Provider Newsletter

providers.amerigroup.com

2016
Quarter 2

A message from President John Koehn

For calendar year 2016, the Division of Medical Assistance and Health Services (DMAHS) has made an additional investment into New Jersey physician rates – Amerigroup Community Care has created an incentive program to distribute those funds for services provided in 2016. The goals of this incentive program are:

- Strengthening member access to physician services
- Promoting routine and preventive care behavior

Over the past several weeks you should have received information from Amerigroup regarding the rollout of several physician incentive programs.

Qualified participating Amerigroup providers are eligible for incentive payments when the following services are provided to our members:

- Preventive care for adults and children, including: completing immunizations, child and adult well-visits, body mass index (BMI) scores on adult or child claims, and child nutrition counseling:
- Timely prenatal and postpartum visits; and
- Diabetes management including HBA1C testing and control and screening for retinopathy and nephropathy.

For details or more information regarding the Provider Incentive Program, visit the Amerigroup provider website at https://providers.amerigroup.com or contact your Provider Relations representative. Thank you for the continued commitment and care that you give our members – your patients.

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Amerivantage is an HMO plan with a contract with the State Medicare program. Enrollment in Amerivantage depends on contract renewal.

Message from Dental Director Lon Rosen, DMD

In October 2015, I proudly joined Amerigroup Community Care as the New Jersey Dental Director. Prior to joining Amerigroup, I was the owner of various dental offices for more than 30 years. I graduated from Howard University College of Dentistry in 1983.

New Jersey Smiles is a dental program started in 2006 as a Medicaid-quality collaborative focused on improving oral health in young children. Some highlights of the program are:

- The program serves children birth to six years old.
- Children should have their first dental visit around the time of their first tooth eruption and no later than age one.
- Amerigroup will pay for oral exams and cleanings for children twice per year.
- You and our patients can find a directory of dentists participating in New Jersey Smiles on our website at https://providers.amerigroup.com/NJ > Provider Resources & Documents > New Jersey Smiles Dental Program > New Jersey Smile Directory.

Another aspect of the New Jersey Smiles program is children's fluoride varnish application from non-dental providers. This is a program where, after training, pediatricians and their appropriate staff may apply fluoride varnish up to four times per year to children six months through six years of age. This application of fluoride varnish in no way limits a dentist's ability to provide and get reimbursement for fluoride treatment placed in the dental office. Additionally, a pediatrician will only get credit for fluoride varnish treatment after a referral is made to a dental provider's office.

I am here to help you and can be contacted at Lon.Rosen@amerigroup.com.

Medicaid

Precertification via the Amerigroup website

Did you know that you can use our provider self-service website to determine whether a service requires precertification or notification?

You can also submit the following requests for members:

- Precertification for services
- Emergent admissions
- Maternity/obstetric global services

Click here to access the Amerigroup Website User Guide: Precertification Requests.

Managed long term services and supports (MLTSS) overview

As our member's health care provider, you share a common bond with Amerigroup Community Care – to have the frail population we serve maintain optimal health in the environment of their choice, for as long as possible.

The information below is a brief summary of our MLTSS Program. Our goal is to prevent the institutionalization of our members in order for them to remain safely in their communities. Please familiarize yourself with our program and contact us with questions about how we can assist you in serving your patients.

The MLTSS Program assists members so they can live independently in their homes and communities. MLTSS also addresses the needs of individuals residing in nursing facilities, for whom independent living is not an immediate option. MLTSS helps individuals in the community obtain services to assist them with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). These services range from providing assistance with eating, dressing and toileting, to assisting with managing a home, preparing food and light housekeeping.

Each individual's need varies in complexity. Members may require services from multiple providers and systems. Often times, navigating the complexities of long term services and supports can be challenging for members and can lead to gaps in service delivery. The Amerigroup care management model helps minimize these gaps by identifying, evaluating, coordinating and managing individual needs. This may involve coordination of care, assisting members in accessing community-based resources, providing disease-specific education or any number of a broad range of interventions designed to improve the quality of life and functionality of members and to make efficient use of available health care and community-based resources.

Please contact us if you see the need for intervention from our team or if you have any questions concerning our services.

MLTSS toll free number: 1-855-661-1996 (Please call this number to speak with a MLTSS representative.)

MLTSS fax numbers
MLTSS fax: 1-888-826-9762
Personal care services fax: 1-888-240-4716
Medical day care fax: 1-888-240-4717

Pediatric lead screening

Childhood lead exposure remains a major environmental health problem throughout the United States and New Jersey. Recent news reports of lead contamination in public water supplies and the ongoing contamination crisis in Flint, Michigan, has many parents concerned about lead poisoning. This offers an opportunity for providers to discuss and encourage lead screening for children.

Today, there are at least four million households in the United States where children are exposed to high levels of lead. There are approximately 500,000 children one to five years of age with blood lead levels above five micrograms per deciliter (ug/dL).

Lead exposure can affect nearly every system in the body. Because lead exposure often occurs with no obvious symptoms, it frequently goes unrecognized. Other facts about lead poisoning include:

- No safe blood lead level in children has been identified
- Blood lead levels above five ug/dL is the reference level at which the Centers for Disease Control (CDC) recommends public health actions be initiated
- The CDC's Childhood Lead Poisoning Prevention Program is committed to the Healthy People 2020 goal of eliminating blood lead levels ≥ 10 ug/dL

What can you do?

Encourage parents to bring their children in for regular checkups and lead screenings.

When should children be screened for lead poisoning?

- All children should be screened for lead poisoning at 12 and 24 months of age
- Any child between three and six years of age who has never previously been screened
- Any child who is six months of age or older and is exposed to a known or suspected lead hazard should be screened

Below is a brief lead risk assessment questionnaire (this is not considered a lead screening).

Does your child:

- Live in or regularly visit a house built before 1960 with peeling or chipping paint? (This could include a childcare center, preschool or home of a baby sitter).
- Live in or regularly visit a house built before 1960 with recent (past six months), ongoing or planned renovation?
- Live with an adult whose job or hobby involves exposure to lead? (Examples include working in foundries, construction or working with batteries, pottery or other materials containing lead.)
- Have an elevated blood lead level (10 or higher) when last screened? (If the child has not been previously tested and is 12 months or older, consider this a "yes" response.)

- Have a household member who uses traditional, folk or ethnic remedies or cosmetics or who routinely eats food imported informally (e.g., by a family member) from abroad?
- Have a family member or friend who has or did have an elevated blood lead level?
- Is your child a recent immigrant, refugee or foreign adoptee?
- Have family designated at increased risk for lead exposure by the health department because the family has local risk factors for lead exposure (e.g., residence in a designated high-risk ZIP code or near a known point source)?

A "yes" or "I don't know" answer to any of these questions indicates a need for more frequent screening.

Screening guidelines:

- All children by law (N.J.A.C. §8:51A) are required to be screened.
- Every PCP and health care facility that provides care to children less than six years of age is required to comply with the law (State of New Jersey Department of Health).

Did you know that there is an alternative to traditional venous collection for lead screening?
We know that patients do not always take their child to a lab for the traditional venous collection required for the lead screening. Being able to offer a less invasive, less traumatic, in-office option may be a better choice. We want to make you aware of such an option – filter paper lead testing through MedTox.

MedTox is part of LabCorp's specialty testing group and is a Clinical Laboratory Improvement Amendment (CLIA), Community Alternatives Program (CAP), and Substance Abuse and Mental Health Services Administration-accredited lab that has been in the lead testing business for nearly 30 years. MedTox offers a simple lead screening process that may be performed with only two drops of blood collected during a routine office visit.

Content source:
Centers for Disease Control and Prevention: National Center for Environmental Health
Centers for Disease Control and Prevention: Division of Emergency and Environmental Health Services
Centers for Disease Control and Prevention: *cdc.gov/nceh/lead/about/program.htm*
Centers for Disease Control and Prevention:
cdc.gov/nceh/lead/data/Website_StateConfirmedByYear_1997_2013_11182015.htm
Centers for Disease Control and Prevention: *cdc.gov/mmwr/preview/mmwrhtml/rr4914a1.htm*
State of New Jersey Department of Health: *nj.gov/health/fhs/newborn/lead.shtml*

Improving provider/patient communication

Clear communication is an important part of a patient's ability to understand and act upon health information. This can include a patient's ability to follow instructions after a doctor visit. Patient compliance can be related to the quality of the interaction between doctor and patient. Positive transactions with patients will help patients feel empowered, cared about and encouraged to take an active role in their health care.

Five steps to improve provider/patient communication and patient compliance:

1. Greet the patient with a smile (e.g., knock on door, make eye contact, introduce yourself if it is your first meeting and sit down with the patient instead of standing)
2. Set a realistic agenda with the patient for the visit
3. Listen to and address the patient's important health concerns
4. Slow down and use simple terms (without jargon and acronyms) or words that he or she would use
5. End the visit by asking the patient to tell you what he or she understood from the visit

Like many patients, Amerigroup Community Care members come from diverse cultural backgrounds. They have a wide variety of traditions, languages and ways of perceiving others and the world around them.

Medicine has its own culture, with customs and mores that patients must learn. Doctors interpret this set of cultural values by communicating the patient's health condition, illness or treatment in a way that the patient understands. Even if you are unfamiliar with a particular culture, there are still ways to have a meaningful interaction based on mutual respect.

Amerigroup is here to help

Amerigroup policy is designed to ensure meaningful access to health care services for both members and providers.

Amerigroup provides training opportunities to staff and network providers about cultural awareness and ways to effectively interact with members. Amerigroup promotes respect for all people among. To schedule training for your office, call 732-452-6092 or 732-452-6007.

Upon request, written member materials are available in braille, in large print, on tape and in languages other than English. Member materials are written at appropriate reading levels.

If you are serving an Amerigroup member with whom you cannot communicate, call Member Services at 1-800-600-4441 to access an interpreter. For immediate needs, Amerigroup has Spanish language interpreters available without delay and can provide access to interpreters of other languages in minutes.

Additionally, for members with impaired hearing, providers are required to offer interpretive services to members who may need services. Amerigroup can help you telephonically communicate with patients via a translation device. In-office sign language assistance is available if requested in advance. Call Member Services at 1-800-600-4441 to arrange for these services. Both the telephonic and in-office interpreter services are covered by Amerigroup.

Vaccines fee schedule change

Amerigroup Community Care values the input of participating providers. Many of you recently informed us of the need to revise our vaccine fee schedule for specific CPT-4 codes for vaccines. You spoke and we listened!

Effective February 1, 2016, Amerigroup changed its vaccine fee schedule to reflect the Centers for Disease Control and Prevention (CDC) private sector pricing. This change should enable you to regularly maintain the appropriate supply of vaccines in your office.

If you have any questions regarding this change, please contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

Thank you for your continued participation and the quality services you provide to our members.

Routine cervical cancer screening

We recently communicated with you regarding cervical cancer screening coverage for women younger than 21 years of age. This communication provides new coverage information on the frequency of cervical cancer screening of women at average risk. It does not address women with a history of prior abnormal results, precancerous cervical lesions, cervical cancer or those who are immunocompromised.

Additional coverage information

As previously communicated, routine screening pap testing will not be reimbursed for women younger than 21 years of age. In addition, effective October 30, 2016, routine screening frequency for women age 21 to 65 will be reimbursed no more frequently than once every three years. Also, reimbursement for routine pap testing for women 66 and older, with prior negative screening results, will be denied.

Screening method and intervals

The U.S. Preventive Services Task Force[1], the American College of Obstetricians and Gynecologists[2], the American Cancer Society[3], the American Society for Colposcopy and Cervical Pathology and the American Society for Clinical Pathology all agree that the optimal screening interval is not more frequently than every three years.

Population	Recommended screening
Women younger than 21 years	No screening
Women aged 21-29 years	Cervical pap alone every three years
Women aged 30-65 years	Human papillomavirus (HPV) and cervical pap co-testing every five years or cervical pap alone every three years

Population	Recommended screening
Women older than 65 years	No screening is necessary after adequate negative prior screening results
Women who underwent total hysterectomy (with no residual cervix)	No screening is necessary

We encourage you to adopt this medical society and industry recommendation in the interest of improving patient quality and reducing harm from unnecessary follow up.

1. United States Preventive Services Task Force. Cervical Cancer. March 2012.
2. American College of Obstetricians and Gynecologists. Practice Bulletin Number 157: Screening for Cervical Cancer. Obstet Gynecol. 2016; 127:e1-20.
3. Saslow D, Solomon D, Lawson HW, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. CA Cancer J Clin 2012; 62:147-72.

New Claims Status Listing Tool

On June 18, 2016, a new Claims Status Listing Tool will be offered on the Amerigroup Community Care Payer Spaces on Availity. This application enables you to generate a list and view the status of multiple claims submitted to Amerigroup.

Besides your current claims status inquiry functionality on Availity, we will provide an added benefit with the Claims Status Listing Tool. With this tool, you can obtain a list of your claims submitted to Amerigroup for a specified period of time (span of up to 30 days) and up to two years back. You will have the opportunity to see the status of multiple claims in one report, if you choose, instead of looking them up one at a time.

Here's how to access the Claims Status Listing Tool:

- Log into the Availity Web Portal
- From the Availity Web Portal home page, select *Payer Spaces*
- Select the *Payer* from the list of payer options
- Select Applications, then select *Open* located below *Claims Status Listing Tool*

My organization does not use Availity. What do I need to do?

To initiate the registration process, have your primary controlling authority (PCA), a person who is authorized to sign on behalf of your organization, register. Click *Get Started* under the *Register Now* button and complete the online registration wizard.

After your PCA completes registration for the organization, your designated primary access administrator (PAA) will receive an email from Availity with a temporary password and next steps. Once logged in, the PAA can add users, providers and additional enrollments, if applicable. Please make sure each user has his or her own login and password. Logins and passwords should not be shared.

For questions or additional registration assistance, call Availity Client Services at 1-800-282-4548, Monday through Friday, 5 a.m.-4 p.m., Pacific time. If you have questions about this communication, received this fax in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

Adherence to access and availability standards improves access to care

Amerigroup Community Care has established access and availability standards to ensure timely health services are accessible to all members. These standards comply with regulatory requirements and are periodically measured through member satisfaction surveys, member complaint analysis, provider office-site visits and special surveys.

Availability standards

The following standards apply:

Type of care	Standard
Emergency care	Immediately; otherwise, refer to an emergency room
Urgent care	Within 24 hours
Routine care/preventive care (well-visits)	Within 28 days of request
Symptomatic acute care (nonurgent, symptomatic conditions or chronic problems)	Within 72 hours of request
Specialty care	Within four weeks of referral, based on severity of condition
Urgent specialty care	Within 24 hours of referral
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	In accordance with the Bright Futures/American Academy of Pediatrics periodicity schedule for well-child examinations and the Centers for Disease Control and Prevention (CDC) immunization schedule
Initial health visit – adult	Within 180 days of enrollment with Amerigroup
Initial health visit – child and adult Division of Developmental Disabilities clients	Within 90 days of enrollment with Amerigroup or in accordance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) periodicity schedule
After-hours care	Answering service or telephone message with directions on how to obtain urgent care must be available 24 hours a day, 7 days a week
Prenatal care:	
Initial visit	• Within three weeks of positive pregnancy test
High-risk visit	• Within three days of identification of high risk
Visit in first and second trimester	• Within seven days of request
Visit in third trimester	• Within three days of request
Laboratory/radiology services	• Within three weeks for routine appointments • Within 48 hours for urgent services
Dental services	• Within 48 hours of emergency • Within three days of referral for urgent care services
Behavioral health/substance abuse	• Immediately for emergency services • Within 24 hours for urgent care • Within 10 days of request for routine care

Access standards

Participating providers are responsible for offering members access to covered services 24 hours a day, 7 days a week. Access includes regular office hours on weekdays and the availability of a provider or designated agent by telephone after regular office hours, on weekends and on holidays. When unavailable, providers must arrange for on-call coverage by

another participating provider. The covering provider may not sign members out of the emergency room during his or her shift.

Additional access standards include:

- Member in-office wait times for an appointment must be within 45 minutes
- Provider response time for telephone call-back wait time, including:
  - After regular business hours, within 30 to 45 minutes for nonemergent, symptomatic issues
  - Same-day call-back for nonsymptomatic concerns
  - Call-back within 15 minutes for crisis situations

Provider offices must have telephone protocols in place to ensure the following situations are handled appropriately:

- Answering telephone inquiries in a timely manner
- Prioritizing appointments
- Scheduling a series of appointments and follow-ups as needed
- Identifying and rescheduling missed appointments
- Identifying special member needs while scheduling appointments (for example, wheelchair-bound members and members with interpretive linguistic needs)
- Triage noncompliant individuals with behavioral health issues for medical and dental conditions and special behavioral needs

Noncompliance

In the event a provider's office is found noncompliant with our standards, the provider's office is notified and resurveyed approximately six months later. If, upon resurvey, the provider's office remains noncompliant, a Provider Relations representative will visit the office to review the standards and to discuss corrective actions.

Questions?

Call your local Provider Relations representative at 732-452-6000.

Amerivantage

Dual Eligible Special Needs Plans (D-SNP) training required

In 2016, Amerigroup Community Care is offering Dual Eligible Special Needs Plans (D-SNPs) to people who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs) in CA. D-SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid. These plans are $0 premium plans. Some include a combination of supplemental benefits such as hearing, dental, vision as well as transportation to doctors' appointments. Some D-SNP plans also may include a card or catalog for purchasing over-the-counter items.

D-SNPs are a kind of Medicare Advantage plan that are approved by Medicare and also contract with the state Medicaid agency. Providers who see Amerigroup Medicare Advantage members in CA are "in network" and available to see Amerigroup D-SNP members effective January 1, 2016, unless they have opted out of participating with the D-SNP plan.

Providers should understand that D-SNP members are protected from all balance billing. Amerigroup D-SNPs are "zero cost share" plans, meaning we only enroll dual-eligible beneficiaries (people eligible for both Medicare and Medicaid) who have Medicare cost sharing protection under their Medicaid benefits. The provider may not seek payments for cost sharing from dual-eligible members for health care services. Providers cannot bill D-SNP members for services not reimbursed by Medicaid or Amerigroup's D-SNP plan, nor can providers balance bill for the difference between what has been paid and the billed charges.

Providers who are contracted for D-SNP plans are required to take annual training to keep up-to-date on plan benefits and requirements, including coordination of care and Model of Care elements. Providers contracted for our D-SNP plans received notices in January that contained information for online training, either through scheduled WebEx sessions or through self-paced training on our provider portal. Every provider contracted for our D-SNP plans is required to complete an attestation stating that they have completed the annual training. These attestations are located at the end of the self-paced training document and can be completed by individual providers or at the group level with one signature along with a roster of providers that participate within the group.

To take the self-paced training, please go to the Training Programs link at https://providers.amerigroup.com/NJ.

Reimbursement Policies

New Policy
Medical Recalls
(Policy 06-111, effective 10/01/2016)

Amerigroup Community Care does not allow reimbursement for repair or replacement of items due to a medical recall. The following are applicable items:

- Durable medical equipment
- Supplies
- Prosthetics
- Orthotics
- Drugs/vaccines

Amerigroup will allow reimbursement of medically necessary procedures to remove and replace recalled or replaced devices. Amerigroup will not be responsible for the full cost of a replaced device if an inpatient or outpatient facility is receiving a partial or full credit for a device due to recall. Payment will be reduced by the amount of the device credit.

For additional information, refer to the Medical Recalls reimbursement policy at https://providers.amerigroup.com.

New Policy
Multiple Procedure Payment Reduction
(Policy 15-002, effective 10/01/2016)

When services are performed on the same date of service during the same patient encounter and by the same physician or health care professional with the same National Provider Identifier (NPI) or multiple providers in the same group practice with the same group NPI, the following will be subject to Multiple Procedure Payment Reductions (MPPR):

- "Always therapy" services
- Cardiovascular procedures
- Ophthalmology procedures

For specific information regarding reimbursement for these services and procedures, refer to the Multiple Procedure Payment Reduction policy at https://providers.amerigroup.com.

Policy Updates
Assistant at Surgery (Modifiers 80/81/82/AS)
(Policy 06-005, effective 07/01/2013)

Amerigroup Community Care allows reimbursement for one assistant surgeon when eligible procedures are billed with Modifiers 80, 81, 82 or AS.

Assistant at surgery services are eligible for reimbursement as follows:

- Modifier 80: 20 percent
- Modifier 81: 20 percent
- Modifier 82: 20 percent
- Modifier AS: 85 percent of MD 'Assistant Surgeon' fee

Amerigroup uses code editing software to process claims billed for assistant at surgery. If an applicable modifier is not billed appropriately, the procedure may be denied.

For additional information, refer to the Assistant at Surgery (Modifiers 80/81/82/AS) reimbursement policy at https://providers.amerigroup.com.

Policy Reminder
Facility Take Home DME and Medical Supplies
(Policy 06-081, effective 12/22/2009)

Amerigroup Community Care does not allow reimbursement of Durable Medical Equipment (DME) and medical supplies dispensed by a facility for take-home use under the inpatient or outpatient hospital benefit. Facility claims submitted for DME and medical supplies billed with revenue codes denoting take-home use will be denied.

To be considered for reimbursement, claims for take-home DME and medical supplies should be submitted by a DME/supply vendor. Reimbursement is based on the:

- Contract or negotiated rate for participating vendors
- Out-of-network fee schedule or negotiated rate for non-participating vendors

Amerigroup allows reimbursement of facility claims for medical supplies dispensed to the member at discharge and billed with revenue codes other than take-home for the following items:

- Crutches
- Medical supplies for no more than 72 hours if the provider was not able to obtain supplies from a vendor by discharge

For additional information, refer to the Facility Take Home DME and Medical Supplies reimbursement policy at https://providers.amerigroup.com.

Medicaid/Medicaire

Effective November 1, 2016 ClaimsCheck® upgrade to ClaimsXten™

Amerigroup Community Care appreciates your participation in our network. Amerigroup uses ClaimCheck 10.2, a comprehensive nationally recognized code auditing system, to ensure consistent physician and facility reimbursement by automatically evaluating provider claims in accordance with accepted industry coding standards. The purpose of this update is to notify you that we are upgrading ClaimCheck 10.2 to ClaimsXten, McKesson's next generation code auditing system. As with ClaimCheck 10.2, ClaimsXten uses rules derived from a combination of CMS coding guidelines, AMA/CPT, Specialty Society guidelines and Amerigroup policy. The upgrade will become effective November 1, 2016.

What is ClaimsXten?

ClaimsXten is an auditing software product from McKesson that in combination with claims processing systems:

- Reinforces compliance with standard code edits and rules
- Ensures correct coding and billing practices are being followed
- Determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes
- Processes those services according to industry standards

Why are we upgrading from ClaimCheck 10.2 to ClaimsXten?

We periodically update our claims logic to:

- Conform to changes in coding standards
- Include new procedure and diagnosis codes

How will the upgrade to ClaimsXten affect you?

Providers will continue to see similar edits as under ClaimCheck 10.2. ClaimsXten has enhanced audit logic and the ability to analyze claims submission history. Outpatient services will be analyzed for such issues as:

- Rebundled or unbundled services
- Multi-channel services
- Mutually exclusive services
- Incidental procedures
- Incorrect use of CPT codes
- Fragmented billing of pre- and postoperative care
- Diagnosis to procedure mismatch
- Upcoded services

Other procedures and categories that are reviewed include:

- Cosmetic procedures
- Obsolete or unlisted procedures
- Age/sex mismatch procedures
- Investigational or experimental procedures
- Procedures being billed with inappropriate modifiers

What types of edits appear on my explanation of payment (EOP) when an edit is applied by ClaimsXten to a service I submitted?

The following list, which is not all inclusive, contains edits that may appear on your EOP when rule is triggered in ClaimsXten:

Rule	Provider type	Description
Inappropriate age	Professional/ facility	Procedure code is either inappropriate for the member's age or an age-specific CPT code does not match the member's age.
Deleted code	Professional/ facility	Procedure code has been deleted from CPT.
Invalid diagnosis code	Professional/ facility	Procedure submitted with an invalid diagnosis code.
Inappropriate gender	Professional/ facility	Procedure code is either inappropriate for the member's gender or a gender-specific CPT code does not match the member's gender.
Invalid modifier-procedure	Professional/ facility	Modifier used is invalid with the submitted procedure code.
Multiple radiology reduction	Facility	Reduction applied to multiple contiguous radiology procedures using the same modality on the same date of service (DOS).
Assistant surgeon	Professional	Assistant surgeon not eligible for procedure.
Base code quantity	Professional	Base code with units >1, where add-on code would be appropriate.
Bundled services	Professional	Services incidental to the primary procedure.
Multiple surgery reduction	Professional	Reduction applies to multiple procedures on the same DOS. Procedure with highest reimbursement paid as primary.
Global surgical edits	Professional	Pre-op visit, post-op visit, procedure or other service considered part of the global surgical period.
Maximum units	Professional	Medically unlikely number of units on the same DOS.
Global component	Professional/ facility	Audits across multiple providers to ensure that professional and technical components are not reimbursed more than once for the same member, procedure and date of service.
Anesthesia not eligible	Professional	Audits claim lines containing nonanesthesia services submitted by an anesthesiologist as described by the American Society of Anesthesiologists.
Outpatient consultations	Professional	Audits for claim lines containing an outpatient consultation when another outpatient consultation was billed for the same member by the same provider with at least one matching diagnosis within a six-month period.

Rule	Provider type	Description
Inpatient consultations	Professional	Audits for 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 five-day period.
New patient code for established patient	Professional	Audits for 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.
Duplicate line items	Professional	Audits for claim lines that match a previously submitted claim line on a different claim for the same member, provider, procedure, modifier, date of service, quantity and billed amount.

If you have questions regarding ClaimsXten edits that you receive on your explanation of payment, please call the Provider Services at 1-800-454-3730 and select the appropriate prompt.