

Clinical Edits**Date of origin: May 28, 2026****Review dates: None yet recorded****DEFINITION**

We reimburse facility services according to provider contracts, payment policies, and related plan benefits. We often review itemized statements for inpatient hospitalizations to verify services and items are billed appropriately, especially when billed separately.

"Clinical edits" refers to the evaluation of billed codes in relationship to each other for the purpose of identifying unbundled procedures, surgical coding errors, invalid data relationships, patterns of utilization that deviate from practice standards and diagnoses or procedures that may be invalid for the age and/or gender of the patient. We use clinical editing software to perform our clinical edits.

We apply Medicare guidelines for clinical edits to all claims submitted by facilities or professionals, in and out of network, for all our medical plans, including Medicaid and Medicare, individual / ACA, group commercial, self-funded and fully funded. We've adopted criteria to align with and follow Medicare guidelines.

FOR MEDICARE

For indications that don't meet the criteria of NCD, local LCD, or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD [in our Provider Manual](#).

POLICY SPECIFIC INFORMATION

We base our clinical editing decisions on a combination of Medicare edits such as Medically Unlikely Edits (MUE) or National Correct Coding Initiative (NCCI edits), CMS guidelines, CPT guidelines, ICD-10 guidelines, standard clinical practices and recommendations from medical societies. CMS and NCCI guidelines will take precedence in editing when discrepancies or conflicts exist with recommendations from medical societies.

Providers often assume that if there isn't an NCCI to edit for the code combination they have submitted, then we should pay for both codes. However, the claim may generate a clinical edit from any of the other sources of our clinical edit database.

- Review of code usage in billing for medical services is a standard industry practice that supports fair reimbursement for medical services and supplies, accurate data collection, and identification of billing and coding errors.
- Integrating clinical editing with claims adjudication ensures greater consistency in applying coding rules, greater efficiency, and more timely claims processing.
- We've developed internal clinical editing processes that balance business needs against the integrity of the application database. This process entails automated application of edits to claims and limited review by certified medical coders.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information [in our Provider Manual](#).

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Coding specifics

See the edit rationale that was applied to your claims

When you use the Claims Inquiry tool to review your claims, you can see the clinical edit denial reason and review the rationale behind any clinical edits applied to your claims.

Medicare local coverage determinations (LCDs)

LCDs are different for members under Medicare Part C vs. Original Medicare. To review the Medicare policy that relates to an LCD denial, [go to www.cms.gov](http://www.cms.gov).

Asking for an exception

We'll consider requests for individual claim exceptions to clinical edits. A multi-departmental, interdisciplinary oversight committee makes decisions on whether to customize edits based on evidence provided in the claim documentation.

To ask that we review a clinical edit denial, submit a [Level I Appeal](#) with supporting documentation such as operative, procedural or office notes.

Payment Integrity code edit relationships and edits are based on guidelines from specific State Medicaid Guidelines, Centers for Medicare and Medicaid Services (CMS), Federal CMS guidelines, AMA and published specialty specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule Relative File (NPFSS), the Medically Unlikely Edit table (MUE), the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD) and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Resources

<https://www.cms.gov/>

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and

abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available [in our Provider Manual](#).

CHANGE / REVIEW HISTORY

Date	Revisions made
May 2026	New Policy