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Introduction to Edifecs' Clinical Insights (CI)

The Plan is working with Edifecs to enable CI, a solution designed to alert providers when diagnosis codes are potentially missing from a claim. This is accomplished by sending the biller the standard unsolicited clam status (277CA) associated with claim alerts that are integrated into the claim submission process. The automated rejected messages appear in the billing solution alert queue and are triggered on claims that may be incomplete or inaccurate for patients with historic claim data, such as evidence of an established diagnosis of a chronic condition that may not be present on the current claim.

Sample Alert Message (277CA):

The following is an example of the type of alert you will receive if there is a suspected diagnosis coding gap, presenting the diagnosis code(s):

> Patient's recent history contains evidence of the following conditions: [ICD-10 Code History Here]. Review the medical record on this date of service to validate the claim diagnoses codes are complete and accurate; then promptly RESUBMIT the claim maintaining the original patient control number (CLM01/CMS-1500-Box26) within the Practice Management System.

If Your Office Receives an Alert Message (277CA):

Once CI is initiated, your office may receive this message for those members with evidence of an existing diagnosis of a chronic condition within medical history. At that time, you should take the following actions:

- **Engage a qualified coder** or appropriate professional to review the patient's medical record to confirm that the diagnosis(es) coded on the claim are complete and accurate.
- If the coding on the **claim is complete** as-is, resubmit the claim for clearinghouse processing maintaining the patient control number.
- If **changes are necessary**, make the changes where appropriate and resubmit the claim maintaining the patient control number.
    - If a **diagnosis is added to** or **removed from** the claim, billers should ensure that the medical record for the date of service completely supports the revised claim. Also ensure that all affected claim fields are aligned appropriately (i.e., order of the diagnoses reported, Diagnosis Pointers), being careful to consider Centers for Medicaid and Medicare Services Form 1500 and ICD-10 CM Coding Guidelines.

For **general program questions please contact your Provider Account Executive.**

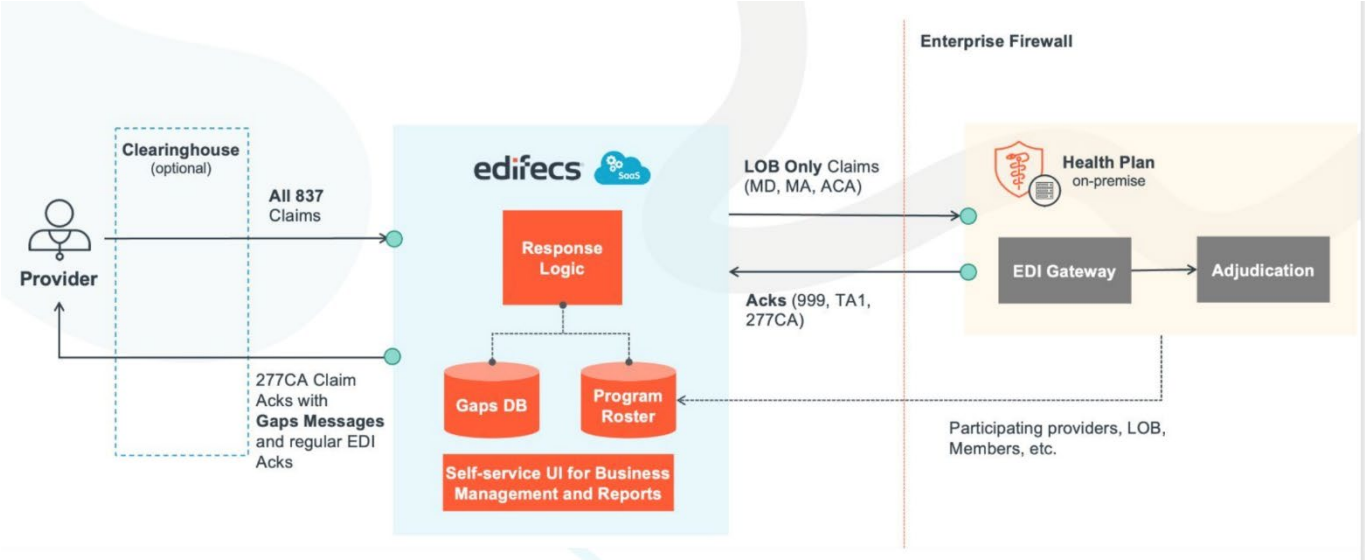
Program Benefits:

When focusing on upfront submission, the Plan's goals are to gain in-depth insight into a member's historical health conditions, minimize office disruptions by reducing traditional inquiries, allow more time for claim processing, offer Real-time Soft Closure to reduce duplicative work, increase the number of diagnoses captured on claims by comparing historical data, enhance member outcomes by alerting the provider of conditions that require addressing.

Benefits:

For the member, CI enhances the medical provider's awareness of their potential medical conditions, thereby increasing the opportunity or need to receive the right level of care and services or follow-up care and services from their medical Health Plan and its provider network.

For the provider, the CI solution brings another opportunity for awareness of their patient's medical history and helps ensure a line of sight to the accuracy of their billing practices within the medical office. The solution may also reduce some of the administrative rework associated with the existing Health Plan's chart review process that frequently occurs to maximize Health Plan quality standards and measures. The CI tool fosters improved accuracy and agreement between the patient's medical record and the claim submission.



Frequently Asked Questions

Q1 What is "CI"?

CI is a claims software tool that validates gaps within the existing claims submission process utilized today without any new software installed or additional portal logins. As part of the Plan's Care Optimization programs, the Plan is placing more focus on the upfront claims submission process to drive more complete and accurate clinical documentation and coding of chronic conditions. This software review is within the provider's existing billing workflow and channel of submission for the Plan's program.

- This upfront focus will help to deliver:
- Complete view of a member's historical chronic health conditions
- Less provider office disruption through traditional chase list inquires
- More timely claims processing
- Improved quality of care for our members

The Plan will work with Edifecs to enable this workflow to help ensure complete and accurate diagnosis coding on claims before submission to health plans. The tool uses Edifecs member care analytics scoring engine to identify patients whose claims history shows diagnosis coding for chronic conditions. If the claim submitted does not include any of the chronic conditions documented in the patient's claims history, a real-time or next day CI claims status message is sent to the Provider's Practice Management System alert queue. Historical chronic conditions, suspected diagnosis codes are displayed as an actionable alert based on the patient's claims history.

These chronic diagnoses may indicate that a diagnosis was overlooked in the initial chart review and that further review will confirm whether an ongoing or other condition should be reported. Having information about the patient's prior diagnoses may also make the chart review more efficient.

Messages are not intended to suggest what coding is or may be appropriate and the Messages must not be interpreted to do so.

Q2 How did the provider get selected for participation with CI?

As CI is a subset of the Plan program. All providers who participate in the Plan network are defaulted into the CI program as part of their network participation..

Q3a Is it mandatory to participate in this program?

No, it is not mandatory. Please contact your Provider Account Executive for additional information.

Q4 Which claim types are subject to a "CI" Message?

CI applies to professional claims (also known as CMS 1500/837P) with the Medicaid line of business.

Q5 How does this new messaging system benefit contracted providers?

CI alert messaging benefits providers by helping to ensure complete and accurate submission of patient diagnosis(es) on claims. Additionally, the near real-time provision of historical information promotes review and correction, where appropriate, based on the medical record, prior to claim submission. Including historical chronic diagnoses in the Message likely indicates that a diagnosis code was overlooked. This process allows providers to self-audit, which increases accuracy, supports efficient chart review, and reduces the need for burdensome external chart reviews. Moreover, to the extent a chronic

condition was unknown to the provider, the provider may explore the relevance of such condition with the patient in a future visit, if appropriate, potentially improving the quality of care and effectiveness of treatment.

Q6 How does this new messaging system benefit the Health Plan?

CI alert messaging helps to ensure complete and accurate diagnosis coding on submitted claims. Complete capture of diagnosis codes allows Health Plans the ability to develop condition centric programs for members and assists with data accuracy for risk adjustment calculations, including those required by government programs.

Q7 What should I do when I receive a Message?

The Message indicates an opportunity within the claim to self-audit and, if supported in the record, editing of the reported diagnoses on the claim. Therefore, when you receive a message, you should have a qualified coder or other appropriate professional re-review the medical records for the encounter being billed.

If the coder finds that a diagnosis(es) was overlooked on the original claim, the provider should adjust the coding on the claim based on documentation in the chart to help ensure complete and accurate diagnosis reporting and resubmit the claim.

If the coder determines that the diagnosis(es) coding on the original claim was complete and accurate, the provider should resubmit it without modification.

***Example**. The patient visits the doctor for an eye issue and submits the bill, coding only unspecified retinopathy (ICD 10 H35.00) on the claim. The CI alert is displayed for diabetes. The coder reviews the medical record and sees that diabetes is supported. Since the main reason for the visit was retinopathy due to the patient's diabetic condition, the provider should resubmit the claim with the correct diagnosis code of Type I diabetes mellitus with unspecified diabetic retinopathy (E10.31).

Edifecs will not process or submit the claim to the Health Plan until and unless the claim is resubmitted, as described above. Again, whether changes to the coding are made or not, claims must be resubmitted, or they will not be processed and adjudicated.

Q8 When should I respond to the Message?

When the Message is received, providers should determine as soon as possible whether the diagnosis(es) referenced in the Message are supported in the medical record for the associated medical encounter, in accordance with applicable coding guidelines. As indicated above, until the claim is resubmitted, Edifecs will not process or submit it to the health plan for adjudication. **The medical record review and resubmission should occur as soon as possible. Providers, not Edifecs, remain responsible for meeting all timely filing deadlines.**

Q9 How does the CI process impact timely filing of claims from provider to the Health Plan?

CI clearinghouse alerts occur within a same-day or next-day process that starts at the point of claims submission. Providers can resubmit the claim immediately upon medical record review for adjudication by the Health Plan. Providers should ensure claims are submitted well within applicable time limits. As noted above, the medical record review and resubmission should occur as soon as possible. Providers, not Edifecs, remain responsible for meeting all timely filing deadlines.

Q10 Where can CI alerts be found?

CI messages are rejected to the Provider's Practice Management System alert queue.

Q11 How does CI identify and select potentially missing chronic condition diagnosis codes for inclusion in the Message?

CI searches patients' claims histories for chronic diagnoses that are not reported on submitted claims. Diagnoses are selected based first on the most frequent in the patient's history and if there is a tie, then on the most recent diagnosis code. If the provider submitting the claim is a specialist, only the chronic diagnoses codes relevant to the specialty are selected.

Q12 If no condition gaps are found for a member or no Message is sent to the provider, does that mean the patient had no history of chronic conditions?

No. The Client Payer may not have all previous claim history from prior coverage with other Health Plans so it may not have all diagnostic information. Additionally, a data input error by a prior provider, the health plan, or others may render a search ineffective. An error also could conceivably occur in the electronic search. This is one reason the provider's independent medical record review is so important.

Q13 In cases where billers submit claims, are they allowed, and will they have access to the medical records for their patients?

Reviewing the medical record and determining whether it supports a change to any coding is a function that should be performed only by a coder or other qualified professional. While coders need not be certified, they must be knowledgeable and experienced. Billers may function as coders or review medical records only with the express permission of the physician(s) or group for whom they work. The providers are responsible to ensurethat billers are qualified coders.

Q14 When resubmitting a claim, should we fill in item 22 (Resubmission Code/Original Ref. No.) on the CMS 1500?

No. Because a CI Messaged claim has not been submitted to the health plan, the "resubmission" after medical record review and consideration of the diagnosis coding history will still be an original claim submission – not a resubmission of a claim accepted by the health plan. According to Nation Uniform Claim Committee (NUCC) reference manual for 2017, page 33, Item Number 22 is not intended for use for original claims submissions.
http://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2012_02-v5.pdf.

Q15 Are there other items on the claim we should modify before resubmission?

Review the Diagnosis Pointer in Field 24E on the CMS 1500/837p. Upon review of the medical record, the coder may need to re-assess and change which diagnosis code (item 21) applies to which procedure code in Field 24D.

Q16 If a patient's current office visit is for a condition or problem not related to the alert Messages, how should the alert Message be handled?

If the condition(s) listed in an alert are not relevant to the claim submitted for the patient's medical encounter, i.e., the condition listed on the alert was not addressed at this visit and adding the condition(s) from the alert would not be in compliance with coding conventions defined in the ICD-10 manual and/or applicable standard and coding guidelines, then do not include on the claim for resubmission. In general, upon confirming the original claim diagnoses were complete and accurate, providers will not make any changes and should resubmit the claim for adjudication in its original form.

***Example**. The CI alert is displayed for diabetes. The patient visits the doctor for a right elbow injury. The provider should resubmit the claim in its original form unless the medical record documentation indicates otherwise.

If research points to the possibility the patient may have a certain diagnosis, but documentation is unclear in the medical record, the rendering physician should be consulted. If the diagnosis is not in the medical record, do not add it to the claim.

Q17 How can we ensure the CI Messages will not lead to "up-coding"?

Providers are obligated by law to submit accurate and complete diagnosis information on claims. The alert, provider letters, training, marketing materials, provider webinars and other materials referring to CI specifically reiterate providers' sole responsibility to ensure that coders and others who submit the claims are:

- properly trained to codify medical claims that comply with all applicable coding manuals, standards, and guidelines.
- never modify a diagnosis code based on the Chronic Condition Alert alone,
- aligned with underlying medical record,
- ensure that any change to the diagnosis coding is supported by the medical record.

Additionally, Health Plan have Program Integrity programs and tools in place to detect potential instances of up-coding.

Q18 Does the Message violate HIPAA?

No. HIPAA regulations allow the use and disclosure of PHI for Treatment, Payment, and Healthcare Operations. "Ready access to treatment and efficient payment for health care, both of which require use and disclosure of protected health information, are essential to the effective operation of the health care system.

To avoid interfering with an individual's access to quality health care or the efficient payment for such health care, the Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations activities." 45 CFR 164.506.

The Plan, a covered entity by HIPAA, is allowed to disclose appropriate PHI information of their members to business associates when done in accordance with state and federal laws. Edifecs is the Plan's business associate and has a HIPAA-compliant business associate agreement with the Plan.

Q19 Will CI reject "clean claims"?

Possibly. Generally, a claim is not "clean" if elements are missing that are necessary to process for payment. However, the required elements must be complete, legible, and accurate. If a claim is submitted that is later changed to help ensure the diagnosis coding is complete and accurate, the original claim cannot be considered a "clean claim." If the original claim submitted contains complete and accurate information, the provider can resubmit the original claim in its original state. CI includes programming to prevent overly excessive alerts that can adversely impact the provider's business operations. Careful analysis links recent medical history and appropriate provider specialties known to treat the member's existing chronic condition care gaps.

***This example is only for illustrative purposes and should not be considered or relied upon for specific coding guidance.**