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ClaimsXten: Phase I

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Introduction

Coding claims completely and accurately is critical to ensure benefits and reimbursement are applied correctly.

We've upgraded our claims-auditing system to better align our claims adjudication with:

- Benefit plans
- Medical policies
- Centers for Medicare & Medicaid Services' (CMS') National Correct Coding Initiatives (NCCI)

Our previous code-auditing system, ClaimCheck®, has been replaced with ClaimsXten™.

ClaimsXten is produced by Change Healthcare.

This upgrade took place **March 2, 2019**.

What is ClaimsXten?

ClaimsXten is robust code auditing software that:

- Ensures correct coding
- Aligns logic closely with NCCI
- Audits in context to the member's claims' history

Benefits of Upgrading:

- Streamlined claims adjudication
- Clinically supported rules and logic
- Enhances processing accuracy and consistency
- Reduces manual reviews

What is NCCI?

Three Major Types of Edits:

Procedure-to-Procedure (PTP) Edits

- PTP edits ensure appropriate payment of services that should be reported together.
- If a provider reports two codes for the same beneficiary, on the same date of service, the second code is only payable when a clinically appropriate NCCI-associated modifier is also reported.

Medically Unlikely Edits (MUEs)

- MUEs prevent payment for an inappropriate number/quantity of the same service on a single day.
- The MUE for a HCPCS/CPT code is the maximum number of units of service.

Add-on Code Edits

- Add-on code edits consist of a listing of HCPCS and CPT add-on codes with their respective **primary** codes.
- An add-on code is eligible for payment if, and only if, one of its primary codes is also eligible for payment.

Edits and Implementation

Many of the edits within the ClaimsXten system are enhancements of edits that our previous system, ClaimCheck, used.

These enhancements make the interpretation and application of the edits more effective.

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ClaimsXten Rules/Edits

	Rule	Description	Example
1.	**CMS Correct Coding Initiative**	Recommends the denial of claim lines for which the submitted procedure is not recommended for reimbursement when submitted with another procedure as defined by a code pair found in the National Correct Coding Initiative (NCCI).	When procedure code 0213T (injection with ultrasound guidance) is submitted with 19304 (mastectomy), procedure code 0213T is recommended for denial.
2.	**Unbundling**	Recommends the denial of claim lines where a procedure is submitted with another procedure that is one of the following: A more comprehensive procedure, a procedure that results in overlap of services, or procedures that are medically impossible or improbable to be performed together on the same date of service.	Procedure code 49000 (exploratory laparotomy) is recommended for denial when submitted with procedure code 44010 (duodenotomy, exploration biopsy).
3.	**Allowed Once Per Date of Service**	Recommends the denial of claim lines containing procedure codes that should only be performed once per date of service.	Bilateral tenotomy procedure 27392 is recommended for denial if submitted more than once on the same date of service.

ClaimsXten Rules/Edits

	Rule	Description	Example
4.	**Medicare Medically Unlikely Edit (MUE) – DME**	This rule checks for the line quantity billed on a claim line and recommends denial if the line quantity exceeds the MUE for the HCPCS/CPT code with MAI of 1, 2 or 3 reported by the same provider or across providers (depending on the provider setting configuration), for the same member, on the same date of service. This rule evaluates date ranges to determine if the MUE has been met or not.	A claim is submitted for A4235 (replacement battery, for use with home blood glucose monitor) with seven units, across three days. The line quantity is spread across the three days to determine the quantity per day: 7 units / 3 days = 2.33 per day. The total is rounded to the nearest whole number, 2. The MUE for A4235 is 2 and the MAI is 1. Only this line is considered and the daily value is equal to the MUE allotted, therefore, the line will be allowed.
5.	**Allowed Multiple Times Per Date of Service**	Recommends the denial of claim lines when the quantity billed for the procedure code exceeds the maximum allowed per date of service per site.	Procedure 29125 (for short arm splint application), has a maximum allowance of twice per date of service. If the submission of the procedure is three times, the third occurrence is recommended for denial.

ClaimsXten Rules/Edits

	Rule	Description	Example
6.	**CMS Always Bundled Procedures**	Recommends the denial of claim containing lines with procedure codes indicated by CMS as always bundled when billed with any other procedure not indicated as always bundled for the same member for the same provider ID for the same date of service.	Procedure code 36416 (collection of blood specimen) is identified by CMS as a bundled service. When this procedure is submitted with another procedure that is not considered a bundled service (for example, 33510, coronary artery bypass), 36416 is recommended for denial.
7.	**Base Code Quantity**	Recommends the denial of claim lines containing base codes billed with a quantity greater than one per date of service.	When procedure code 63102 (vertebral body resection) is submitted more than once for the same date of service, and no other line on same claim or in history, the line is recommended for denial and replaces procedure code 63102 with a quantity of 1.
8.	**New Patient Code for Established Patient**	Recommends the denial of claim lines containing a new patient E&M code for established patients.	New patient code 99204 is recommended for denial when submitted within three years (by the same provider or provider group/specialty) of another E&M code. It is replaced with the appropriate established patient code as indicated in the new patient crosswalk.

ClaimsXten Rules/Edits

	Rule	Description	Example
9.	**Same Day Visit**	Recommends the denial of claim lines with E&M codes billed on the same date of service as a procedure code within a global period.	E&M procedure code 99213 is recommended for denial when submitted on the same date of service as procedure code 49000.
10.	**Bilateral**	Identifies the same code billed twice for the same date of service where the first code has the bilateral -50 modifier appended. The rule recommends the denial of the second submission regardless if submitted with or without a bilateral modifier.	When myringotomy procedure code 69420 is submitted twice and at least one of the lines has modifier -50, the line without the modifier -50 (or the second line with modifier -50) is recommended for denial.
11.	**Post-Operative Visit**	Recommends the denial of claim lines containing E&M codes billed within the post-operative period.	E&M procedure code 99213 is recommended for denial when submitted within the 90-day post-op period of procedure code 49000.
12.	**Co-Surgeon**	Identifies claim lines containing procedure codes billed with the co-surgery modifier (62) that have not met the criteria for submitting a procedure for co-surgery payment according to CMS.	Procedure A4890-62 (repair and maintenance of hemodialysis equipment) is recommended for denial as this procedure does not warrant co-surgeons according to CMS.

ClaimsXten Rules/Edits

	Rule	Description	Example
13.	**Pre-Operative Visit**	Recommends the denial of claim lines containing E&M codes billed within the pre-operative period.	E&M procedure code 99213 is recommended for denial when submitted within the one-day pre-op period of procedure code 49000.
14.	**Medicare Medically Unlikely Edit (MUE) – Practitioner**	Recommends the denial of claim lines where the MUE for a CPT/HCPCS code is exceeded by the same provider, for the same member, on the same date of service. Procedure codes with an MUE adjudication indicator (MAI) of 1 will edit as a single line edit. Procedure codes with an MAI of 2 or 3 will consider frequency from other claim lines to determine if the MUE is met or exceeded. This rule will evaluate date ranges to determine if the MUE has been met or not.	1. A claim is submitted with procedure code 26110 (arthrotomy with biopsy; interphalangeal joint), modifier 55 and line quantity = 2. This procedure code MUE allowed value is 3 and the MAI = 1. The line will be allowed , since the MUE value has not been not exceeded. 2. A claim is submitted with procedure code 11771 (excision of pilonidal cyst or sinus), line quantity = 2 and 2-days' time interval. This procedure code daily MUE allowed value is 1 and the MAI = 2. The calculated individual line quantity is 1 so the current claim line will be allowed.

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ClaimsXten Rules/Edits

	Rule	Description	Example
15.	**Add On Without Base Code**	There are CPT and HCPCS defined add-on codes for which the AMA has assigned specific base code(s). This rule audits those codes, and recommends the denial of claim lines containing the add-on codes when the defined base code cannot be found by the same member for the same date of service. This rule also audits that vaccine supply and immune globulin supply codes are submitted with their associated administration procedure code as is required according to CPT Guidelines.	CPT add-on procedure code 15787 (abrasion; each additional 4 lesions or less) is submitted without the base procedure code 15786 (abrasion; single lesion) present on the claim or in any history lines. Procedure code 15787 is recommended for denial.
16.	**Assistant Surgeon**	Recommends the denial of claim lines containing procedure codes inappropriately submitted with an assistant surgeon modifier 80, 81, 82, or AS in any of the four modifier positions.	When procedure code 10021 (fine needle aspiration) is submitted with modifier -80, the line is recommended for denial.
17.	**Modifier To Procedure Validation – Payment Modifiers**	Recommends the denial of procedure codes when billed with any payment-affecting modifier that is not likely or appropriate for the procedure code billed.	Anesthesia procedure 00560 is recommended for denial when submitted with modifier -50.

ClaimsXten Rules/Edits

	Rule	Description	Example
18.	**Multiple Code Rebundling**	Recommends the denial of claim lines when another more comprehensive procedure exists. If the more comprehensive code is also submitted for this member by the same provider, for the same date of service, the component codes are denied and the comprehensive code is recommended for reimbursement. If the more comprehensive code is not submitted for this member by the same provider for the same date of service, it will be added to the claim.	When laboratory procedures 82465 (cholesterol), 83718 (HDL cholesterol) and 84478 (triglycerides) are submitted together for the same date of service, all are recommended for denial and replaced with the panel code 80061 (lipid panel).
19.	**Global Component**	Identifies instances where the sum of all payments (total, professional, technical) for a procedure across multiple providers exceeds the amount that would have been paid for the total procedure. This rule audits for the same member ID, the same date of service, ***across*** providers.	When procedure code 51725-26 (simple cystometrogram) is submitted and 51725 was previously submitted by a different provider on the same date of service, 51725-26 is recommended for denial.
20.	**CMS Modifier to Procedure Validation**	Recommends the denial of claim lines containing invalid procedure code and modifier combinations based on the CMS Physician Fee Schedule (and select DME modifiers) and the date of service.	Procedure code 51784-50 (electromyography studies of anal or urethral sphincter, other than needle) is recommended for denial, as this procedure is not valid with modifier -50.

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ClaimsXten Rules/Edits

	Rule	Description	Example
21.	**Modifier To Procedure Validation – Non-Payment Modifiers**	Recommends the denial of procedure codes when billed with any non-payment-affecting modifier that is not likely or appropriate for the procedure code billed.	Hysterectomy procedure 58150 is recommended for denial when submitted with modifier –LT.
22.	**Duplicate Component Billing**	Recommends the denial of claim lines containing procedure codes billed with a professional or technical modifier when the procedure code was previously submitted as a global procedure for the ***same*** provider ID for the same member for the same date of service.	When procedure code 51725–26 is submitted and 51725 was previously submitted for the same provider, same date of service, 51725–26 is recommended for denial.
23.	**Age Code Replacement**	Identifies claim lines containing procedure codes that are inconsistent with the patient's age, and replaces the line with the age-appropriate code.	Procedure code 42825 (tonsillectomy, younger than age 12) is replaced with procedure code 42826 (tonsillectomy, age 12 or over) when submitted for a 20-year-old patient.
24.	**Age**	Recommends the denial of claim lines containing procedure codes inconsistent with the patient's age.	Maternity procedure code 59400 is recommended for denial when submitted for a 9-year-old patient.

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Claim Adjustment Reason Codes (CARCs)

CARCs explain how a claim or service line was processed.

Code	Description
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
94	Processed in Excess of charges.
95	Plan procedures not followed.
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
119	Benefit maximum for this time period or occurrence has been reached.
170	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Remittance Advice Remark Codes (RARCs)

RARCs provide information to explain an adjustment.

Code	Description
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
N19	Procedure code incidental to primary procedure.
N22	Alert: This procedure code was added/changed because it more accurately describes the services rendered.
N129	Not eligible due to the patient's age.
N182	This claim/service must be billed according to the schedule for this plan.
N362	The number of Days or Units of Service exceeds our acceptable maximum.
N390	This service/report cannot be billed separately.
N430	Procedure code is inconsistent with the units billed.
N657	This should be billed with the appropriate code for these services.
N665	Services by an unlicensed provider are not reimbursable.

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Frequently Asked Questions

1. **Will claims with dates of service prior to the ClaimsXten Implementation date go through ClaimsXten?**
   Yes, claims with dates of service prior to the March 2, 2019 ClaimsXten implementation date will be adjudicated through ClaimsXten. Edits are applied based on when claims are adjudicated.

2. **Does this also apply to claims filed to Avalon?**
   Yes, claims filed to Avalon may also process through ClaimsXten.

3. **Will remits and EOB be obtained from Change Healthcare or BlueCross?**
   ClaimsXten is a product of Change Healthcare but you will still submit claims to BlueCross and BlueChoice. We will continue to process your claims and issue remittances.

4. **Will this auditing software prevent claims from getting to BlueCross' system if they are not correctly coded or will they just be edits on the back end?**
   The auditing software will not prevent claims from entering our claim system and edits will be seen on your remittance advice.

5. **Are you going to be able to see different taxonomies of physicians? Our offices are all under the same tax ID and we get many denials even though the providers are of different specialties.**
   ClaimsXten reads the billing specialty and the rendering specialty. We are able to distinguish between different specialists billing services under the same group tax ID or NPI.

Frequently Asked Questions

6. **For the New Patient Code rule, would you be checking that it was a different specialty under the same TIN?**
   Yes. The rule looks to see if the patient was treated by the same rendering provider or a provider with the same specialty within the same organization.

7. **I've noticed that there are code combinations that were previously paid but now, many are bundling. Why is that?**
   Our previous claim system was not as closely aligned with CMS' NCCI or AMA coding guidelines as ClaimsXten is today. The edits you're seeing reflect industry-standard coding practices using clinically supported rules and logic.

8. **My claim denied due to the modifier not being appropriate with the procedure. What is the appropriate modifier I should use with this service?**
   You should use the modifier that reflects the care given. Be sure your coding system is using the latest modifiers and please refer to the latest coding resources.

9. **If we identify errors with the edits/rules, is there a direct contact?**
   If you notice any adverse trends related to ClaimsXten rules and edits, please contact your Provider Relations and Education Advocate.

10. **Will you indicate on the remit if/when a code is changed?**
    If a code was changed due to a rule, your remittance will include a CARC/RARC to indicate a change was made.

Other Information

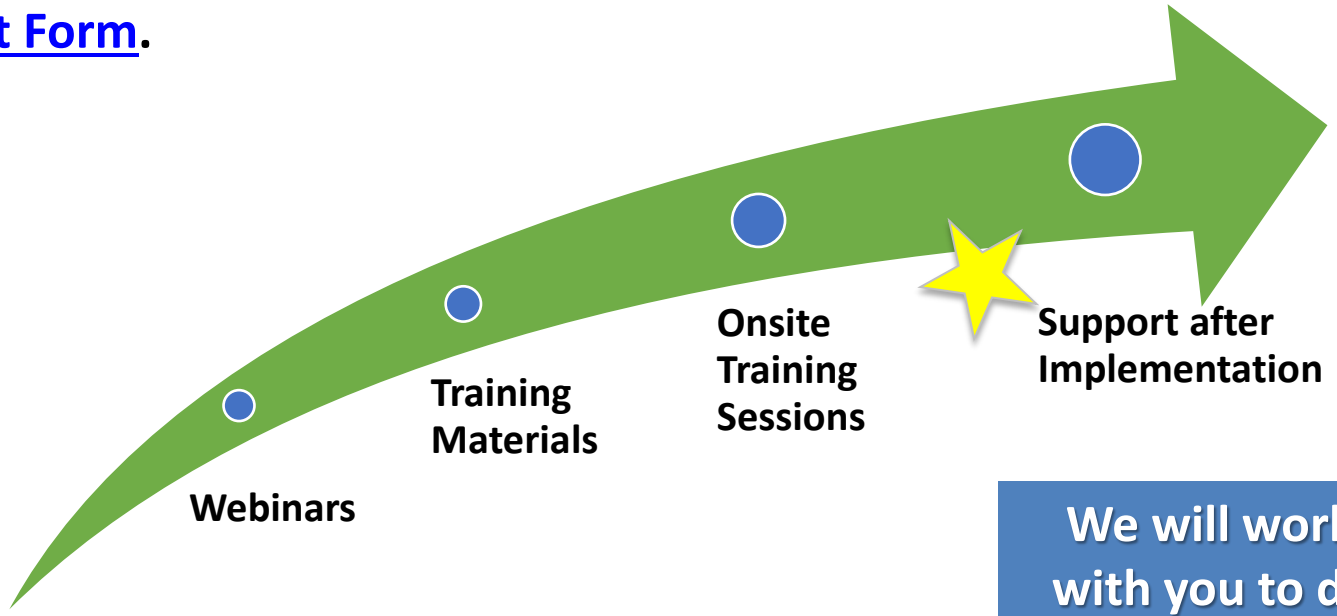
- Continue to file claims to BlueCross and BlueChoice®.
- Remittances still come from BlueCross and BlueChoice.
- Remittances include verbiage to let you know when a code has been replaced.
- The system will look across patients' claim history.
- ClaimsXten takes into consideration the rendering provider's specialty.
- The logic and rules also apply to claims submitted to Avalon.
- This phase of implementation does **not** impact providers billing facility charges (**UB04**).

Provider Outreach

Provider Relations and Education is here to guide you through this transition.

Monitor your remittances and contact Provider Relations and Education if you notice any trends.

Contact Provider Relations and Education by submitting the Provider Education Contact Form.



We will work directly with you to determine resolution.

Modifier System Enhancements

In December 2018, we implemented a project to strengthen the way we recognize modifiers you file on claims and verify that the modifier is appropriate for the service.

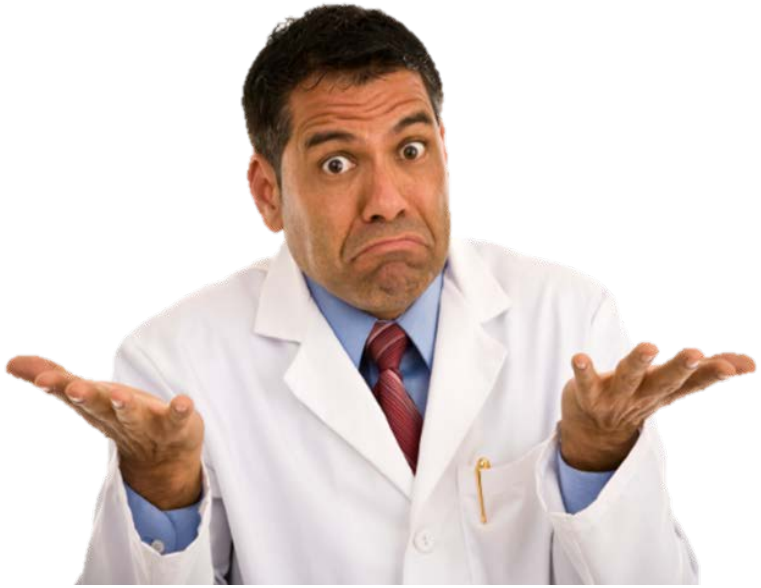
This project:

1. Recognizes any valid HIPAA modifier filed in any of the 4 modifier claim fields.
2. Recognizes modifiers you use to identify certain programs or services in order to process your claims more effectively.

Modifier System Enhancements

A sample of claims across all business lines for 2018 were evaluated and revealed this suite of **invalid** modifiers:

V9	H	1	10
R	W3	SZ	AL
J	30	L1	G
0	OO	21	-
16	L	G0	60



Claims submitted with invalid modifiers will now be stopped at the gateway.

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Stay Connected

We encourage providers to:

- Review your current coding practices
- Consult with all business partners (billers, clearinghouses) who code and bill on your behalf
- Ensure all appropriate staff are refreshed on correct coding guidelines
- Review our training materials and share it with appropriate staff members
- Identify potential impacts and make changes
- File modifiers that are valid and appropriately related to the services performed

Resources

This slide contains links to a third party site. That organization is solely responsible for the contents and privacy policies on its sites. Centers for Medicare and Medicaid Services (CMS) is an independent organization that offers information you may find helpful.

CMS: www.cms.gov

National Correct Coding Initiative Edits: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

NCCI Policy Manual Archive (downloads): https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Manual-Archive.html

Medically Unlikely Edits:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

Modifiers:
https://search.cms.gov/search?utf8=%E2%9C%93&affiliate=cms-new&dc=&query=modifier+coding

BlueCross BlueShield of South Carolina:
https://web.southcarolinablues.com/UserFiles/scblues/Documents/Providers/Provider%20Education/ClaimsXten%20rev%206-14-19.pdf

BlueCross BlueShield of South Carolina Provider Relations and Education:
https://web.southcarolinablues.com/providers/contactus/provideradvocates.aspx