

<b>Commercial Reimbursement Policy</b>	
Subject: <b>Code and Clinical Editing Guidelines – Professional and Facility</b>	
Policy Number: <b>C-25002</b>	Policy Section: <b>Administration</b>
Last Approval Date: <b>03/25/2025</b>	Effective Date: <b>10/01/2025</b>

**Disclaimer**

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member’s benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member’s state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

**Policy**

The health plan applies Code and Clinical Editing Guidelines (CCEG) to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits unless provider, state, federal contracts, and/or mandates indicate otherwise.

The health plan uses software products that ensure compliance with standard code edits and rules. These products increase consistency of payment for providers by ensuring correct coding and billing practices and may automatically apply edits using the software’s editing logic. CCEG consists of the following measures:

- Code editing software, CMS National Correct Coding Initiative (NCCI) edits, and Outpatient Code Edits (OCE)
  - Code editing software is updated to conform to changes in coding standards
  - National Correct Coding Initiative (NCCI) edits are updated according to CMS published updates:
    - PTP (procedure to procedure)
    - MUE (Medically Unlikely Edits)
- Clinical criteria
- Claims processing platform
- Uniform Billing Editor

Per state requirements, we publish the use of specific commercial code editing software.

The Health Plan only customizes applicable CCEG measures due to compelling business reasons.

The health plan also uses a coding algorithm approach to automatically adjudicate Evaluation and Management claims based on the applicable level of complexity or severity in accordance with diagnosis codes reported on the claims.

CCEG measures are updated as applicable and as needed to incorporate new codes, code definition changes, and edit rule changes.

All claims submitted after the configuration implementation date, regardless of service date, will be processed according to up to date CCEG measures. No retrospective payment changes, adjustments, and/or requests for refunds will be made when processing changes are a result of new code editing rules within a module update. The member is not responsible and should not be balance billed for any procedures for which payment has been denied or reduced as the result of CCEG measures. Please refer to the Health Plan’s reimbursement policies for specific reimbursement rules.

**Nonreimbursable**

The Health Plan will not reimburse in the event of a conflict with CCEG.

Note: When a service unit exceeds an MUE, the claim line(s) will be denied.

<b>Related Coding</b>	
Standard correct coding applies	

<b>Policy History</b>	
03/25/2025	Initial approval 03/25/2025 and effective 10/01/2025: retired Code and Clinical Editing- Professional (C-09004) and combined into a new blended policy titled Code and Clinical Editing- Professional and Facility (C-25002)

<b>References and Research Materials</b>	
This policy has been developed through consideration of the following: <ul style="list-style-type: none"> <li>• CMS</li> <li>• NCCI</li> </ul>	

- Optum EncoderPro 2024

## Definitions

Editing	<p>The practice or procedure pursuant to which one or more adjustments are made to CPT® codes or HCPCS codes included in a claim that result in:</p> <ul style="list-style-type: none"> <li>• payment being made based on some, but not all, of the CPT®/HCPCS' codes included in the claim</li> <li>• payment being made based on different CPT®/HCPCS codes than those included in the claim</li> <li>• payment for one or more of the CPT®/HCPCS codes included in the claim being lowered by application of multiple procedure logic</li> </ul> <p>payment for one or more of the CPT®/HCPCS codes being denied, or any combination of the above</p>
General Reimbursement Policy Definitions	

## Related Policies and Materials

After-Hours, Emergency, and Miscellaneous E/M Services - Professional and Facility
Anesthesia Services - Professional
Bundled Services and Supplies - Professional
Bundled Services and Supplies - Facility
Emergency Department: Leveling of Evaluation and Management Services
Frequency Editing - Professional
Global Surgical Package - Professional
Global Surgery - Facility
Health and Behavior Assessment and Intervention - Professional
Injection and Infusion Administration and Related Services and Supplies - Professional
Laboratory and Venipuncture Services – Professional and Facility
Modifier Usage - Professional
Modifiers 25 and 57: Evaluation and Management with Global Procedures
Modifiers 50 and 51: Multiple and Bilateral Surgeries - Professional
Modifiers 80, 81, 82 and AS: Assistant at Surgery – Professional
Multiple Diagnostic Imaging Procedures - Professional
Multiple Diagnostic Imaging - Facility
Multiple Procedure Payment Reduction - Professional
Multiple Surgery - Facility
Outpatient Facility Revenue Code Billing Requirements - Facility
Screening Services with Related Evaluation and Management Services - Professional
Three-Dimensional (3D) Radiology Services – Professional and Facility

## Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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