COMMON GROUND
HEALTHCARE COOPERATIVE

ADMINISTRATIVE POLICY STATEMENT
Wisconsin Marketplace

Policy Name & Number	Date Effective
Claims Editing and Review-WI MP-AD-1465	01/01/2025
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Administrative Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Administrative Policy Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Claims Editing and Review

B. Background

All health care providers are expected to utilize the same standard coding sets and rules to codify the services provided during encounters with patients. This codification is used to bill insurance carriers for reimbursement, known as a 'claim'. In the codification process, there are rules that must be followed to appropriately codify the encounter into a claim, which is then sent to the insurance carrier for reimbursement.

All claims submitted to Common Ground Healthcare Cooperative (CGHC) for reimbursement consideration are subject to claims editing. This ensures that appropriate coding sets are used and, rules are applied in billing by the provider. This also ensures that appropriate reimbursement is made to the provider for services rendered. This policy aims to outline the source of edits and rules CGHC utilizes for claims editing and review.

C. Definitions

NA

D. Policy

I. To ensure appropriate and timely reimbursement for services rendered to enrollees, CGHC utilizes automated claims editing to enforce appropriate coding and billing practices by providers when submitting claims.
   A. Appropriate coding and billing of claims allows for the accurate adjudication and reimbursement for services rendered to a CGHC enrollee.
   B. All claims submitted to CGHC are subject to this editing.

II. CGHC models edits and rules from the following sources:
   A. Industry standard coding rules, manuals, guidelines, directives, and relevant state and federal regulations for claims editing
   B. Resources used to source these coding and billing standards include, but are not limited to, the following list:
      1. X12 or ASC X12 - The Accredited Standards Committee (ASC) X12 - claim submission rules and edits applied to inbound electronic claims - www.x12.org
      2. WEDI SNIP or SNIP - Workgroups for Electronic Data Interchange Strategic National Implementation Process – claim submission rules and edits applied to inbound electronic claims related to HIPAA compliant file exchanges
      3. Current Procedural Terminology (CPT) Manual from AMA (American Medical Association)
      4. HCPCS - Healthcare Common procedure Coding System – Level II coding guidelines

5. UB Editor - Manual from the American Hospital Association (AHA) Coding directives
6. International Classification of Diseases, Tenth Edition Clinical Modifications (ICD-10-CM) manual
7. Centers for Medicare and Medicaid Services (CMS) rules and notifications
    a. CMS Billing rules and instructions (www.cms.gov)
    b. Medicare National Correct Coding Initiative (NCCI) Instructions/ Manual
    c. Medicaid NCCI Instructions/ Manual
    d. National Coverage Determination (NCD) & Local Coverage Determination (LCD) Bulletins
    e. National Physician Fee Schedule (NPFS) instructions
8. Food and Drug Administration (FDA) guidelines (www.fda.gov)
9. Centers for Disease Control and Prevention (CDC) guidelines (www.cdc.gov)
10. U.S. Preventive Services Task Force (www.uspreventiveservicestaskforce.org)
11. Wisconsin Department of Health Services (dhs.wisconsin.gov)
12. State and nationally recognized medical associations and specialty experts including, but not limited to:
    a. American College of Radiology
    b. American Academy of Pediatrics
    c. American College of Obstetricians and Gynecologists
13. CGHC's Website (www.commongroundhealthcare.org)
    a. policies
    b. provider manuals
    c. provider notifications

III. CGHC strives to keep editing current with all industry changes as they occur; as such, edits may be added, modified, or removed based on changes, clarifications, and new directives received from these resources and any other resources that may become applicable.

IV. CGHC sends providers the outcomes of the edits through the standard Explanation of Payment (EOP) process. Providers' EOPs indicate the outcomes by using industry standard Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) coding systems. The provider can obtain additional information by reviewing CGHC's Provider Portal and/or the CGHC Provider Manual (www.commongroundhealthcare.org).

V. Providers may file a dispute and provide additional information to support a position for reconsideration of reimbursement. Instructions to file a dispute related to a denial or rejection of a claim can be found on CGHC's website (www.commongroundhealthcare.org). Please refer to the Provider Manual, under "Claim Dispute Process."

E. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	09/25/2024	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2025	
Date Archived		

H. References
NA

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.