



State of New Jersey  
Department of Human Services  
Division of Medical Assistance & Health Services

# NEWSLETTER

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**TO:** Advanced Practice Nurses, Chiropractors, Freestanding ESRDs, FQHCs, Home Health Providers, Hospice Providers, Hospitals (please forward to Billing staff), Independent Clinical Laboratories, Independent Clinics, Nurse Midwives, Physicians, Podiatrists, Psychologists, Residential Treatment Centers, Substance and Alcohol Abuse Treatment Centers and Vision Service Providers - **For Action**  
Health Maintenance Organizations - **For Information Only**

**SUBJECT:** Introduction to the McKesson ClaimCheck® Solution

**EFFECTIVE:** The McKesson ClaimCheck® Solution will become effective prior to June 30, 2007. A specific date will be announced in the next newsletter.

**PURPOSE:** To introduce the McKesson ClaimCheck® Solution software.

**BACKGROUND:** The McKesson ClaimCheck® Solution (ClaimCheck®) is designed to enhance the quality of claim payments to NJFC/Medicaid fee-for-service (FFS) providers. ClaimCheck® is a comprehensive claims auditing software system that automatically audits and adjusts professional billing errors and detects common code manipulations to avoid claim overpayments. ClaimCheck® has been used for code auditing purposes for more than 16 years. The ClaimCheck® software is currently utilized by 14 Medicaid programs, TriCare and the Health Administration Center (formerly the Veterans Administration). Approximately 83% of the commercial market uses ClaimCheck®.

The New Jersey Division of Medical Assistance and Health Services (DMAHS), Unisys, the State's fiscal agent and McKesson have partnered to deliver the ClaimCheck® Solution to NJFC/Medicaid FFS providers.

**ACTION:** For your information, ClaimCheck® will be activated in the near future for all claims adjudicated by the NJFC/Medicaid FFS claims adjudication system.

ClaimCheck® will focus on the following areas of claims adjudication in order to avoid overpayment/incorrect payment for services:

- Rebundling Edits: Avoiding payment of individual procedures when procedures are collectively identified as a bundled procedure;
- Mutually Exclusive Edits: Avoiding payment for two procedures that differ in technique or approach but lead to the same clinical outcome and represent overlapping of services;
- Incidental Edits: Avoiding payment for procedures that are clinically integral to a more complex procedure;
- Duplicate Procedure Edits: Avoiding payment for duplicative procedures on the same date of service;
- Assistant Surgeon Edits: Determines whether a surgical procedure requires the surgical expertise of an assistant surgeon;
- Pre-operative and Post-operative Edits: Including payment of pre-operative and post-operative visits as part of a surgical procedure;
- Evaluation and Management (E & M) Edits: Avoiding payment for an Evaluation and Management service when a substantial diagnostic or therapeutic procedure is performed on the same date of service;
- Age Edits: Applying age parameters to certain procedures;
- Gender Edits: Applying gender limits to certain procedures;
- Cosmetic Procedure Edits: Identifying cosmetic procedures and restricting payments as required;
- Unlisted/Deleted Procedure Edits: Ensuring payment only of approved procedure codes;
- Experimental Procedure Code Edits: Avoiding payments for experimental procedures;
- Obsolete Procedure Code Edits: Avoiding payment for obsolete procedure codes; and
- Modifier Edits: Assuring appropriate reporting of procedure modifiers on claims.

You will receive a follow-up newsletter soon with more information on ClaimCheck®.

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