

Pre-Adjudication of Provider Claims for Diagnosis Accuracy

Reimbursement Policy ID: RPC.0139.2100

Recent review date: 01/2026

Next review date: 01/2027

AmeriHealth Caritas Louisiana reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas Louisiana may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

Edifecs CI compares inbound claims submissions with AmeriHealth Caritas Louisiana historical claims data to ensure diagnosis coding is complete and accurate. Potential addition of chronic diagnoses are identified real-time or next day for provider review.

Exceptions

N/A

Reimbursement Guidelines

Upon provider claim submission, comparisons are made against AmeriHealth Caritas Louisiana's historical claims data. If the data substantiates a potential diagnosis coding discrepancy, Edifecs CI issues a claim acknowledgement alert message to the provider. The provider has the opportunity to review the diagnosis codes on the claim for completeness and accuracy, which may include reviewing the member's medical record for documentation to support the recommended diagnosis.

If the provider disagrees with the addition of recommended diagnosis codes, or the suggested diagnosis codes are not supported by the member's medical record, the provider should resubmit the claim using the original claim ID.

If diagnosis coding modifications are suggested, if supported in the medical record, the provider should make the necessary modifications to the claim which may include addition or deletion of diagnosis codes to reflect accurate coding. The claim must then be resubmitted using the original claim ID.

When a diagnosis code is added to the claim, the provider must ensure all affected fields are addressed, including the order of the diagnosis codes submitted and the diagnosis pointer in alignment with the CMS-1500 Claim Form requirements and the ICD-10-CM coding guidelines.

After the resubmission of the claim it is then passed directly to the plan. No additional Edifecs edits will be applied to the resubmitted claims.

Definitions

N/A

Edit Sources

- I. Current Procedural Terminology (CPT) and associated publications and services.
- II. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).
- III. Healthcare Common Procedure Coding System (HCPCS).
- IV. Centers for Medicare and Medicaid Services (CMS).
- V. The National Correct Coding Initiative (NCCI).
- VI. Applicable Louisiana Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

<u>01/2026</u>	<u>Reimbursement Policy Committee Approval</u>
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