Attachment 1A (Rule Category Descriptions)

Multiple Surgeons
CMS has defined surgical codes that allow co-surgeons, team surgeons and assistant surgeons. Payment for multiple surgeons will only be considered when CMS indicates multiple surgeons can be billed on a code. All other codes will be denied.

Add On
These rules follow the direction set forth in the Introduction section of CPT-4 book. This section describes "Add on codes" as "procedures/services that are always performed, by the same physician"; and "are always performed in addition to the primary service/procedure, and must never be reported as stand-alone codes." They also describe additional intra-service work associated with the primary procedure/service, and are designated in the CPT manual with a + symbol. Add-on codes can also be identified by specific language in the code descriptor, such as "each additional" or "(List separately in addition to primary procedure)." A summary of CPT Add On codes is found in Appendix D of the CPT Manual. Any add-on code, billed in the absence of the primary procedure/service code will be denied.

CCI — Correct Coding Initiative
The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding. The coding policies are based on coding conventions defined in the American Medical Association'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. The edits include table-based and narrative-based edits. When a CCI code combination is billed, without a CCI modifier or is billed on a CCI code combination that does not allow for the use of CCI modifiers, the column 2 code will be denied.

Age / Gender
The Age / Gender module contains two distinct categories:
Age based edits: These edits evaluate the minimum and maximum age appropriate for a procedure code against the age of the patient.
Gender based edits: These edits identify claim lines where a provider has filed a procedure that should be reported for a patient of a particular gender and where the gender of the patient does not match the procedure code description.
If a patient is not of the recommended age and/or gender for a code, the code will be denied.

Duplicates
Duplicate edits fire when an identical code is billed on multiple claims or claim lines. Included in the Duplicate category are:
Date Range Duplicates: This type is specific to procedures within the defined time frame of the identified procedures (i.e. pacemaker insertion/replacement) Lifetime Duplicates: This type is specific to procedures billed once per lifetime (i.e. hysterectomy, autopsy).
Same date of service Duplicates – When a code is billed on more than one line or claim, for the same date of service.

E/M — Evaluation and Management
Evaluation and Management codes are used to "describe the intensity of a medical encounter as measured by the risks and complexities associated with the diagnosis and medical decision-making. The more detailed the components and the more complex the diagnosis and treatment plan, the more valuable the E/M service. Correct coding of E/M services stipulates only one E/M code may be reported per day, for the same patient/provider. In rare instances a modifier may be used to indicate that two separately identifiable E/M services were performed on the same date of service. If the same provider bills multiple E/M services, for the same date of service, in the absence of a modifier, the code will be denied.

New Visit
The AMA and CPT-4 defines a new patient as 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 3 years." The term "professional services" applies to any face-to-face visit or service with a provider. This includes procedures as well as E/M visits. If a new visit code is billed and it is determined that the patient was not a new patient, the code will be denied and replaced with the appropriate level established patient E/M code.

Global Surgery
CMS has defined specific periods when services related to a surgical procedure, furnished by the physician who performed the surgery, are to be included in the payment of the procedure code. This is called the global surgical package. Procedure codes are separated into Major and Minor service categories by CMS, with different defined global day allocation for each. If an E/M or surgical code is billed, during the global surgery period of a surgical procedure, an edit may fire. Use of a separate diagnosis, to specify an unrelated E/M services does NOT supersede the need to append a global surgery modifier. Documentation will be required whenever similar diagnoses are billed.

Incidental Procedures
The Incidental Procedures category of edits identifies procedure codes classified as not payable due to a status code of B,P or T on the CMS National Physician Fee Schedule Relative Value File. These codes are not separately payable when billed with any other service.

Medical Necessity
CMS has determined medical necessity guidelines for national coverage determinations (NDC's) and local coverage determinations (LCD's). ConVergence point analyzes the diagnosis code(s) billed on the claim to ensure that the code meets the medical necessity guidelines as described in NCD/LCD's. If the diagnosis code does not meet the medical necessity requirement, as described in these determinations, the code will be denied.

Maternity Care
Per AMA, the total obstetric package includes the provision of antepartum care, delivery, and postpartum care. ConVergence Point logic applies acceptable methods of billing obstetric services, and identifies duplicate billing or unbundling of maternity care services as well as appropriate and/or inappropriate use of modifiers.

Lab Panel
According to the Medicare Claims Processing Manual, Chapter 12, Section 30, When components of a specific laboratory panel are billed separately, they must be bundled into the comprehensive panel code as appropriate; that includes the multiple component tests. If all of the component codes of a panel are billed individually, the component codes will be denied and replaced with the comprehensive lab panel code.

Multiple Units
Convergence Point claim analytics identifies claims where more than one unit has been billed on the same line or multiple lines of the same claim. If multiple units are billed, and the appropriate modifier is NOT appended, payment for that line will be cut back to 1 unit.