Code Editing Software (Claim Check)

In order to keep pace with ever changing medical technology and coding complexities, Scott and White Heath Plan utilizes (McKesson ®) Claim Check, a code editing software program designed to evaluate billing and coding accuracy on submitted claims.

Claim Check uses clinically valid edits for automated claims-coding verification and to ensure that SWHP is processing claims in compliance with general industry standards.

The following list represents an example of the different edits and their definitions.

Rebundling edits
Unbundling occurs when two or more procedures are used to describe a service when a single, more comprehensive procedure exists which more accurately describes the complete service performed by the provider. Procedure codes are re-bundled as a single procedure code and paid the correct reimbursement for that one code.

Mutually exclusive auditing
Identifies two or more procedures that are usually not performed during the same patient encounter on the same date of service and therefore not allowable for separate reimbursement.

Incidental procedure auditing
Identifies procedures that are performed at the same time as a more complex primary procedure and not allowable for separate reimbursement.

Medical Visits auditing
Adheres to the "Surgical Package Concept" and does not allow separate reporting of E&M services when a substantial diagnostic or therapeutic procedure is performed. CPT guidelines for E&M services support this medical visit auditing.

Pre-Operative and Post-Operative edits
Identifies E&M services that are reported with surgical procedures during the associated pre/post operative periods. The pre and post operative periods are designated in CMS's National Physician Fee Schedule. Claim check denies medical visits related to the procedure, within the timeframe, as an unbundled component of the total surgical package.
   Minor Surgical procedures have a 0-day preoperative and 0 or 10 day(s) postoperative timeframe.
   Major Surgical procedures have a 1-day preoperative, and 90 day(s) postoperative timeframe.

 Age/Sex conflicts
Identifies a discrepancy between the billed procedure codes that are inconsistent with the patient's age or gender.

Assistant surgeon edits
Determines if an assistant surgeon is clinically necessary for the billed procedure.

Cosmetic surgery edits
Identifies procedures that SWHP considers to be cosmetic and suspends the claim for Medical review.

Duplicate edits

There are six duplicate categories:

Category I: Bilateral procedure can only be performed once on a single date of service

Category II: Unilateral/Bilateral procedure can be performed only once on a single date of service

Category III: Unilateral or Single procedure with a procedure whose description specifies bilateral with performance of the same procedure, the unilateral can only be performed once on a single date of service.

Category IV: Procedures allowed specified number of times per date of service, per lifetime or per site specific modifier

Category V: Procedures billed more than once on a single date of service and not addressed by Categories I, IV or VI are flagged for further review

Category VI: Procedures bypassed from Duplicate editing and may be performed an indefinite amount of times on a single date of service.

New visit frequency edits

This edit prevents the inappropriate reporting of a new patient E&M service and is based on following CPT guideline:

> A new patient is one who has not received any professional services from the physician or another physician of the same specialty that belongs to the same group practice, within the past three years

Intensity of service edits

Reviews edits that identifies when the intensity of the E&M code submitted is higher than expected based on the accompanying diagnosis. The claim review replaces the submitted code with the most intensive code expected for the diagnosis.

Diagnosis to procedure edits

This edit encompasses all billed <u>professional</u> claims and occurs when the procedure billed is unexpected based on the diagnosis billed.

> Example: claim billed with diagnosis code of 424.0 (Mitral Valve Disorders) and procedure code 43500 (gastrotomy; with exploration or foreign body removal). This procedure would be identified as unexpected for the diagnosis and would deny.

Correct Coding Initiative (CCI)

The purpose of the CCI edits is to prevent improper payment when incorrect code combinations are reported. CMS developed the edit tool for coding policies based on coding conventions defined in the AMA's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

Outpatient Code Editing (OCE)

These are targeted edits that help manage outpatient facility claims. OCE, a subset of the CCI, applies to outpatient facility and ambulatory surgical center (ASC) edits.

Multiple Component Billing (MCB)

Example 73550 x-ray exam of thigh. Global code billed by Provider A. Same date of service: 73550-26 professional component billed by Provider B. MCB edit will deny.

NOTE: Depending on our settings for this edit, either the current or the history code would be denied. The claim processed first will get paid and the second will be recommended for denial.

Duplicate Component Billing (DCB)

Example 73550 x-ray exam of thigh. Global code billed by Provider A. Same date of service: 73550-26 professional component billed by Provider B.

NOTE: Depending on our settings for this edit, either the current or the history code would be denied. The claim processed first will get paid and the second will be recommended for denial.

All Claim Check edits are reflected in the Explanation Code on the appropriate service line of the Explanation of Payment (EOP) issued to the provider. Providers who disagree with an edit, may send a corrected claim with the appropriate modifier or request a review of the claim. A request for review/appeal will need appropriate documentation along with medical records which should be sent to the SWHP claims department. The Medical Directors will review the documentation for appropriateness and send back a response to the provider with the determination.