BlueCross BlueShield of Oklahoma

ClaimsXten™ Rule Descriptions

RULE NAME	RULE DESCRIPTION
Surgical Inclusive Edit **Effective** **Oklahoma 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 CMS has assigned a global period. **Source:** As per the Centers for Medicare and Medicaid Services (CMS) Program Manuals Pub. 100-04 Chapter 12, Section 40.1.A, additional payment should not be made for some supplies when billed on the same day as certain surgical procedures. This list includes but is not limited to "Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes." https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Incidental Edit **Effective** **Oklahoma 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. **Source:** Include the American Medical Association's Current Procedural Terminology (CPT), the CPT Assistant, the CPT Coding Symposium, National Specialty Society coding guidelines and CMS/Medicare guidelines. McKesson maintains a Clinical Consulting Network of 600 practicing physician consultants with specific clinical and coding expertise. McKesson's Clinical Outreach initiative is a program to invite review of the auditing logic by national medical specialty societies.
Multicode Rebundle Edit **Effective** **Oklahoma 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. **Source:** Include the American Medical Association's Current Procedural Terminology (CPT), the CPT Assistant, the CPT Coding Symposium, National Specialty Society coding guidelines and CMS/Medicare guidelines. McKesson maintains a Clinical Consulting Network of 600 practicing physician consultants with specific clinical and coding expertise. McKesson's Clinical Outreach initiative is a program to invite review of the auditing logic by national medical specialty societies.
Mutually Exclusive Edit **Effective** **Oklahoma 04/18/2011**	This edit will deny a claim line that would not reasonably performed on the same patient on the same day. **Source:** Include the American Medical Association's Current Procedural Terminology (CPT), the CPT Assistant, the CPT Coding Symposium, National Specialty Society coding guidelines and

	CMS/Medicare guidelines. McKesson maintains a Clinical Consulting Network of 600 practicing physician consultants with specific clinical and coding expertise. McKesson's Clinical Outreach initiative is a program to invite review of the auditing logic by national medical specialty societies.
Same Day Visit Edit **Effective** **Oklahoma 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. **Source:** Medicare Claims Processing Manual (Pub. 100-04), Chapter 12, Section 40.1.A National Physician Fee Schedule Relative Value File (Global Period Days)
Pre-Op Visit Edit **Effective** **Oklahoma 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. **Source:** Medicare Claims Processing Manual (Pub. 100-04), Chapter 12, Section 40.1.A (Pub. 100-04), National Physician Fee Schedule Relative Value File (Global Period Days)
Post Op Visit Edit **Effective** **Oklahoma 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. **Source:** Medicare Claims Processing Manual (Pub. 100-04), Chapter 12, Section 40.4.A (Pub. 100-04), Chapter 12, Section 40.2.B (Pub. 100-04) National Physician Fee Schedule Relative Value File (Global Period Days)
Age Replacement Edit **Effective** **Oklahoma 04/18/2011** **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. **Source:** CPT Code-Age Specific Descriptor CPT Assistant May 2008
Modifier to Procedure Edit **Effective** **Oklahoma 04/18/2011**	This edit will deny claim lines with invalid modifier to procedure code combinations for those modifiers identified as payment modifiers. **Source:** AMA- CPT Coding Guidelines- A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers enable health care professionals to effectively respond to payment policy requirements established by other entities. CMS -CMS Manual, Medicare Claims Processing Manual, Chapter 23

	McKesson Clinical Review -Modifiers are used to indicate that a service or procedure has been altered by some specific circumstance, or to provide more specific information regarding the procedure performed. Most modifiers apply to a specific group of codes and may only be reported with those specified codes.
Same Day Laboratory 1 **Effective** **Oklahoma 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. **Source**: Medicare Claims Processing Manual. There may be circumstances that may require the performance of a repeat laboratory test for the same member on the same date of service to obtain several test results. According to CMS regulations, modifier 91 should be appended to repeat or subsequent laboratory studies where the units submitted are greater than one.
Same Day Laboratory 2 **Effective** **Oklahoma 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. **Source**: Medicare Claims Processing Manual. On rare occasions, it may be appropriate to repeat studies over a period of time to obtain additional laboratory results. According to CMS regulations, modifier 91 should be appended to repeat laboratory studies where the units submitted are greater than the MUE allowed per day.
Procedure to Diagnosis Quantity- OK/NM ONLY **Effective** **Oklahoma 02/04/2012**	This rule will deny claim lines submitted with procedure code 86001, 86003 or 83516 and a diagnosis of food allergy with units of service greater than 25. **Source:** Medically Unlikely Edit (MUE)- An MThe MUE edits were developed based on anatomic considerations, HCPCS/CPT code descriptors, CPT instructions, CMS policies, nature of service/procedure, nature of analyte, nature of equipment, and clinical judgment. Prior to implementation, all edits were reviewed by national healthcare organizations, and their alternative recommendations were taken into consideration. Source: CMS Office of Financial Management / Program Integrity Group; CMS Pub 100-08 Medicare Program Integrity- Transmittal 155, Change Request 4209. The McKesson Edit Development Process involves a comprehensive evaluation and analysis of nationally recognized and accepted medical coding guidelines and referenced sources. A standardized process is utilized during the development cycle of each clinical Knowledge Pack update. The clinical integrity of the Auditing Logic and Rules is intended to withstand the scrutiny of payors, providers, experts, regulators, lawyers and special interest groups. Sources referenced include the American Medical Association's Current Procedural Terminology (CPT), the CPT Assistant, the CPT

	Coding Symposium, National Specialty Society coding guidelines and CMS/Medicare guidelines. McKesson maintains a Clinical Consulting Network of 600 practicing physician consultants with specific clinical and coding expertise. McKesson's Clinical Outreach initiative is a program to invite review of the auditing logic by national medical specialty societies.
Co-Surgeon **Effective** **Oklahoma 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 Centers for Medicare & Medicaid Services (CMS), and Current Procedural Terminology (CPT®) co-surgeon guidelines. **Source:** According to the Medicare Physician Fee Schedule, this procedure has a Co Surgery indicator of 0. According to this indicator, Co Surgeons are not permitted for this procedure. The McKesson Edit Development Process involves a comprehensive evaluation and analysis of nationally recognized and accepted medical coding guidelines and referenced sources. A standardized process is utilized during the development cycle of each clinical Knowledge Pack update. The clinical integrity of the Auditing Logic and Rules is intended to withstand the scrutiny of payors, providers, experts, regulators, lawyers and special interest groups. Sources referenced include the American Medical Association's Current Procedural Terminology (CPT), the CPT Assistant, the CPT Coding Symposium, National Specialty Society coding guidelines and CMS/Medicare guidelines. McKesson maintains a Clinical Consulting Network of 600 practicing physician consultants with specific clinical and coding expertise.
Age Code Replacement Rule **Effective** **Oklahoma 03/21/2016**	This rule will identify claim lines containing procedure codes or preventive evaluation and management (E/M) codes that are inconsistent with the member's age for which an alternate code is more appropriate for the age. **Source:** According to CPT guidelines published by the AMA, "Preventive Medicine Services codes 99381-99397 reflect an age and gender appropriate history/exam". An age review occurs when an age-specific Evaluation and Management procedure is submitted for a patient whose age is outside the designated range for that procedure. Sources referenced include the American Medical Association's Current Procedural Terminology (CPT), the CPT Assistant, the CPT Coding Symposium, National Specialty Society coding guidelines and CMS/Medicare guidelines. McKesson maintains a Clinical Consulting Network of 600 practicing physician consultants with specific clinical and coding expertise. McKesson's Clinical Outreach initiative is a program to invite review of the auditing logic by national medical specialty societies.

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Obstetrics Package Rule **Effective** **Oklahoma 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. **Source:** The McKesson Edit Development Process involves a comprehensive evaluation and analysis of nationally recognized and accepted medical coding guidelines and referenced sources. A standardized process is utilized during the development cycle of each clinical Knowledge Pack update. The clinical integrity of the Auditing Logic and Rules is intended to withstand the scrutiny of payors, providers, experts, regulators, lawyers and special interest groups. Sources referenced include the American Medical Association's Current Procedural Terminology (CPT), the CPT Assistant, the CPT Coding Symposium, National Specialty Society coding guidelines and CMS/Medicare guidelines. McKesson maintains a Clinical Consulting Network of 600 practicing physician consultants with specific clinical and coding expertise. McKesson's Clinical Outreach initiative is a program to invite review of the auditing logic by national medical specialty societies.
Medically Unlikely Edits (MUEs) DME Multiple Lines **Effective** **Oklahoma 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 (DMEPOS). **SOURCE:** CMS for DME MUE Values (CMS DME MUE) The Centers for Medicare and Medicaid Services (CMS) developed the Medically Unlikely Edit (MUE) program to reduce the paid claims error rate for Part B claims. The edits were developed based on anatomic considerations, HCPCS/CPT code descriptors, CPT instructions, CMS policies, nature of service/procedure, nature of equipment, and clinical judgment. An MUE (Medically Unlikely Edit) is a unit of service (UOS) edit for a Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code for services rendered by a single provider/supplier to a single beneficiary on the same date of service. The ideal MUE is the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims.
Continuous Positive Airway Pressure or Bi-level Positive Airway Pressure (CPAP/ BIPAP) Supply Frequency **Effective** **Oklahoma 09/29/2014**	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

	SOURCE: CMS Local Coverage Policy for CPAP Supplies (CMS CPAP) Accessories used with a Positive Airway Pressure (PAP) device are covered when the coverage criteria for the device are met. If the coverage criteria are not met, the accessories will be denied as not medically necessary. Quantities of supplies greater than those described in a CMS Local Coverage Determination policy as the usual maximum amounts will be denied as not medically necessary. This is also true for the renewal time interval. For example, procedure A4604 (Tubing with integrated heating element for use with positive airway pressure device) - CMS Local Coverage Determination L11528 states that a frequency of one PAP accessory every three months represents the usual maximum amount for this type of accessory expected to be medically necessary. This rule will deny (with Certainty of APPLY) the submission of procedure A4604 when submitted prior to the 90-day timeframe. Sourcing for this rule is based upon the following Local Coverage Determination Policies. The contractor type for each of these policies is DME MAC. Please find the contractor's name applicable to each LCD policy listed below. LCD11528 – NHIC, Corp. LCD171 – Noridian Administrative Services LCD27230 – National Government Services, Inc.
MUEs Multiple Lines **Effective** **Oklahoma 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. **Source:** Medically Unlikely Edit (MUE)- An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply. The MUE edits were developed based on anatomic considerations, HCPCS/CPT code descriptors, CPT instructions, CMS policies, nature of service/procedure, nature of analyte, nature of equipment, and clinical judgment. Prior to implementation, all edits were reviewed by national healthcare organizations, and their alternative recommendations were taken into consideration. Source: CMS Office of Financial Management / Program Integrity Group; CMS Pub 100-08 Medicare Program Integrity- Transmittal 155, Change Request 4209.
Frequency Validation – Allowed Multiple Times Per Date of Service Filter **Effective** **Oklahoma 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. **SOURCE:**

	The maximum allowed is the total number of times per date of service that a given procedure code may be appropriately submitted. This is reflective of the total number of times it is clinically possible or clinically reasonable to perform a given procedure on a single date of service across all anatomic sites. After the maximum number of times is reached, additional submissions of the procedure are not recommended for reimbursement. Duplicate values are assessed for accuracy based on the number of submissions of a specific procedure according to anatomic sites and CPT/CMS guidelines. The procedures audited will not include those that have a published MUE policy according to CMS
Frequency Validation – Allowed Once Per Date of Service Filter **Effective** **Oklahoma 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) Center for Medicare and Medicaid Services (CMS) This edit occurs when a procedure code description contains terminology that does not warrant multiple submissions of that procedure for a single date of service. This includes the following terms: Bilateral, Unilateral/Bilateral or Single/Multiple. This edit also occurs when a procedure code is submitted multiple times, exceeding the maximum allowance that would be clinically appropriate. The procedures audited will not include those that have a published MUE policy according to CMS.
CMS National Correct Coding Initiative **Effective** **Oklahoma 03/23/2015**	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. **Source:** The CMS NCCI coding policies are based on the coding conventions defined in the AMA's Current Procedural Terminology (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. HCPCS/CPT codes define procedures include services that are integral. Integral services have CPT codes for reporting service when not performed as an integral part of another procedure. Services integral to HCPCS/CPT code are procedures included in services based on standards of medical/surgical practice. It is inappropriate to report services alone that are integral to another procedure. NCCI edits are based on standards of medical/surgical practice. Services that are integral to another become component parts of comprehensive service. Integral component services have their own HCPCS/CPT codes, NCCI edits place comprehensive service in column one and component service in column two. A component service integral to comprehensive service is not separately

	reportable; column two codes cannot be reported separately with column one code. Services are integral to large numbers of procedures. Other services are integral to a limited number of procedures. Examples of large number of procedures include:" Cleansing, shaving and prepping of skin" Draping and positioning" Insertion of intravenous access for medication administration" Insertion of urinary catheter" Sedative administration by physician performing procedure (Chapter II, Anesthesia Services)" Local, topical or regional anesthesia administered by physician performing procedure" Surgical approach including identification of anatomical landmarks, incision, evaluation of surgical field, debridement of traumatized tissue, lysis of adhesions, isolation of structures limiting access to surgical field such as bone, blood vessels, nerve, muscles including stimulation for identification or monitoring" Surgical cultures" Wound irrigation" Insertion/removal of drains, suction devices, pumps into same site" Surgical closure and dressings" Application, management, and removal of postoperative dressings and analgesic devices (peri-incisional" TENS unit" Institution of Patient Controlled Anesthesia" Preoperative, intraoperative and postoperative documentation, including photographs, drawings, dictation, or transcription necessary to document services provided" Surgical supplies, for specific situations where CMS policy permits separate payment Chapters in Manual address issues related to standards of medical/surgical practice for procedures covered. It is not possible because of space limitations to discuss all NCCI edits based on principle of standards of medical/surgical practice. There are general principles that can be applied to edits as per Chapter 1, General of the CMS NCCI Manual.
Outpatient Facility – MUEs Multiple Lines **Effective** **Oklahoma 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. **Source:** Medically Unlikely Edit (MUE)- An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply. The MUE edits were developed based on anatomic considerations, HCPCS/CPT code descriptors, CPT instructions, CMS policies, nature of service/procedure, nature of analyte, nature of equipment, and clinical judgment. Prior to implementation, all edits were reviewed by national healthcare organizations, and their alternative recommendations were taken into consideration. Source: CMS Office of Financial Management / Program Integrity Group; CMS Pub 100-08 Medicare Program Integrity- Transmittal 155, Change Request 4209.
Facility Outpatient Code Editor (OCE) CMS CCI Bundling Rule **Effective** **Oklahoma 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). **Source:**

	One of the functions of the I/OCE is to edit claims data to identify errors for one of the following reasons: -Procedure is a mutually exclusive procedure that is not allowed by the Correct Coding Initiative (CCI). -Procedure is a component of a comprehensive procedure that is not allowed by the CCI. CMS often publishes coding instructions in its rules, manuals, and notices. Physicians must utilize these instructions when reporting services rendered to Medicare patients. The CPT Manual also includes coding instructions which may be found in the "Introduction", individual chapters, and appendices. In individual chapters the instructions may appear at the beginning of a chapter, at the beginning of a subsection of the chapter, or after specific CPT codes. Physicians should follow CPT Manual instructions unless CMS has provided different coding or reporting instructions. The American Medical Association publishes CPT Assistant which contains coding guidelines. CMS does not review nor approve the information in this publication. In the development of NCCI edits, CMS occasionally disagrees with the information in this publication. If a physician utilizes information from CPT Assistant to report services rendered to Medicare patients, it is possible that Medicare Carriers (A/B MACs processing practitioner service claims) and Fiscal Intermediaries may utilize different criteria to process claims.
Facility Unbundled Pairs Outpatient Rule **Effective** **Oklahoma 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. **Source:** Incidental- The health plan agrees that the payment for facility services, when described and/or identified by a CPT code, includes all facility services that could be associated with the code, including any CPT service which is considered incidental to the more global CPT code on the professional level. The identified code pairs generally represent specific procedure code combinations that are not typically paid separately and are clinically supported through the use of industry standard sources. Mutually Exclusive- HCPCS/CPT codes define procedures include services that are integral. Integral services have CPT codes for reporting service when not performed as an integral part of another procedure. Services integral to HCPCS/CPT code are procedures included in services based on standards of medical/surgical practice. It is inappropriate to report services alone that are integral to another procedure. NCCI edits are based on standards of medical/surgical practice. Services that are integral to another become component parts of comprehensive service. Integral component services have their own HCPCS/CPT codes, NCCI edits place comprehensive service in column one and component service in column two. A

	component service integral to comprehensive service is not separately reportable; column two codes can not be reported separately with column one code.Services are integral to large numbers of procedures. Other services are integral to a limited number of procedures. Examples of large number of procedures include:" Cleansing, shaving and prepping of skin" Draping and positioning" Insertion of intravenous access for medication administration" Insertion of urinary catheter" Sedative administration by physician performing procedure (Chapter II, Anesthesia Services)" Local, topical or regional anesthesia administered by physician performing procedure" Surgical approach including identification of anatomical landmarks, incision, evaluation of surgical field, debridement of traumatized tissue, lysis of adhesions, isolation of structures limiting access to surgical field such as bone, blood vessels, nerve, muscles including stimulation for identification or monitoring" Surgical cultures" Wound irrigation" Insertion/removal of drains, suction devices, pumps into same site" Surgical closure and dressings" Application, management, and removal of postoperative dressings and analgesic devices (peri-incisional" TENS unit" Institution of Patient Controlled Anesthesia" Preoperative, intraoperative and postoperative documentation, including photographs, drawings, dictation, or transcription necessary to document services provided" Surgical supplies, for specific situations where CMS policy permits separate payment. Chapters in Manual address issues related to standards of medical/surgical practice for procedures covered. It is not possible because of space limitations to discuss all NCCI edits based on principle of standards of medical/surgical practice. CMS manuals and instructions often describe groups of HCPCS/CPT codes that should not be reported together for the Medicare program. Edits based on these instructions are often included as misuse of column two code with column one code. A HCPCS/CPT code descriptor does not include exhaustive information about the code. Physicians who are not familiar with a HCPCS/CPT code may incorrectly report the code in a context different than intended. The NCCI has identified HCPCS/CPT codes that are incorrectly reported with other HCPCS/CPT codes as a result of the misuse of the column two code with the column one code. If these edits allow use of NCCI-associated modifiers (modifier indicator of "1"), there are limited circumstances when the column two code may be reported on the same date of service as the column one code.
Global Component **Effective** **Oklahoma 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. **Source:** The Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value file directs that a global procedure includes reimbursement for both the professional and technical components of certain procedures. A single provider can bill for both components (global procedure), or different providers can each bill for different components. Claims for these types of procedures

	should only be paid up to the total of the global procedure (both technical and professional components combined). Any submission of the same procedure must be evaluated against previous submissions to determine if any or all components of the procedure have already been paid. The current claim is adjusted accordingly.
Component Billed **Effective** **Oklahoma 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. **Source:** The Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value file directs that a global procedure includes reimbursement for both the professional and technical components of certain procedures. The component procedure being billed has already been submitted as a global procedure by the same provider for the same member on the same date of service.
Add-On Without Base **Effective** **Oklahoma 09/18/2017**	This rule identifies claim lines containing a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (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. **Source:** According to the AMA, "add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code."
Add-On Without Base 2 **Effective** **Oklahoma 09/18/2017**	This rule identifies claim lines containing a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (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. **Source:** According to the AMA, "add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code."
New Patient EM **Effective** **Oklahoma 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. **Source:** According to the AMA, "A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years."

Verification of 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.

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