IHCP bulletin

INDIANA HEALTH COVERAGE PROGRAMS BT201102 FEBRUARY 15, 2011

Enhanced physician code auditing

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

Multiple Component Rebundling

As part of this enhanced code auditing, effective for claims received on or after April 1, 2011, the program will begin applying Component Rebundling logic to physician claims. This claim editing process will identify claims containing two or more procedure codes used to report individual components of a service when a single, more comprehensive procedure code exists that more accurately represents the service performed. During Component Rebundling, individual unbundled procedures will be denied.

The initial scope of this rule will include the rebundling of lab components into laboratory panels when each component of the panel is present on the claim. The Current Procedural Terminology (CPT®[1]) manual describes these laboratory tests as Organ or Disease-oriented Panels and identifies the component tests that make up a particular panel. This auditing logic will not be limited to laboratory services; additional rebundling logic will be added throughout 2011 and routinely thereafter when CPT updates occur.

Continue

Due to the new editing process, a new rebundling Explanation of Benefit (EOB) code has been created to identify when the claim processing has encountered an unbundling of a healthcare service.

New Multiple Component Rebundling Explanation of Benefit (EOB) Code

The IHCP has developed a new Explanation of Benefit code that specifically identifies when a claim detail has encountered a Component Rebundling edit or a claim that could not process through Component Rebundling editing due to an unexpected event. The following table identifies the new EOB codes and provides a detailed explanation of the EOB's purpose.

New Component Rebundling EOB Code

New	EOB Description	Purpose of EOB
4186	Service denied. This is a component of a more comprehensive service. This service is reimbursed under a distinct comprehensive code.	This EOB identifies when individual components of a bundled service, performed at a single encounter, are represented by a comprehensive CPT code. Healthcare services should be reported with the procedure code that most comprehensively describes the services performed.

Example of Component Rebundling

Line Number	From Date of Service	To Date of Service	Procedure Code	Description	Billed Amount	Component Rebundle Audit
01	4/1/2011	4/1/2011	82040	Albumin; serum, plasma or whole blood	$100	Detail is **denied** with EOB 4186*
02	4/1/2011	4/1/2011	82247	Bilirubin; total	$100	Detail is **denied** with EOB 4186*
03	4/1/2011	4/1/2011	82248	Bilirubin; total direct	$100	Detail is **denied** with EOB 4186*
04	4/1/2011	4/1/2011	84075	Phosphatase, alkaline	$100	Detail is **denied** with EOB 4186*
05	4/1/2011	4/1/2011	84155	Protein, total, except by refractometry; serum, plasma or whole blood	$100	Detail is **denied** with EOB 4186*
06	4/1/2011	4/1/2011	84450	Transferase; aspartate amino (AST) (SGOT)	$100	Detail is **denied** with EOB 4186*
07	4/1/2011	4/1/2011	84460	Transferase; alanine amino (ALT) (SGPT)	$100	Detail is **denied** with EOB 4186*

** See the EOB table for EOB description.*

Continue

Billing Reminders

Use of modifiers

Modifiers may be appended to HCPCS/CPT codes only when clinical circumstances justify the use of the modifier. It is imperative that physician claims incorporate the correct use of modifiers. A modifier should not be appended to an HCPCS/CPT code solely to bypass Component Rebundling auditing. The use of modifiers affects the accuracy of claims billing, reimbursement, and Component Rebundling auditing. If multiple units of the same procedure are performed during the same session, the provider should roll all the units to a single line, unless otherwise specified in medical policy. Refer to bulletin BT200907 for general guidance in appropriate use of modifiers.

The Centers for Medicare & Medicaid Services (CMS) provides carriers with guidance and instructions on the correct coding of claims and using modifiers through manuals, transmittals, and the CMS Web site. Providers can access the CMS Web site at http://www.cms.gov/. The CPT Assistant and AMA Coding with Modifiers are other valuable resources for correct modifier usage.

Modifier 91

This modifier is used to report repeat laboratory tests on the same day to obtain subsequent (multiple) test results. This modifier is not used when tests are performed additional times to confirm initial results or because of testing problems with specimens or equipment. Also, this modifier is not used for any other reason when a normal, one-time, reportable result is all that is required; or when other codes describe a series of test results.

> **Example**: A patient is treated for low potassium. A potassium test is run initially, before treatment begins. After treatment, the physician orders three more potassium tests on the same day to determine if potassium levels have normalized. The initial test is billed without modifier 91, and one (1) unit of service. The three (3) additional tests are billed using modifier 91 and three (3) units of service.

Claims submitted via Web interChange

Providers that submit claims via Web interChange may view those claims within two hours via the Claim Inquiry function. As a result of Component Rebundling auditing, there may be rare events when claims will not be available for viewing within the usual two-hour time frame. If the delay is longer than 24 hours, providers may contact HP Customer Assistance to determine the reason for the delay.

When performing an electronic void of a claim that was subject to code rebundling auditing, providers must wait until the following day to resubmit claims related to the voided claim.

QUESTIONS?

If you have questions about this bulletin, 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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