BlueCross BlueShield of Illinois

ClaimsXten™ Rule Descriptions

RULE NAME	RULE DESCRIPTION
Surgical Inclusive Edit	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 (CMS) has assigned a global period.
Incidental Edit	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	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	This edit will deny a claim line that would not reasonably be performed on the same patient on the same day.
Same Day Visit Edit	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	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	This edit will deny claim lines containing E/M codes billed within the post-operative period of a procedure code with a global period.
Age Replacement Edit	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	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	This edit will deny claim lines with invalid modifier to procedure code combinations for those modifiers identified as payment modifiers.
Same Day Laboratory	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	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	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 (CPT®) co-surgeon guidelines.
Obstetrics Package Rule	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.

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RULE NAME	RULE DESCRIPTION
Medically Unlikely Edits (MUEs) DME Multiple Lines	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 (DMEPOS).
Continuous Positive Airway Pressure or Bi-level Positive Airway Pressure (CPAP/ BIPAP) Supply Frequency	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	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	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	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	The CMS National Correct Coding Initiative (NCCI) policies are based on coding conventions defined in the American Medical Association (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	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 (OCE) CMS CCI Bundling Rule	This rule will deny outpatient facility claim lines containing code pairs found to be unbundled according to CMS Integrated Outpatient Code Editor (I/OCE).
Facility Unbundled Pairs Outpatient Rule	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.
Age Code Replacement Rule	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.

Checking eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the member's ID card.