Clinical Editing

Last Updated: 3/12/2025 **Last Reviewed: 3/12/2025** **Originally Effective: 1/22/2004**

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a **Policy #: RPM002**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** All

Reimbursement Guidelines

A. General

We use HIPAA-compliant code editing software in the processing of medical claims to improve accuracy and efficiency in claims processing, payment, and reporting. Our clinical edit set focuses on correct coding methodologies and accurate, appropriate adjudication of claims.

Our claims editing software detects and documents coding errors on provider claims prior to payment by analyzing CPT, HCPCS, ICD-10, modifier, place of service, and revenue codes against correct coding guidelines. The software contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures, cross-provider unbundling or duplication, laterality inconsistencies, and other coding inconsistencies. Each rule is linked to a generally accepted coding principle.

B. Sources

Our clinical edit policies are based on coding conventions defined by a variety of established sources, including but not limited to:

- The American Medical Association's (AMA) CPT manual
- The AMA CPT Assistant newsletter articles
- The Centers for Medicare & Medicaid Services (CMS) policies, fee schedule status indicators, and guidelines
- The Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (CCI) and Associated Policies
- The Centers for Medicare & Medicaid Services (CMS) Medicare Code Editor (MCE) and Definitions of Medicare Code Edits.
- The Centers for Medicare & Medicaid Services (CMS) internet-only manuals, transmittals, articles, and other documentation.
- Coding guidelines developed by national professional specialty societies
- Specialty clinical practice guidelines
- Clinical research and practice pattern analysis
- Clinical experience of physician reviewers
- Numerous medical journals
- Medical texts
- Medical newsletters
- Coding industry newsletters
- Public health data studies
- Proprietary health data analysis

- Other general coding and claim payment references

C. Modifier Bypass of Edits

Some edits are eligible for a modifier bypass and other edits are not eligible for bypass. If an edit is eligible for a modifier bypass, it is preferable to append the modifier to the code which the edit would otherwise deny. If the same modifier is appended to both the allowed and the denied code, the clinical editing software applies additional logic and may still fire the edit. Only an appropriate and NCCI-associated modifier may be used to bypass the edit. To locate a current list of NCCI-associated modifiers, consult the most recent CMS NCCI Policy Manual, Chapter 1, § E, "Modifiers and Modifier Indicators." [10]

"Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI edit if the clinical circumstances do not justify its use." [11] If the NCCI Policy Manual, modifier definition, or source guideline imposes restrictions on the use of a modifier, the modifier may only be used to bypass an edit if the restrictions and/or requirements are fulfilled and documented.

While code auditing software is a useful tool to ensure provider compliance with correct coding, it will not wholly evaluate all clinical patient scenarios. We may request medical records or other documentation to verify that all procedures and/or services billed are properly supported in accordance with correct coding guidelines.

D. Carrier-specific Edits, Policies, & Guidelines

1. We recognize that there is no one-size-fits-all-carriers for clinical edits or reimbursement policy; each carrier has some carrier-specific policies and edits. We recommend that providers familiarize themselves with the locations of our Reimbursement Policies and make note of our carrier-specific edits as they encounter them, as well as for each health plan with which they do business and make best efforts to incorporate these into their regular workflow.

2. The American Medical Association's published guidelines address carrier-specific edits, policies, and reimbursement guidelines from commercial carriers and third-party payors:
   a. "Since each third-party payor may establish reporting guidelines that vary from coding guidelines, a clear understanding of CPT coding guidelines, as well as third-party payor reporting guidelines is essential." [3]
   b. "CPT coding guidelines may differ from third-party payer guidelines. Eligibility for payment, as well as coverage policy, is determined by each individual insurer or third-party payer. For reimbursement or third-party payer policy issues, please contact your local third-party payer." [4]

3. The Medicare National Correct Coding Initiative Policy Manual specifically states:
   a. "The National Correct Coding Initiative Policy Manual for Medicare Services and the edits were developed for the purpose of encouraging consistent and correct coding and reducing inappropriate payment. The edits and policies do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination." [1]
   b. "NCCI does not contain edits based on this rule because Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits." [2]
   c. "NCCI contains many, but not all, possible edits based on these principles." [2]
   d. "The NCCI contains many, but not all, edits bundling laparoscopic procedures into open procedures. Since the number of possible code combinations bundling a laparoscopic procedure

into an open procedure is much greater than the number of such edits in NCCI, the principle stated in this paragraph is applicable regardless of whether the selected code pair combination is included in the NCCI tables. A provider should not select laparoscopic and open HCPCS/CPT codes to report because the combination is not included in the NCCI tables." [5]

e. "The NCCI does not address issues related to HCPCS/CPT codes describing services that are excluded from Medicare coverage or are not otherwise recognized for payment under the Medicare program." [6]

f. "Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination." [8]

4. Our clinical editing system contains some edits which are not found on the NCCI edit tables, in the same manner as mentioned above regarding regional Medicare Carriers (A/B MACs) having separate edits. These edits are based upon correct coding guidelines and principles and have the same general purpose as the NCCI edits, to prevent inappropriate payment.

E. Determining Specialty for Non-Physician Practitioners (NPP)

The CMS and CPT guidelines differ for determining specialty for non-physician practitioners (NPP).

1. CMS: "…classifies NPPs in a specialty that is not the same as a physician with whom the NPP is working…" [16, 17]

2. AMA/CPT: "When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician." [5]

3. Moda follows the AMA/CPT guidelines for NPP specialty determination.

   This affects certain clinical edits which are dependent upon provider specialty and manual reviews for correct coding and documentation validation.

F. Source/Rationale Information for an Individual Code-Specific Clinical Edit

Upon request to Moda Health Customer Service, Moda Health will research and respond back to you within 30 days with the source that defines the policy standard for a specific clinical edit.

G. Edits Applied to Specific Types of Providers

1. Claims submitted on CMS1500 forms or the electronic equivalent are subject to professional clinical edits, CCI PTP edits, and MUE edits. Note: CMS applies professional practitioner PTP edits to Freestanding Ambulatory Surgery Center (ASC) claims.[7]

2. Claims submitted on CMS1450/UB forms or the electronic equivalent with type of bill (TOB) 013x are subject to outpatient hospital CCI PTP and MUE edits.
   a. Critical Access Hospital (CAH) claims submitted with TOB 085x will be exempt from OPPS edits, status indicators, and rules.
   b. Rural Health Center (RHC) claims submitted with TOB 071x will be exempt from OPPS edits, status indicators, and rules.
   c. Federally Qualified Health Center (FQHC) claims submitted with TOB 077x [13, 18] are exempt from OPPS edits, status indicators, and rules.

3. Hospital-based Ambulatory Surgery Center (ASC) claims submitted on CMS1450/UB forms or the electronic equivalent with type of bill (TOB) 083x are subject to outpatient hospital CCI PTP and MUE edits.

Definitions

Acronyms/Abbreviations

Acronym	Definition
AMA	American Medical Association
APP	Advanced Practice Provider
ASC	Ambulatory Surgical Center
CCI	Correct Coding Initiative (see "NCCI")
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DRG	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
MAC	Medicare Administrative Contractor
MS DRG	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
MUE	Medically Unlikely Edits
NCCI	National Correct Coding Initiative (aka "CCI")
NPP	Non-Physician Practitioner
OPPS	Outpatient Prospective Payment System
PTP	Procedure-To-Procedure (a type of CCI edit)
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	Uniform Bill

Definition of Terms

Term	Definition
Advanced practice provider (APP)	'Advanced Practice Provider' is a general title used to describe individuals who have completed the advanced education and training that qualifies them to (1) manage medical problems and (2) prescribe and manage treatments within the scope of their training. Some specific types of APPs include clinical nurse specialists, nurse practitioners, and physician assistants. This term is approximately equivalent to the Medicare term Non-physician practitioner (NPP).
Non-physician Practitioner	A Medicare term which Medicare defines as: Health care providers who practice either in collaboration with or under the supervision of a physician, including physician assistants, nurse practitioners, and clinical nurse specialists, are referred to as non-physician practitioners (NPPs). [14] This term is approximately equivalent to the non-Medicare term Advanced Practice Provider (APP).

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Modifiers 62 & 66 - Co-surgery (Two Surgeons) and Team Surgery (More Than Two Surgeons)." Moda Health Reimbursement Policy Manual, RPM035.
C. "Medically Unlikely Edits (MUEs)." Moda Health Reimbursement Policy Manual, RPM056.

Resources

1. CMS. National Correct Coding Initiative Policy Manual. Introduction, pg. Intro-5.
2. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § D, "Evaluation and Management (E&M) Services", pg. I-17.
3. American Medical Association. "A Closer Look at the Use of Surgical Modifiers." *CPT Assistant*, March 1996: 8.
4. American Medical Association. "Frequently Asked Questions." *CPT Assistant*, January 2016: 11.
5. CMS. National Correct Coding Initiative Policy Manual. Chapter 1 General Correct Coding Policies, § E.1.c), "Modifiers and Modifier Indicators, Modifier 58", pg. I-22.
6. CMS. National Correct Coding Initiative Policy Manual. Chapter 1 General Correct Coding Policies, § S, "Excluded Service," pg. I-35.
7. CMS. National Correct Coding Initiative Policy Manual. Introduction, pg. Intro-3.
8. CMS. National Correct Coding Initiative Policy Manual. Introduction, pg. Intro-5.
9. CMS. National Correct Coding Initiative Policy Manual. Introduction, pg. Intro-3.
10. CMS. National Correct Coding Initiative Policy Manual. Chapter 1 General Correct Coding Policies, § E, "Modifiers and Modifier Indicators", pg. I-19.
11. CMS. "How to Use the Medicare National Correct Coding Initiative (NCCI) Tools." Medicare Learning Network. January 2016: 6.
12. CMS. National Correct Coding Initiative Policy Manual. Introduction, pg. Intro-2.
13. Noridian. "Federally Qualified Health Centers (FQHC) Billing Guide." Noridian Health Solutions. https://med.noridianmedicare.com/web/jea/provider-types/fqhc/fqhc-billing-guide . Last updated September 6, 2018; last accessed May 10, 2019.
14. CMS. "Glossary and Acronyms." Medicare and Medicaid Services. Last accessed July 27, 2022. https://www.cms.gov/OpenPayments/Glossary-and-Acronyms#non-physician-practitioner-covered-recipient .
15. American Medical Association. "Instructions for Use of the CPT Codebook." *Current Procedural Terminology (CPT) 2022, Professional Edition.* Chicago: AMA Press, p. xiv.
16. CMS. "Critical Care Furnished Concurrently by Practitioners in the Same Specialty and Same Group (Follow-Up Care)." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.12.4.
17. CMS. "Physicians in Group Practice." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.5.
18. CMS. "FQHC Processing Under FQHC PPS." *Integrated OCE (IOCE) CMS Specifications V23.2*, § 5.22. https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs .

Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
3/12/2025	Formatting updates. No policy changes.
2/14/2024	Updated CMS documentation sources. No policy changes.
6/14/2023	Annual review. No updates.

Date	Summary of Update
8/10/2022	Clarified same specialty determination for non-physician practitioners; no policy changes. Definition of Terms added. Acronyms & Resources updated. Formatting updates. Policy History entries prior to 2022 omitted (in archive storage).
1/22/2004	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/22/2004	Original Effective Date (with or without formal documentation). Policy based on administrative decisions by Claims leadership & review of national coding guidelines.