ClaimsXten® — Claims Audit Software

CATEGORY	RULE
Gender	Edits claim lines containing procedure codes that are inconsistent with a member's gender.
Age Edit – Procedure	Edits claim lines containing procedure codes inconsistent with the patient's age.
Modifier To Procedure Validation – Payment Modifiers	Edits procedure codes when billed with any payment-affecting modifier that is not likely or appropriate for the procedure code billed.
Modifier To Procedure Validation – Non-Payment Modifiers	Edits procedure codes when billed with any non-payment-affecting modifier that is not likely or appropriate for the procedure code billed.
Base Code Quantity	Edits claim lines containing base codes billed with a quantity greater than one per date of service.
CMS Correct Coding Initiative	Edits 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).
Multiple Code Rebundling	Edits 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.
Pay Percent – Multiple Procedures	This rule recommends an adjustment in the pay percent when multiple procedures are submitted on the same date by the same provider. Procedure codes eligible for this cutback are identified in the Physician Fee Schedule with a Multiple Procedure Indicator = 1, 2 or 3. Additional adjustments may be made for bilateral submission, multiple quantity, and additional payment modifiers.
Pay Percent – Multiple Radiology Procedures	This rule recommends an adjustment in the pay percent when multiple radiology procedures within the same radiology family are submitted on the same date. The rule has the ability to look at the same provider or across providers within the same Group Practice. Procedure codes eligible for this cutback are identified in the CMS Physician Fee Schedule with a Multiple Procedure Indicator = 4. Adjustments are made individually for both the Professional and Technical components of the service, as appropriate, based on the modifiers submitted. Additional adjustments may be made for bilateral submission, multiple quantity, and additional payment modifiers.
Pre-Operative Visit	Edits claim lines containing E&M codes billed within the pre-operative period.
Same Day Visit	Edits claim lines with E&M codes billed on the same date of service as a procedure code within a global period.
Post-Operative Visit	Edits claim lines containing E&M codes billed within the post-operative period.
Non-covered Procedures	Edits claim lines containing procedure codes that are considered to be non-covered based on health plan medical and/or payment policy.
Unbundling Rule	Edits 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.
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 denies 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, 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.

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ASA Anesthesia Not Eligible	Edits claim lines containing procedure codes that cannot be cross-walked for one of the following reasons: it is not a primary procedure code, anesthesia care is not normally required, it is a radiology service related to a diagnostic or therapeutic service, or the CPT book states this procedure is performed without anesthesia.
ASA Anesthesia Multiple Crosswalk	Edits claim lines containing non-anesthesia services submitted by an anesthesiologist.
Duplicate Line Items	Edits claim line that matches a previously submitted claim line on a different claim. This is not a "frequency" edit. This rule is intended to detect true duplicate claim submissions.
Global Component (GLOBAL_COMP)	Edits 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 and the same date of service, across providers.
Related Services	Edits claim lines containing procedure codes or revenue codes submitted on the same claim or a different claim by the same or a different provider within 10 days prior to, on the same day as, or within seven days after a non-covered procedure.
Missing Professional Component Modifier	Edits claim lines containing a procedure code submitted without a professional component modifier-26 in a facility setting (POS 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, and 61).
Assistant Surgeon	Edits claim lines containing procedure codes billed with an Assistant Surgeon modifier (80, 81, 82, or AS) that typically do not require an assistant surgeon according to CMS.
Medicare Status Codes	Edits claim lines containing procedure codes that are defined by CMS as assigned a status code of N, I, P, M, R, or C. These statuses indicate that there is a payment restriction for the procedure code.
MUE Multiple Lines Rule	MUE (Medically Unlikely Edits) are frequency edits defined by CMS. These edits were developed by CMS based on anatomic considerations, HCPCS/CPT code descriptors, CPT instructions, CMS policies, nature of service/procedure, nature of analyte, nature of equipment, and clinical judgment. This rule edits claim lines where the MUE frequency value for a CPT/HCPCS code is exceeded across all claim lines by the same provider, for the same member, on the same date of service for non-facility claims.
Frequency Validation – Alternate Procedure Code Recommended Filter	Edits claim lines containing procedure codes that represent a single/unilateral procedure billed with a quantity greater than one.
Frequency Validation – Allowed Once Per Date of Service Filter	Edits claim lines containing procedure codes that should only be performed once per date of service when billed with a quantity greater than one.
Diabetic Supply Frequency (Applies to PPO Claims only)	Identifies claim lines containing diabetic supply codes associated with diabetes that are being submitted at a frequency that exceeds the usual or customary rate recommended in the Local Coverage Determination (LCD). This rule will distinguish the quantity of supplies necessary for those patients that are insulin dependent and those that are non-insulin dependent.
Pre-Operative and Post-Operative Diagnosis Change	Edits evaluation and management services that are billed within another procedure's pre-operative and/or post-operative period by the same provider.
Medical Policy Procedure to Place of Service Professional	Edits claim lines found to be not payable according to the health plan's Medical Policy. It edits procedures unlikely to be performed in a place of service.
Outpatient Consultations	This rule edits claim lines containing an outpatient consultation when another historical outpatient consultation was billed for the same member by the same provider ID within a six-month period.

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Frequency Validation – Allowed Multiple Times Per Date of Service Filter	This rule identifies claim lines when the quantity billed for the procedure code exceeds the maximum allowed per date of service per site.
Frequency Validation – Allowed Once Per Date of Service	This rule edits when the maximum allowance is exceeded. In instances where the description of the procedure code dictates how many times it can be performed on a single date of service, an appropriate duplicate edit is assigned. This rule contains content for which there is no specific recommendation for times per date it can be performed.
Pay Percent – Assistant Surgeon	This rule recommends an adjustment in the pay percent for lines submitted with an assistant surgeon modifier (-80, -81, -82, -AS) by the same provider for the same date of service. Additional adjustments may be made for multiple procedures, bilateral submission, multiple quantity, and additional payment modifiers.
Bilateral Procedures	Identifies the same code billed twice for the same date of service, where the first code has the bilateral -50 modifier appended. The rule denies the second submission regardless if it is submitted with or without a bilateral modifier.
Bundled Service	Identifies claim lines containing procedure codes indicated by CMS as always bundled when billed with any other procedure for the same member for the same provider ID for the same date of service. The rule allows bundled codes to pay if billed alone or if billed with only other procedure codes indicated as always bundled.
New Patient Procedures	Identifies claim lines containing a new patient E&M code when another claim line containing any E&M code was billed within a three-year period by the same provider.
Pay Percent – Multiple Cardiology	Identifies claim lines that are eligible for a Multiple Procedure Payment Reduction – Technical Component (TC) of Diagnostic Cardiovascular Procedures. Assigns appropriate pay percentage to the eligible line(s), including adjustments for multiple procedures, as well as bilateral, multiple quantity, and additional payment modifiers.
Pay Percent – Multiple Ophthalmology	Identifies claim lines that are eligible for a Multiple Procedure Payment Reduction - Technical Component (TC) of Diagnostic Ophthalmology Procedures. Assigns appropriate pay percentage to the eligible line(s), including adjustments for multiple procedure, as well as bilateral, multiple quantity, and additional payment modifiers
Co-Surgeon (CO_SURGEON_MADV)	Identifies claim lines containing procedure codes, submitted with co-surgery modifier –62 in any of the four modifier positions, where there is a payment restriction for co-surgery according to the CMS Medicare Physician Fee Schedule.
CPAP BIPAP Supply Frequency	Identifies supply codes associated with the Continuous Positive Airway Pressure or Bi-level Positive Airway Pressure (CPAP/BIPAP) therapy that are being submitted at a rate that exceeds the usual or customary rate. This rule will also identify those supply codes submitted without modifier –KX (Requirements specified in the medical policy have been met). This rule recommends the denial of claim lines containing CPAP/BIPAP supply codes submitted with modifier –KX prior to the determined renewal interval. This rule identifies quantities of supplies greater than the usual maximum amounts. Additionally, this rule identifies claim lines containing CPAP/BIPAP supply codes submitted with modifiers –EY, –GA, or –GZ. If a claim is submitted without modifier –KX, this line will also be denied.
Obstetrics Services	Identifies 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: 280 or 322 days with postpartum services.
Ambulance Bundled Service	Identifies claim lines with a procedure code for services that CMS considers inclusive to a valid ambulance HCPCS service or mileage code billed with an ambulance HCPCS code for the same member, same date of service, by the same provider and on Same Claim Only.

Ambulance Frequency	Identifies ambulance claim lines when the frequency exceeds the maximum limits assigned to an ambulance HCPCS code reported for the same member on the same date of service.
Valid Ambulance Modifiers	Identifies ambulance services that lack an appropriate origin-destination modifier or modifier QL, lacks an appropriate arrangement modifier (QM or QN) for facility-based claims and two claims lines billed for the same date that lack identical origin-destination or arrangement modifiers.
Valid Ambulance Services	Identifies inappropriate ambulance services as defined by CMS, which typically requires two lines of coding (a line for the transport/service code and one line for the mileage code). In addition, this rule will identify ambulance services lacking an origin-destination modifier and facility-based claim lines lacking an appropriate required arrangement modifier.
DME – Own	Identifies a claim line for a DME item that has been submitted with an ownership modifier (NU – New, NR – New when rented, UE – Used), when the same DME item has previously been paid with the same or different ownership modifier.
DME – Rent to Own	Identifies claims lines submitted for the rental of a DME item in which the rental payment for the DME item exceeds the maximum number of rental payments as defined by CMS.
DME – Rent to Own History	Identifies claim lines submitted for the rental of a DME item (Rental Modifier: RR) when the same DME item shows a history of beneficiary ownership (Ownership modifiers: NU – New, NR – New when rented, UE – Used).