Claims Editing Software Payment Policy

Policy

The Plan has implemented software designed to evaluate billing and coding accuracy on submitted claims. The software is guided by the coding criteria and protocols established by various industry sources including, but not limited to, the Centers for Medicare and Medicaid Services (CMS), the CPT Manual published by the American Medical Association (AMA), and specialty society guidelines.

Use of automated method(s) to aid in the proper processing of claims ensures consistent application of Plan payment policies across all claims. The Plan has customized its claims editing software and is continually in the process of evaluating the software and modifying it to accommodate Plan payment policy.

Specific contract terms will apply.

Reimbursement

The following list represents an example of the different edits and their definitions, but is by no means an all-inclusive list.

Age conflicts:
Identifies billed procedure codes that are inconsistent with the age of the member.

Assistant surgeon edits:
Determines if an assistant surgeon is clinically necessary for the billed procedure.

Cosmetic surgery edits:
Identifies procedures that the Plan considers to be cosmetic and suspends the claim for additional review.

Experimental/investigational procedures:
Identifies codes that are considered experimental/investigational and determined not to be reimbursable by the Plan.

Incidental procedure editing:
Identifies procedures that the Plan considers to be clinically integral to the primary procedure and not allowable for separate reimbursement.

Intensity of service editing:
Compares the ICD diagnosis to the intensity of the billed office visit. Recommends the appropriate evaluation and management (E&M) code and is stated on the Remittance Advice Summary.

Modifier editing:
Compares the CPT/HCPCS procedure with the billed modifier for clinical appropriateness.

Multiple component billing / duplicate component billing:
Identifies instances where the sum of all payments (i.e., total, professional, technical) for a procedure across multiple providers exceeds the amount that would have been paid for the total procedure.

Multiple Procedures Payment Reduction:
When multiple services are performed by the same provider on the same member on the same date of service, the procedure with the highest intensity will be reimbursed at 100% and the subsequent procedure(s) will be reimbursed at a reduced rate. The Plan follows the rules set forth in the Centers for Medicare and Medicaid Services (CMS) Multiple Procedures Payment Reduction (MPPR).

Multiple units per single date of service:
Identifies instances where procedure codes are submitted with more units than are medically likely for one date of service. The unit assignment list is subject to change based on review of industry standard coding updates including, but not limited to, the CMS Medically Unlikely Edit (MUE) program.

Mutually exclusive editing:
Identifies two or more procedures that produce the same clinical result but are performed by different methods, or are procedures that usually are not performed together during the same patient encounter and therefore not allowable for separate reimbursement.

Unbundling editing:
Identifies billing scenarios where two or more procedures are listed separately when a more accurate comprehensive procedure code exists. The correct codes for the clinical scenario will be allowed and/or automatically added to the claim.

Gender conflicts:
Identifies billed procedures that are inconsistent with the patient's gender.

- The KX modifier is a multipurpose, informational modifier and can be used to identify services for transgender, ambiguous genitalia, and hermaphrodite beneficiaries in addition to its other existing uses. Physicians and non-physician practitioners should use modifier KX with procedure codes that are gender specific in the particular cases of transgender, ambiguous genitalia, and hermaphrodite beneficiaries.
- Include the KX modifier for professional claims; condition code 45 for facility claims.

Unlisted procedure edits:
Identifies procedure codes defined by CPT as unlisted services. Unlisted procedure codes should never be used when a more descriptive procedure code is available. Unlisted codes require prior authorization.

The Plan compares claims for the same date of service when submitted on separate claims.

Billing/coding guidelines

Providers are required to submit claims to the Plan that accurately reflect the services performed and utilize the appropriate coding systems including CPT, HCPCS and ICD-10-CM, AMA and CMS guidelines.

The Plan reserves the right to edit claims for inappropriate coding and take further action including, but not limited to, pending and denying of claims, and recovery of monies.

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	02/28/01
Previous revision date(s):	04/16/03, 03/17/04, 10/13/04, 09/28/05, 09/27/06, 11/07/07 05/01/2010 - moved to new policy template 05/01/2013 - added examples of the types of edits. 11/01/2014 - Updated Multiple Procedures Payment Reduction discussion and moved to Fallon Health logo and template. 09/01/2015 - Annual review and moved to new Plan template. 05/01/2016 - Annual review.
Connection date & details:	January 2017 – Updated the reimbursement section. April 2018 – Annual Review, no updates. April 2019 – Annual Review, no updates.

April 2020 – Policy name changes from Claims Auditing Software to Claims Editing Software.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.