

WellCare uses a McKesson claims editing software, ClaimsXten 2.0, in addition to the following edits to process claims.

X	rule applies to LOB
	rule does not apply to LOB

Rule Description	Claim Type	New York			
		CHP	FHP	NMD	NMR
Identifies claim lines that are not eligible to be denied in a ClaimsXten rule.	BOTH	X	X	X	X
Identifies claim lines that are not eligible to be used as support across all ClaimsXten rules.	BOTH	X	X	X	X
This rule will pre filter claim lines from being reviewed by IC rules based on certain criteria set by the Client	BOTH	X	X	X	X
Identifies duplicate claim lines that have been submitted on a previous claim.	BOTH	X	X	X	X
This charge was previously processed.	BOTH	X	X	X	X
Identifies multiple OB Global codes when billed for the same member (same or different provider) within a 6 month period	PROF	X	X	X	X
Identifies claim lines containing preventive evaluation and management codes that are inconsistent with the member's age.	PROF	X	X	X	X
Identifies claim lines that have been submitted after the filing deadline.	PROF				X
Denies claim lines on professional claims that have been submitted after the filing deadline based on WCARE policy.	PROF	X	X	X	X
CMS default rule for non par Medicare facility claims	INST				X
Time limit for claim submission. Denies claim lines on facility claims that have been submitted after the filing deadline based on WCARE policy.	INST	X	X	X	X
Time limit for claim submission. Denies claim lines on non par facility claims that have been submitted after the filing deadline based on WCARE policy.	INST	X	X	X	
Identifies claims containing incomplete ICD-9 diagnosis codes.	BOTH	X	X	X	X
Identifies claim lines containing consultation codes that are billed by a member's primary care physician (PCP).	PROF	X	X	X	X
Identifies misuse of procedure codes designated for Federal holidays or Sundays.	PROF	X	X	X	X
Identifies Blood drawing procedure codes when they are billed by Labs.	PROF	X	X	X	
Identifies claim lines containing procedure codes that are typically not covered	PROF				X
Ambulance bundling	PROF				
Identifies EPSDT procedure codes that are not billed with appropriate DX in the line diagnosis 1 field.	PROF				
Identifies procedure codes are all inclusive with EPSDT procedure codes	PROF				
The limitation for this service has been met	PROF				
The limitation for this service has been met	PROF				
Identifies CPT lab procedure codes that are inclusive with Evaluation & Management (E&M) codes	PROF				
Identifies claim lines containing procedure codes billed with an assistant surgeon modifier that typically do not require an assistant surgeon	PROF	X	X	X	X
Identifies B12 injections that have not been billed with an ICD-9 diagnosis code that is typically required for reimbursement	PROF	X	X	X	X
Identifies claim lines containing supplies that have been submitted for the same date of service as a surgical procedure. Supply codes are established by CMS.	PROF	X	X	X	X
Identifies Evaluation & Management (E&M) or certain supply codes billed within a procedure's follow-up period	PROF	X	X	X	X
Identifies claim lines containing an add-on code billed without the presence of the related primary service/procedure	PROF	X	X	X	X
Identifies claim lines containing procedure codes that are inconsistent with the member's gender	PROF	X	X	X	X
Identifies claim lines containing procedure codes that are inconsistent with the member's gender	PROF	X	X	X	X
Identifies claims containing diagnoses that are inconsistent with the member's gender	PROF	X	X	X	X
Identifies claims containing diagnoses that are inconsistent with the member's gender	PROF	X	X	X	X

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Denies claim lines containing code pairs which are not payable according to GA DCH guidelines	PROF				
Identifies claim lines containing procedure codes indicated by The Centers for Medicare and Medicaid Services (CMS) as always bundled when billed with any other procedure.	PROF	X	X	X	X
Identifies claim lines where the submitted procedure code has already been billed with a modifier -50 for the same date of service	PROF	X	X	X	X
Identifies procedure codes inappropriately billed with a bilateral modifier. Rule denies the charge, informing the provider that modifier 50 is not valid for the CPT billed.	PROF	X	X	X	X
Identifies claim lines with bilateral CPT procedure code have been billed with a modifier 50 and a quantity greater than one. Rule denies the charge indicating that the bilateral procedure quantity has been billed incorrectly.	PROF	X	X	X	X
Identifies claims containing code pairs found to be unbundled according to the CMS National Correct Coding Initiative.	PROF	X	X	X	X
Identifies claim lines containing procedure codes that are typically not recommended for reimbursement when submitted with certain other procedure codes on the same date of service	PROF	X	X	X	
Identifies claim lines containing procedure codes that require a reduction based on multiple procedure guidelines. Rule denies the charge indicating that the procedure requires a multiple surgery reduction.	PROF	X	X	X	X
Identifies anesthesia procedure codes billed by a non anesthesia specialty. Industry accepted sources and Payer guidelines have established that non-anesthesia providers should not be reimbursed for anesthesia procedures.	PROF	X	X	X	X
Identifies claim lines containing new patient procedure codes that are submitted for established patients.	PROF	X	X	X	X
Identifies claim lines containing office or other outpatient consultations that should have been billed at the appropriate level of office visit, established patient or subsequent hospital care.	PROF	X	X	X	X
Identifies claim lines containing initial inpatient consultations that should have been billed at the appropriate level of subsequent hospital care.	PROF	X	X	X	X
Identifies claim lines where a Modifier 26, denoting professional component, should have been reported for the procedure performed at the noted place of service.	PROF	X	X	X	X
Rebundled Service	PROF	X	X	X	
Identifies claim lines containing new patient procedure codes that are submitted for established patients.	PROF	X	X	X	X
Identifies inappropriate billing of outpatient consultation codes, based on a match of provider specialty and FTIN	PROF	X	X	X	X
Only one initial inpatient consultation should be reported per inpatient admission.	PROF	X	X	X	X
Identifies a service or procedure that is billed with a frequency exceeding a given norm within a certain time period	BOTH	X	X	X	X
Ambulance bundling rule	BOTH				
Ambulance bundling rule	BOTH				
Rule identifies used and rented DME for CT Medicaid	BOTH				
Total OB care should be billed after the delivery date. Rule denies E/M 99201-99233 when billed with diag V22-V23.3.	PROF	X	X	X	X
Rule looks back within the past 300 days from current OB code for an E&M with a maternity DX code	PROF	X	X	X	X
Inappropriate Specialty with MOD	PROF				
Denies claim lines with the lower base value when an anesthesiologist bills two or more CPT non ASA codes for anesthesia.	PROF			X	X
Bundling rule for ASA codes	PROF			X	X
Identifies claim lines submitted by anesthesiologists for non-anesthesia services that have a one-to-many relationship with anesthesia services. These services need to be reviewed to determine the appropriate anesthesia Procedure Code.	PROF	X	X	X	X

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		CHP	FHP	NMD	NMR
Identifies claim lines submitted by anesthesiologists for non-anesthesia procedure codes that are not eligible to be cross walked to an anesthesia procedure code	PROF	X	X	X	X
Identifies claim lines submitted by anesthesiologists for non-anesthesia services that have a one-to-one relationship with anesthesia services	PROF	X	X	X	X
Behavioral health bundling rule	PROF				
Duplicate claim logic for facilities	INST				
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 code(s).	PROF	X	X	X	X
Duplicate Inpatient Claim	INST	X	X	X	X
Duplicate of claim already processed.	INST	X	X	X	X
Duplicate of claim already processed.	INST	X	X	X	X