POLICY AND PROCEDURE

DEPARTMENT: Coding Analytics	**DOCUMENT NAME:** Claim Coding Decisions—ClaimsXten
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APPROVED DATE: 08/2020	**RETIRED:**
EFFECTIVE DATE: 08/2020	**REVIEWED/REVISED:** 08/2020
PRODUCT TYPE: All	**REFERENCE NUMBER:** LA.CCM.08.19

SCOPE:
Payment Integrity, Coding Analytics, Plan Medical Management, Plan Provider Relations, Plan Provider Contracting and the Claims Department.

PURPOSE:
To ensure claim payment processing decisions are made in a fair, impartial and consistent manner using written, objective criteria based on nationally recognized coding standards.

POLICY:
Louisiana Healthcare Connections utilize licensed code auditing software to detect, correct, and document improper coding, including unbundling, upcoding and fragmentation. The application of such software will provide consistent, objective claims review by applying common coding guidelines developed by the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS) and national specialty societies. Code auditing is applied to professional claims, facilities and independent laboratory services.

Louisiana Healthcare Connections currently utilize McKesson's ClaimsXten®, code auditing software product to audit professional service claims, facilities and independent laboratory services. ClaimsXten uses a comprehensive clinical database that is developed and maintained by a team of full-time physicians, registered nurses, coding experts and other healthcare professionals. McKesson also utilizes a clinical support network consisting of a broad range of board-certified physicians from a variety of specialty areas.

ClaimsXten's code auditing logic is based on coding sources including:

- Current Procedural Terminology (CPT)
- Healthcare Common Procedure Coding System (HCPCS)
- Internal Classification of Diseases Clinical Modification (ICD-CM)
- American Medical Association (AMA) guidelines
- Centers for Medicare and Medicaid Services (CMS) guidelines
- Specialty society guidelines (i.e. ACOG, ACS)

Homegrown or other nonstandard codes are not reviewed through ClaimsXten®.

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To ensure that criteria is current and accurate, McKesson reviews the code auditing edit logic on a quarterly basis and a new release of the product is distributed to the health plan. Providers are notified (mailings, provider manual and newsletters) of the criteria utilized by the Plan, as well as their right to request an explanation of the criteria used to audit a claim.

Some ClaimsXten rules require approval by the Chief Medical Officer and/or Plan President to override the CXT default edit logic.

PROCEDURE:

For Automated system edits:

I ClaimsXten rules are applied to claims processed by AMISYS that are in a payable status, identifying potential incorrect payments on a prepayment basis.

A ClaimsXten rules look at such areas as:

- Bundling/unbundling of services
- Incidental services
- Mutually Exclusive services
- Global surgical follow-up days
- Maximum frequency of services per day
- Duplicate claims
- Invalid codes/Unlisted procedures
- Bilateral services
- Incorrect procedures submitted for patient age and/or gender

II. ClaimsXten recommends a pay, deny or manual review decision regarding a billed service.

A. Services determined as coded correctly and appropriately billed (i.e. not unbundled) will systematically pay the codes, as billed, and the claim will process for payment according to other claims system rules.

B. Services determined to be coded incorrectly/ inappropriately are systematically denied, with the explanation for the denial communicated to the provider via the claim explanation of payment (EOP).

C. Services determined to be coded incorrectly, may be replaced with appropriate replacement codes indicated in the code editing software (i.e. inappropriate CPT code for member's age), or be rebundled component lab codes into the comprehensive panel code. In this circumstance, the replacement codes are paid and the claim will process for payment according to other claims system rules. Payment information is communicated to the provider via the claim explanation of payment (EOP).

Pre Payment Manual Review

A. Certain CPT codes or CPT code pairs that may be coded incorrectly or billed inappropriately, pend for manual review.

1. Claims pended for manual review are reviewed by Coding Analytics.

2. Claim history and the code auditing rule justification will be requested, as indicated, per the rule or, as needed, to make a payment decision.

   a. A Coding Analytics Nurse will review claims with rules that require review of clinical information.
   b. All other claims, which do not indicate that review by a clinical professional is required, are reviewed by a Coding Analytics Specialist.

3. Rule information is screened using the CXT user interface, current version of the AMA CPT Code book, State regulations, contract requirements, CMS, medical information and national specialty society guidelines (if needed).

   a. The pend will be issued a pay or deny recommendation based on the manual review findings.

4. A decision is made based on the information provided above within 10 days of the claim receipt.

   a The decision and the specific rationale for the decision are documented in CenPas and/or the AMISYS system.
   b The provider is notified of the decision via a claim explanation of payment (EOP).

c If a decision is rendered to deny reimbursement, the provider is notified via a written letter which includes specific rationale

B. Appeals received regarding claims denied or reduced as a result of the claim auditing software (either systematically or manually) are processed according to the Claims Appeals Policy & Procedure (LA.CLMS.07.72)

III. On a quarterly basis, an update to the code auditing software is installed to reflect the most current coding guidelines.

IV. On a monthly basis, the Coding Analytics staff responsible for making payment decisions are audited for consistency in decision-making and documentation according to Quality Audit Policy and Procedure (LA.CCM.08.05)

REFERENCES: Quality Audit Policy and Procedure (LA.CCM.08.05) Code Audit Review Selection Process (LA.CCM.08.02)

ATTACHMENTS:

DEFINITIONS: CCM: Compliance Coding Management

REVISION LOG

REVISION	DATE
Converted corporate to local policy.	08/15/2020

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____Electronic Signature on File_____

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