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## 2013 ClaimCheck Implementation

HealthSmart will begin using McKesson's ClaimCheck® products effective April 1, 2013. Claims processed after this date regardless of service date(s), will process through ClaimCheck edits in addition to current system edits. We previously used McKesson's Code Review product for code editing, but McKesson is no longer offering or supporting the Code Review product.

ClaimCheck is an automated procedure code editing system that uses clinically valid edits for automated claims-coding verification that will supplement our current claims processing system to ensure HealthSmart is processing claims in compliance with general industry standards. This product evaluates billing information and coding accuracy with edits based on widely accepted industry practices, coding guidelines, and specialty society standards.

The ClaimCheck knowledge base incorporates guidelines from industry-standard and essential clinical coding sources, including:

- Current Procedural Terminology (CPT®)
- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Diseases Clinical Modification (ICD-CM)
- American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) guidelines
- Specialty society guidelines
- Medical policy and literature research and standards
- Input from academic affiliations

**The following claims edits are examples of those that will become effective with the implementation of ClaimCheck. Some of these edits may already be in use today.**

- **Incidental Procedure Edits** - An incidental procedure is one that is performed at the same time as a more complex primary procedure. Procedures considered incidental when billed with related primary procedures on the same date of service will be disallowed for reimbursement.
- **Rebundling Procedure Edits** - Procedure unbundling occurs when two or more procedure codes are used to report a service when a single, more comprehensive procedure code is available. ClaimCheck rebundles the single procedure codes to the comprehensive CPT/HCPCS code.
- **Pre-Operative and Post-Operative edits** - Identifies E&M services that are reported with surgical procedures during the associated pre/post-operative periods. Claims for services considered directly related to a procedure's global allowance are considered integral to that service and will not be separately reimbursed. Follow-up office visits during the post-operative time period are included in the procedure's global allowance and will not be separately reimbursed.  
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 is inconsistent with the patient's age or gender.

- **Assistant Surgeon Edits** – Identifies when an assistant surgeon is clinically necessary for the billed procedure.
- **Cosmetic, Investigational/Experimental Edits** - Identifies procedures that are considered to be cosmetic or investigational/experimental.
- **Modifier Edits** - Performs procedure to modifier validity checks to determine if a procedure code is valid with a specific modifier.
- **New Visit Frequency Edits** - Prevents the inappropriate reporting of a new patient E&M service and is based on 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** - 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.
- **Procedure to Diagnosis Edits** - This edit encompasses all billed professional 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 be denied.
- **National Correct Coding Initiative (NCCI)** - The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported
- **Multiple Surgery Reduction**: When more than one surgical procedure is performed same date of service, the 50/51 modifiers should 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'