BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Corporate Payment Policy 32
CLAIMSXTEN-SELECT™ EDITS
Approved 08.27.2020

Effective Date: January 1, 2021

Overview

Blue Cross and Blue Shield of Vermont (BCBSVT) utilizes ClaimsXten-Select™ as its clinical code editing software to facilitate accurate claim processing for claims for services provided to members of BCBSVT commercial health plans. This policy provides an overview of the system as well as a description of the edits that will be in place starting January 1, 2021.

The ClaimsXten-Select™ edit logic is based on a thorough review by doctors of current clinical practices, specialty society guidance, and industry standard coding, and the logic incorporates guidelines from industry-standard and essential clinical sources that include, but are not limited to: Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), Internal Classification of Diseases Clinical Modification (ICD-10-CM), American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) guidelines, specialty society guidelines, medical policy and literature research and standards, and input from academic affiliations.

As used in this policy, an "edit" refers to the practice by which one or more rule recommendations are made to CPT® or HCPCS Level II codes included in a claim that result in: (1) reimbursement being made based on some, but not all, of the CPT®/HCPCS codes included in the claim, (2) reimbursement being made based on different CPT®/HCPCS codes than those included in the claim, (3) reimbursement for one or more of the CPT®/HCPCS codes included in the claim being decreased by application of multiple procedure logic, and (4) reimbursement for one or more of the CPT®/HCPCS codes being denied, or any combination of the above. Where an appropriate replacement procedure code or quantity exists, an edit may also involve denial of the incorrect procedure code or quantity and addition of a new claim line with the appropriate procedure code or quantity for processing.

ClaimsXten-Select™ also performs history editing, which involves identifying previously submitted claims within our claims processing system that may be related to new claim submissions, and it may also result in adjustments to previously processed claims.

BCBSVT uses ClaimsXten-Select™ to administer some of our payment, medical, and administrative policies, as well as some provisions of our benefit plans.

BCBSVT's code edit disclosure tool, Clear Claim Connection™ is available on the secure provider portal. This tool allows users to enter coding scenarios and immediately view the audit results. Clinical edit

rationales, as well as edit sourcing, are provided for any coding scenario for which Clear Claim Connection™ shows a claim would be disallowed. Please note, however, that this tool does not tie into claim history, so results are subject to change.

Code edits and National Correct Coding Initiative (NCCI) edits are applied to new CPT® and HCPCS codes which are introduced four times per year in January, April, July, and October. Updates to coding guidelines and NCCI edits will be applied quarterly for ClaimsXten-Select™.

Edits

Below is a summary of the ClaimsXten-Select™ edits that will go into effect starting January 1, 2021.

CLAIMSXTEN-SELECT™ CODE EDIT	DEFINITION AND INFORMATION	CLAIM TYPE	CURRENT EDIT IN CLAIM CHECK™ TODAY?	SOURCE
Age Code Replacement	Identifies claim lines containing procedure codes that are inconsistent with the member's age for which an alternative code is more appropriate for the age. When an age inconsistency is identified on a claim, the code(s) in question will be denied. Where an appropriate replacement procedure code exists, the inappropriate procedure code will be denied and a new claim line with the appropriate procedure code may be added to the claim and processed accordingly.	Professional Claims, CMS 1500	Yes, is a current edit in Claim Check™ however, CXT-S will substitute the correct CPT® code and will not require re-submission from provider	AMA/CMS
Anesthesia Not Eligible to Bill	Identifies Claim lines submitted by anesthesiologists for non-anesthesia procedure codes that are not eligible to be cross walked to an anesthesia procedure code. According to the American Society of Anesthesiologists (ASA) the code cannot be cross walked for one of the following reasons: it is not a primary procedure code, anesthesia care is not normally required, it is a radiology services related to a diagnostic or therapeutic service, the CPT® manual states this procedure is performed without anesthesia, or it is a non-specific unlisted procedure code. Certain non-anesthesia services, when rendered by anesthesiologists who are acting as the principle operator for some services, are excluded from this rule including, but not limited to, pain management services, insertion of arterial lines and radiology services when the anesthesiologist is performing the service.	Professional claims, CMS 1500	Not a current edit in Claim Check™	ASA/AMA

CLAIMSXTEN-SELECT™ CODE EDIT	DEFINITION AND INFORMATION	CLAIM TYPE	CURRENT EDIT IN CLAIM CHECK™ TODAY?	SOURCE
Anesthesia Standard Crosswalk	Identifies claim lines submitted by anesthesiologists for non-anesthesia services that have a one-to one relationship with anesthesia services. The ASA Cross Walk Table converts procedure codes to anesthesia codes as appropriate when a claim for anesthesia services, as identified by provider type, specialty or identification number is submitted with other than a designated anesthesia code. The rule recommends denial of claim lines containing non-anesthesia services submitted by an anesthesiologist. The rule replaces any non-anesthesia services that have a one-to-one crosswalk identified by ASA with the procedure code specified in the ASA Crosswalk Table. Many non-anesthesia CPT® codes often describe procedures that may be done in a variety of anatomic regions, while anesthesia CPT® codes are specific to both procedure and region.	Professional claims, CMS 1500	Not a current edit in Claim Check ™	ASA/AMA
Anesthesia Multiple Crosswalk	Identifies claim lines submitted by an anesthesiologist for non-anesthesia services that have a one-to-many relationship with anesthesia services. According to the ASA, in general, there is only one anesthesia code for any single CPT® code. However, many CPT® codes often describe procedures that may be done in a variety of anatomic regions while anesthesia CPT® codes are specific for both procedure and region. In these cases, multiple anesthesia CPT® possibilities exist. Certain non-anesthesia services, when rendered by anesthesiologists who are acting as the principle operator for some services, are excluded from this rule including, but not limited to, pain management services, insertion of arterial lines and radiology services when the anesthesiologist is performing the service.	Professional claims, CMS 1500	Not a current edit in Claim Check ™	ASA/AMA
Assistant Surgeon	Identifies claim lines containing procedures billed with an assistant surgeon modifier (80, 81, 82, AS) that typically do not require an assistant surgeon. Claim line will deny.	Professional claims, CMS 1500	Yes, is a current edit in Claim Check™	CMS/AMA/ACS
Bundled Services	Certain procedure codes are designated by CMS as “bundled” by a status code indicator of “B” on the CMS National Physician Fee Schedule	Professional claims, CMS 1500	Yes, is a current edit in Claim Check™	CMS

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	Relative Value File. When billed with any other procedure code that is not indicated as a "bundled" service, these procedures are considered a component of, or incident to, the overall service provided, and separate reimbursement is not warranted.			
CMS Correct Coding Initiative	Identifies claims containing code pairs found to be unbundled according to the CMS NCCI. The CMS NCCI coding policies are based on coding conventions defined in the 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 recommends the denial of claim lines for which the submitted procedure is not recommended for reimbursement when submitted with another procedure as defined by a code pair found in the NCCI. Both codes must have same provider ID, same member, and same date of service. NCCI code pair edits may be reviewed online at www.cms.gov.	Professional claims, CMS 1500 And Outpatient Facility Claims submitted on a UB-04	Yes, is a current edit in Claim Check™	CMS
CMS Unbundling	Identifies claim lines containing procedure codes typically not recommended for reimbursement when submitted with other procedure codes on the same date of service for the same member. Identifies code pairs that are created based on coding standards such as to procedure codes not reasonably performed on the same date of service or procedure codes that are a component of another procedure code. This rule recommends the denial of claim lines where the submitted procedure is not recommended for reimbursement when submitted with one of the following: a more comprehensive procedure, a procedure that results in overlap of services, or procedures that are medically impossible or improbable	Professional claims, CMS 1500	Yes, is a current edit in Claim Check™	CMS

<table>
<tr><th>CLAIMSXTEN-SELECT™ CODE EDIT</th><th>DEFINITION AND INFORMATION</th><th>CLAIM TYPE</th><th>CURRENT EDIT IN CLAIM CHECK™ TODAY?</th><th>SOURCE</th></tr>
<tr><td></td><td>to be performed together on the same date of service.

There are three sub-rules within the CMS_UNBUN_PAIRS rule, each with its own specific clinical justification. Each sub-rule is identified using the following acronyms:
ULT_PARENT: Ultimate Parent
ME: Mutually Exclusive
INC: Incidental</td><td></td><td></td><td></td></tr>
<tr><td>Consultations Outpatient</td><td>This rule recommends the denial of claim lines containing an outpatient consultation when another outpatient consultation was billed for the same member by the same Provider ID with at least one matching diagnosis within a 6-month period.
<table><tr><th>OUTPATIENT CONSULTATION CODE</th><th>ESTABLISHED PATIENT</th></tr><tr><td>99241</td><td>99212</td></tr><tr><td>99242</td><td>99213</td></tr><tr><td>99243</td><td>99214</td></tr><tr><td>99244</td><td>99215</td></tr><tr><td>99245</td><td>99215</td></tr><tr><td>TELEHEALTH CONSULTATION CRITICAL CARE INITIAL</td><td>TELEHEALTH CONSULTATION CRITICAL CARE SUBSEQUENT</td></tr><tr><td>G0508</td><td>G0509</td></tr></table>The rule will add the claim line with the appropriate level of office visit, established patient.</td><td>Professional claims, CMS 1500</td><td>Not a current edit in Claim Check ™</td><td>CMS</td></tr>
<tr><td>CPAP/BIPAP Frequency</td><td>Identifies supply codes associated with the Continuous Positive Airway Pressure or Bilevel Positive Airway Pressure (CPAP/BIPAP) therapy that are being submitted at a rate that exceeds the usual or customary rate.
Many CPAP/BIPAP supplies associated with sleep therapy are designed to be disposable. Masks, tubing, filters, and headgear are not designed to last extreme amounts of time. Based on the recommended replacement schedule for CPAP/BIPAP supplies from Medicare, this rule will fire when the current claim for the submission of an associated</td><td>Professional claims, CMS 1500</td><td>Not a current edit in Claim Check ™</td><td>CMS</td></tr>
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CLAIMSXTEN-SELECT™ CODE EDIT	DEFINITION AND INFORMATION	CLAIM TYPE	CURRENT EDIT IN CLAIM CHECK™ TODAY?	SOURCE
	CPAP/BIPAP supply is being submitted at a rate that will exceed the recommended replacement schedule. The history line and the current line quantities are summed for the same DOS and provider. If the total quantity exceeds the recommended replacement rate, only the incorrect line is denied (all current lines are not denied). A new line may added with the allowed quantity and processed accordingly.			
Diabetic Supply Frequency	Identifies claim lines submitted with diabetic supply codes when the utilization of these supplies is at a frequency over the usage recommended by LCDs or other health plan policies. This rule distinguishes the quantity of supplies necessary for those patients that are insulin dependent and those that are non-insulin dependent. The rule also provides an option to perform a diagnosis validation check on the claim containing the supply code as ICD-10 diagnosis code(s) describing the condition that necessitates glucose testing must be included on each claim for the supplies. The default rule will check both claim and line level diagnosis. This rule allows for a grace period to be applied to eligible claim lines submitted with diabetic supply codes. For example, if a diabetic supply code has a limitation of 1 every 90 days and a refill is shipped on the 91st day, i.e. the end date of the current supply usage, delivery time needs to be considered. Applying the grace period will ensure there is no gap due to delivery time. (Medicare also allows the grace period for this reason.) The history line and the current line quantities are summed for the same DOS and provider. If the total quantity exceeds the recommended usage rate, only the incorrect line is denied (all current lines are not denied). A new line may be added with the allowed quantity and processed accordingly.	Professional claims, CMS 1500	Not a current edit in Claim Check ™	CMS

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Global Comp	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. The following scenarios are audited: Global vs. Global Global vs. Professional Global vs. Technical Professional vs. Global Technical vs. Global Professional vs. Professional Technical vs. Technical	Professional claims, CMS 1500 And Outpatient Facility Claims submitted on a UB-04	Yes, is a current edit in Claim Check™	CMS
Lifetime Event	Audits claims to determine if a procedure code(s) has been submitted more than once or twice on same date of service or across dates of service when it can only be performed once or twice in a lifetime. The Lifetime Value is the total number of times that a given procedure may be appropriately submitted in a lifetime. This is reflective of the total number of times it is clinically possible or clinically reasonable to perform a given procedure on same date of service or across dates of service. After the maximum number of times is reached, additional submissions of the procedure are not recommended for reimbursement. Lifetime values are assigned according to anatomic sites and AMA/CMS guidelines associated with each procedure. This rule will deny a claim that contains a procedure code that has been submitted more than once or twice on same date of service or across dates of service because it has been identified as a procedure that can only be performed once or twice in a lifetime.	Professional claims, CMS 1500	Not a current edit in Claim Check ™	AMA
Medicare Medically Unlikely Edits	This rule identifies claim lines where the MUE has been exceeded for a CPT®/HCPCS code with MUE adjudication indicator (MAI) = 1, 2	Professional claims, CMS 1500	Not a current edit in Claim Check ™	CMS

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(MUE) Durable Medical Equipment (DME)	or 3, reported by the same provider or across providers (depending on the provider setting configuration), for the same member, on the same date of service. This rule will evaluate date ranges to determine if the MUE has been met or not. - MAI = 1 claim line edit - MAI = 2 date of service edits (based on policy) - MAI = 3 date of service edits (based on clinical benchmarks) MUE for a HCPCS/CPT® code is maximum units of service that a provider would report under most circumstances for a single member on a single date of service. The MUE values are based upon anatomic considerations, HCPCS/CPT® code descriptors, HCPCS/CPT® instructions, CMS policies, nature of the analyte, nature of service/procedure, nature of the equipment, and/or clinical judgment prescribing information and claims data. The history line and the current line quantities are summed for the same DOS and provider. If the total quantity exceeds the recommended value, only the incorrect line is denied (all current lines are not denied). A new line may be added with the allowed MUE and processed accordingly.		Historically, MUE rules have been applied retrospectively and claims adjusted to follow MUE coding guidelines	
Medicare Medically Unlikely Edits (MUE) Outpatient Hospital DOS	This rule identifies claim lines where the MUE has been exceeded for a CPT®/HCPCS code with MUE adjudication indicator (MAI) = 1, 2 or 3, reported by the same provider, for the same member, on the same date of service. Guidelines found in the National Correct Coding Initiative Policy Manual for Medicare Services, Chapter I, General Correct Coding Policies, under Section V for Medically Unlikely Edits (MUEs) state: "To lower the Medicare Fee-For-Service Paid Claims Error Rate, CMS has established units of service edits referred to as Medically Unlikely Edit(s) (MUEs). An MUE for a HCPCS/CPT code	Outpatient Facility Claims submitted on a UB-04	Not a current edit in Claim Check ™ Historically, MUE rules have been applied retrospectively and claims adjusted to follow MUE coding guidelines	CMS

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	is the maximum number of units of service (UOS) under most circumstances allowable by the same provider for the same [member] on the same date of service. The ideal MUE value for a HCPCS/CPT code is the unit of service that allows the vast majority of appropriately coded claims to pass the MUE." The MUE values are based upon anatomic considerations, HCPCS/CPT® code descriptors, HCPCS/CPT® instructions, CMS policies, nature of analyte, nature of service/procedure, nature of equipment, and/or clinical judgment prescribing information and claims data. In addition to the MUE value assigned to each procedure code in the MUE table, an MAI (MUE adjudication indicator) value of 1, 2 or 3 is also assigned. This rule will evaluate date ranges to determine if the MUE has been exceeded. The history line and the current line quantities are summed for the same DOS and provider. If the total quantity exceeds the recommended value, only the incorrect line is denied (all current lines are not denied). A new line may be added with the allowed MUE and processed accordingly.			
Medicare Medically Unlikely Edits (MUE) Practitioner DOS	This rule identifies claim lines where the MUE has been exceeded for a CPT®/HCPCS code with MUE adjudication indicator (MAI) = 1, 2 or 3, reported by the same provider, for the same member, on the same date of service. This rule will evaluate date ranges to determine if the MUE has been met or not. MAI = 1 claim line edit MAI = 2 date of service edits (based on policy) MAI = 3 date of service edits (based on clinical benchmarks) MUE for a HCPCS/CPT® code is maximum units of service that a provider would report under most circumstances for a single member on a single date of service. The MUE	Professional claims, CMS 1500	Not a current edit in Claim Check ™ Historically, MUE rules have been applied retrospectively and claims adjusted to follow MUE coding guidelines	CMS

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	values are based upon anatomic considerations, HCPCS/CPT® code descriptors, HCPCS/CPT® instructions, CMS policies, nature of analyte, nature of service/procedure, nature of equipment, and/or clinical judgment prescribing information and claims data. This rule will evaluate date ranges to determine if the MUE has been exceeded. The history line and the current line quantities are summed for the same DOS and provider. If the total quantity exceeds the recommended value, only the incorrect line is denied (all current lines are not denied). A new line may be added with the allowed MUE and processed accordingly.			
Missing Professional Component Modifier 26	Identifies claim lines where a modifier -26, denoting professional component, should have been reported for the procedure performed at the noted POS. The CMS guidelines establish that certain procedures, when performed in certain settings, require the billing of the professional component modifier. Procedure codes with a modifier -26 line in the National Physician Fee Schedule Relative Value File are included in this list of procedures. This rule recommends the denial of claim lines containing a procedure code submitted without a professional component modifier –26 in a facility setting (POS 02, 19, 21, 22, 23, 24, 26, 31, 34, 51, 52, 53, 56, and 61). The rule replaces the line with a new line with the same procedure code and the professional component modifier –26.	Professional claims, CMS 1500	Not a current edit in Claim Check ™	CMS
Modifier to Procedure Validation Payment Modifiers	Identifies claim lines with invalid modifier to procedure code combinations for those modifiers identified as payment modifiers. This rule recommends the denial of procedure codes when billed with any payment-affecting modifier that is not likely or appropriate for the procedure code billed. When multiple modifiers	Professional claims, CMS 1500	Yes, is a current edit in Claim Check™	AMA/CMS

CLAIMSXTEN-SELECT™ CODE EDIT	DEFINITION AND INFORMATION	CLAIM TYPE	CURRENT EDIT IN CLAIM CHECK™ TODAY?	SOURCE
	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.			
Multiple Code Re-bundling	Identifies claims containing two or more procedure codes used to report a service when a single, more comprehensive procedure code exists that more accurately represents the service performed. This is typically identified by the CPT® code description of each code. Occasionally, the code that represents the comprehensive procedure is added to the claim resulting in the component procedures being disallowed. To correct this type of coding error, the unbundled procedure code(s) is re-bundled to the comprehensive procedure code. This rule recommends the denial of claim lines when another more comprehensive procedure is submitted for the same date of service for the same provider ID. The rule may also recommend denial of multiple claims lines with replacement of those claim lines with a single, more comprehensive procedure code.	Professional claims, CMS 1500	Yes, is a current edit in Claim Check™	AMA
New Patient Code for Established Patients	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." When a new patient Evaluation and Management code is found on the claim, but another Evaluation and Management or other Face-to-face professional service was performed within the last three years, the new patient code is denied and replaced with the appropriate established patient code. When a new patient code inconsistency is identified on a claim, the code(s) in question will be denied. Where an appropriate replacement procedure code exists, the inappropriate procedure code will be denied and a new claim line with the appropriate procedure code may	Professional claims, CMS 1500	Yes, a current edit in Claim Check ™ Historically, this edit has also been applied retrospectively through audits	AMA/CMS

CLAIMSXTEN-SELECT™ CODE EDIT	DEFINITION AND INFORMATION	CLAIM TYPE	CURRENT EDIT IN CLAIM CHECK™ TODAY?	SOURCE
	be added to the claim and processed accordingly.			
Obstetrics Package	This rule audits 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, i.e., 59400, 59510, 59610 and 59618) were submitted with another global OB care code or a component code such as the antepartum care, postpartum care, or delivery only services, during the average length of time of the typical pregnancy (and postpartum period as applicable) 280 and 322 days respectively.	Professional claims, CMS 1500	Not a current edit in Claim Check ™ Historically, this edit has been applied retrospectively and claims adjusted to follow coding guidelines	AMA
Outpatient Code Editor CMS CCI Bundling	Identifies claims containing code pairs found to be unbundled according to CMS Integrated Outpatient Code Editor (I/OCE). 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. Critical Access Hospitals (bill type 85x) submitting claims containing both facility services and professional services that are reported with revenue codes (096x, 097x, 098x), do not have NCCI editing applied across facility and professional services appearing on the same day; NCCI editing is applied for the professional services separately from facility services. This rule recommends the denial of claim lines for which the submitted procedure is not recommended for reimbursement when submitted with another procedure as defined by a code pair found in the I/OCE. Both codes must have the same provider ID, same member, and same date of service.	Outpatient Facility Claims submitted on a UB-04	Yes, is a current edit in Claim Check™	CMS

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Pay Percent Assistant Surgery	Identifies claim lines that are eligible for an Assistant Surgeon Pay Percent reduction. Assigns appropriate pay percentage to the eligible line(s), including adjustments for assistant surgeon status, multiple procedure, *bilateral, *multiple quantity, and *additional payment modifiers.	Professional claims, CMS 1500	Yes, is a current edit in Claim Check™	AMA/CMS
Pay Percent for Single Lines with Payment Modifiers or Multiple Quantity	Identifies claim lines that are eligible for Pay Percent adjustments for bilateral, multiple quantity, and/or payment modifiers. Also, identifies claim lines/certain procedures that are subject to payment reduction when the x-rays are taken using film or computed radiography. Such procedures are required to be submitted with modifier FX or FY and will receive a reduction in payment	Professional claims, CMS 1500	Yes, is a current edit in Claim Check™	AMA/CMS
Pay Percent Multiple Radiology	Identifies claim lines that are eligible for a Multiple Procedure Payment Reduction-Multiple Diagnostic Imaging services. Also, identifies claim lines/ certain procedures that are subject to payment reduction when the CT equipment does not meet (NEMA) Standard XR-29-2013. Such procedures are required to be submitted with modifier CT and will receive a reduction in payment. Assigns appropriate pay percentage to the eligible line(s), including adjustments for multiple procedure, as well as bilateral, multiple quantity, and additional payment modifier. Editing occurs across claims and will follow applicable guidelines based on the date of service. If a claim for a primary procedure is received subsequent to claim(s) already processed for procedures determined to be cut-back, the previously processed claims may be adjusted accordingly.	Professional claims, CMS 1500 This includes CMS 1500 claims submitted with a facility POS	Not a current edit in Claim Check ™	CMS
Pay Percent Therapy Facility	Identifies claim lines which should receive the reduced reimbursement on certain therapy procedures per CMS for institutional facility (UB-04) claims.	Outpatient Facility Claims submitted on a UB-04	Not a current edit in Claim Check ™	CMS

CLAIMSXTEN-SELECT™ CODE EDIT	DEFINITION AND INFORMATION	CLAIM TYPE	CURRENT EDIT IN CLAIM CHECK™ TODAY?	SOURCE
Pay Percent Procedures Modifier 51	Identifies claim lines that are eligible for a Multiple Procedure Pay Percent- Multiple Surgeries reduction. Assigns appropriate pay percentage to the eligible line(s), including adjustments for multiple procedure, as well as bilateral, multiple quantity, and additional payment modifiers.	Professional claims, CMS 1500	Yes, is a current edit in Claim Check™	CMS
Pre-operative Visit	Identifies procedure codes billed by the same provider within a procedure's preoperative period. Claim Line will deny.	Professional claims, CMS 1500	Yes, is a current edit in Claim Check™	CMS
Post-operative Visit	Identifies and recommends denial of E&M or global procedure codes billed by the same provider within a procedures post-operative period. Claim Line will deny.	Professional claims, CMS 1500	Yes, is a current edit in Claim Check™	CMS
Same Day Visit	This claim editing logic identifies when an E&M service is billed on the same day as a surgical procedure or substantial diagnostic or therapeutic (such as dialysis, chemotherapy, and osteopathic manipulative treatment) procedure. An E&M code reported for the same date of service as a procedure rendered by that same provider is considered included within the global reimbursement for that procedure. In such circumstances, CXT editing will not consider the E&M service for reimbursement and line will be denied.	Professional claims, CMS 1500	Yes, is a current edit in Claim Check™	CMS

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Approved by **Date Approved: ____08/27/2020_____**

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