KERN HEALTH SYSTEMS

PROVIDER bulletin

June 20, 2018

Claims Editing Software (CES)

Dear Provider:

This is a follow up notification to the bulletin sent on May 18, 2018.

Effective July 1, 2018, Kern Health Systems (KHS) will be implementing a new claims editing software program. This software will ensure claims received by KHS comply with all the Medi-Cal billing guidelines. If claims are billed incorrectly, they will be denied..

For the last several years, KHS has been lenient in processing incorrectly billed claims. However, due to an increase in auditing and increased data integrity oversight by CA State Medi-Cal, claims billed with common errors will no longer be fixed but will be denied.

In reviewing claims submitted to Kern Health Systems that will deny effective 7/1/2018, the largest edit that will result in the line code or claim being denied are:

- Edit 9028 (Patient age invalid for service)
- Edit 9533 (Documentation or authorization required)
- Edit 9508 (Missing, invalid, or inappropriate revenue code)
- Edit 9062 (Typical daily frequency exceeded)

Below are specific examples for your review:

Surgical Procedures:

One of the most prevalent changes that will impact anyone who bills for a surgical procedure for any service in the code range 10000-69999.

ALL primary surgeries will require the AG modifier in the first field. (EVEN IF ONLY 1 SURGICAL PROCEDURE BILLED)

ALL secondary surgeries (including add-ons) will require the 51 modifier in the first field.

Examples:

CPT	NAME	MODIFIER NEEDED
CLAIM 1 EXAMPLE		
43300	Esophagoplasty	AG
CLAIM 2 EXAMPLE		
19000	Puncture aspiration of cyst of breast	AG
19001	each additional cyst	51
CLAIM 3 EXAMPLE		
15100	Split-thickness autograft, trunk; first 100 sq cm or less	AG
15101	each additional 100 sq cm	51
15155	Tissue cultured skin autograft, face, first 25 sq cm or less	51

Diagnosis Code:

Another one of the most prevalent changes that will impact many providers is the appropriate diagnosis validation. Diagnoses will now require highest specificity.
It will also require the correct line referencing for accurate claims payment as well as the Diagnosis being valid for the patient and service.

Be sure that the Diagnosis is appropriate for the patient's sex. Here are examples of Diagnosis and invalid patient sex edits that have occurred.

DIAGNOSIS	DESCRIPTION	LIMIT	REMINDER
CLAIM 1 EXAMPLE			
DX Z39.1	Encounter for Maternal Postpartum care and examination	Female patient only	Don't bill under newborn
CLAIM 2 EXAMPLE			
DXQ53.10	Undescended and ectopic testicle	Male patient only	Don't bill under mother!
CLAIM 3 EXAMPLE			
DX N73.0	Other female pelvic inflammatory disease	Female patient only	Be sure you are selecting the correct DX!

KERN HEALTH SYSTEMS

PROVIDER bulletin

Be sure to bill with a Diagnosis that is needed or is appropriate for a service based on Medi-Cal rules. Here are two examples of claims for incorrect or missing Diagnosis.

BILL EXAMPLE	BILLING NEED/ISSUE
CLAIM 1 EXAMPLE DX billed: E11.42, L60.0, B35.1 CPT 11720 – Nail Debridement	B35.1 must be 2nd DX or claim will deny.
CLAIM 2 EXAMPLE DX billed: E11.65, K06.3 82607	CPT 82607 is only payable with specific diagnoses in Medi-Cal Manual thus this claim will deny.

Please ensure that your biller or billing service are following Medi-Cal guidelines and are aware of the impact incorrect billing can have on your practice.

In the meantime, if you have any questions, please contact the Provider Relations Department at (661) 664-5566 or the KHS Claims Department at (800) 391-2000.