IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201134 JUNE 28, 2011

Changes to Code Auditing Methodologies—Hospitals

The Indiana Health Coverage Programs (IHCP) is implementing enhanced code auditing in the claims processing system. This enhanced code auditing supports the Office of Medicaid Policy and Planning's (OMPP's) efforts to promote and enforce correct coding for more appropriate and accurate program reimbursement.

Code auditing rules that are being implemented in the Medicaid claims processing system represent correct coding methodologies and other coding methods based upon general guidance from the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), specialty society guidance, industry standard coding, and prevailing clinical practice.

The following coding methodologies are being implemented and are explained in this bulletin:

- Code auditing on *UB-04* outpatient claims that are billed with multiple units of the same laboratory code on the same date of service
- Bilateral services billed with a unit of service quantity greater than one

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Effective for dates of service on or after July 15, 2011

This implementation includes the following:

- Code auditing on UB-04 outpatient claims that are billed with multiple units of the same lab code on the same date of service.

As part of this enhanced code auditing, effective for date of service (DOS) on or after July 15, 2011, the system will begin applying the following rules:

New Explanation of Benefit (EOB) for dates of service on or after July 15, 2011

New EOB	EOB Description	Purpose of EOB
4189	Multiple units of the same laboratory procedure billed for the same date of service	Claim lines containing multiple units of the same laboratory procedure code billed without modifier 91 (repeat clinical diagnostic laboratory tests), when submitted by either the same or a different provider for the same member and for the same date of service, will be denied.

Example 1: Same Day Laboratory Rule – Different Provider

Two claims were submitted for procedure code *82374 – Carbon dioxide [bicarbonate]* for the same member, same date of service, but by **different** providers. The second claim received was denied.

Same Day Laboratory Rule Claim Example 1 – Different Providers

Line Number	From Date of Service	To Date of Service	Revenue code	Procedure Code	Modifier	Units of Service	Explanation
Claim submitted by provider A							
01	7/15/2011	7/15/2011	300	82374	NA	1	Detail is allowed*
Claim submitted by provider B							
01	7/15/2011	7/15/2011	300	82374	NA	1	Detail is denied with EOB 4189**

*The first claim received in the system will be the first one considered for payment

**See the *New Explanation of Benefits (EOB) or date of service on or after July 15, 2011* table for complete explanation.

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Example 2: Same Day Laboratory Rule – Same Provider

One claim was submitted with multiple detail lines of procedure code *82374 – Carbon dioxide [bicarbonate]* for the same member, same date of service, and **same** provider. The second detail line used modifier 91, indicating the clinical diagnostic laboratory test was repeated. Both detail lines were allowed.

Same Day Laboratory Rule Claim Example 2 – Same Provider

Line Number	From Date of Service	To Date of Service	Revenue code	Procedure Code	Modifier	Units of Service	Explanation
01	07/30/2011	07/30/2011	300	82374	NA	1	Detail is allowed.
02	07/30/2011	07/30/2011	300	82374	91	1	Detail is allowed.

See the *New Explanation of Benefits (EOB) for date of service on or after July 15, 2011* table for complete explanation.

Effective for dates of service on or after August 31, 2011

This implementation includes the following:

- Code auditing of bilateral services billed with a unit of service quantity greater than one

New Explanation of Benefits (EOB) for date of service on or after August 31, 2011

New EOB	EOB Description	Purpose of EOB
4195	Identifies claim lines where the procedure code is submitted with modifier 50 (bilateral procedure) and the line quantity is greater than one.	Procedures billed with modifier 50 indicate a bilateral procedure and a line quantity greater than one is not allowed. Specific bilateral procedures (conditionally bilateral and independently bilateral) that should not be billed with a quantity greater than one are denied.

Example 1: Bilateral Procedure billed with a quantity greater than one unit

The procedure code *69420 – Myringotomy* with modifier 50 (bilateral procedure) and quantity of two was submitted by a provider. The detail line was denied because a quantity of two is not allowed.

Bilateral Quantity Greater than One Rule Claim Example

Line Number	From Date of Service	To Date of Service	Procedure Code	Modifier	Units of Service	Explanation
01	8/31/2011	8/31/2011	69420	50	2	Detail is denied with EOB 4195*

*See the *New Explanation of Benefits (EOB) for date of service on or after August 31, 2011* table for complete explanation.

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Clear Claim Connection

On July 1, 2011, the Web -based tool, Clear Claim Connection™[1], will be available to assist the provider community in understanding the coding rules and editing rationales. The benefits of this tool include the following:

- Provides the rationale for many edits
- Provides policy and editing logic to improve physician and outpatient hospital coding
- Reduces provider administrative costs associated with claim resubmissions
- Gives providers access to code auditing methodologies 24 hours a day, seven days a week

The tool can be accessed through Web interChange where claim information is entered and the claim audit results will be displayed including the clinical edit clarification. This will assist providers in determining the rationale for the claim denial. Please refer to bulletin BT201131 for additional Clear Claim Connection information.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

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