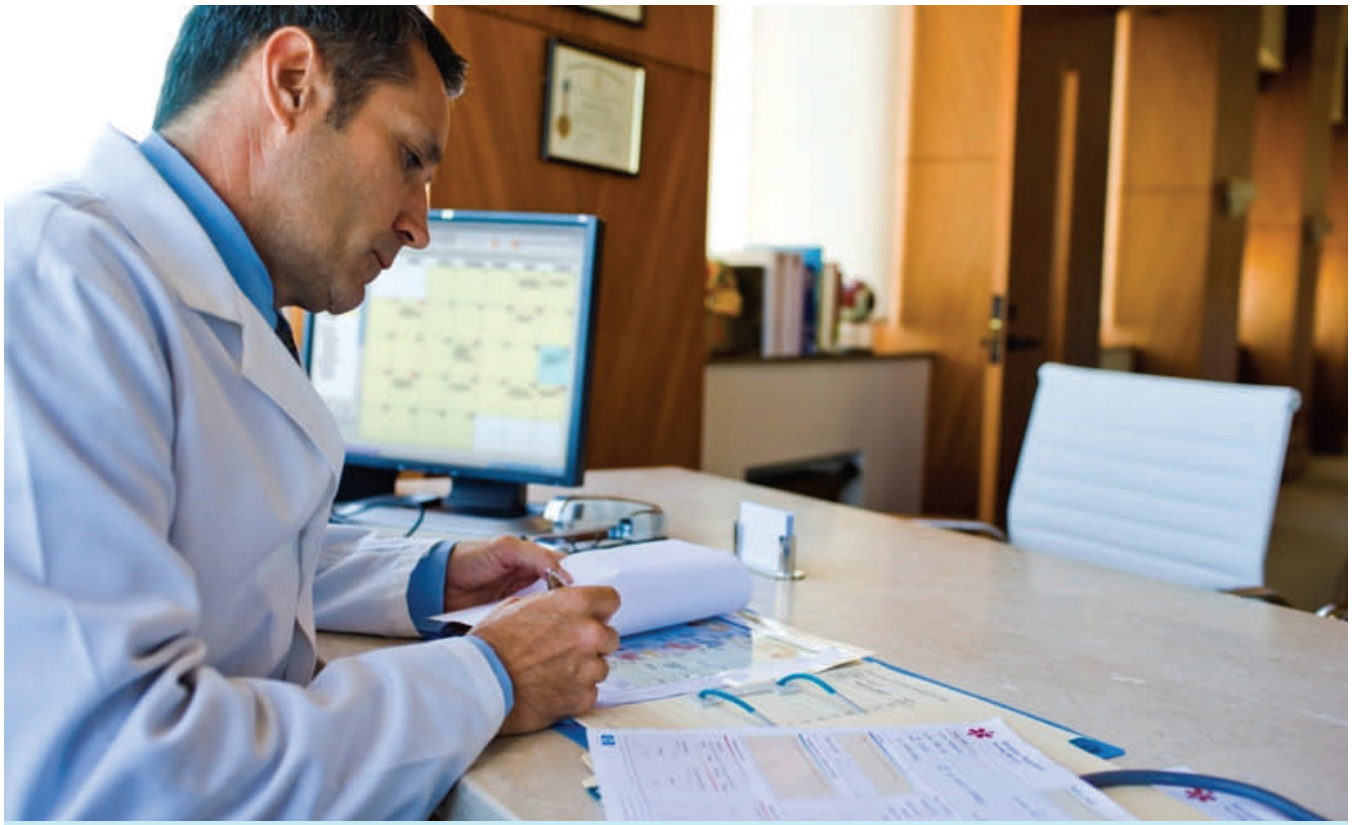
IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201135 JUNE 28, 2011



Changes to Code Auditing Methodologies—Physicians

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:

- CMS-1500 claims that are billed with multiple units of the same laboratory code on the same date of service.
- Current Procedural Terminology (CPT®[1]) add-on codes reported without reporting a corresponding primary procedure/service

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- Reporting multiple units of a primary service when add-on codes should be used
- Non anesthesia services submitted by an anesthesia provider specialty where the service billed is not normally performed by an anesthesia provider specialty
- Non anesthesia services submitted by an anesthesia provider specialty where there is a more appropriate anesthesia code that should be used for billing
- Evaluation and Management codes billed on the same date of services as a procedure with a global period
- Evaluation and Management codes billed within the pre- and post-operative period

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

This implementation includes code auditing of the following:

- CMS-1500 claims that are billed with multiple units of the same laboratory code on the same date of service.
- CPT add-on codes reported without reporting a corresponding primary procedure/service
- Reporting multiple units of a primary service when add-on codes should be used

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 Benefits (EOB) for date of service on or after July 15, 2011

New EOB	EOB Description	Purpose of EOB
4189	Multiple units of the same laboratory service are not payable for the same date of service, same member and same or different provider without medical necessity.	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.
4190	Add-on codes are performed in addition to the primary service or procedure and must never be reported as a stand-alone code.	Claim lines reported for a unique member on a single date of service that contain a CPT-designated add-on code, for which no corresponding primary service or procedure is also reported, will be denied. “Add-on” codes are always performed in addition to the primary service. The add-on codes are identified in CPT with a plus sign (+) next to the code. The add-on codes are also listed in the Appendix of the CPT book.
4191	A primary service or procedure code is limited to one unit per date of service.	When an add-on code is available, claim lines containing primary procedure/service codes billed with a quantity greater than one per date of service will be denied. To correct, bill the primary service/procedure with a quantity of one and then bill the additional services beyond the primary service/procedure as add-on codes.

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Example 1: Same Day Laboratory Rule – Different Providers

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	Procedure Code	Modifier	Units of Service	Explanation
Claim submitted by provider A						
01	7/15/2011	7/15/2011	82374		1	Detail is allowed*
Claim submitted by provider B						
01	7/15/2011	7/15/2011	82374		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) for date of service on or after July 15, 2011* table for complete explanation.

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	Procedure Code	Modifier	Units of Service	Explanation
01	07/30/2011	07/30/2011	82374		1	Detail is allowed.
02	07/30/2011	07/30/2011	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.

Example 3: Add-on without Primary Code Rule

CPT add-on procedure code *15401 – Xenograft each additional 100 sq cm* was submitted without the primary procedure code *15400 – Xenograft first 100 sq cm or less* present on the claim or in any history lines. The detail was denied.

Add-on without Primary Code Rule Claim Example

Line Number	From Date of Service	To Date of Service	Procedure Code	Explanation
01	7/25/2011	7/25/2011	15401	Detail is denied with EOB 4190*

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

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Example 4: Primary Code with Add-on Rule

CPT add-on procedure code *15401 – Xenograft each additional 100 sq cm* was submitted with the primary procedure code *15400 – Xenograft first 100 sq cm* or less present on the claim. Because the primary and add-on procedure codes were both present on the claim, the details were allowed.

Primary Code with Add-on Example

Line Number	From Date of Service	To Date of Service	Procedure Code	Explanation
01	7/27/2011	7/27/2011	15400	Detail is allowed
02	7/27/2011	7/27/2011	15401	Detail is allowed

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

Example 5: Primary Code Quantity Rule

Procedure code *63102 – Lumbar, single segment* was submitted with multiple units of service for the same date of service. The detail was denied.

Primary Code Quantity Rule Claim Example

Line Number	From Date of Service	To Date of Service	Procedure Code	Units of Service	Explanation
01	7/15/2011	7/15/2011	63102	2	Detail is denied with EOB 4191*

*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 1, 2011

This implementation includes code auditing of the following:

- Non anesthesia services submitted by an anesthesia provider specialty where the service billed is not normally performed by an anesthesia provider specialty
- Non anesthesia services submitted by an anesthesia provider specialty where there is a more appropriate anesthesia code that should be used for billing

The anesthesia-related code auditing rules will apply only to providers who are enrolled with the anesthesia specialty. Multiple specialty providers will not be subjected to this type of code auditing.

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New Explanation of Benefits (EOB) for date of service on or after August 1, 2011

New EOB	EOB Description	Purpose of EOB
4192	Non anesthesia services are not reimbursable for the anesthesiology provider specialty billed.	Claim lines will be denied for one of the following reasons: ■ The procedure code is not a primary procedure code; anesthesia care is not normally required ■ The procedure code is a radiology service related to a diagnostic or therapeutic service; the CPT book states that this procedure is performed without anesthesia, based on the provider's specialty ■ The procedure code is a non-specific unlisted procedure code not eligible for the provider specialty billed
4193	Non anesthesia services are not reimbursable for the anesthesiology provider specialty billed.	Claim lines containing non-anesthesia services submitted by an anesthesiology provider specialty will be denied. Providers may resubmit the denied details with the anesthesia code(s) as appropriate.

Example 1: American Society of Anesthesiologists (ASA) Anesthesia Not Eligible Rule

An anesthesiologist submitted procedure code *20979 – Low intensity ultrasound stimulation to aid bone healing, noninvasive [nonoperative]*. The detail was denied.

ASA Anesthesia Not Eligible Rule Claim Example

Line Number	From Date of Service	To Date of Service	Procedure Code	Provider Specialty	Explanation
01	8/1/2011	8/1/2011	20979	311	Detail is denied with EOB 4192*

**See the New Explanation of Benefits (EOB) for date of service on or after August 1, 2011 table for complete explanation.*

Example 2: ASA Anesthesia Standard Crosswalk Rule

An anesthesiologist submitted procedure code *11005 – Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure*. The detail was denied.

ASA Anesthesia Standard Crosswalk Rule Claim Example

Line Number	From Date of Service	To Date of Service	Procedure Code	Provider Specialty	Explanation
01	8/1/2011	8/1/2011	11005	311	Detail is denied with EOB 4193*

**See the New Explanation of Benefits (EOB) for date of service on or after August 1, 2011 table for complete explanation.*

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

This implementation includes code auditing of the following:

- Evaluation and Management codes billed on the same date of services as a procedure with a global period
- Evaluation and Management codes billed within the pre- and post-operative period

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

New EOB	EOB Description	Purpose of EOB
4194	Identifies procedure codes billed by the same provider on the same date of service as a code with a global period.	Claim details containing Evaluation and Management codes billed on the same date of service as a procedure code with a global period will be denied unless appropriate modifiers are present on the claim and/or medical necessity is established.
4196	Identifies procedure codes billed by the same provider within a procedure's pre-operative period.	Claim details containing Evaluation and Management codes billed within the pre-operative period will be denied unless appropriate modifiers are present on the claim and/or medical necessity is established.
4197	Identifies procedure codes billed by the same provider within a procedure's post-operative period.	Claim details containing Evaluation and Management codes billed within the post-operative period will be denied unless appropriate modifiers are present on the claim and/or medical necessity is established.

Example 1: Same Day Visit Rule

A provider billed Evaluation and Management procedure code *99213 – Office or other outpatient visit for the evaluation and management of an established patient of low to moderate severity* on the same date of service as procedure code *49000 – Exploratory laparotomy, exploratory celiotomy with or without biopsy[s] [separate procedure]*. The Evaluation and Management detail line was denied.

Same Day Visit Rule Claim Examples

Line Number	From Date of Service	To Date of Service	Procedure Code	Explanation
Claim 1 submitted by Provider A for Member 1				
01	8/31/2011	8/31/2011	99213	Detail is denied with EOB 4194*
Claim 2 submitted by Provider A for Member 1				
01	8/31/2011	8/31/2011	49000	Detail is allowed

**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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Example 2: Pre-Operative Visit Rule

A provider billed Evaluation and Management procedure code 99213 within the 1-day pre-op period of procedure code 49000. The diagnosis code on the claim line for both procedures is *158.8 – Malignant neoplasm of specified parts of peritoneum*. The Evaluation and Management detail line was denied.

Pre-Operative Visit Rule Claim Example

Line Number	From Date of Service	To Date of Service	Procedure Code	Diagnosis Code	Quantity	Explanation
Claim 1 submitted by Provider A for Member 1						
01	8/31/2011	8/31/2011	49000	158.8	1	Detail is allowed
Claim 2 submitted by Provider A for Member 1						
01	8/31/2011	8/31/2011	99213	158.8	1	Detail is denied with EOB 4196*

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

Example 3: Post-Operative Visit Rule

A provider billed Evaluation and Management procedure code 99213 within the 90-day post-operative period of procedure code 49000. The Evaluation and Management detail line was denied.

Post-Operative Visit Rule Claim Example

Line Number	From Date of Service	To Date of Service	Procedure Code	Diagnosis Code	Quantity	Explanation
Claim 1 submitted by Provider A for Member 1						
01	8/31/2011	8/31/2011	49000	158.8	1	Detail is allowed
Claim 2 submitted by Provider A for Member 1						
01	9/30/2011	9/30/2011	99213	158.8	1	Detail is denied with EOB 4197*

**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™[2], 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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