Payment Policy: Code Editing Overview

Reference Number: CC.PP.011
Product Types: ALL
Effective Date: 01/01/2013
Last Review Date: 11/01/2020

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Policy Overview
The purpose of this policy is to serve as a reference guide for general coding and claims editing information.

Application
This policy applies to facility and professional claims.

Policy Description

Code Editing Overview

The Health Plan uses HIPAA-compliant code editing software for physician and outpatient facility coding verification. The software detects, corrects, and documents coding errors on provider claims prior to payment by analyzing CPT, HCPCS, ICD-10, modifier and place of service codes against correct coding guidelines. These principles are aligned with a correct coding "rule." When the software audits a claim that does not adhere to a coding rule, a recommendation known as an "edit" is applied to the claim.

While code editing software is a useful tool to ensure provider compliance with correct coding, it does not wholly evaluate all clinical patient scenarios. Consequently, the Health Plan uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. For example, clinicians review all claims billed with modifiers -25 and -59 for clinical circumstances which justify separate reimbursement for the service performed.

The Health Plan may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

CPT and HCPCS Coding Structure

CPT codes are a component of the Healthcare Common Procedure Coding System (HCPCS). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding. Current Procedural Terminology (CPT) codes belong to the Level I subset and consist of the terminology used to describe medical terms and procedures performed by health care professionals. CPT codes are published by the American Medical Association (AMA). CPT codes are updated (added, revised and deleted) on an annual basis.

1. *Level I HCPCS Codes (CPT):* This code set is comprised of CPT codes that are maintained by the AMA. CPT codes are a 5-digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are then used to bill health insurance companies.

2. *Level II HCPCS Codes*: The Level II subset of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics, prosthetics, etc.). Level II codes are an alphabetical coding system and are maintained by CMS. Level II HCPCS codes are updated on an annual basis.

3. *Miscellaneous/Unlisted Codes:* These codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims submission. If the records are not submitted, the provider receives a denial indicating that medical records are required. Providers billing miscellaneous codes must submit medical documentation that clearly defines the procedure performed including, but not limited to, office notes, operative report, and pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered. Clinical validation also includes identifying other procedures and services billed on the claim for correct coding that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

4. *Temporary National Codes***:** These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered *temporary* and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.

5. **HCPCS Code Modifiers:** Modifiers are used by providers to include additional information about the HCPCS code billed. On occasion, certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

6. *International Classification of Diseases (ICD-10)***:** These codes represent classifications of diseases. They are used by healthcare providers to classify diseases and other health problems.

7. *Revenue Codes:* These codes represent the location where services were performed in a hospital or the type of services received. These codes are billed by institutional providers. HCPCS codes may be required on the claim in addition to the revenue code.

Reimbursement

Code Editing and the Claims Adjudication Cycle
Code editing is the final stage in the claims adjudication process. Once a claim has completed all previous adjudication phases (such as benefits and member/provider eligibility review), the claim is ready for analysis.
As a claim progresses through the code editing cycle, each service line on the claim is processed through the code editing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member/provider history.
Depending upon the code edit applied, the software may make the following recommendations:
Deny: Code editing rule recommends denial of a service line. The appropriate explanation code is documented on the provider's explanation of payment along with reconsideration/appeal instructions.
Pend: Code editing rule recommends that the service line pend for clinical review and/or validation. This review may result in a pay or deny recommendation. The appropriate decision is documented on the provider's explanation of payment along with reconsideration/appeal instructions.
Replace and Pay: Code editing rule recommends the denial of a service line and a new line is added and paid. In this scenario, the original service line is left unchanged and a new line is added to reflect the software's recommendations. For example, an incorrect CPT code is billed for the member's age. The software denies the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing, as the original billing remains on the claim.

Claims Editing Software Updates
The claims editing software is updated quarterly to incorporate the most recent medical practices, coding principles, industry standards and annual changes to the AMA's CPT manual.

Edit Sources
The claims editing software application contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied. This information is provided by clinical consultants, health plan medical directors, research and etc.
 The software applies edits that are based on the following sources:
- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) for professional and facility claims. The NCCI edits include column 1/column 2, medically unlikely edits (MUE), mutually exclusive and outpatient code editor (OCE) edits. These edits were developed by CMS to control incorrect code combination billing contributing to incorrect payments.
- Public domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).

- CMS Claims Processing Manual
- CMS Medicaid NCCI Policy Manual
- State Provider Manuals, Fee Schedules, Periodic Provider Updates (bulletins/transmittals)
- CMS coding resources, such as HCPCS Coding Manual, National Physician Fee Schedule, Provider Benefit Manual, Claims Processing Manual, MLN Matters and Provider Transmittals
- AMA resources
  - CPT Manual
  - AMA Website
  - Principles of CPT Coding
  - Coding with Modifiers
  - CPT Assistant
  - CPT Insider's View
  - CPT Assistant Archives
  - CPT Procedural Code Definitions
  - HCPCS Procedural Code Definitions
- Billing Guidelines Published by Specialty Provider Associations
  - Global Maternity Package data published by the American Congress of Obstetricians and Gynecologists (ACOG)
  - Global Service Guidelines published by the American Academy of Orthopedic Surgeons (AAOS)
- State-specific policies and procedures for billing professional and facility claims
- Health Plan policies and provider contract considerations

Code Editing Software
- **ClaimsXten**
  - ClaimsXten™ is a rule-based software application that edits submitted claims for adherence to Centene Corporation medical coverage policies, reimbursement coverage policies, benefit plans, and industry-standard coding practices based mainly on Centers for Medicare & Medicaid Services (CMS) and American Medical Association (AMA) guidelines.
  - ClaimsXten facilitates accurate claim processing for medical and behavioral claims submitted on a CMS 1500 claim form and for certain claims submitted on a UB04 claim form. Code editing within ClaimsXten is based on assumptions about the most common clinical scenarios for services performed by a health care professional for the same patient, and the logic within ClaimsXten is based on a thorough review by doctors of current clinical practices, specialty society guidance, and industry standard coding.
- **Cotiviti**
  - Cotiviti PCI offers claims editing solutions that validate, identify and review claims to comprehensively address Fraud Waste and Abuse.
  - Cotiviti PCI claim review reduces waste and improves payment accuracy. This process detects common errors such as duplicates, improper frequency, the unbundling of services, and inappropriate modifier use.
  - Cotiviti PCI uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation

allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. For example, clinicians review all claims billed with modifiers -25 and -59 for clinical scenarios which justify payment above and beyond the basic service performed.

Claims Editing Principles
Unbundling:
CMS National Correct Coding Initiative
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
CMS developed the correct coding initiative to control erroneous coding and prevent inaccurate claims payment. CMS NCCI edits consist of Procedure to Procedure (PTP) edits for physicians and hospitals and Medically Unlikely Edits for professionals and facilities.

PTP Practitioner and Hospital Edits
CMS has designated certain combinations of codes that should not be billed together. CMS developed the Procedure to Procedure (PTP), also known as Column I/Column II, edits to detect incorrect claims submitted by medical providers. The column I procedure code is the most comprehensive code and reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column II code is considered an integral component of the column I code. While these codes should not typically be billed together, there are circumstances when an NCCI modifier may be appended to the column II code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation will be performed.

PTP for practitioner edits are applied to claims submitted by physicians, non-physician practitioners and ambulatory surgical centers (ASC). PTP hospital edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech-language pathology providers and comprehensive outpatient rehabilitation facilities.

Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities
MUEs reflect the maximum number of units that a provider would typically bill for a single member on a single date of service. These edits are based on CPT/HCPCs code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyte, equipment prescribing information and clinical judgment.

Code Bundling Rules Not Sourced To CMS NCCI Guidelines
Many specialty medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are published and are available for use by the public domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Procedure Code Unbundling
Two or more procedure codes are used to report a service when a single, more comprehensive should have been used. The less comprehensive code is denied.

Mutually Exclusive Editing
These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest RVU is considered the reimbursable code.

Incidental Procedures
These are procedure code combinations that are considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Medical Visit Editing
CMS publishes rules surrounding payment of an evaluation and management service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).
Procedures are assigned a 0-, 10- or 90-day global surgical period. Procedures assigned a 90-day global surgery period are designated as major procedures. Procedures assigned a 0- or 10-day global surgical period are designated as minor procedures.
Evaluation and Management services for a major procedure (90-day period) that are reported 1 day preoperatively, on the same date of service or during the 90-day post-operative period are not recommended for separate reimbursement.
Evaluation and Management services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.
Evaluation and Management services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures.

Global Maternity Editing
Global periods for maternity services are classified as "MMM" when an evaluation and management service is billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days). E/M services are not recommended for separate reimbursement if the procedure code includes antepartum and/or postpartum care.

Diagnostic Services Bundled to Inpatient Admission (3-Day Payment Window)
This rule identifies outpatient diagnostic services provided to a member within three days prior to and including the date of an inpatient admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility, they are considered bundled into the inpatient admission and therefore are not separately reimbursable.

Multiple Code Rebundling
This rule analyzes if a provider billed two or more procedure codes when a single more comprehensive code should have been billed to represent all of the services performed.

Frequency and Lifetime Edits
The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes that are allowed a limited number of times on a single date of service, over a given period of time or during a member's lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period of time or during a member's lifetime. A frequency edit is applied when the procedure code is billed in excess of these guidelines.

Duplicate Edits
Code editing evaluates prospective claims to determine if there is a previously paid claim for the same member and provider in history that is a duplicate to the prospective claim. The software also looks across different providers to determine if another provider was paid for the same procedure, for the same member on the same date of service. Finally, the software analyzes multiple services within the same range of services performed on the same day. An example of this scenario would be if a nurse practitioner and physician bill for office visits for the same member on the same day.

National Coverage Determination Edits
CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services or technologies can be paid under Medicare. These rules evaluate diagnosis to procedure code combinations.

Revision History	
08/29/2016	Changed "code auditing" to "code editing"; added "Claims Editing Updates"
08/30/2016	Updated disclaimer
05/19/2017	Converted to new template
06/11/2018	Conducted Annual review, updated policy
08/27/2019	Conducted review and updated
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed

Important Reminder
For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.