

## CLAIMSXTEN: CORRECT CODING INITIATIVE

August, 2019

Accurate coding and reporting of services on medical claims submitted to Community Health Choice (Community) is critical in assuring proper payment to Providers. Effective **October 1, 2019**, all of Community's lines of business will upgrade their code-auditing system from HMS® to ClaimsXten™, Change Healthcare's next-generation solution for ensuring proper coding on health insurance claims.

The upgrade to ClaimsXten will allow 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). The purpose of the NCCI Procedure-to-Procedure (PTP) edits is to prevent improper payment when incorrect code combinations are reported and to prevent improper payments when services are reported with incorrect units of service.

For Providers, implementation of the ClaimsXten software means that correct coding on claims submitted to Community will be more important than ever. Providers will 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.

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 Community'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.

1. 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.
2. 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.
3. 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.

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.