August 2016 news bulletin

Just for you: Amerigroup lunch-and-learns

Would you like to learn more about what we offer our members? Our community relations team would love to meet with your office staff and share about our focus on whole-person care. Initiatives include community investments, foundation work and value-added benefits built around promoting healthy living. We'll even bring lunch! Just let your Provider Relations representative know you'd like this training.

Easy to do business with – the Provider Services program

If you have an idea for how we can be easier to do business with, please let your local Provider Services representative know.

Get your groove on

Anthem Inc., the parent company of Amerigroup Washington, Inc., launched Anthem Health Champions Radio – a Pandora station with music to inspire your workouts. This station is open to everyone, so please share it with your friends and family. Search Pandora for "Anthem Health Champions Radio" today and get your body moving!

Incentives for well-child exams

Did you know Amerigroup members can receive a gift card as an incentive for completing their annual well-child exam? We can also work together to customize wellness incentive promotions specifically for your patients. Contact our HEDIS manager at 509-590-3346 for more information.

Member incentives include:

- Well-child visits during the first 15 months of life: $25 gift card to Toys"R"Us®
- Well-child visits for patients 3-6 years of age: $25 gift card to Toys"R"Us
- Adolescent well-visits: $25 gift card to iTunes®

To get full credit for rendering annual wellness exams, use the early and periodic screening, diagnostic and treatment CPT codes (99381-99385 and 99391-99365). Also, be sure to fully document the exam in the member's medical record.

Toys"R"Us and iTunes are registered trademarks of Geoffrey, LLC and Apple Inc., respectively.

Incentive for providers taking care of our Medicare members

In April 2016 we announced a new provider incentive, which encourages providers to complete a yearly, comprehensive physical for each of their Amerigroup members. The physicals must be completed during a face-to-face visit and on the date of service.

Providers will receive a **$150 reimbursement** for completing one comprehensive physical for each member per calendar year. The review must be completed by September 30, 2016, and pass the quality review for accuracy and completeness. This deadline is established to allow members to complete all appropriate provider referrals for other needed services (e.g., diabetic eye exams, mammograms, lab work, colorectal cancer screenings, etc.) by the end of the year.

How do I complete the attestation form?

1. Schedule a comprehensive physical exam for the patient for dates of service between January 1, 2016, and September 30, 2016.
2. Document all supporting notes/documentation for applicable diagnoses and gap closures in the patient's medical record.
3. Sign the form and attest.
4. Return the form and supporting medical record documentation via fax or secure email to:
    a. Francia Bowen, senior coding auditor
    Fax number: 1-855-806-3193
    Email: Francia.bowen@anthem.com
5. Submit a claim via a clearinghouse, our self-service website or mail a paper claim to:
    a. Amerigroup Washington, Inc.
    P.O. Box 61010
    Virginia Beach, VA 23466-1010

When the claim is paid, you will receive an additional **$150 reimbursement** for each Amerigroup member per calendar year.

Flu season 2016-2017

The Department of Health's Vaccine Advisory Committee on Immunization Practices (ACIP) voted that the live attenuated influenza vaccine (LAIV, also known as the nasal spray flu vaccine), should not be used during the 2016-2017 flu season. Data from 2013 through 2016 showed poor or relatively lower effectiveness of LAIV. The ACIP also voted to remove FluMist from the Vaccines for Children program. Neither the Health Care Authority nor Amerigroup will pay for FluMist during the 2016-2017 flu season. A yearly flu vaccination is still recommended for everyone 6 months and older.

Effective January 1, 2017: cumulative morphine equivalent dosing edit

Beginning January 1, 2017, Amerigroup will implement a cumulative morphine equivalent (MEq) dosing edit at the point of sale (POS).

This MEq dosing edit will identify members taking a cumulative dose that exceeds the set daily dose. There is a higher risk for overdose when exceeding the set MEq dosing limit; this patient-safety edit is intended to reduce that risk. The claim(s) will be rejected at the POS and will require a prior authorization review if the cumulative dose is over the set daily limit. Certain members may be excluded from the edit (e.g., members with cancer). The edit supports CMS guidance mandating that Medicare plans implement a cumulative dosing edit. We anticipate that this edit will impact a fairly high number of claims.

Cervical cancer screening frequency update

We recently communicated with providers regarding cervical cancer screening coverage for women younger than 21 years of age. This communication provides new coverage information about the frequency of cervical cancer screening for 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.

Please note the following:

- Routine screening Pap testing will not be reimbursed for women younger than 21 years of age.
- Effective October 30, 2016, routine screening frequency for women 21 to 65 years of age will be reimbursed no more frequently than once every three years.

- For women 66 and older with prior negative screening results, routine Pap testing reimbursement will be denied.

Screening method and intervals

The U.S. Preventive Services Task Force, the American College of Obstetricians and Gynecologists, the American Cancer Society, the American Society for Colposcopy and Cervical Pathology and the American Society for Clinical Pathology all agree that the optimal screening interval is no more frequently than every three years.

Population	Recommended screening
Women younger than 21 years of age	No screening
Women 21-29 years of age	Cervical Pap alone every three years
Women 30-65 years of age	Human papillomavirus (HPV) and cervical Pap cotesting every five years or cervical Pap alone every three years
Women older than 65 years of age	No screening necessary (after adequate negative prior screening results)
Women who underwent total hysterectomy (with no residual cervix)	No screening necessary

In the interest of improving patient quality and reducing harm from unnecessary follow-up, we encourage providers to adopt this industry recommendation.

Medical policies and clinical utilization management guidelines update

Updated medical policies

On May 5, 2016, the Medical Policy and Technology Assessment committee (MPTAC) approved the following medical policies applicable to Amerigroup. These medical policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the listing below. Note: Existing precertification requirements have not changed.

Effective date	Policy number	Medical policy	Medical policy (new/revised)
May 19, 2016	DRUG.00082	Daratumumab (DARZALEX™)	New
May 19, 2016	DRUG.00083	Elotuzumab (Empliciti™)	New
May 19, 2016	DRUG.00084	Interferon gamma-1b (Actimmune®)	New
June 28, 2016	DRUG.00085	Ixabepilone (Ixempra®)	New
June 28, 2016	DRUG.00086	Mecasermin (Increlex®)	New
June 28, 2016	GENE.00045	Detection and quantification of tumor DNA using next generation sequencing in lymphoid cancers	New
July 1, 2016	SURG.00143	SpaceOAR® system	New
May 12, 2016	DRUG.00028	Intravitreal treatment for retinal vascular conditions	Revised
May 12, 2016	DRUG.00063	Ofatumumab (Arzerra®)	Revised
June 28, 2016	DRUG.00076	Blinatumomab (Blincyto®)	Revised
May 19, 2016	DRUG.00077	Monoclonal antibodies to interleukin-17A	Revised
June 28, 2016	MED.00119	High-intensity focused ultrasound (HIFU) for oncologic indications	Revised

Medical policies were made publicly available on the Amerigroup provider website on the effective date listed above. To search for specific policies, visit https://medicalpolicies.amerigroup.com/search.

Updated clinical utilization management guidelines
On May 5, 2016, the MPTAC approved the following clinical utilization management (UM) guidelines. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the below listing. This list represents the clinical UM guidelines adopted by the medical operations committee for the Government Business Division on June 7, 2016. Note: Existing precertification requirements have not changed.

Effective date	Clinical UM guideline number	Guideline title	New/ revised
June 28, 2016	CG-DME-39	Dynamic low-load prolonged-duration stretch devices	New
June 28, 2016	CG-DRUG-48	Azacitidine (Vidaza®)	New
June 28, 2016	CG-DRUG-49	Doxorubicin hydrochloride liposome injection	New
June 28, 2016	CG-DRUG-50	Paclitaxel, protein-bound (Abraxane®)	New
June 28, 2016	CG-DRUG-51	Romidepsin (Istodax®)	New
June 28, 2016	CG-DRUG-52	Temsirolimus (Torisel®)	New
June 28, 2016	CG-DRUG-53	Drug dosage, frequency and route of administration	New
June 13, 2016	CG-SURG-55	Intracardiac electrophysiological studies (EPS) and catheter ablation	New
June 28, 2016	CG-DRUG-15	Gonadotropin releasing hormone analogs	Revised
June 28, 2016	CG-DRUG-34	Docetaxel (Docefrez™, Taxotere®)	Revised
June 28, 2016	CG-SURG-27	Sex reassignment surgery	Revised
May 19, 2016	CG-SURG-44	Coronary angiography in the outpatient setting	Revised
June 28, 2016	CG-THER-RAD-01	Fractionation and radiation therapy in the treatment of specified cancers	Revised

These clinical guidelines were made publicly available on the Amerigroup provider website on the effective date listed above. To see the full UM guidelines, visit https://medicalpolicies.amerigroup.com/search.

Cultural and linguistic services, capabilities and training

Our population continues to become more culturally diverse. While we celebrate the richness this brings to our state, we recognize this puts more pressure on providers to effectively serve patients in culturally aware ways. Understanding the cultural and linguistic capabilities of your practice is important, and we

want to make Amerigroup members aware of the support available from your practice. Please help us promote your practice's cultural and linguistic services and capabilities by taking a brief, five-minute survey at https://www.surveymonkey.com/r/QQM3KK7. Thank you for all you do to optimize care for patients in your practice!

Washington population data on language

Like you, we aim to effectively serve the needs of diverse patients. It's important for all of us to be aware of the cultural and linguistic needs of our communities. For this reason, we are sharing this list of some of the current languages most frequently spoken by eligible members in Washington:

- Chinese
- Korean
- Russian
- Spanish or Spanish Creole
- Tagalog
- Vietnamese

Language support services

As a reminder, we provide language assistance services for our members with limited-English proficiency (LEP) or hearing, speech or visual impairments. Please see the Amerigroup provider manual for details and instructions on how to access resources; we have several resources available to you and your practice that can provide guidance on communicating and serving diverse populations effectively.

Cultural competency training and toolkit

Health care providers need a practical set of tools that will enable them to become culturally aware and proficient to help provide a positive, rewarding and quality care experience to patients. We encourage providers and their office staff to take the Amerigroup cultural competency training online at https://providers.amerigroup.com/WA> **Training Programs** > **Cultural Competency Training**, and read through the *Cultural Competency Toolkit*, which contains information, tips and resources regarding language, interpreter services, cross-cultural issues and more:

- Encounter tips for providers and their staff
- Help in identifying literacy problems
- An interview guide for hiring clinical staff
- Tips for locating and working with interpreters
- Common signs and common sentences in many languages
- "I Speak" cards to help identify patients' preferred language (the cards can be posted in provider offices and/or given to patients)
- A sample employee language skills self-assessment tool to help you evaluate the language skills of your staff

You can also obtain no-cost continuing medical education credits through further study of cultural competency topics at https://www.thinkculturalhealth.hhs.gov/Content/ContinuingEd.asp.

Zika virus update

The Zika virus pandemic continues to evolve. We want to update you on what we know about the public health effects of the virus and to support your efforts in providing care to Amerigroup patients at risk for exposure.

The Zika virus was declared a worldwide health emergency in February 2016. It is a mosquito-borne virus capable of causing a mild illness that in most people is asymptomatic. It can, however, pose a risk in pregnant women of serious birth defects, including microcephaly and other brain abnormalities. The virus can be sexually transmitted. Guillain-Barré syndrome, a rare disorder causing muscle weakness and sometimes paralysis, has also been reported in patients following suspected Zika virus infection. Here is what is known about the Zika virus:

- The virus is actively transmitted in many areas, including Puerto Rico, Mexico and 20 countries in Central and South America, the Caribbean, the Pacific Islands and Africa.
- The mosquitos that carry Zika are present in 30 U.S. states. The areas most likely to be affected include the gulf states, with cities in southern Florida and south Texas.
- In April 2013, the Centers for Disease Control and Prevention (CDC) published a "Special Report" in the New England Journal of Medicine concluding that there is a causal relationship between prenatal Zika virus and microcephaly and other neurological disorders, including Guillain-Barré syndrome.
- The FDA has begun emergency use approval for commercially available tests that can detect the Zika virus during the first week of symptoms. The CDC performs antibody testing that can be done after the virus is gone from the blood stream.
- The CDC has established a Zika registry for pregnant women exposed to the virus.
- There is no treatment or vaccine for Zika virus infections. Medical care is directed at alleviating symptoms. The focus is on prevention of exposure by protecting against mosquito bites and avoiding travel to areas with active Zika transmission.
- Our medical coverage includes testing and evaluation for the Zika virus. We support the CDC's current recommendations for screening, testing and management of pregnant women, including serial ultrasounds in certain scenarios.
- Recommendations on counseling, diagnosis and testing of persons exposed, including pregnant women and women considering pregnancy, can be found at http://www.cdc.gov/zika/hc-providers/index.html.
- For your state's Zika information, visit http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/ZikaVirus.

Mental health billing for evidence-based practices

Evidence-based medicine, evidence-based practice, research-based practice and evidence-based health care (collectively known as EBPs) include programs such as cognitive behavioral therapy (CBT) and the Positive Parenting Program (Triple P). The Health Care Authority requires us to collect data on EBPs for its membership. Providers who provide these services to patients younger than 21 years of age should include the appropriate expedited prior authorization (EPA) number from the following table when billing for EBPs.

Programs/coding for mental health professionals	EPA number
Behavioral parent training for children with disruptive behavior disorders	870001393
Bonding and attachment via the theraplay model (promising practice)	870001333
Brief strategic family therapy	870001390
Child-parent psychotherapy	870001389

Cognitive behavioral therapy (CBT)	870001334
CBT+ for behaviors, anxiety and depression	870001331
Eye movement desensitization and reprocessing (EMDR) for child trauma	870001391
Families and schools together (FAST)	870001392
Fast track prevention program	870001396
Full fidelity wraparound for youth with a serious emotional disturbance (SED)	870001397
Guiding good choices	870001395
Incredible years	870001394
Parent-child interaction therapy (PCIT)	870001330
Positive Parenting Program (Triple P, level 2)	870001318
Positive Parenting Program (Triple P, level 3)	870001319
Strengthening Families program	870001335
Trauma-focused (TF) CBT	870001332

Electronic medical records checklist

Maximize your electronic medical record (EMR) to make sure you are meeting quality standards for all Medicaid patients. Below is a list of what you should review with your EMR:

- **Link4Health**: Talk with your vendor about submitting data to OneHealthPort. No later than February 1, 2017, provider organizations with certified electronic health records (EHRs) must begin submitting clinical summaries from the EHR to the Link4Health Clinical Data Repository (CDR) after each visit. OneHealthPort is hosting monthly webcasts to share information about how provider organizations and their EHR vendors can prepare and get started on data submissions to the CDR. Beginning June 14, 2016, provider webcasts will be held monthly on Tuesday mornings from 9 a.m.-10 a.m. Pacific time. Please register for one or more of the webcasts by going to: https://onehealthport.formstack.com/forms/cdr_clinical_webcast_registration.
- **Screening, brief intervention and referral to treatment (SBIRT) coding**: If you are billing for SBIRT services, be sure your providers are SBIRT-certified with the Health Care Authority (HCA). Also, be sure to check HCA's billing guidelines for allowed CPT and ICD-10 code combinations.
- **Coding for quality**: Capture all revenue due to you with proper billing. Do you have questions about the proper claims coding for HEDIS®* compliance? We have tips available for you with correct coding for measures. Contact your local Provider Services representative or our national Provider Services team at 1-800-454-3730.
- **Quality reports to Amerigroup**: You can reduce the work of copying medical records by setting up regular reporting directly to us from your EMR. We will work with you to set up the reports

and when HEDIS season comes around, we won't have to ask you for copies of records. Contact us at HealthPromotionTeam@amerigroup.com for more information.

**HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).*

New provider orientation

Did you miss out on your new provider orientation? If you haven't participated in a new provider orientation and would like to schedule an in-person training for your office, please let your local Provider Relations representative know. If you don't know who that is, call Provider Services at 1-800-454-3730, and we'll connect you.

Behavioral health services

All Amerigroup members have a behavioral health benefit. In mid-August, we are sending a directory of our contracted behavioral health providers to all primary care offices. You may also locate such providers at any time by using our provider search function online at https://providers.amerigroup.com. If you do not receive a printed directory and wish to have one sent to you, please contact your local Provider Relations representative. If you have questions, contact Provider Services at 1-800-454-3730.

Vascular embolization or occlusion services to require prior authorization

Effective September 1, 2016, vascular embolization or occlusion services will require prior authorization (PA). Vascular embolization or occlusion services requests must be reviewed by Amerigroup for PA for dates of service on and after September 1, 2016. To request PA, call 1-800-454-3730 or fax 1-800-964-3627.

For a list of Amerigroup reimbursement policies and more information on PA requirements, please visit our website at https://providers.amerigroup.com/WA and under *Provider Resources & Documents*, select **Quick Tools**.

- For reimbursement policies, select **Reimbursement Policies**.
- For authorization requirements, select **Precertification Lookup Tool**.

If you have questions, call Provider Services at 1-800-454-3730.

Quarterly pharmacy formulary change notice

The formulary changes listed in the table below were reviewed and approved by the Washington Health Care Authority and are effective August 15, 2016. The changes outlined below apply to all Amerigroup patients.

Therapeutic class	Drug	Revised status	Potential alternatives
NARCOTIC ANTAGONISTS	SUBOXONE 2 MG-0.5 MG SL FILM SUBOXONE 4 MG-1 MG SL FILM SUBOXONE 8 MG-2 MG SL FILM SUBOXONE 12 MG-3 MG SL FILM	NONPREFERRED (CURRENT UTILIZERS TO BE GRANDFATHERED)	BUPRENORPHINE 2 MG TABLET SL BUPRENORPHINE 8 MG TABLET SL

Please review these changes and work with your Amerigroup patient(s) to transition them to formulary alternatives. If you determine preferred formulary alternatives are not clinically appropriate for specific

patients, you will need to obtain prior authorization to continue coverage beyond the applicable effective date.

We recognize the unique aspects of patients' cases. If, for medical reasons, your Amerigroup patient cannot be converted to a formulary alternative, call our Pharmacy department at 1-800-454-3730 and follow the voice prompts for pharmacy prior authorization. You can find the preferred drug list on our provider website at https://providers.amerigroup.com.

If you need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

Nondiscrimination and accessibility requirements update

On May 13, 2016, the Department of Health and Human Services Office of Civil Rights (DHHS OCR) released the Nondiscrimination in Health Programs and Activities Final Rule (Final Rule) to improve health equity under the Affordable Care Act (ACA). Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, gender, gender identity, age or disability by providers, health programs and activities that a) receive financial assistance from the federal government, and b) are administered by any entity established under Title I of the ACA.

How does the Final Rule apply to managed care organizations?
Amerigroup Washington, Inc. complies with all applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, gender, gender identity, age or disability in its health programs and activities. Amerigroup provides free tools and services to people with disabilities to communicate effectively with us. Amerigroup also provides free language services to people whose primary language isn't English (e.g., qualified interpreters and information written in other languages).

We notified your Amerigroup patients these services can be obtained by calling the Member Services phone number on their member ID card.

Who can I talk to if Amerigroup isn't following these guidelines?
If you or your patient believe that Amerigroup has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our grievance coordinator via:

- Mail: 705 5th Ave. S., Suite 300, Seattle, WA 98104
- Phone: 1-800-600-4441 (TTY: 1-800-855-2880)
- Fax: 1-877-271-2409

If you or your patient need help filing a grievance, the grievance coordinator is available to help. You or your patient can also file a civil rights complaint with the DHHS OCR:

- Online at the OCR complaint website: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: 1-800-368-1019 (TTY/TTD: 1-800-537-7697)

Complaint forms are available at www.hhs.gov/ocr/filing-with-ocr/index.html. For additional details about Section 1557 and the Final Rule, visit:

- The DHHS OCR information page: www.hhs.gov/civil-rights/for-individuals/section-1557/index.html
- Frequently asked questions published by the DHHS: www.hhs.gov/sites/default/files/2016-05-13-section-1557-final-rule-external-faqs-508.pdf

Effective November 1, 2016: ClaimsCheck® upgrade to ClaimsXten™

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

Other procedures and categories that are reviewed include:

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

What type 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.
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 Provider Services at 1-800-454-3730 and select the appropriate prompt.