Payment Integrity – Correct Code Editing

Meridian wants to inform you of correct code editing related changes effective April 1, 2022 to address the growing problem of Fraud, Waste, and Abuse (FWA) in health care as we migrate to our new claims processing platform, Amisys. Meridian currently uses Change Healthcare's Prepay Insight Supplemental Code Edits and Cotiviti's Prospective Payment Management (PMM) as their Payment Integrity claims editing solution. On April 1, 2022 with the migration to Amisys, Meridian will phase out both Change Healthcare Prepay Insight Supplemental Code Edits and Cotiviti Prospective Payment Management (PMM) and will start utilizing Change Healthcare's ClaimsXten, Cotiviti's Coding Validation, as well as internal Payment Integrity editing solutions to ensure accurate and precise correct code editing.

We will be setting up the above code editing programs for Meridian in conjunction with our Corporate Office, Centene Corporation, and our strategic business partners, Change Healthcare and Cotiviti for their respective programs. These programs will help protect Meridian from the unnecessary expenditures resulting from wastefully billed claims. The vendors, aforementioned, will provide clinically based rule content to evaluate claims against complex payment and medical policies to ensure accurate reimbursement.

Once Meridian migrates to Amisys on 4/1/2022, some providers will observe that more exacting programs are now in place to assure that only accurately and properly coded and billed services will be reimbursed. **For more information on the correct code editing program, more details about the vendors mentioned above, as well as sourcing of the correct code editing please visit the** Meridian **website at mimeridian.com.**

Code Editing Overview

Meridian 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.

Meridian 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.

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, 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
- ICD-10 CM Manual
- 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

- **Change Healthcare 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 Coding Validation**
    - Cotiviti Coding Validation offers claims editing solutions that validate, identify and review claims to comprehensively address Fraud Waste and Abuse.
    - Cotiviti Coding Validation 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 Coding Validation 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.

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

CPT and HCPCS Manuals

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.

NCCI 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.

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.

Meridian takes the responsibility of detecting fraudulent, wasteful and abusive claims very seriously. These processes will enable us to more effectively and universally implement fair reimbursement, prevent fraud and provide equitable reimbursement to all providers. We are aware that the system changes on 1/1/2021 will impact some claims payments for providers, and there will be a period of adjusting to the implementation of the aforementioned processes. We are committed to being fair and consistent to providers, members and our clients as we pursue our goal of eliminating waste in the payment of healthcare claims.