# Payment Policy: Code Editing Overview

Reference Number: CC.PP.011
Product Types: ALL
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Coding Implications
Revision Log

**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 verifies correct coding using internal and vendor-sourced HIPAA-compliant code editing software tools. The software detects, corrects, and documents coding errors on provider claims prior to payment by analyzing Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), 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 medical procedures and services. In certain circumstances, the Health Plan uses clinical validation by a team of experienced nursing, physicians, and/or coding experts to further identify claims for potential billing errors. Clinical validation supports the evaluation of exceptions to standard coding guidelines by ensuring that reimbursement decisions-whether additional payment is appropriate or not-are based on accurate and clinically justified documentation. For example, clinicians may review claims billed with Modifier 25 and Modifier 59 for clinical circumstances which justify separate reimbursement for the service performed.

Additionally, some correct coding edits are derived from proprietary clinical and payment policies that guide coding decisions in alignment with internal organizational criteria.

The Health Plan may have policies that deviate from correct coding principles. Consequently, to guarantee compliance with Centene's policies and to enable accurate claims reimbursement, it could be necessary to make exceptions to the basic correct coding principles.

**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.

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**
Claims editing software is updated routinely to incorporate the most recent medical practices, coding principles, industry standards, changes to CPT, ICD-10 and CMS guidelines, and proprietary clinical and payment policy revisions.

**Edit Sources**
Claims editing software contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, frequency limitations, 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, etc.

This software applies edits that are publicly sourced to correct coding guidelines, such as the following listed examples:

- 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, etc.).
- 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
- State-specific policies and procedures for billing professional and facility claims
- Health Plan policies and provider contract considerations
- Internally developed clinical and reimbursement policies reflecting organizational standards beyond publicly available coding guidelines.

**Claims Editing Principles**

The health plan is committed to adhering to all applicable coding guidelines, regulations, and standards set forth by federal and state authorities to ensure the accuracy, integrity, and transparency of claims submitted for payment. The health plan follows correct coding practices in accordance with but not limited to:

1. **Current Procedural Terminology (CPT) Codes**
2. **International Classification of Diseases (ICD) Codes**
3. **Healthcare Common Procedure Coding System (HCPCS)**
4. **National Correct Coding Initiative (NCCI) Edits**
5. **Other applicable federal and state regulations**

These coding standards are implemented to prevent fraud, waste, and abuse by ensuring that all services provided are accurately documented, appropriately coded, and billed for in accordance with legal and regulatory requirements.

The health plan is committed to maintaining the highest ethical standards and protecting program integrity by ensuring all claims reflect the services actually rendered and comply with applicable coding and billing regulations.

**References:**

1. **Centers for Medicare & Medicaid,** *CMS, NCCI Medicare Policy Manual* https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-policy-manual
2. **Centers for Disease Control and Prevention**, *CDC, https://www.cdc.gov/nchs/icd/icd-10/index.html*
3. **Centers for Medicare & Medicaid,** *CMS, Global Surgery Booklet* https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf

4. **Centers for Medicare & Medicaid,** *CMS Claims Processing Manual, Chapter 12 – pages 36 and 77* https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912
5. **Centers for Medicare & Medicaid,** *CMS, NCCI Medicaid Policy Manual* https://www.cms.gov/medicare/coding-billing/ncci-medicaid

| 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 |
| 11/30/2021 | Annual Review completed; no major updates required |
| 12/01/2022 | Annual Review completed; no major updates required |
| 11/07/2023 | Annual Review completed; updated dates and reviewed policy |
| 02/27/2024 | Annual Review Completed; Updated policy; Updated paragraph 2 to include and/or; Updated Modifier 24 verbiage to meet AMA; Updated AMA & CMS Annual change process; Updated Global Surgery paragraph for clarification; Added references & links for support. |
| 11/22/2024 | Annual Review completed; no major updates required |
| 2/12/2025 | Annual Review completed; Expanded abbreviations for CPT, HCPCS, ICD-10-CM & RVUs; Updated links for NCCI Manual, CDC NCHS ICD10, CMS Claims Processing Manual & Removed CMS Global Surgery Data Collection Files links. |
| 3/7/2025 | Modification made to Code editing overview, Removing CPT and HCPS Coding Structure, Verbiage change to Claims Editing Software Updates and Edit Sources, Coding Editing software section removed, Claims Editing Principals Modified. |
| 11/13/2025 | Annual Review completed; Validated policy content, references and links; Added revision date. Updated Reference Links to Manuals. |
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**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.

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