BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

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ClaimsXten: Correct Coding Initiative Reference for Providers

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Your Partners in Outstanding Quality, Satisfaction and Service

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Introduction

Accurate coding and reporting of services on medical claims submitted to BlueCross BlueShield of South Carolina and BlueChoice HealthPlan is critical in assuring proper payment to providers. During the first quarter of 2019, all BlueCross and BlueChoice® lines of business will upgrade their code-auditing system from ClaimCheck® to ClaimsXten™, Change Healthcare's next-generation solution for ensuring proper coding on health insurance claims.

The upgrade to ClaimsXten will allow BlueCross to better validate claims-coding accuracy and more closely align claims adjudication with medical policies, benefit plans, and the Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI). The purpose of NCCI is to control improper coding leading to incorrect payment for medical claims.

For providers, implementation of the ClaimsXten software means that correct coding on claims submitted to BlueCross and BlueChoice will be more important than ever. While most of the existing ClaimCheck edits will continue to exist within ClaimsXten, providers could see new edits on their remittance notices when claims are not coded in accordance with current coding practices.

What is ClaimsXten?

ClaimsXten is robust code-auditing software designed to ensure health insurance claims are coded properly. The software relies on clinically supported rules and logic influenced by national medical societies, current coding practices and the NCCI.

ClaimsXten contains rules, each of which consists of the logic necessary to execute a specific payment policy or guideline. Each rule has an associated set of clinical data that, when applied, results in an edit. The edit is a recommendation to deny, review, modify, or allow a specific claim line.

ClaimsXten simplifies payment rules and analyzes claims in the context of claims history. It offers enhanced analysis of coding for issues such as deleted CPT codes, unbundled services, appropriateness of procedures for age and gender, invalid modifiers, medically unlikely number of units for the same date of service, and investigational procedures.

The first phase of ClaimsXten consists of edits that apply to providers that bill professionally.

Providers will see benefits of the ClaimsXten upgrade that include:

- Improved adjudication accuracy and consistency
- Streamlined claims adjudication
- Fewer manual reviews
- Enhanced payment transparency
- Reduced appeals
- Clinically supported rules and logic

What is NCCI?

The ClaimsXten auditing logic will better align BlueCross' and BlueChoice's claims adjudication with CMS' National Correct Coding Initiative.

CMS developed the NCCI to promote national correct coding methodologies and to control improper coding and incorrect payments for medical services. The coding policies are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT) Manual*, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and current coding practice.

According to the NCCI Policy Manual, NCCI includes three types of edits: NCCI Procedure-to-Procedure (PTP) edits, Medically Unlikely Edits (MUEs), and Add-on Code Edits.

NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column one code is eligible for payment but the column two code is denied unless a clinically appropriate NCCI-associated modifier is also reported.

Medically Unlikely Edits (MUEs) prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances reportable by the same provider for the same beneficiary on the same date of service.

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.

Provider Education Outreach

The Provider Relations and Education staff is committed to keeping providers informed throughout the ClaimsXten implementation. Providers will have the opportunity to attend webinars, view presentations and other materials on our website and may also request on-site training as we prepare for the transition.

If you have questions, please contact Provider Relations and Education by submitting the Provider Education Contact Form or by calling 803-264-4730 and a knowledgeable education specialist will respond. You can also request on-site training by completing the Provider Advocate Training Request Form.

ClaimsXten Rules

The rules below include a description and an example of how each rule is applied. Some examples include procedure codes which do not represent all applicable coding. Procedure codes are updated periodically and the coding referenced is current and valid as of the date of this publication.

Rule	Description	Example
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 National Correct Coding Initiative (NCCI).	When procedure code 0213T (injection with ultrasound guidance) (column two code) is submitted with 19304 (mastectomy) (column one code), procedure code 0213T is recommended for denial.
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).
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.
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 will evaluate 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.
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.	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.

Rule	Description	Example
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, the same provider and 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.
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.
New Patient Code for Established Patient	Recommends the denial of claim lines containing a new patient evaluation and management (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.
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.
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.
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.
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 is recommended for denial as this procedure does not warrant co-surgeons according to CMS.

Rule	Description	Example
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. The diagnosis code is the same on the claim line for both procedures.
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 indictor (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.	A provider submits a claim with procedure code 11771 (excision of pilonidal cyst or sinus; extensive), 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 exit the rule.
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. In addition to the add-on code content in this rule, 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.
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.
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.

Rule	Description	Example
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 will be denied and the comprehensive code will be 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).
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.
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.
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.
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 (simple cystometrogram) is submitted and 51725 was previously submitted by the same provider on the same date of service, 51725-26 is recommended for denial.
Age Code Replacement	Recommends the denial of claim lines containing procedure codes and preventive Evaluation and Management (E&M) 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.
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.

Additional Resources

These links lead to a third party website. The owner of this site is solely responsible for the contents and privacy policies on their site.

- **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