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<tr><td> </td><td colspan="2">Reimbursement Policy</td></tr>
<tr><td colspan="3">Subject: Code and Clinical Editing Guidelines</td></tr>
<tr><td>Effective Date: 09/14/20</td><td>Committee Approval Obtained: 09/14/20</td><td>Section: Administration</td></tr>
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*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.amerigroup.com**.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Medicare Advantage 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 CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

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

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

Amerigroup Medicare Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup Medicare Advantage strives to minimize these variations.

Amerigroup Medicare Advantage reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup Medicare Advantage 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 or CMS contracts and/or requirements indicate otherwise.

	Amerigroup Medicare Advantage 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:
	    o Code editing software is updated to conform to changes in coding standards.
	    o NCCI edits are updated according to CMS published updates
	• Clinical criteria
	• Licensed clinical medical review
	• Claims processing platform
	
	Per state requirements, we publish its use of specific commercial code editing software. We only customize 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
	Amerigroup Medicare Advantage will not reimburse in the event of a conflict with CCEG.

Exemptions	• None
History	**Policy History:** • Biennial review approved and effective 09/14/20: minor administrative updates; added language referencing coding algorithms. • Biennial review approved 10/03/18: policy template updated • Biennial Review approved 10/03/16: policy template updated • Review approved and effective 11/09/15: policy language updated • Biennial review approved 05/21/12: policy template updated • Initial committee approval 05/16/07 with effective date of 05/01/05: Initial committee approval 05/16/07 with effective date of 05/01/05: Policy adapted from: bundling guidelines, #05-002, effective 05/01/05, ClaimCheck®, #05-003, effective 05/01/05, Consistency Guidelines, #05-005, effective 02/05
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid agencies • State contracts
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• None
Related Materials	• National Coverage Determinations • NCCI