



Dear Peach State Health Plan Provider,

Thank you for your continued partnership with Peach State Health Plan. We are committed to continuously evaluating and improving overall Payment Integrity solutions as required by State and Federal governing entities. As a reminder, we have partnered with Optum who is supporting us in performing prepayment claim reviews. The purpose of our review is to verify the extent and nature of the services rendered for the patient’s condition and that the claim is coded correctly for the services billed.

For claims received on or after **6/1/2026**, providers may experience a slight increase in written requests for medical record submission prior to payment based on the areas outlined below. These requests will come from Optum and will contain instructions for providing the documentation. Should the requested documents not be returned, the claim(s) will be denied. Providers will have the ability to dispute findings through Optum directly in the event of a disagreement.

Editing Area	Description
<b>Trauma Activation with No Ambulance Service</b>	This analytic will identify outpatient claims with revenue codes for trauma response (Rev 681 – 689) when there are no claims in history for ambulance services with HCPCS codes between A0021 and A0999 for the same member on the same date of service.
<b>High Dollar Hardware</b>	This analytic identifies outpatient claims billing high dollar pass-through payment for hardware with code C1713 (anchors/screws).
<b>Unsupported Lab Tests on High Dollar Claims</b>	This analytic reviews high dollar lab claims with at least 5 lines and a payment greater than \$500 that are potentially unsupported by an order from a qualified healthcare professional.
<b>Cross-coder Outpatient Facility Surgical Claims</b>	This analytic identifies outpatient facility claims with surgical procedure codes that do not match the professional claim codes for similar services provided to the same patient on the same date of service. Records will be reviewed to ensure coding/documentation guidelines are met.
<b>Upcoding of Incision and Drainage Codes</b>	This analytic identifies claims billing incision and drainage (I&D) procedure codes that are suspected to be non-incision or lower-level incision and drainage which may have been incorrectly submitted to achieve additional reimbursement, reviewing simple I&D procedure codes 10060, 10080, 10140 and complicated/multiple I&D procedure codes 10061, 10081
<b>Misbilling of Third Order Selective Catheter Placement</b>	This algorithm targets codes for arterial selective catheter placement of the third order for placement above the diaphragm (36217) and below the diaphragm (36247) when claim details suggest that a first or second order arterial branch above the diaphragm or below the diaphragm was more likely the location of the procedure. Records will be reviewed to determine if the coding guidelines required to bill arterial selective catheter placement of the third order are met.



<b>Cross-coder Professional vs. Outpatient Facility Surgery Claims</b>	This analytic identifies professional claims with surgical procedure codes that do not match the outpatient facility claim codes for similar services provided to the same patient on the same date of service. Records will be reviewed to ensure coding/documentation guidelines are met
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Associated Code for EOP	Description
<b>EXbo</b>	Medical Records and/or Other Service Documentation Required

We appreciate your ongoing collaboration as we work together to enhance health outcomes and provide the highest quality of care for our members.

Sincerely,

Peach State Health Plan