ClaimsXten™

Phase II

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

Independent licensees of the Blue Cross and Blue Shield Association

Introduction

To ensure benefits and reimbursements are applied correctly to claims, it is imperative that claims are coded completely and accurately.

In the first quarter of 2021, we will implement Phase II of ClaimsXten™, which includes additional rules and logic that will continue to better align our claims adjudication with:

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

Rule	Description	Example
Duplicate Line Items	Recommends the denial of a claim line that matches a previously submitted claim line on a different claim or the current claim. Fields that must match are the member, provider, procedure code, modifier, date of service, quantity and billed amount.	See example below

Claim 1

Claim	Line	Mem	Prov	CPT	Mod	Qty	DOS	Total
AB12	1	001	123	74150	26	1	8/1/19	$350

Claim 2

Claim	Line	Mem	Prov	CPT	Mod	Qty	DOS	Total
AB34	1	001	123	74150	26	1	8/1/19	$350

Claim 2 will be denied, as is matches Claim 1.

OR

Claim 1

Claim	Line	Mem	Prov	CPT	Mod	Qty	DOS	Total
AB12	1	001	123	74150	26	1	8/1/19	$350
AB12	2	001	123	99213	N/A	1	8/1/19	$80
AB12	3	001	123	74150	26	1	8/1/19	$350

Line 3 of the claim will be denied, as it matches Line 1 of the same claim.

Rule	Description	Example
Missing Professional Component Modifier	Recommends the denial of a claims lines containing a procedure code submitted without a professional component modifier -26 in a facility setting (POS 02, 19, 21, 22, 23, 24, 26, 31, 34, 51, 52, 53, 56 or 61). The rule will replace the line with a new line with the same procedure code and the professional component modifier -26.	Laboratory procedure 88106 is submitted without modifier -26 with a POS of 21, 22 or 24 and this claim line is denied. The same procedure (88106) is then added to the claim with the modifier -26 appended for payment.
Obstetrics Package Rule	Audits potential overpayments for obstetric care. It evaluates claim lines to determine if any global obstetric (OB) care codes (defined as containing antepartum, delivery and postpartum services, i.e. 59400, 59510, 59610 and 59618) were submitted with another global OB care code or a component code such as the antepartum care, postpartum care, or delivery only services, during the average length of time of the typical pregnancy (and postpartum period as applicable) 280 and 322 days respectively.	A claim line is submitted with global obstetrical procedure code 59400 (routine obstetric care including antepartum care, vaginal delivery and postpartum care) on 03/01/2018. In history, global obstetrical procedure code 59400 was previously submitted on 2/1/2018 for the same member, and was paid. The claim line would be denied with a Certainty of Apply. Global obstetrical code 59400 was submitted within 322 days of this current submission of global code 59400.

<table>
<tr><th>Rule</th><th>Description</th><th>Example</th></tr>
<tr><td>Inpatient Consultations</td><td>Recommends the denial of claim lines containing an inpatient consultation when another inpatient consultation was billed by the same provider for the same member with at least one matching diagnosis within a specified interval of time.</td><td>Inpatient consultation code 99252 was previously submitted on another claim for the same member and provider, with a claim line date of service within five days of the date for the current claim line submitted with inpatient consultation code 99253. Both claims have 250.82 as the diagnosis reported. Inpatient consultation code 99253 is denied with Evaluation and Management services code 99499.</td></tr>
<tr><td>Ambulance Bundled Services</td><td>Recommends the denial of any claim lines with a procedure code other than a valid ambulance HCPCS service or mileage code reported along with a valid ambulance HCPCS procedure code for the same beneficiary, same date of service, by the same provider and on Same Claim Only.</td><td>A claim has a HCPCS code for ground transport and a non-ambulance CPT code for the same member, same date of service, and by the same provider.
<table>
<tr><th>Claim</th><th>Line</th><th>Mem</th><th>Prov</th><th>CPT</th><th>DOS</th><th>Total</th></tr>
<tr><td>AB123</td><td>1</td><td>001</td><td>12345</td><td>AD428</td><td>8/1/19</td><td>$100</td></tr>
<tr><td>AB123</td><td>2</td><td>001</td><td>12345</td><td>A4931</td><td>8/1/19</td><td>$50</td></tr>
</table>
Line 2 (A4931) will deny using Line 1 (AD428) as support.</td></tr>
</table>

Rule	Description	Example
Ambulance Modifier Procedure Validation	Recommends the denial of ambulance services for the following reasons: • Claim lacks an appropriate origin-destination modifier or modifier QL. • Institutional (facility-based) claim lacks an appropriate arrangement modifier (QM or QN). • Two claim lines for the same date of service lack identical origin-destination and arrangement modifiers.	There are two lines of coding for a supplier (professional) claim. (see table A) Both lines will deny, as the modifier is not appropriate for the air ambulance codes submitted.
Valid Ambulance Services	Recommends the denial of inappropriate ambulance services for supplier and provider claims, as defined by CMS. Generally, two lines of coding (i.e. mileage code and transport/service code) are required in most ambulance billing scenarios. This rule also recommends the denial of claim lines, which lack the presence of an ambulance origin-destination modifier and institutional claim lines which lack appropriate arrangement modifiers as required.	There are two lines of coding a mileage code and a transport/service code on the same claim ID. (see table B) Both lines will deny, as Line 1 has a valid mileage code, but an unsupported transport/service code and Line 2 has an invalid transport/service code due to the revenue code.

Table A

Claim	Line	Mem	Prov	CPT	Mod	DOS	Total
AB123	1	001	12345	AD430	DG	8/1/19	$100
AB123	2	001	12345	AD435	DG	8/1/19	$50

Table B

Claim	Line	Mem	Prov	CPT	Mod	Rev	DOS	Total
AB12	1	001	123	A0425	RH,QN	540	8/1/19	$100
AB12	2	001	123	A0428	RH,QN	000	8/1/19	$50

<table>
<tr><th>Rule</th><th>Description</th><th>Example</th></tr>
<tr><td>Ambulance Frequency</td><td>Recommends the denial of an ambulance claim line when the frequency exceeds than allowed limits for a valid ambulance HCPCS service code reported for the same member on the same date of service from.</td><td>There is a single line of coding reported for the supplier (professional) claim.

<table><tr><th>Claim</th><th>Line</th><th>Mem</th><th>CPT</th><th>Mod</th><th>Qty</th><th>DOS</th><th>Total</th></tr><tr><td>AB123</td><td>1</td><td>001</td><td>A0428</td><td>DG</td><td>2</td><td>8/1/19</td><td>$100</td></tr></table>
The claim will deny, as the frequency (quantity) is exceeded for the A0428.</td></tr>
<tr><td>Local Coverage Determinations Procedure to Diagnosis Coverage

Note: Only applies to Medicare Advantage claims.</td><td>Identifies claim lines for certain procedure codes associated with a single diagnosis code/multiple diagnosis codes or no diagnosis code, modifier, age and frequency requirement where the procedure is not considered medically necessary, payable, or has payment constraints according to Local Coverage Determinations (LCDs).</td><td>Place of Service (POS) Check

A Medicare Part B claim (POS 22) is submitted for procedure code 11055.

The claim line will exit the rule since POS 22 with procedure code 11055 does not qualify for the LCD policy.</td></tr>
</table>

Rule	Description	Example
National Coverage Determination Procedure to Diagnosis Coverage **Note: Only applies to Medicare Advantage claims.**	Identifies claim lines for certain procedure codes associated with a single diagnosis code/multiple diagnosis codes or no diagnosis code, modifier, age and frequency requirement where the procedure is not considered medically necessary, payable, or has payment constraints according to National Coverage Determinations (NCDs).	*Multiple Explicit Diagnoses Covered and Non-covered* An inpatient facility claim (Bill Type 111) is submitted with procedure code 43645 and several claim diagnosis codes. Per NCD policy, diagnosis code G83.9 is covered, Z00.00 requires additional review and F01.50 is not covered with procedure code 43645. The default rule will evaluate claim level diagnosis fields only for facility claims. The claim line will exit the rule since the diagnosis code G83.9 is identified as covered when submitted with procedure code 43645 according to the applicable NCD policy. This example illustrates how a single covered diagnosis code will satisfy the coverage criteria and outweigh the documentation review and non-covered recommendations.

Rule	Description	Example
National Coverage Determination Procedure to Diagnosis: Exclusionary Lab Policy **Note: Only applies to Medicare Advantage claims.**	Recommends the denial of procedure code claim lines if any of the claim header or line diagnoses are defined by CMS to meet one of following two conditions: According to this Exclusionary policy, CMS has a defined list of "ICD-10-CM Codes That Do Not Support Medical Necessity." Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the non-payable conditions list. **OR** Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the CMS defined list of "Non-covered ICD-10-CM Codes for All NCD Edits" in the Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report.	An outpatient facility claim (Bill Type 131) is submitted with a procedure code 85049 and claim diagnosis code of D23.9: The default rule will evaluate claim level diagnosis fields only for facility claims. 85049 is denied (with Certainty of APPLY) because diagnosis code D23.9 is in the CMS defined list of "ICD-10-CM Codes That Do Not Support Medical Necessity." Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the non-payable conditions list.

Rule	Description	Example
National Coverage Determination Procedure to Diagnosis: Inclusionary Lab Policy **Note: Only applies to Medicare Advantage claims.**	Recommends the denial of procedure code claim lines if any of the claim header or line diagnoses are defined by CMS to meet one of following two conditions: According to this Inclusionary policy, CMS has a defined list of "ICD-10-CM Codes Covered by Medicare Program." Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is not part of the payable list. **OR** Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the CMS defined list of "Non-covered ICD-10-CM Codes for All NCD Edits" in the Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report.	An outpatient facility claim (Bill Type 131) is submitted a procedure code 80074 and claim diagnosis code of K76.1: The default rule will evaluate claim level diagnosis fields only for facility claims. 80074 is denied (with Certainty of APPLY) because diagnosis code K76.1 is not in the CMS defined list of "ICD-10-CM Codes Covered by Medicare Program" or in the CMS defined list of "Non-covered ICD-10-CM Codes for All NCD Edits." Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is not part of the payable list.

Stay up to date...

We encourage providers to:

- Review your current coding practices
- Consult with all business partners 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 your staff members
- Identify potential impacts and make changes