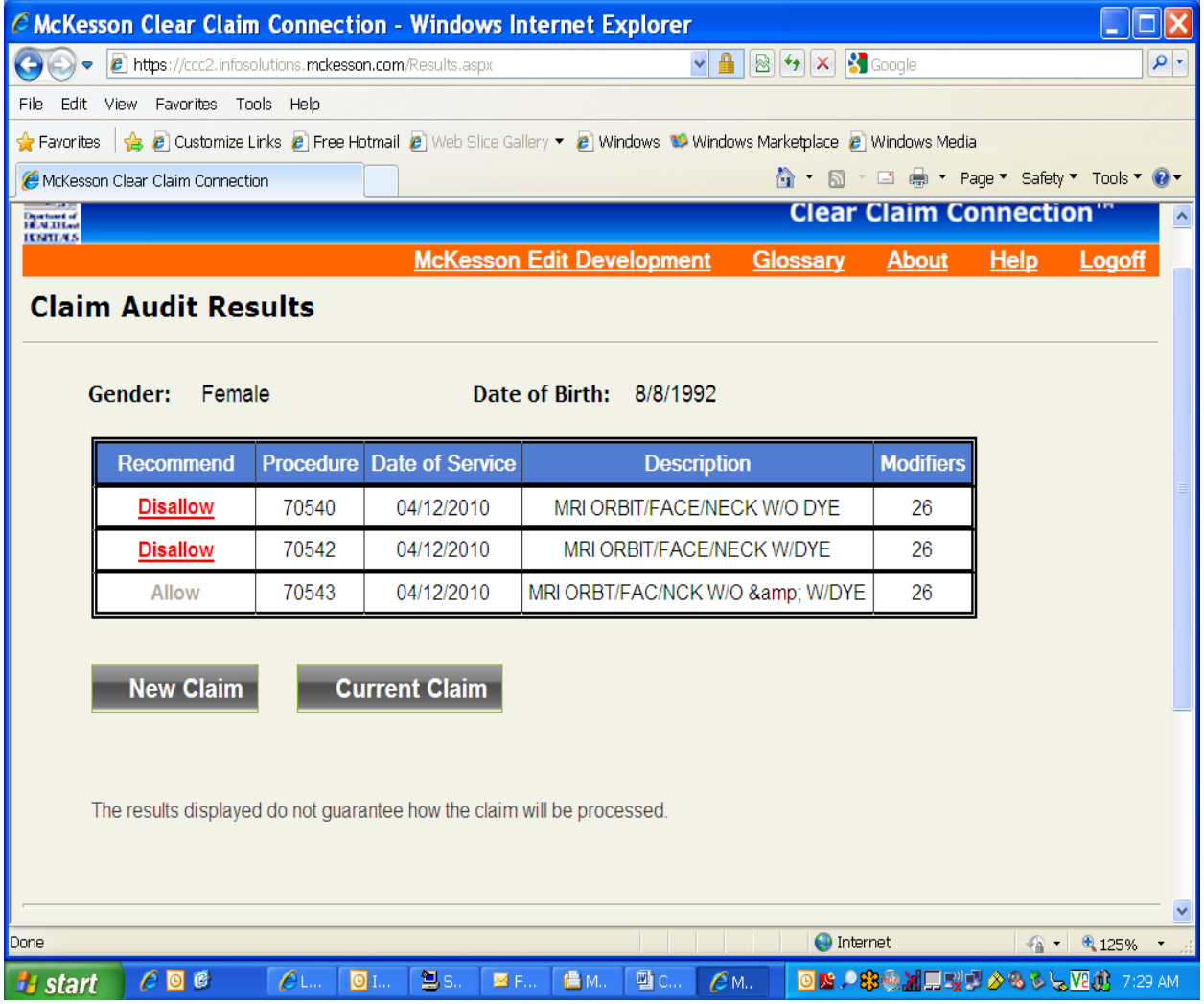
By depressing the "Disallow" button, Clear Claim Connection will provide the rationale related to the recommendation.



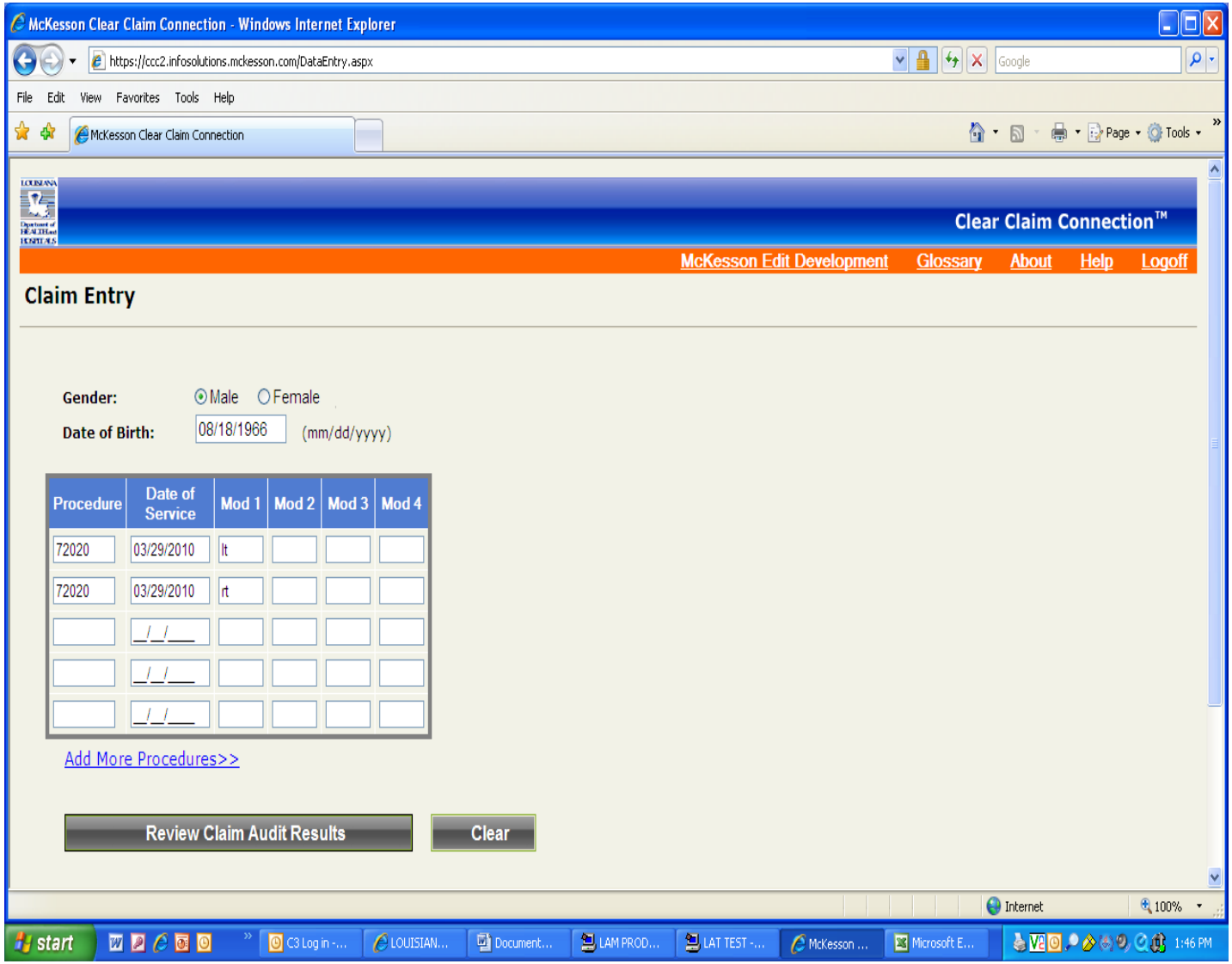



Clear Claim Connection will reference the sources that reviewed and approved the edit clarification.

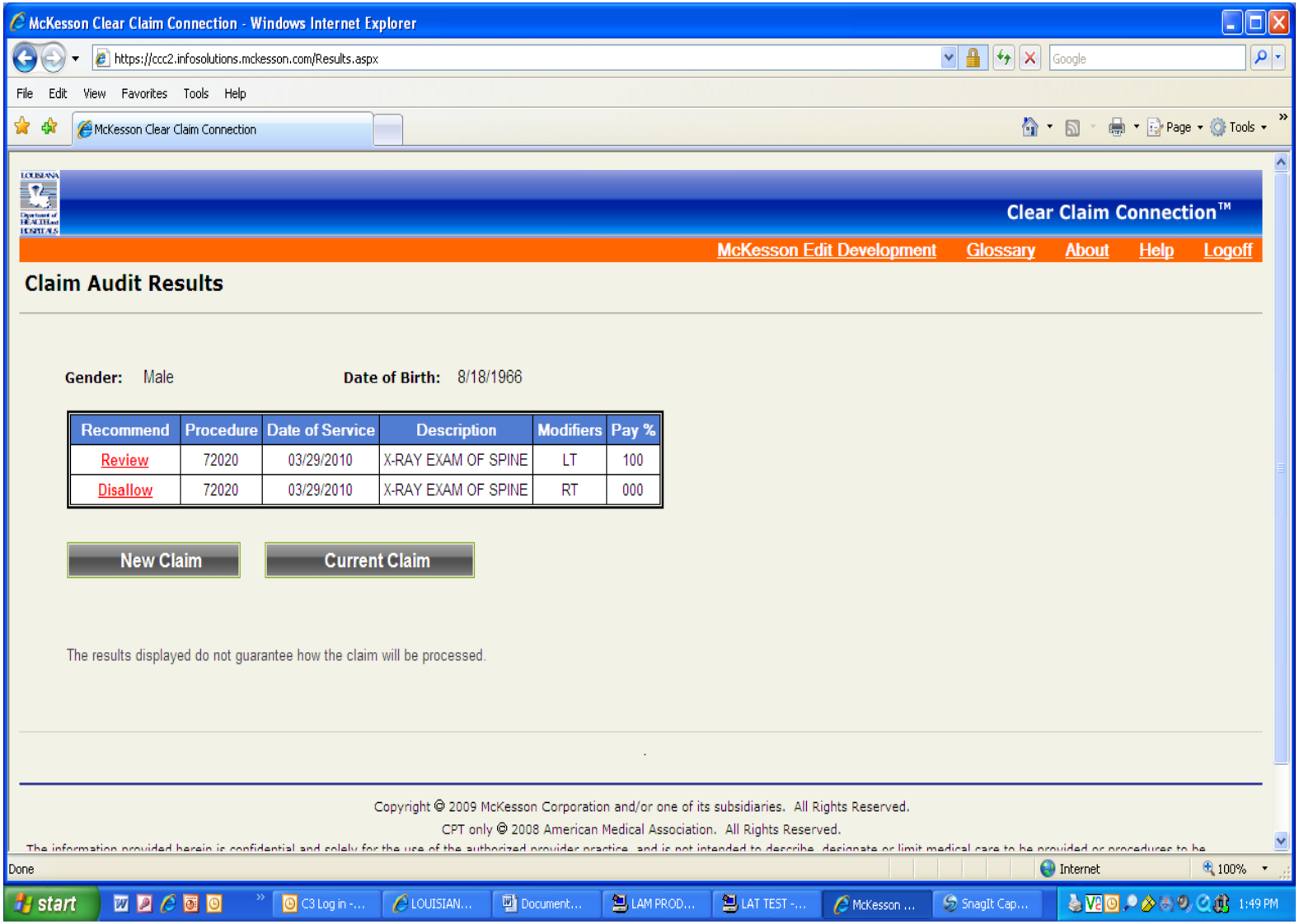
When "internal physicians" is identified it is referring to both the McKesson Clinical Consulting Network which is a cross section of physicians with extensive clinical practice, academic, and/or medical management experience and Louisiana Medicaid concurrence.



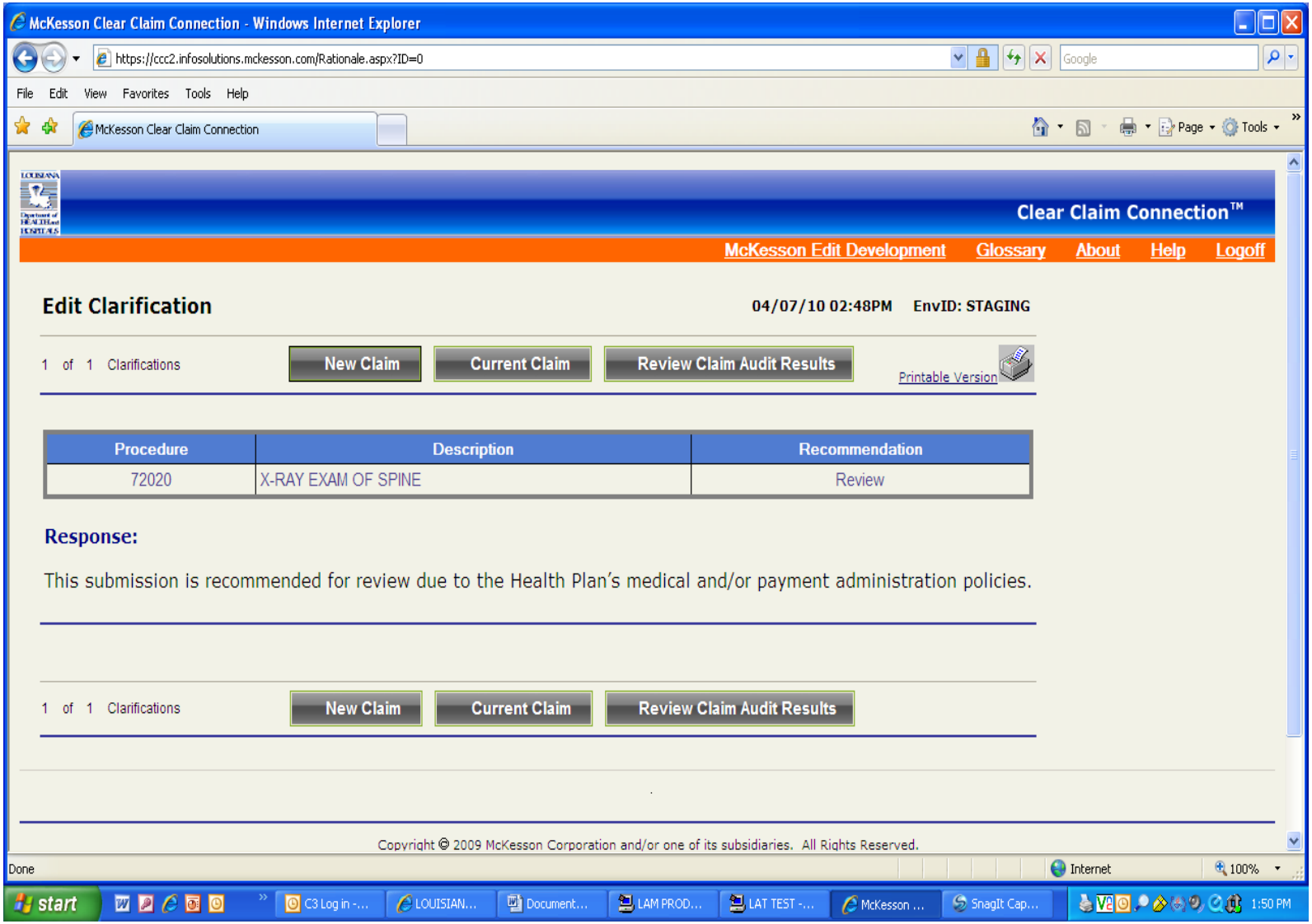

New claim information can be entered by depressing the "New Claim" key or you can return to the current claim information by depressing the "Current Claim" key.



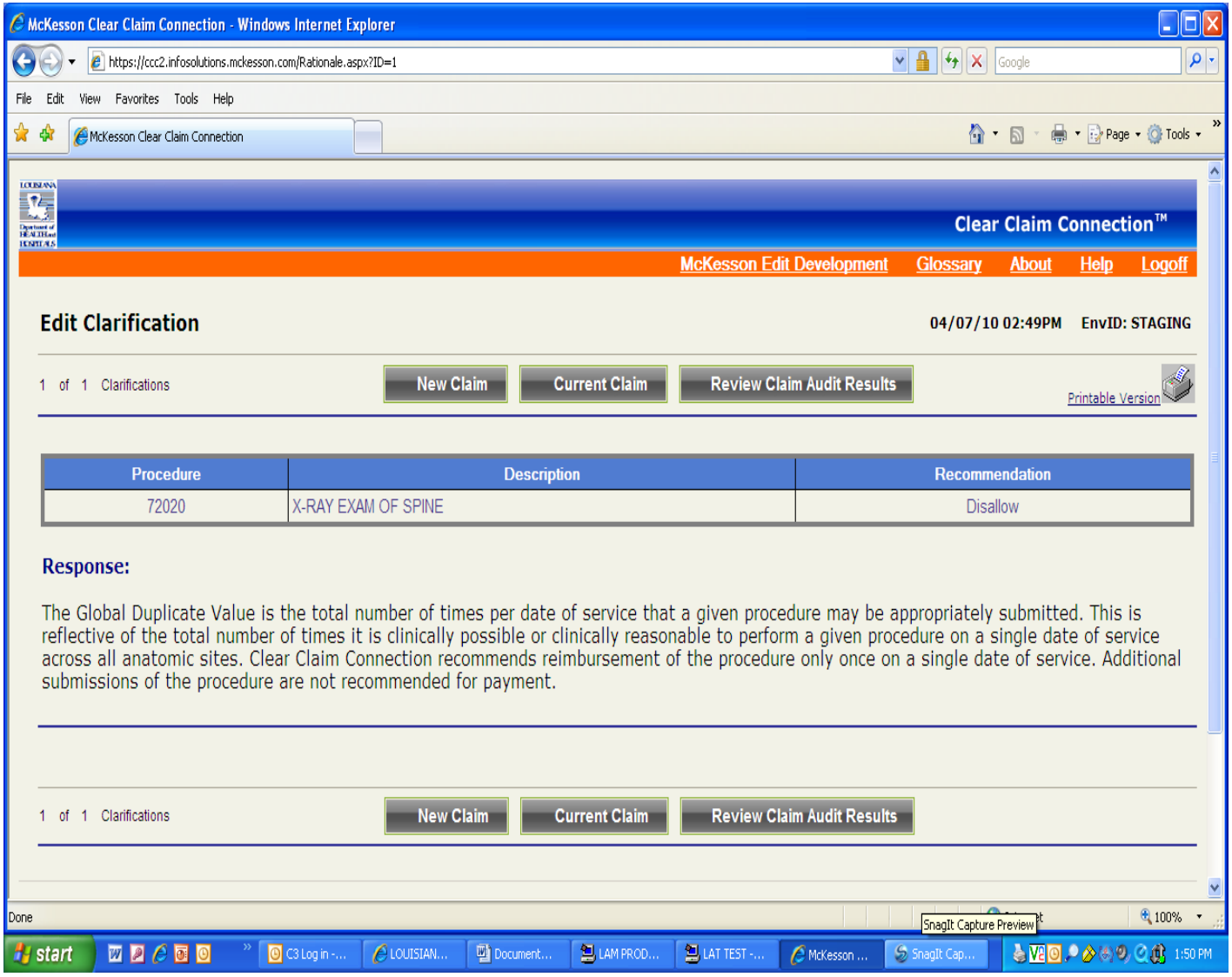

Enter new claim data here.




The first claim line recommendation indicates ‘Review’.




The 'Review' indicates the procedure/modifier should be reviewed by the provider. The modifier/procedure code combination does not reflect standard usage.




The 'Response' provided indicates the rationale for a 'disallow' recommendation.

# ClaimCheck® Reminders

- Providers billing electronically are strongly encouraged to contact/notify their software vendors/clearinghouse should any changes to provider specific software be needed.
- Claims are subject to post payment review and recoupment.
- Implementation of ClaimCheck does not affect the CommunityCare referral process or a specific referral requirement.
- Providers that are unsure of their specialty/sub-specialty designation with LA Medicaid are encouraged to verify these designations.
- The implementation of ClaimCheck will not affect the Radiology Utilization Management requirement for prior authorization of MRI's, CT's and Nuclear Cardiac Imaging services
- If a prior authorization is required for the services billed and ClaimCheck rebundles the services to a different procedure code, the rebundled code will process under the original authorization.

# Provider Assistance

Unisys Provider Relations Call Center
1-800-473-2783 or 225-924-5040

Unisys Provider Relations Field Analyst
List on www.lamedicaid.com
Provider Support Link

Unisys Provider Enrollment
225-216-6370

If verification is needed, inquiries concerning provider specialty should be faxed to
225-216-6392

Questions regarding ClaimCheck and Clear Claim Connection
fax to
225-216-6334

# Helpful Resources

Centers for Medicare and Medicaid Services (CMS)
www.cms.gov

American Medical Association (AMA)
www.ama-assn.org

AMA-CPT Current Procedural Terminology (CPT)
www.ama-assn.org/ama/pub/category/3113.org

National Correct Coding Initiative (CCI)
www.1cms.gov/nationalcorrectCodeinited.org

American College of Surgeons (ACS)
www.facs.org

# Questions and Answers