Clinical Editing Tips

We hope that the information and suggestions below help you avoid the need for filing a clinical editing review request. If you do need to file, the tips below will help to ensure a successful submission.

To learn more, attend our Navigating the Blues Billing class. You can sign up for a session at **ExcellusBCBS.com/ProviderStaffTraining,** or contact your Provider Relations representative to schedule training. The Navigating the Blues Billing guidebook is available at the web address listed above, under the *View Presentations & Videos* tab.

Before completing our Clinical Editing Review Request form:

- ✓ Check the current year's CPT® code book and/or HCPCS codes to confirm that you've billed correctly, in accordance with current coding guidelines.
- ✓ Visit our website, **ExcellusBCBS.com/Provider**, to check for a clinical editing policy and/or a communication related to the clinical editing denial.
- ✓ Review the Centers for Medicare & Medicaid (CMS) website for:
  - National Coverage Decision and/or Local Coverage Decision rationale, **www.cms.gov/medicare-coverage-database**
  - National Correct Coding Initiative coding rationale, **www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Index.html**
- ✓ Verify the denial reason codes
  - The remittance includes information that supports the payment and/or adjudication of the claim. The clinical editing explanation codes, or EXCDs, used to process claims begin with lower case **e, f, g, h, i, j, k or l** and upper case **X or Z**, and are displayed when viewing claim information on our website, as well as on the paper remittance. If the EXCD doesn't begin with one of these letters, the denial is not related to a clinical editing dispute. Review the chart on the reverse for some EXCD denial verbiage examples.
  - Since EXCDs are not recognized by the Health Insurance Portability and Accountability Act (HIPAA), they are not displayed on the 835 electronic remittance. Instead, claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) are included on the 835 electronic remittance. Visit **www.wpc-edi.com/reference/** for a complete listing of CARC/RARC definitions.

Continued on the reverse

Excellus

How and when to submit our Clinical Editing Review Request form:

IMPORTANT: Our Request for Research/Claim Adjustment/Claim Retraction form must be used for all denials that are **not** related to clinical editing. Submissions using the incorrect form will be returned.

Clinical editing EXCD denial verbiage examples

Inclusive/incidental	Mutually exclusive	Unbundled/rebundled codes
Global procedure	Pay percent reduction	Code included in previous service
Quantity exceeds maximum units allowed	Repeat lab	Modifier billing error
Procedure inconsistent with diagnosis	Assistant/co-surgeon not required	Not covered in place of service
NCCI Column I/Column II	NCCI manual policies	Administrative policies

- Clinical editing disputes can be submitted electronically through our website, **ExcellusBCBS.com/Provider**, or by mail.

- Be sure to use the most current version of the Clinical Editing Review Request form, available on our website under *Print Forms* from the Quick Links menu, or click here for direct access.

- Complete every field on the form legibly and provide any documentation to support the dispute, including medical records to support the addition of modifiers and any medical literature that is pertinent to your request. Incomplete forms will be returned, delaying your request.

- Do not resubmit a claim when a claim line(s) has denied for a clinical edit as this will cause additional denials for duplicate submission.

- Timely filing guidelines apply to clinical editing disputes. You have **120 calendar days** from the date the claim was processed/denied to the date your clinical editing review request is received by us.

- Our Clinical Editing team has **45 business days** to respond to your request. If no response is received from us after 45 business days, contact Customer Care at 1-800-920-8889. Do not submit another Clinical Editing Review Request form, as duplicate submissions will cause delays.

- After your request has been reviewed, if the edit on the original remittance is upheld, you will receive a letter which includes the rationale. The letter will also include how to file a grievance. If the edit is overturned, the adjustment will be reflected on your next remittance.

- Second level grievances may be submitted by participating physicians (MDs and DOs) and facilities only. Participating non-physicians or ancillary providers do not have second level grievance rights. The rule of thumb is that only providers eligible for membership with the Medical Society of the State of New York have grievance rights.

- Second level grievances must be submitted in writing and cannot be requested verbally through Customer Care. You have **90 calendar days** from the date on the letter you receive from us to submit a grievance.