



St. Francis Health Network

Sisters of St. Francis Health Services, Inc.

Attention St. Francis Health Network Office Managers

St. Francis Health Network is implementing claim editing software that is designed to evaluate billing information and coding accuracy on submitted claims. It is guided by the coding criteria and protocols in the CPT Manual that are published by the American Medical Association.

The new editing software is effective for Hoosier Healthwise claims with date of service 4/1/11 and after. The date for Commercial claims will be released soon. Please be certain to **share this information with appropriate staff in your office and with your billing office, if applicable.**

Please see the attached Claim Processing Edits. If you submit a claim that triggers one of these edits, you will receive a HIPAA compliant message on the Explanation of Benefits (EOB).

If you have any questions, please contact Terry Monroe, Manager of Operations and Provider Services at (317) 782-6931 or Diana Poore, Manager of Provider Relations at (317) 782-6553.

Claim Processing Edits

TYPE OF EDIT	DESCRIPTION	PROVIDER OPTIONS
Rebundling	Two or more procedure codes were billed to describe the procedure, or event, when a single procedure code exists that comprehensively describes the situation (combination code).	Review the coding on the claim. The codes that are being denied can be re-billed with the correct combination code as listed in the CPT book. Resubmit a Corrected Claim if necessary.
Incidental Services	Certain procedures are commonly performed in conjunction with other procedures as a component of the overall service provided. An incidental procedure is performed at the same time as a more complex primary procedure and is clinically integral to the outcome of the primary procedure.	CPT guidelines and the Correct Coding Initiative define all CPT codes and incidental codes. An incidental edit may not be re-billed.
Mutually Exclusive	This edit consists of procedure combinations that differ in technique or approach, but lead to the same outcome. In some instances the combination of procedures may be anatomically impossible. Procedures that represent overlapping services, or accomplish the same result, are considered mutually exclusive. In addition, reporting an initial service and subsequent service is considered mutually exclusive.	<p>* If the coding is correct and there is a medical reason for the procedure to have been performed with the paid procedure, please resubmit for Reconsideration to the Care Management Department with:</p> <ol style="list-style-type: none"> 1. History and Physical 2. Operative report and/or Medical documentation 3. Copy of the Remittance Advice
Medical Visit	Surgical package CPT guidelines are checked when an E&M code is billed on the same date of service as a surgical code.	Please refer to the CPT guidelines for the global surgical package or network guidelines for E&M billed with surgery
New Visit E&M Frequency	One new patient visit is allowed per provider within a three-year time frame. Any subsequent new patient E&M visit codes will be replaced with a comparably established patient E&M visit code.	Resubmit a Corrected Claim with the appropriate established patient E&M code.
Diagnosis to Procedure Code Appropriateness	A diagnosis to procedure audit occurs when the procedure listed on the claim is not expected based on the documented diagnosis.	Review the patient's medical record for the appropriate diagnosis for the procedure. Resubmit a Corrected Claim with the appropriate diagnosis.
Procedure Code/ Modifier Appropriateness	A procedure to modifier validity check is performed to determine if a procedure code is valid with a specific modifier.	Review the patient's medical record. If needed, resubmit a Corrected Claim with the appropriate modifier.

* Documentation should be sent to:
Terry Monroe, Manager of Operations & Provider Services
St. Francis Health Network
700 E. Southport Road
Indianapolis, IN 46227