Frequently Asked Questions:

Q1 What is "CRA"?

"CRA" is a provider-based tool that works within the billing workflow to ensure complete and accurate diagnosis coding on claims before submission to health plans. The tool uses Edifecs Risk 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 CRA claims status message ("Message") is sent to the professional claim biller's Practice Management System to the individual or entity that submitted the claim ("Submitter"). The Message provides the most frequent chronic diagnoses codes located in 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. Thus, CRA improves completeness and accuracy in diagnosis reporting and allows the coder or other qualified Submitter to make any necessary changes to the claim before re-submission to the clearinghouse. "CRA" Messages are delivered to the Submitter and intended for internal use only.

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 CRA?

Based on the provider's specialty, claim type submission methods and the Health Plan's network participation status, the provider is included in the initial program inclusion list.

Q3a Is it mandatory to participate in this program?

No, it is not mandatory. See question 3b for the Opt-out process.

Q3b Can providers opt out of the program?

Yes, while not desired as it adversely impacts the success of the program, providers can Opt-out. Edifecs maintains a provider support website https://help.edifecsfedcloud.com/CRAEducationCenter/Content/Home.htm where Opt-out requests are managed. If your preference is to not participate in the solution, please include the following:

- Rendering NPI
- Rendering Provider Name
- Billing NPI
- Billing Provider Name
- Contact Name
- Contact email or phone number

The above list is need for each provider Opt-out request. This will allow Edifecs to have written documentation of which providers are no longer active.

Note: Providers may also Opt back in to the program at any time.

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

CRA applies to professional claims (also known as CMS 1500/837P).

Q5 How does this new messaging system benefit contracted providers?

CRA 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?

CRA 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 Do providers receive incentives for participation with the "CRA" tool?

Edifecs does not offer payments or similar financial incentives related to the CRA services. Health Plans determine whether or not they incentivize providers.

Q8 What should I do when I receive a Message?

The Message indicates the claim was rejected to provide an opportunity for self-auditing 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 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 CRA 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 payer until and unless the claim is resubmitted, as described below. Again, whether changes to the coding are made or not, claims must be resubmitted, or they will not be processed and adjudicated.

Q9 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.**

Q10 How does the CRA process impact timely filing of claims from provider to the Health Plan?

CRA clearinghouse rejections occur within a same-day or next day process that initiates at the point of claims submission. Providers have the ability to 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.

Q11 As a Change Healthcare submitter, where do I find CRA alerts?

If you are a Change Healthcare Office (Vision) user, CRA alerts will be found under My Alerts on the Home page.

If you are a Change Healthcare Claim Master user, CRA Alert claim status Messages will be available in the Claim Log, Payer RPT 10 report, and Change Healthcare Report.

If you are a Change Healthcare batch Submitter, CRA alert claim status Messages will be found in RPT-5 and RPT-11 reports.

Q12 How does the CRA identify and select potentially missing chronic condition diagnosis codes for inclusion in the Message?

CRA searches up to three (3) years of 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.

Q13 If CRA databases doesn't locate historical diagnosis information 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 payers so it may not have three (3) years of 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.

Q14 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 should ensure that billers are qualified coders.

Q15 When resubmitting a claim, should we fill in item 22 (Resubmission Code/Original Ref. No.) on the CMS 1500?

No. Because a CRA 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.

Q16 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.

Q17 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 CRA 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.

Q18 How can we ensure the CRA 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 CRA 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 Plans have Program Integrity programs and tools in place to detect potential instances of up-coding.

Finally, CRA monitors changes and may audit both unedited and edited claims for compliance and/or may provide information to health plans about which claims they should audit.

Q19 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.

Q20 Will CRA 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 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. CRA includes programming to prevent overly excessive rejections that can adversely impact the provider's business operations. At a rendering provider level, on average less than 3 claims are stopped per month. Careful analysis links recent medical history and appropriate provider specialties known to treat the member's existing chronic condition care gaps.

Q21 Does CRA analyze provider responses?

Yes, Edifecs and the Health Plan monitor the number and types of changes a provider makes, and other submission behaviors. Behaviors indicating that medical records are not being reviewed before claims are resubmitted may raise compliance concerns. When such behavior is suspected, Edifecs may report such behavior to affected health plans, audit a sample set of claims and medical records, or take other action designed to remediate concerns.

Q22 What Provider Specialties (via Primary Taxonomy Code) may be evaluated by CRA?

PROVIDER TAXONOMY CODE	PROVIDER TAXONOMY DESCRIPTION
208D00000X	Allopathic & Osteopathic Physicians/General Practice
207Q00000X	Allopathic & Osteopathic Physicians/Family Medicine
207QA0401X	Allopathic & Osteopathic Physicians/Family Medicine, Addiction Medicine
207QA0000X	Allopathic & Osteopathic Physicians/Family Medicine, Adolescent Medicine
207QA0505X	Allopathic & Osteopathic Physicians/Family Medicine, Adult Medicine
207QB0002X	Allopathic & Osteopathic Physicians/Family Medicine, Bariatric Medicine
207QG0300X	Allopathic & Osteopathic Physicians/Family Medicine, Geriatric Medicine
207QH0002X	Allopathic & Osteopathic Physicians/Family Medicine, Hospice and Palliative Medicine
207QS1201X	Allopathic & Osteopathic Physicians/Family Medicine, Sleep Medicine
207QS0010X	Allopathic & Osteopathic Physicians/Family Medicine, Sports Medicine
207R00000X	Allopathic & Osteopathic Physicians/Internal Medicine
207RA0401X	Allopathic & Osteopathic Physicians/Internal Medicine, Addiction Medicine
207RA0000X	Allopathic & Osteopathic Physicians/Internal Medicine, Adolescent Medicine
207RA0201X	Allopathic & Osteopathic Physicians/Internal Medicine, Allergy & Immunology
207RB0002X	Allopathic & Osteopathic Physicians/Internal Medicine, Bariatric Medicine
207RC0000X	Allopathic & Osteopathic Physicians/Internal Medicine, Cardiovascular Disease
207RI0001X	Allopathic & Osteopathic Physicians/Internal Medicine, Clinical & Laboratory Immunology
207RC0001X	Allopathic & Osteopathic Physicians/Internal Medicine, Clinical Cardiatric Electrophysiology
207RC0200X	Allopathic & Osteopathic Physicians/Internal Medicine, Critical Care Medicine
207RE0101X	Allopathic & Osteopathic Physicians/Internal Medicine, Endocrinology, Diabetes, & Metabolism
207RG0100X	Allopathic & Osteopathic Physicians/Internal Medicine, Gastroenterology
207RG0300X	Allopathic & Osteopathic Physicians/Internal Medicine, Geriatric Medicine
207RH0000X	Allopathic & Osteopathic Physicians/Internal Medicine, Hematology
207RH0003X	Allopathic & Osteopathic Physicians/Internal Medicine, Hematology & Oncology
207RI0008X	Allopathic & Osteopathic Physicians/Internal Medicine, Hepatology
207RH0002X	Allopathic & Osteopathic Physicians/Internal Medicine, Hospice and Palliative Medicine
207RI0200X	Allopathic & Osteopathic Physicians/Internal Medicine, Infectious Disease
207RM1200X	Allopathic & Osteopathic Physicians/Internal Medicine, Magnetic Resonance Imaging (MRI)
207RX0202X	Allopathic & Osteopathic Physicians/Internal Medicine, Medical Oncology
207RN0300X	Allopathic & Osteopathic Physicians/Internal Medicine, Nephrology
207RP1001X	Allopathic & Osteopathic Physicians/Internal Medicine, Pulmonary Disease
207RR0500X	Allopathic & Osteopathic Physicians/Internal Medicine, Rheumatology
207RS0012X	Allopathic & Osteopathic Physicians/Internal Medicine, Sleep Medicine
207RS0010X	Allopathic & Osteopathic Physicians/Internal Medicine, Sports Medicine
207RT0003X	Allopathic & Osteopathic Physicians/Internal Medicine, Transplant Hepatology
208000000X	Allopathic & Osteopathic Physicians/Pediatrics
2080A0000X	Allopathic & Osteopathic Physicians/Pediatrics, Adolescent Medicine
2080I0007X	Allopathic & Osteopathic Physicians/Pediatrics, Clinical & Laboratory Immunology
2080P0006X	Allopathic & Osteopathic Physicians/Pediatrics, Developmental¿Behavioral Pediatrics
2080H0002X	Allopathic & Osteopathic Physicians/Pediatrics, Hospice and Palliative Medicine
2080T0002X	Allopathic & Osteopathic Physicians/Pediatrics, Medical Toxicology
2080N0001X	Allopathic & Osteopathic Physicians/Pediatrics, Neonatal-Perinatal Medicine
2080P0008X	Allopathic & Osteopathic Physicians/Pediatrics, Neurodevelopmental Disabilities
2080P0201X	Allopathic & Osteopathic Physicians/Pediatrics, Pediatric Allergy & Immunology
2080P0202X	Allopathic & Osteopathic Physicians/Pediatrics, Pediatric Cardiology
2080P0203X	Allopathic & Osteopathic Physicians/Pediatrics, Pediatric Critical Care Medicine
2080P0204X	Allopathic & Osteopathic Physicians/Pediatrics, Pediatric Emergency Medicine
2080P0205X	Allopathic & Osteopathic Physicians/Pediatrics, Pediatric Endocrinology
2080P0206X	Allopathic & Osteopathic Physicians/Pediatrics, Pediatric Gastroenterology
2080P0207X	Allopathic & Osteopathic Physicians/Pediatrics, Pediatric Hematology-Oncology
2080P0208X	Allopathic & Osteopathic Physicians/Pediatrics, Pediatric Infectious Diseases
2080P0210X	Allopathic & Osteopathic Physicians/Pediatrics, Pediatric Nephrology
2080P0214X	Allopathic & Osteopathic Physicians/Pediatrics, Pediatric Pulmonology
2080P0216X	Allopathic & Osteopathic Physicians/Pediatrics, Pediatric Rheumatology
2080T0004X	Allopathic & Osteopathic Physicians/Pediatrics, Pediatric Transplant Hepatology
2080S0012X	Allopathic & Osteopathic Physicians/Pediatrics, Sleep Medicine
2080S0010X	Allopathic & Osteopathic Physicians/Pediatrics, Sports Medicine
207QG0300X	Allopathic & Osteopathic Physicians/Family Medicine, Geriatric Medicine
207RG0300X	Allopathic & Osteopathic Physicians/Internal Medicine, Geriatric Medicine
363L00000X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner
363LA2100X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Acute Care
363LA2200X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Adult Health
363LC1500X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Community Health
363LC0200X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Critical Care Medicine
363LF0000X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Family
363LG0600X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Gerontology
363LN0000X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Neonatal
363LN0005X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Neonatal, Critical Care
363LX0001X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Obstetrics & Gynecology
363LX0106X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Occupational Health
363LP0200X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Pediatrics
363LP0222X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Pediatrics, Critical Care
363LP1700X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Perinatal
363LP2300X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Primary Care
363LP0808X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Psychiatric/Mental Health
363LS0200X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, School
363LW0102X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Women¿s Health
363A00000X	Physician Assistants & Advanced Practice Nursing Providers/Physician Assistant
363AM0700X	Physician Assistants & Advanced Practice Nursing Providers/Physician Assistant, Medical
363AS0400X	Physician Assistants & Advanced Practice Nursing Providers/Physician Assistant, Surgical