ClaimsXten™ Training for the Ensuring Appropriate Claims Payment Project

Health First Colorado

(Colorado's Medicaid Program)

Training Objectives

1) Explain what the Ensuring Appropriate Claims Payment Project is
2) Explain how ClaimsXten™ affects claim processing
3) Identify and understand rules activated by ClaimsXten™ when viewing a remittance advice (RA)

Introduction

The Ensuring Appropriate Claims Payment Project

The key goals of the project are:

- To increase billing transparency
- To help providers submit accurate claims

Introduction

The Ensuring Appropriate Claims Payment Project

The project is comprised of several components:

- Updating internal processes for reviewing outpatient hospital claims [3M Enhanced Ambulatory Patient Grouping (EAPG)]
- Implementing ClaimsXten™ to automatically review professional and outpatient claims

Introduction

The Ensuring Appropriate Claims Payment Project

- The claim submission process is **not** impacted by ClaimsXten™.
- The Provider Web Portal claim entry tool is **not** changing with the implementation of ClaimsXten™.

ClaimsXten™

The ClaimsXten™ editing tool:

- Works to ensure that professional and outpatient claims adjudicate correctly
- Automatically reviews professional and outpatient claims to identify inappropriate bill coding and reduce overpayments

ClaimsXten™

Claims that are ***not*** impacted by ClaimsXten™ include:

- Professional claims from Home & Community-Based Services providers
- Outpatient claims from Hospital – General, Community Clinic providers with Type of Bill (TOB) 13X claims
- Professional and Institutional Medicare Crossover claims
- Dental, Inpatient and Long Term Care claims
- Encounter claims

Rules

ClaimsXten™ automatically reviews claims to identify inappropriate bill coding. The reviewing process is mediated by *rules*.

Rules

To give a simplified example of how a rule works:

Rule…	The rule is “Certain procedure codes can only be billed for child services”
If…	If a provider bills for a procedure code for child services for an adult
Then…	The claim line will not be allowed

Rules

To give a more detailed example of how a rule works:

Rule…	The rule is “More than one unit/quantity not allowed for procedure 93986”
If…	If a provider bills procedure 93986 with quantity greater than one
Then…	The claim line will not be allowed

Rules

#1

Rule: Add on without base code 1
Explanation of Benefits (EOB) Code: 7800

Brief Description: The “Add on without base code 1” rule identifies claim lines containing a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) assigned add-on code billed without the presence of one or more related primary service/base procedure(s) and contains content related to vaccine and immunoglobulin administration requirements. The Explanation of Benefits (EOB) code description reads “The procedure code billed on claim is missing the primary/base service procedure(s).”

Rules

#2

Rule: Add on without base code 2
Explanation of Benefits (EOB) Code: 7800

Brief Description: Add on without base code (2) identifies claim lines containing a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) add-on code billed either as the sole code for that date of service, only with another add-on code, or without a code from a valid base code module. The Explanation of Benefits (EOB) code description reads “The procedure code billed on claim is missing the primary/base service procedure(s).”

Rules

#3

Rule: Assistant Surgeon
Explanation of Benefits (EOB) Code: 7822

Brief Description: The “Assistant Surgeon” rule identifies claim lines containing procedure codes billed with an assistant surgeon modifier that typically do not require an assistant surgeon according to the Centers for Medicare and Medicaid Services (CMS). The Explanation of Benefits (EOB) code description reads “Assistant-Surgeon procedure/modifier combination billed is not allowed for the procedure.”

Rules

#4

Rule: Base Code Quantity
Explanation of Benefits (EOB) code: 7810

Brief Description: The "Base Code Quantity" rule identifies claim lines where a provider is billing a primary service/procedure with a quantity greater than one, rather than billing the appropriate add-on (“each additional”) code(s). The Explanation of Benefits (EOB) code description reads "The procedure code billed does not represent the quantity provided when another more descriptive procedure is available".

Rules

#5

Rule: Bilateral
Explanation of Benefits (EOB) code: 7823

Brief Description: The "Bilateral" rule identifies claim lines where the submitted procedure code has already been billed with a modifier -50 for the same date of service. The Explanation of Benefits (EOB) code description reads "the Bilateral procedure or proc/mod combination billed is not allowed".

Rules

#6

Rule: CMS Always Bundled
Explanation of Benefits (EOB) code: 7801

Brief Description: The “CMS Always Bundled” rule identifies claim lines containing procedure codes indicated by the Centers for Medicare and Medicaid Services (CMS) to be always bundled when billed with any other procedure. The Explanation of Benefits (EOB) code description reads “Service is denied because it is content of service of another procedure on the current and/or previous claim”.

Rules

#7

Rule: Co-Surgeon
Explanation of Benefits (EOB) code: 7824

Brief Description: The "Co-Surgeon" rule identifies claim lines containing procedure codes billed with a co-surgery modifier that typically do not require co-surgeons according to the Centers for Medicare and Medicaid Services (CMS). The Explanation of Benefits (EOB) code description reads "The Co-Surgeon procedure/modifier combination billed is not allowed for the procedure".

Rules

#8

Rule: Frequency Validation – Alternate Procedure Code Recommended Filter
Explanation of Benefits (EOB) code: 7808

Brief Description: The "Frequency Validation - Alternate Procedure Code Recommended Filter" rule identifies claim lines containing procedure codes with “single” or “unilateral” in the description that have been submitted more than once per date of service and recommends replacement for all occurrences of the “single/unilateral” with the corresponding “multiple” or “bilateral” code. The Explanation of Benefits (EOB) code description reads "Claim line contained single/unit proc[edure] billed with qty greater than 1 on a curr[ent] or hist[orical] claim when proc[edure] code for multiple/bilateral proc[edure] is available".

Rules

#9

Rule: Medicaid Medically Unlikely Edit Durable Medical Equipment – State level edits
Explanation of Benefits (EOB) code: 7811

Brief Description: The "Medicaid Medically Unlikely Edit Durable Medical Equipment – State level edits" rule identifies that CMS Medically Unlikely Edits (MUE) are single code edits intended to limit the number of times a procedure can be billed in a given time period. The Explanation of Benefits (EOB) code description reads "A National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) sets when the units of service are billed in excess of established standards for services that a member receives on a single date of service".

Rules

#10

Rule: Medicaid Medically Unlikely Edit Outpatient Hospital – State level edits
Explanation of Benefits (EOB) code: 7812

Brief Description: CMS Medically Unlikely Edits (MUE) are single code edits intended to limit the number of times a procedure can be billed on a single date of service. The Explanation of Benefits (EOB) code description reads "A National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) sets when the units of service are billed in excess of established standards for services that a member receives on a single date of service".

Rules

#11

Rule: Medicaid Medically Unlikely Edit Practitioner– State level edits
Explanation of Benefits (EOB) code: 7813

Brief Description: CMS Medically Unlikely Edits (MUE) are single code edits intended to limit the number of times a procedure can be billed on a single date of service. The Explanation of Benefits (EOB) code description reads "A National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) sets when the units of service are billed in excess of established standards for services that a member receives on a single date of service".

Rules

#12

Rule: Medicaid NCCI DME – State Edits
Explanation of Benefits (EOB) code: 7814

Brief Description: The "Medicaid NCCI DME - State Edits" rule identifies claims containing code pairs found to be unbundled in accordance to the Centers for Medicare and Medicaid (CMS) National Correct Coding Initiative (NCCI) for Durable Medical equipment (DME) claims. The Explanation of Benefits (EOB) code description reads "This service is not payable for the same date of service as another service included on the current or history claim per National Correct Coding Initiative".

Rules

#13

Rule: Medicaid NCCI Practitioner for State level edits
Explanation of Benefits (EOB) code: 7816

Brief Description: The "Medicaid NCCI Practitioner for State level edits" rule identifies claims containing code pairs found to be unbundled in accordance to the Centers for Medicare and Medicaid (CMS) National Correct Coding Initiative (NCCI) for practitioner claims or ambulatory surgery center claims. The EOB description reads “This service is not payable for the same date of service as another service included on the current or history claim per National Correct Coding Initiative”.

Rules

#14

Rule: Modifier to Procedure Validation – Non-Payment Modifiers
Explanation of Benefits (EOB) code: 7802

Brief Description: The "Modifier to Procedure Validation - Non-Payment Modifiers" rule identifies claim lines with invalid modifier to procedure code combinations for those modifiers identified as non-payment modifiers. The Explanation of Benefits (EOB) code description reads "The non-payment modifier is not appropriate with the billed procedure code".

Rules

#15

Rule: Modifier to Procedure Validation - Payment Modifiers
Explanation of Benefits (EOB) code: 7817

Brief Description: The "Modifier to Procedure Validation - Payment Modifiers" rule identifies claim lines with invalid modifier to procedure code combinations for those modifiers identified as payment modifiers. The Explanation of Benefits (EOB) code description reads "The payment modifier is not appropriate with the procedure code billed".

Rules

#16

Rule: Multiple Code Rebundling
Explanation of Benefits (EOB) code: 7803

Brief Description: The "Multiple Code Rebundling" rule identifies claims containing two or more procedure codes used to report a service when a single, more comprehensive procedure code exists that more accurately represents the service performed. This is typically identified by the CPT code description of each code. The Explanation of Benefits (EOB) code description will read "Service is denied because a single procedure code exists to describe the services. Separate payment is not allowed".

Rules

#17

Rule: New Patient Code for Established Patient
Explanation of Benefits (EOB) code: 7809

Brief Description: The "New Patient Code for Established Patient" rule identifies claim lines containing new patient procedure codes that are submitted for established patients. The Explanation of Benefits (EOB) code description reads "Only one new patient visit is allowed to the same provider group practice and specialty within three years".

Rules

#18

Rule: Outpatient Code Editor (OCE) CMS CCI Bundling
Explanation of Benefits (EOB) code: 7818

Brief Description: The "Outpatient Code Editor (OCE) CMS CCI Bundling " rule identifies claims containing code pairs found to be unbundled according to Centers for Medicare and Medicaid Services (CMS) Integrated Outpatient Code Editor (I/OCE). The Explanation of Benefits (EOB) code description reads "Procedure is mutually exclusive or a component of a comprehensive code that is not allowed by the Integrated Outpatient Code Editor (I/OCE)".

Rules

#19

Rule: Post-Operative Visit
Explanation of Benefits (EOB) code: 7819

Brief Description: The "Post-Operative Visit" rule identifies and recommends denial of E&M or global procedure codes billed by the same provider within a procedures post-operative period. The Explanation of Benefits (EOB) code description reads "No additional payment warranted for this Post-Op procedure as this service was included in the payment for the surgery".

Rules

#20

Rule: Pre-Operative Visit
Explanation of Benefits (EOB) code: 7820

Brief Description: The "Pre-Operative Visit" rule identifies procedure codes billed by the same provider within a procedure's pre-operative period. The Explanation of Benefits (EOB) code description reads "No additional payment warranted for this Pre-Op procedure as this service was included in the payment for the surgery".

Rules

#21

Rule: Frequency Validation – Allowed Multiple Times per Date of Service Filter
Explanation of Benefits (EOB) code: 7825

Brief Description: The "Frequency Validation - Allowed Multiple Times per Date of Service Filter" rule identifies claim lines that contain procedure codes that have exceeded the maximum number of times allowed for a single date of service. The Explanation of Benefits (EOB) code description reads "Procedure code has exceeded the maximum number of times allowed for a date of service”.

Rules

#22

Rule: Frequency Validation – Allowed once per Date of Service Filter
Explanation of Benefits (EOB) code: 7826

Brief Description: The "Frequency Validation - Allowed Once per Date of Service Filter" rule denies claim lines that contain procedure codes that have been submitted more than once per date of service, when the maximum allowance is defined as once per date of service. The Explanation of Benefits (EOB) code description reads "Procedure code is not allowed to be submitted more than once per date of service".

Rules

#23

Rule: Same Day Visit
Explanation of Benefits (EOB) code: 7821

Brief Description: The "Same Day Visit" rule identifies procedure codes billed by the same provider on the same date of service as a code with a global period. The Explanation of Benefits (EOB) code description reads "No additional payment warranted for this same day service as it was included in the payment for the surgery”.

Rules

#24

Rule: Unbundling
Explanation of Benefits (EOB) code: 7804

Brief Description: The "Unbundling" rule identifies claim lines containing procedure codes typically not recommended for reimbursement when submitted with certain other procedure codes on the same date of service. The Explanation of Benefits (EOB) code description reads "Separately billed services must be bundled as they are considered components of the same procedure. Separate payment is not allowed".

Rules

#25

Rule: Unbundled Pairs Outpatient
Explanation of Benefits (EOB) code: 7805

Brief Description: The "Unbundled Pairs Outpatient" rule identifies the unbundling of multiple surgical codes when submitted on facility claims. This rule detects surgical code pairs where either one code is a component of the other code or the codes would not reasonably be performed together on the same date of service. The Explanation of Benefits (EOB) code description reads "Separately billed services must be bundled as they are considered components of the same procedure. Separate payment is not allowed".

Rules

#26

Rule: Unlisted Procedure
Explanation of Benefits (EOB) code: 7827

Brief Description: The "Unlisted Procedure" rule identifies claim lines containing procedure codes that are unlisted. The Explanation of Benefits (EOB) code description reads "Unlisted procedure code should not be used when a more descriptive procedure code representing the service provided is available”.

System Edits

Name of System Edit	Explanation of Benefits (EOB) Code	Description
CXT-S Portal Clm Large Volume of Details	EOB Code 7894	CXT-S Claim suspended for internal review, no actions needed by the provider.
CXT-S SYSTEM ERROR	EOB Code 7895	CXT-S System Error - Claim suspended for internal review.
CXT-S Error Abend	EOB Code 7896	CXT-S Claim suspended for internal review - Abend.
CXT-S Error No Response from TPIC	EOB Code 7897	CXT-S Claim suspended for internal review - TPIC.
CXT-S ERR-C Validation errors were detected on clm	EOB Code 7898	CXT-S Claim suspended for internal review - Data Validation Errors.
No iC Edit exits for CXT-S rule	EOB Code 7899	CXT-S Claim suspended for internal review - No mapped rule found.
CXT-S Process Suspend	EOB Code 7900	CXT-S Claim suspended for internal review - Processing issues.

Resources

Quick Guides Web Page (https://www.colorado.gov/hcpf/interchange-resources)

- Provider Web Portal Quick Guides

Billing Manuals Web Page (https://www.colorado.gov/hcpf/billing-manuals)

- Billing Manuals
- Appendix R

Provider Contacts Web Page (https://www.colorado.gov/pacific/hcpf/provider-help)

- Provider Services Call Center – 1-844-235-2387

Ensuring Appropriate Claims Payment Web Page (https://www.colorado.gov/pacific/hcpf/claimsxten)

- More information about ClaimsXten™

Thank you!