BlueCross BlueShield of Oklahoma

ClaimsXten™ Rule Descriptions

RULE NAME	RULE DESCRIPTION
Surgical Inclusive Edit Effective: 04/18/2011	This edit will deny claim lines containing supplies when billed for the same date of service as a surgical procedure for which the Centers for Medicare & Medicaid Services, has assigned a global period.
Incidental Edit Effective: 04/18/2011	This edit will deny a claim line clinically integral to accomplishing the principal procedure/service or considered a component of the more comprehensive procedure.
Multicode Rebundle Edit Effective: 04/18/2011	This edit will deny a claim line when two or more procedures are used to describe a service when a single, more comprehensive procedure exists that more accurately describes the complete service performed.
Mutually Exclusive Edit Effective: 04/18/2011	This edit will deny a claim line that would not reasonably performed on the same patient on the same day.
Same Day Visit Edit Effective: 04/18/2011	This edit will deny claim lines containing Evaluation and Management codes billed on the same date of service as a procedure code with a global period.
Pre-Op Visit Edit Effective: 04/18/2011	This edit will deny claim lines containing Evaluation and Management codes billed within the pre-operative period of a procedure code with a global period.
Post-Op Visit Edit Effective: 04/18/2011	This edit will deny claim lines containing Evaluation and Management codes billed within the post-operative period of a procedure code with a global period.
Gender Replacement Edit Effective: 04/18/2011	This edit will deny claim lines containing procedure codes which are inconsistent with the member's gender and replaces the line with the gender-appropriate code.
Modifier to Procedure Edit Effective: 04/18/2011	This edit will deny claim lines with invalid modifier to procedure code combinations for those modifiers identified as payment modifiers.
Procedure Quantity Effective: 02/04/2012	This rule will deny claim lines submitted with procedure code 86003 with units of service greater than 25.
Co-Surgeon Effective: 12/17/2012	This rule will deny claim lines submitted with modifier -62 (Co-Surgeon) when the procedure code typically does not require co-surgeons as determined by CMS, and Current Procedural Terminology co-surgeon guidelines.
Age Code Replacement Rule Effective: 03/21/2016	This rule will identify claim lines containing procedure codes or preventive evaluation and management codes that are inconsistent with the member's age for which an alternate code is more appropriate for the age.
Obstetrics Package Rule Effective: 09/29/2014	This rule will deny potential overpayments for obstetric care. It will evaluate claim lines to determine if any global obstetric care codes (defined as containing antepartum, delivery and postpartum services, for example code 59400) were submitted with another global **OB care** delivery code.
Medically Unlikely Edits DME Effective: 12/15/2014	This rule will deny claim lines when the units of service for the DME items has been exceeded for a HCPCS code submitted by a provider or multiple providers for the same member and same date of service. The rule is based upon the MUE values from CMS Durable Medical Equipment, Prosthetics, Orthotics and Supplies.
MUEs Effective: 05/06/2013	This rule will deny claim lines when the units of service submitted for CPT/HCPCS codes by the same provider, same member, same date of service, exceeds the MUEs established by CMS for that CPT/HCPCS code.
Frequency Validation – Allowed Multiple Times Per Date of Service Effective: 05/06/2013	This rule will deny claim lines that contain procedure codes that have been submitted more than the maximum number of times allowed per date of service when the code description is defined as once per date of service.

BlueCross BlueShield of Oklahoma

RULE NAME	RULE DESCRIPTION
Frequency Validation – Allowed Once Per Date of Service Effective: 05/06/2013	This rule will deny claim lines when the quantity billed for the procedure code exceeds maximum allowed per date of service, per site. Source: American Medical Association (AMA)
CMS National Correct Coding Initiative Effective: 03/23/2015	The CMS National Correct Coding Initiative policies are based on coding conventions defined in the AMA CPT manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice and/or current coding practice. This rule will deny claim lines for which the submitted procedure is not recommended for reimbursement as defined by a code pair found in the NCCI.
Outpatient Facility – MUEs Effective: 02/29/2016	This rule will deny outpatient facility claim lines when the units of service submitted for CPT/HCPCS codes by the same provider, same member, same date of service, exceeds the MUEs established by CMS for that CPT/HCPCS code.
Facility Outpatient Code Editor CMS CCI Bundling Rule Effective: 02/29/2016	This rule will deny outpatient facility claim lines containing code pairs found to be unbundled according to CMS Integrated Outpatient Code Editor.
Facility Unbundled Pairs Outpatient Rule Effective: 02/29/2016	This facility rule identifies the unbundling of multiple surgical codes when submitted on facility claims. The rule detects surgical code pairs that may be inappropriate for one of the following reasons: one code is a component of the other code, or these codes would not be reasonably performed together on the same date of service.
Global Component Effective: 09/18/2017	This rule identifies claim lines with procedure codes which have components (professional and technical) to prevent overpayment for either the professional or technical components or the global procedure. The rule also detects when duplicate submissions occurred for the total global procedure or its components across different providers.
Component Billed Effective: 09/18/2017	This rule identifies when a professional or technical component of a procedure is submitted, and the same global procedure was previously submitted by the same provider ID for the same member for the same date of service.
Add-On Without Base Effective: 09/18/2017	This rule identifies claim lines containing a Current Procedural Terminology or Healthcare Common Procedure Coding System assigned add-on code billed without the presence of one or more related primary service/base procedure(s). This rule also contains content related to vaccine and immunoglobulin administration requirements.
Add-On Without Base 2 Effective: 09/18/2017	This rule identifies claim lines containing a CPT or 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.
New Patient E&M Effective: 09/18/2017	This rule recommends the denial of claim lines containing a new patient E&M code when another claim line containing any E&M code or other Face-to-face professional services was billed within a three-year period, by the same provider (using the same provider ID) or Same Provider group and same specialty.
Lifetime Event Effective: 4/20/2020	This rule audits claims to determine if a procedure code has been submitted more than once or twice on the same date of service or across dates of service when it can only be performed once or twice in a lifetime for the same member. The Lifetime Event is the total number of times that a procedure may be submitted in a lifetime. This is the total number of times it is clinically possible or reasonable to perform a procedure on a single member. After reaching the maximum number of times, additional submissions of the procedure are not recommended for reimbursement.
Multiple Medical Same Day Visits Effective: 4/20/2020	This outpatient facility rule identifies and recommends the denial of claims with multiple E&M codes and other visit codes that are: Submitted on the same date of service; Performed at the same facility; Submitted with the same revenue code; and Submitted with a second and subsequent E&M code that lacks the required modifier –27.

BlueCross BlueShield of Oklahoma

RULE NAME	RULE DESCRIPTION
Bilateral Services for Professional Claims Effective: 06/15/2020	This rule identifies claim lines where the submitted procedure code was already billed with a modifier –50 for the same date of service. The same service performed bilaterally should not be billed twice when reimbursement guidelines require the code to be billed once with a bilateral modifier. The rule denies the second submission. Reminder: Modifier 50 is used to report bilateral procedures that are performed during the same operative session. The use of modifier 50 is applicable only to services and/or procedures performed on identical anatomic sites, aspects, or organs. This modifier can be used for diagnostic, radiology, and surgical procedures. Modifier 50 should not be used when the code descriptor indicates unilateral or bilateral and should not be used when RT and LT would be applicable to the services. For correct billing, enter the bilateral procedure code with modifier 50 on one line with one (1) unit of service.
Modifier to Procedure Validation Effective: 06/15/2020	This rule identifies claim lines with an invalid modifier to procedure code combination. It denies procedure codes when billed with a modifier that is not likely or appropriate for the procedure code billed. When multiple modifiers are submitted on a line, all are evaluated and if at least one is found invalid with the procedure code, the line is denied.
Bundled Service Effective: 03/1/2024	This rule identifies claim lines containing procedure codes indicated by the CMS to be always bundled when billed with any other procedure. According to the CMS National Physician Fee Schedule Relative Value File, this procedure has a status code indicator of "B," which is defined as: "Payment for covered services is always bundled into payment for other services not specified." This rule is appropriate for professional claims only.
CMS Add-on Without Base Code Facility Effective: 03/1/2024	This rule identifies claim lines containing a CPT or HCPCS assigned add-on code when billed without acceptable supporting primary procedure/base code by the same practitioner for the same patient on the same date of service, per CMS. According to CMS, add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. An add-on code is eligible for payment if its related primary procedure/base code is also eligible for payment to the same practitioner for the same patient on the same date of service. This rule is appropriate for outpatient facility claims only.
Ancillary Procedures Effective: 03/1/2024	This rule identifies claim lines billed by the same or a different provider either on the same day or different day (depending on the procedure code) after a non-covered service. This rule can consider both facility and non-facility claims. Before denying an ancillary service, the rule check for other covered services that may have been performed on the same day as the non-covered procedure. If found, the rule will allow the ancillary service. This rule is appropriate for professional claims and outpatient facility claims only.