

## CHAMPVA POLICY MANUAL

CHAPTER: 3  
SECTION: 5.2  
TITLE: CLAIMCHECK®

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AUTHORITY: 38 CFR 17.270(a) and 38 CFR 17.272(b)

RELATED AUTHORITY: 32 CFR 199.4

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### I. EFFECTIVE DATE

January 15, 1996

### II. DESCRIPTION

ClaimCheck® is a fully automated cost containment program that is designed to ensure appropriate coding on **outpatient and inpatient** professional claims. ClaimCheck® is a reviewed, approved and customized version of **McKesson/HBO & Company** (formerly GMIS) ClaimCheck®. Edits are developed through a Clinical Information Services Department, with input from the Clinical Consulting Network. This includes **annual CPT/HCPCS** updates and incorporation of Medicare (**CMS**) and **American Medical Association (AMA)** guidelines as well as Specialty Society guidelines.

### III. POLICY

A. ClaimCheck® will be applied to claims based on the date of service. The appropriate reimbursement methodology will be applied in conjunction with ClaimCheck® auditing guidelines.

B. Edits. The following edits are considered when auditing claims:

1. Integral: A procedure that is carried out at the same time as a larger more complex primary procedure. It requires little additional physician resources and/or is an integral part of the primary procedure; thus it will not be reimbursed separately on a claim.

2. Mutually exclusive: The separate billing for two or more procedures that are usually not performed during the same patient encounter on the same date of service. Under ClaimCheck®, only the most clinically intensive procedure is allowed.

3. Assistant surgeon: When a procedure is submitted with an assistant surgeon (AS) modifier (-80, -81, -82, or AS), ClaimCheck® determines whether that procedure always, sometimes, or never requires an assistant surgeon. If the determination is always, the modified code will pay, if the determination is never, the modified code will be rejected, if the determination is sometimes, medical review of the procedure will be necessary.

4. Duplicate: ClaimCheck® uses duplicate checking to identify procedures which appear two or more times on a claim that can only be performed once on a single date of service. Duplicate procedures will be rejected if one of these conditions exist.

5. Age conflict: Identifies procedures that are inappropriate for a patient's age. Claims, which indicate an age conflict, will be reviewed for the appropriateness of the code.

6. Sex conflict: Identifies procedures that are inappropriate for a patient's sex. Claims, which indicate a sex conflict, will be reviewed for the appropriateness of the code.

7. Cosmetic procedures: Identifies procedures that are usually performed for cosmetic reasons. Claims with cosmetic procedures will be reviewed for medical necessity.

8. Unlisted procedures: Identifies CPT codes that are used for procedures that do not have a specific code assignment. Claims with unlisted procedures will be reviewed.

9. Obsolete procedures: Identifies CPT codes that are no longer performed under prevailing medical standards. Claims with obsolete procedures will be reviewed.

#### **IV. POLICY CONSIDERATIONS**

Appeals of ClaimCheck® edits will be handled on a case-by-case basis. The provider should submit medical documentation to request additional payment of procedures(s) denied by ClaimCheck®.

#### **V. EXCLUSIONS**

A. The following claims are not subject to ClaimCheck:

1. pharmacy;
2. dental;
3. durable medical equipment (DME); and

4. inpatient institutional claims.

B. Evaluation and Management services (office visits) that are considered to be part of the overall surgical plan or other procedure.

**\*END OF POLICY\***