Medical Review

The Medical Review Department is responsible for several functions, including post-procedural review of claims for manually priced procedures, and review of designated procedures and diagnoses which require medical documentation to ensure compliance with Medicaid policy.

Expediting Correct Payment

Listed below are suggestions for facilitating correct payment:

- All attachments should be clear, legible, and easy-to-read copies.
- All operative reports should be dated correctly.
- Specific, appropriate diagnosis codes should be used.
- Requested documentation should be submitted as soon as possible so that correct payment can be determined quickly. Requested documentation should be attached behind a copy of the original claim form, as there is no mechanism to match incoming medical records with previously submitted claims.
- All procedures performed under the same anesthesia session should be billed on the same CMS-1500 claim form using correct modifiers and attaching all pertinent documents with the claim.
- Assistant surgeons should always append an -80 modifier on each claim line. Assistant surgeons are not required to use the -51 modifier for secondary procedures.
- All reports (i.e. operative, history and physical, etc.) must be submitted as one-sided for accurate imaging.

Billing Information

Bilateral Procedures

A -50 modifier indicates that a bilateral procedure was performed. Providers should submit the appropriate *Current Procedural Terminology* (CPT) code on one claim line, append modifier -50, and place a "1" in the "units" column of the claim form.

The bilateral modifier may only be appended to the CPT code if the procedure can be surgically performed bilaterally. The -50 modifier is not to be added if the CPT definition reads "unilateral or bilateral".

Reimbursement for bilateral procedures is 150% of the fee on file, or the billed charge, whichever is lower.

Multiple Surgical Reductions Reimbursement

Multiple surgery reduction is the general industry term applied to the practice of paying decreasing pay percentages for multiple surgeries performed during the same surgical session. When more than one surgical procedure is submitted for a patient on the same date of service, the 51 modifier should be appended to the secondary code(s). Certain procedure codes are exempt from this process due to their status as "add-on" or "modifier 51 exempt" codes as defined in CPT.

ClaimCheck allows the claims processing system to add or remove the -51 modifier (Multiple Procedures) from the claim, regardless of whether it was applied to the appropriate procedure(s), and then process the claim accordingly. Providers may see the specific ClaimCheck edits when the system identifies such cases.

The primary procedure will be paid at 100% of either the Medicaid allowable fee or the billed charge, whichever is lower. All other procedures will be paid at 50% of the Medicaid allowable fee, or 50% of the billed charge, whichever is less.

Bilateral Secondary Surgical Procedures

Multiple modifiers may be appended to a procedure code when appropriate. Billing multiple surgical procedures and bilateral procedures during the same surgical session should follow Medicaid policy for each type of modifier.

Bilateral secondary procedures should be billed with modifiers 50/51 and if appropriate, will be reimbursed at 75% of the Medicaid allowable fee or 75% of the billed charges, whichever is lowest.

Unlisted Procedures

Claims submitted for unlisted procedure codes are subject to review. Providers should not use unlisted procedure codes when standard codes exist which describe the service. If a CPT code exists describing the service, the claim will be denied. Operative reports or documentation justifying the procedure should be submitted hardcopy each time an unlisted procedure code is submitted. The reports should accurately describe the unlisted procedure. Underlining such portions of the report that describe the services performed will expedite the medical review process.