Central California Alliance for Health

Provider News

October 17, 2016

Highlights of the Alliance's New Claims Processing System

The Alliance initiated a new claims processing system effective October 3, 2016. Claims with a date of service prior to October 1, 2016 will continue to be processed as before, using our legacy system with a check run every Wednesday. Claims with a date of service of October 1, 2016 and beyond will be processed using our new system with a check run every Tuesday.

As always checks will be mailed the day after our check run date and providers receiving payment electronically should expect to receive payment one business day after check run.

ClaimCheck is a comprehensive code auditing tool that assists payers with correct coding and proper reimbursement. Effective October 1, 2016 ClaimCheck now works in conjunction with the Alliance's claims processing system. Prior to October 1, 2016 the Alliance monitored for incidental/integral procedures, mutually exclusive, and Medi-Cal specific guidelines as specified by the California Department of Health Care Services. ClaimCheck now monitors for the following additional situations:

Modifier -51 Edits

ClaimCheck modifier -51 edit automates payment of the highest relative value unit (RVU) procedure at 100%. This expedites correct payment and prevents additional administrative burden for providers by minimizing the need to resubmit claims.

Modifier -51 designates, "multiple procedures, other than Evaluation and Management Services." This modifier indicates that an additional service or procedure has been performed. This modifier should not be used with "add-on" procedures or CPT procedures designated as exempt, as listed in Appendix D and E of the CPT manual. With this update, ClaimCheck will add or remove modifier -51 from the claim when modifier -51 has or has not been applied to the appropriate procedures.

Example- Multiple procedures performed, modifier -51 not submitted
A provider submits procedures 11057 and 11721. ClaimCheck identifies the primary surgical procedure as 11057, denies 11721 and adds 11721 on a separate line to add modifier -51.

Code	Description	Outcome
11057	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); MORE THAN 4 LESIONS	Paid
11721	DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); 6 OR MORE	Denied
11721-51	DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); 6 OR MORE	Added and Paid

Example- No multiple procedures performed

A provider submits procedures 99291-25 and 31624 -51. ClaimCheck identifies the primary surgical procedure as 31624 (no other surgical procedure billed), denies 31624 and adds 31624 on a separate line to remove modifier -51.

Code	Description	Outcome
99291-25	CRITICAL CARE, EVALUATION AND MANAGEMENT OF THE CRITICALLY ILL OR CRITICALLY INJURED PATIENT; FIRST 30-74 MINUTES	Paid
31624-51	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH BRONCHIAL ALVEOLAR LAVAGE	Denied
31624	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH BRONCHIAL ALVEOLAR LAVAGE	Added and Paid

Example- Add on billed with modifier -51

A provider submits procedures 11042- AG and 11045-51. ClaimCheck identifies the primary surgical procedure as 11042. ClaimCheck identifies 11045 as modifier -51 exempt, denies 11045-51 and adds 11045 on a separate line to remove modifier -51.

Code	Description	Outcome
11042	DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED); FIRST 20 SQ CM OR LESS	Paid
11045-51	DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED); EACH ADDITIONAL 20 SQ CM, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Denied
11045	DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED); EACH ADDITIONAL 20 SQ CM, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Added and Paid

Rebundling 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. ClaimCheck will add the comprehensive code if a procedure code that more accurately represents the service exists but is not included on the claim.

Example

A provider submits procedures 93005 and 93010. ClaimCheck denies the unbundled procedure codes and rebundles to the comprehensive CPT/HCPCS procedure code. In this scenario ClaimCheck adds the comprehensive procedure 93000.

Code	Description	Outcome
93005	ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT	Denied
93010	ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS; INTERPRETATION AND REPORT ONLY	Denied
93000	ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS; WITH INTERPRETATION AND REPORT	Paid