BlueCross BlueShield of Texas

ClaimsXten™ Rule Descriptions

RULE NAME	RULE DESCRIPTION
Surgical Inclusive Edit *(Effective: 03/21/2011)*	This edit will deny claim lines containing supplies when billed for the same date of service as a surgical procedure for which Centers for Medicare and Medicaid (CMS) has assigned a global period.
Incidental Edit *(Effective: 03/21/2011)*	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: 03/21/2011)*	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: 03/21/2011)*	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: 03/21/2011)*	This edit will deny claim lines containing Evaluation and Management (E/M) codes billed on the same date of service as a procedure code with a global period.
Pre-Op Visit Edit *(Effective: 03/21/2011)*	This edit will deny claim lines containing E/M codes billed within the pre-operative period of a procedure code with a global period.
Post-Op Visit Edit *(Effective: 03/21/2011)*	This edit will deny claim lines containing E/M codes billed within the postoperative period of a procedure code with a global period.
Age Replacement Edit *(Effective: 03/21/2011)* *(Retired: 03/2016)*	This edit will deny claim lines containing procedure codes inconsistent with the patient's age and replaces the line with the age-appropriate code.
Gender Replacement Edit *(Effective: 03/21/2011)*	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: 03/21/2011)*	This edit will deny claim lines with invalid modifier to procedure code combinations for those modifiers identified as payment modifiers.
Same Day Laboratory 1 *(Effective: 04/15/2013)* *(Retired: 04/16/2018)*	This rule will deny claim lines with a laboratory procedure submitted without modifier -91 when the same laboratory procedure was previously submitted by the same provider for the same member and same date of service.
Same Day Laboratory 2 *(Effective: 07/15/2013)* *(Retired 04/16/2018)*	This rule will deny claim lines with laboratory procedure codes submitted with units of service that exceed the date range on the line and neither modifier -59 nor -91 were appended to the procedure code.
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 the CMS and Current Procedural Terminology (CPT®) co-surgeon guidelines.
Age Code Replacement Rule *(Effective: 03/21/2016)*	This rule will identify claim lines containing procedure codes or preventive E/M codes that are inconsistent with the member's age for which an alternate code is more appropriate for the age.

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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 (MUEs) Durable Medical Equipment (DME Multiple Lines *(Effective: 12/15/2014)*	This rule will deny claim lines when the units of service for the DME items has been exceeded for a Healthcare Common Procedure Coding System (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 (DMEPOS).
Continuous Positive Airway Pressure or Bi-level Positive Airway Pressure (CPAP/ BIPAP) Supply Frequency *(Effective: 09/29/2014)* ***(Retired: 10/14/2019)***	This rule will deny claim lines submitted with supply codes associated with CPAP/BIPAP therapy when the number of units for those supplies exceeds the recommended replacement schedule as determined by CMS. CMS Local Coverage Determination L11518, L11528, L171, L27230 may be located using the Medicare Coverage Database on the CMS website at: http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx
MUEs Multiple Lines *(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 Filter *(Effective: 05/06/2013)*	This rule will deny claim lines that contain procedure codes that have been submitted more than once per date of service when the code description is defined as once per date of service.
Frequency Validation – Allowed Once Per Date of Service Filter *(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.
CMS National Correct Coding Initiative *(Effective: 03/23/2015)*	The CMS National Correct Coding Initiative (NCCI) policies are based on coding conventions defined in the American Medical Association's (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 Multiple Lines *(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 Centers for Medicare and Medicaid (CMS) for that CPT/HCPCS code.
Facility Outpatient Code Editor (OCE) 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 (I/OCE).

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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 CPT or HCPCS 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.
Bilateral Services for Professional Claims ***(Effective: 04/20/2020)***	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
Modifier to Procedure Validation Filter – Non-Payment Modifiers ***(Effective: 04/20/2020)***	For non-payment modifiers, this rule identifies claim lines with an invalid modifier to procedure code combination. It recommends the denial of procedure codes when billed with any non-payment affecting modifier that is not likely or not 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 recommended for denial.
Revenue Codes Requiring (HCPCS) Code ***(Effective: 04/20/2020)***	This rule recommends the denial of claim lines if they are: • Submitted with a revenue code that requires a HCPCS code, and • No HCPCS code is present. If a claim is missing a HCPCS code, the claim line will be denied.

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Lifetime Event *(Effective: 04/20/2020)*	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: 06/15/2020)*	This outpatient facility rule identifies and recommends the denial of claims with multiple Evaluation & Management (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 • Where the second and subsequent E&M code submitted lacks the required modifier –27.
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.
Modifier to Procedure Validation Filter – Non-Payment Modifiers *(Effective: 06/15/2020)*	For non-payment modifiers, this rule identifies claim lines with an invalid modifier to procedure code combination. It recommends the denial of procedure codes when billed with any non-payment affecting 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 recommended for denial.