Claims Editing Software
Payment Policy

Applicability

This Policy applies to the following Fallon Health products:
☒ Fallon Medicare Plus
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ Summit Eldercare PACE
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

Policy

The Plan has implemented software designed to evaluate billing and coding accuracy on submitted claims. The software is guided by the coding criteria and protocols established by various industry sources including, but not limited to, the Centers for Medicare and Medicaid Services (CMS), NCCI, the CPT Manual published by the American Medical Association (AMA), and specialty society guidelines.

Use of automated method(s) to aid in the proper processing of claims ensures consistent application of Plan payment policies across all claims. The Plan has customized its claims editing software and is continually in the process of evaluating the software and modifying it to accommodate Plan payment policy.

Specific contract terms will apply.

Reimbursement

The following list represents an example of the different edits and their definitions, but is by no means an all-inclusive list.

Add-on code without base code:
Identifies claim lines containing a CPT/HCPCS assigned add-on code billed without the presence of one or more related primary service/base procedures.

Age conflicts:
Identifies billed procedure codes that are inconsistent with the age of the member.

Assistant surgeon edits:
Determines if an assistant surgeon is clinically necessary for the billed procedure.

Cosmetic surgery edits:
Identifies procedures that the Plan considers to be cosmetic and suspends the claim for additional review.
Frequency validation (possible duplicate):
Identifies procedure codes that would not normally be reported in duplicate.

Incidental procedure editing:
Identifies procedures that the Plan considers to be clinically integral to the primary procedure and not allowable for separate reimbursement.

Intensity of service editing:
Compares the ICD diagnosis to the intensity of the billed office visit. Recommends the appropriate evaluation and management (E&M) code and is stated on the Remittance Advice Summary.

Medicare Advantage NCD and LCD claim edits:
As a health plan that administers Medicare Advantage products, Fallon Health follows guidance from the Centers for Medicare and Medicaid Services (CMS) for organization determinations. Organization determinations are based on applicable Medicare statutes, regulations, National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). Fallon Health implements claim edits that conform to applicable NCDs and LCDs for Medicare Advantage basic benefits. When an NCD or LCD restricts or conditions coverage, claims that fail NCD or LCD criteria are denied in accordance with § 422.101(b)(1).

Missing modifier 26:
Recommends the denial of claim lines containing a procedure code submitted without a professional component modifier-26 in a facility setting (POS 21, 22, or 24). Applies only to services with a PC/TC indicator of "1" on the Medicare Physician Fee Schedule (MPFS) Relative Value File. Implementation effective April 1, 2026.

Modifier editing:
Compares the CPT/HCPCS procedure with the billed modifier for clinical appropriateness.

Modifier 78 without global procedure:
Recommends denial of claim lines billed with modifier 78 when the same or different 0-, 10- or 90-day procedure code has not been billed on the same date of service for a 0-day post operative period, in the previous 10 days for a code with a 10-day post-operative period, or in the previous 90 days for a code with a 90-day post-operative period, by the same provider group in any specialty. Implementation effective April 1, 2026.

Multiple component billing / duplicate component billing:
Identifies instances where the sum of all payments (i.e., total, professional, technical) for a procedure across multiple providers exceeds the amount that would have been paid for the total procedure.

Multiple Procedure Payment Reduction:
When multiple procedures are performed by the same provider on the same member on the same date of service, the procedure with the highest ranking will be reimbursed at 100% and the second and subsequent procedure(s) (third through fifth) will be reimbursed at 50% of the amount that would have been otherwise applicable for that procedure. The Plan follows the rules set forth in the Centers for Medicare and Medicaid Services (CMS) Multiple Procedures Payment Reduction (MPPR). An RVU will be assigned to each claim line based on the Medicare Physician Fee Schedule. Place of service (POS) is considered. If POS is office (11), the non-facility RVU is assigned, whereas, if POS is facility (e.g., 19, 21, 22, 24), then the facility RVU is assigned. The procedure code with the highest RVU is determined to be the primary procedure. Codes with no assigned RVU or an RVU of 0.00 will not be excluded from ranking. Codes with no assigned RVU or an an RVU value 0.00 and will be ranked as secondary or subsequent procedures when reported with other procedures that have an RVU value higher than 0.00. If multiple procedures with no assigned RVU or an RVU of 0.00 are billed on the same claim, the codes are ranked by billed charges.

Multiple units per single date of service:
Identifies instances where procedure codes are submitted with more units than are medically likely for one date of service. The unit assignment list is subject to change based on review of industry standard coding updates including, but not limited to, the CMS Medically Unlikely Edit (MUE) program.

Mutually exclusive editing:
Identifies two or more procedures that produce the same clinical result but are performed by different methods, or are procedures that usually are not performed together during the same patient encounter and therefore not allowable for separate reimbursement.

Unbundling editing:
Identifies billing scenarios where two or more procedures are listed separately when a more accurate comprehensive procedure code exists. The correct codes for the clinical scenario will be allowed and/or automatically added to the claim.

Gender conflicts:
Identifies billed procedures that are inconsistent with the patient's gender.

- The KX modifier is a multipurpose, informational modifier and can be used to identify services for transgender, ambiguous genitalia, and hermaphrodite beneficiaries in addition to its other existing uses. Physicians and non-physician practitioners should use modifier KX with procedure codes that are gender specific in the particular cases of transgender, ambiguous genitalia, and hermaphrodite beneficiaries.
- Include the KX modifier for professional claims; condition code 45 for facility claims.

Unlisted procedure edits:
Identifies procedure codes defined by CPT as unlisted services. Unlisted procedure codes should never be used when a more descriptive procedure code is available. Unlisted codes require prior authorization.

The Plan compares claims for the same date of service when submitted on separate claims.

Billing/coding guidelines

Providers are required to submit claims to the Plan that accurately reflect the services performed and utilize the appropriate coding systems including CPT, HCPCS and ICD-10-CM, AMA and CMS guidelines.

The Plan reserves the right to edit claims for inappropriate coding and take further action including, but not limited to, pending and denying of claims, and recovery of monies.

Billing Multiple Lines Instead of Multiple Units
A common billing issue we see involves the same procedure code billed on multiple lines for the same date of service instead of one line with multiple units. Making sure claim lines and units are entered correctly is important for timely and accurate reimbursement. Please review the following example for billing a pathology exam on three breast biopsy specimens:

- Correct way: One line with CPT 88305 and 3 units
- Wrong way: Three lines with CPT 88305 with 1 unit each for the same date of service (additional lines appear as duplicates which will cause them to deny)

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	02/28/01
Previous revision date(s):	04/16/03, 03/17/04, 10/13/04, 09/28/05, 09/27/06, 11/07/07 05/01/2010 - moved to new policy template 05/01/2013 - added examples of the types of edits. 11/01/2014 - Updated Multiple Procedures Payment Reduction discussion and moved to Fallon Health logo and template. 09/01/2015 - Annual review and moved to new Plan template. 05/01/2016 - Annual review.
Connection date & details:	January 2017 – Updated the reimbursement section. April 2018 – Annual Review, no updates. April 2019 – Annual Review, no updates. April 2020 – Policy name changes from Claims Auditing Software to Claims Editing Software.

July 2022 – Added Frequency validation (possible duplicate) to the list of edits; added Billing Multiple Lines Instead of Multiple Units under Biling/coding guidelines.
October 2024 – Under Reimbursement, Multiple Procedure Payment Reduction, documented ranking for codes with no assigned RVU or an RVU of 0.00.
January 2026 – Under Reimbursement, added new sections for Add-on code without base code, Medicare Advantage NCD and LCD claim edits, Missing modifier 26, and Modifier 78 without global procedure.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.