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Frequently Asked Questions: Clinical Claim Editor

1. Q What is clinical claim editor?

A Clinical claim editor is claim audit software that analyzes a claim to ensure nationally recognized billing guidelines are followed and then adjudicates the claim appropriately. The version of clinical claim editor that the Division of Health Care Financing and Policy (DHCFP) and HP Enterprise Services have incorporated into the Medicaid Management Information System (MMIS) to process Nevada Medicaid/Nevada Check Up claims was developed by a physician-owned health plan and introduced in 1989. This version, which has received widespread acceptance by physicians, is used by more than 165 health plans.

2. Q What guidelines does the clinical claim editor use to analyze claims?

A Analysis is derived from the most clinically likely scenarios based on American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS) and specialty society guidelines, industry standards and **Nevada Medicaid/Nevada Check Up** policy.

3. Q Does the clinical claim editor analyze all claims?

A No. The editor only analyzes claims for professional and outpatient services.

4. Q Are there special billing instructions to follow?

A No. There are no special billing instructions. If you are not following standard billing and coding practices, your claims will be affected. Affected claims may be denied and then adjudicated with the most appropriate coding for the service being billed. The denied claim and the corresponding adjudicated claim will be shown on the same remittance advice.

5. Q Which edit categories are analyzed by the clinical claim editor?

A Categories include but are not limited to:

- Rebundling.
- Incidental.
- Mutually Exclusive.
- Duplicate.
- Medical Visit.
- Pre- and Post-operative Care.

- Assistant Surgeon.
- Diagnosis to Procedure.
- Age Conflict
- Gender Conflict.
- Obsolete.
- Modifier and Procedure Combination.
- Intensity of Service.

6. Q What is a rebundling edit? Also, if a code is rebundled to another, how will this appear on my remittance advice?

A This edit identifies a single, comprehensive CPT code to describe services performed when two or more codes have been billed.

Example 1: If you bill CPT codes 48140 (Pancrcreatectomy, Partial, with or without Splenectomy) and 38100 (Splenectomy Total (separate procedure)), then the claim will be rebundled and adjudicate with code 48140. Your remittance advice will show codes 48140 and 38100 as denied and 48140 as paid indicated by an ICN ending in “99.”

Example 2: If you bill CPT codes 27705 (Osteotomy; tibia) and 27707 (Osteotomy; fibula), then the claim will adjudicate as 27709 (Osteotomy; tibia and fibula). Your remittance advice will show codes 27705 and 27707 as denied and 27709 as paid.

7. Q What is an incidental edit?

A This edit identifies a procedure that is performed at the same time as a more complex primary procedure. It is performed as a clinically integral component of service and it is performed to gain access to accomplish the primary procedure.

Example: If you bill procedure 44155 (Colectomy, total abdominal, with proctectomy; with ileostomy) and 44005 (Enterolysis, freeing of intestinal adhesion (separate procedure)), then the claim will adjudicate with code 44005 only.

8. Q What is a mutually exclusive edit?

A This edit combines procedures that differ in technique or approach, but lead to the same outcome. The edit reports an initial service and a subsequent service.

Example: If you bill procedure 21470 (Open Treatment, Complicated Mandibular Fracture, Multiple Surgical Approaches) and 21453 (Closed Treatment, Mandibular Fracture, Interdental Fixation), then the claim will adjudicate with code 21453 only.

9. Q What is a duplicate procedure edit?

A This edit occurs when a procedure code description contains terminology that does not warrant multiple submissions of that procedure for a single date of service. A duplicate edit also occurs when a procedure is submitted multiple times, exceeding the maximum allowance that would be clinically appropriate.

Categories for duplicate procedure edits:

- Bilateral.

- Unilateral/Bilateral.
- Unilateral or single with corresponding bilateral or multiple.
- Procedures allowed a specified number of times per date of service, per lifetime or per site specific modifier.
- Procedures that are bypassed from duplicate editing and that may be performed an indefinite amount of times on a single date of service.
- Procedures not addressed by the above categories are flagged for further review.

Example: A claim will receive a Bilateral duplicate procedure edit if procedure 71060 (Bronchography, Bilateral Radiological Supervision & Interpretation) is submitted twice on a claim. Procedure 71060 is allowed only once per date of service.

10. Q What is the medical visit (same day) edit?

A This edit provides extensive medical visit auditing based on surgical package guidelines. Two types of edits are associated with Evaluation & Management (E&M) services:

Global surgery period: Procedures that are assigned a 90-day global surgery period by CMS are designated as *major* surgical procedures; those assigned a 10-day or 0day global surgery period by CMS are designated as *minor* surgical procedures. When a substantial diagnostic or therapeutic procedure is performed, the E&M service is included in the global surgical period.

Same date of service: One E&M service is recommended for reporting on a single date of service.

11. Q Will the claim editor incorporate pre- and post-operative edits?

A Yes. Pre- and post-operative auditing automatically denies E&M services rendered within the pre- and post-operative timeframe as defined by CMS.

12. Q How are modifiers edited in the clinical claim editor?

A Clinical claim editor validates modifiers on three levels by considering:

- Is the modifier valid?
- Is the modifier valid with the procedure billed?
- Is the modifier valid based on Nevada Medicaid/Nevada Check Up requirements?

13. Q Are there be age/gender edits in clinical claim editor?

A Yes. Age and gender edits are used.

Age conflicts are identified when the provider assigns an age-specific procedure to a recipient outside of the designated age range.

Example: If you bill procedure 43831 (Open Neonatal Gastrostomy) to a 45-yearold recipient, the claim will be denied with edit 4571 (Current Procedure Inappropriate for Recipient's Age).

Gender conflicts are flagged when the provider assigns a gender-specific procedure to a recipient of the opposite gender.

Example: If you bill procedure 58150 (a Total Hysterectomy) to a male recipient, the claim will be denied with edit 4576 (Current Procedure Inappropriate for Recipient's Gender).

14. Q On UB claims, will the entire claim deny if the clinical claim editor determines one service line is denied?

A No. Since the UB outpatient claims are processed on a line-by-line basis, just the line that the clinical claim editor determines as inappropriate will deny. The remittance advice will reflect which line item is being denied.

15. Q What other clinical information is analyzed by the clinical claim editor?

A The clinical claim editor also reviews: diagnosis to procedure code compatibility, new visit frequency, and intensity of service.

A diagnosis to procedure code compatibility edit will occur when the procedure billed is unexpected based on the documented diagnosis. This edit assumes the same recipient, same provider, and the same date of service for the current procedure line being billed.

Example: If you bill diagnosis code 424.0 (Mitral Valve Disorders) and procedure code 43500 (Gastrotomy; with exploration or foreign body removal), then the procedure would be identified as unexpected for that diagnosis.

A new visit frequency edit will occur when a recipient has received professional services from the provider or another provider of the same specialty that belongs to the same practice within the past three years.

Example: If you bill procedure 99212 (Established patient visit) on March 3 and later bill procedure 99203 (New patient visit) on May 10 for the same recipient, then code 99203 would be denied and the claim would be adjudicated with a comparable established patient visit.

An intensity of service edit will occur when the intensity of the E&M code submitted is higher than expected based on the accompanying diagnosis code billed with the service. The clinical claim editor will adjudicate the claim with the most intensive code expected for the diagnosis code submitted with the billed service.

Example: If a diagnosis of 072.9 (Mumps without mention of complication) is billed with procedure 99215 (Comprehensive visit), the intensity of visit is higher than expected and the claim would be adjudicated with a lower intensity of service level.

16. Q Does the clinical claim editor compare current claims to previously submitted claims?

A Yes. Clinical claim editor compares the current claim/claim line(s) with a claim/claim line(s) that has been previously paid. Previously adjudicated claims are stored in the MMIS and referenced when needed by the clinical claim editor.

17. Q Can unnecessary modifiers cause clinical claim editor to deny the claim?

A Yes. Please ensure that national coding guidelines are followed.

18. Q Will clinical claim editor be updated periodically to reflect the most recent coding standards? If so, what is the date of the latest update?

A Yes. DHCFP and Magellan Medicaid Administration incorporated an updated version of clinical claim

editor into the MMIS on September 19, 2011. This is the same version that HP Enterprise Services is using as of 12/5/2011.

19. Q Which of my claims will be affected by this update?

A. The current update affects any claims processed on or after September 19, 2011, regardless of date of submission or date of service.

20. Q How will the update affect my claim adjudications?

A. The update incorporates 2009, 2010 and 2011 Common Procedural Terminology (CPT) standard billing and coding practices into clinical claim editor. The updated auditing software will analyze claims according to current standards, which means some claims may adjudicate differently than in the past.