October 1, 2020

CLAIMSXTEN: UPDATE EFFECTIVE JANUARY 1, 2021

BACKGROUND

Accurate coding and reporting of services on medical claims submitted to Community Health Choice (Community) is critical in assuring proper payment to Providers. Community utilizes Change Healthcare's code-auditing system, ClaimsXten™ which allows Community 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).

UPDATE

Effective **January 1, 2021**, Community will implement the following ClaimsXten rules when processing claims.

Rule	Description
Global Component	Identifies claim lines with procedure codes, which have components (professional and technical) to prevent overpayment for either the professional or technical components or the global procedure. The rule also detects when duplicate submissions occurred for the total global procedure or its components across different providers.
Obstetrics Package Rule	This rule audits potential overpayments for obstetric care. It will evaluate claim lines to determine if any global obstetric 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.
Inpatient Consultations	Identifies claim lines containing inpatient consultations that should have been billed at the appropriate level of subsequent hospital care. This rule is appropriate for professional claims only.
Outpatient Consultations	Identifies claim lines containing office or other outpatient consultations that should have been billed at the appropriate level of office visit, established patient or subsequent hospital care.
PCP Consultations	Identifies claim lines containing consultation codes that are billed by a member's primary care physician (PCP).
Ambulance Bundled Services	This rule 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.
Medicaid NCCI DME	Identifies claims containing code pairs found to be unbundled in accordance to the CMS NCCI for Durable Medical equipment (DME) claims.
Therapy Services Professional	Audits claims to determine, if an evaluative or re-evaluative therapy procedure code(s) has been submitted with appropriate therapy modifier, meets functional reporting requirements as well as appropriate times a given untimed evaluative or re-evaluative therapy procedure should be reported on a particular date of service.
Revenue Procedure Validation-Facility	Identifies claim lines containing observation revenue codes and determines if the revenue code was submitted with procedure codes that are not HCPCS observation care services.
Revenue Codes that Require HCPCS Code	CMS Outpatient Prospective Payment System (OPPS) Integrated Outpatient Code Editor (I/OCE) requires certain revenue codes to be reported with a Healthcare Common Procedure Coding System (HCPCS) code. Revenue codes are summary billing codes required on the UB-04 claim form to represent the type of service provided and where it was performed.
Therapy Services Facility	Audits claims to determine, if an evaluative or re-evaluative therapy procedure code(s) has been submitted with an appropriate therapy modifier as well as Revenue code, meets functional reporting requirements as well as appropriate times a given untimed evaluative or re-evaluative therapy procedure should be reported on a particular date of service.

RESOURCES

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

1. NCCI PTP edits https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits
2. Medically Unlikely Edits (MUEs) https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE
3. Add-on code edits https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits

For more information regarding this change, please contact your local Provider Engagement Representative or call Provider Services at 713-295-2295 for Medicaid/STAR or 713-295-6704 for Marketplace.