Reimbursement Policy	
Subject**: Code and Clinical Editing Guidelines**	
Policy Number: **G-07016**	Policy Section: **Administration**
Last Approval Date: **05/19/2023**	Effective Date: **05/19/2023**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.simplyhealthcareplans.com or https://provider.clearhealthalliance.com. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Simply Healthcare Plans, Inc. (Simply) and Clear Health Alliance (CHA) covered the service for the member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use 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, Simply and CHA may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Simply and CHA strives 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

Simply and CHA apply 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, or CMS contracts and/or requirements indicate otherwise.
Simply and CHA 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 are followed. 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*
- Licensed clinical medical review
- Claims processing platform

Per state requirements, Simply and CHA publishes its use of specific commercial code editing software. Simply and CHA only customizes applicable CCEG measures due to compelling business reasons. We also use 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.

Nonreimbursable
Simply and CHA 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.

Related Coding

Standard correct coding applies

Policy History

05/19/2023	Review approved and effective: added language regarding CMS MUE
09/08/2022	Review approved: policy template updated

09/14/202	Review approved: minor administrative updates; added language referencing coding algorithms; References and Research Materials, Definition, and Related Materials sections updated
12/01/2018	Policy template updated
10/03/2018	Review approved: policy template updated
10/03/2016	Review approved: policy template updated
11/09/2015	Review approved and effective: Code editing language reorganized
10/31/2014	Review approved: policy template updated
05/21/2012	Review approved: policy template updated
07/12/2010	Review approved and effective: resources used to develop CCEG updated; timeline requirements for system updates deleted; services reviewed and analyzed clarified; policy template/History updated
05/16/2007	Initial approval and effective 05/01/2005: policy adapted from: • Bundling Guidelines, #05-002, effective 05/01/2005 • #05-003, effective 05/01/05 • Consistency Guidelines, #05-005, effective 02/01/2005

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract
- State Medicaid

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

None