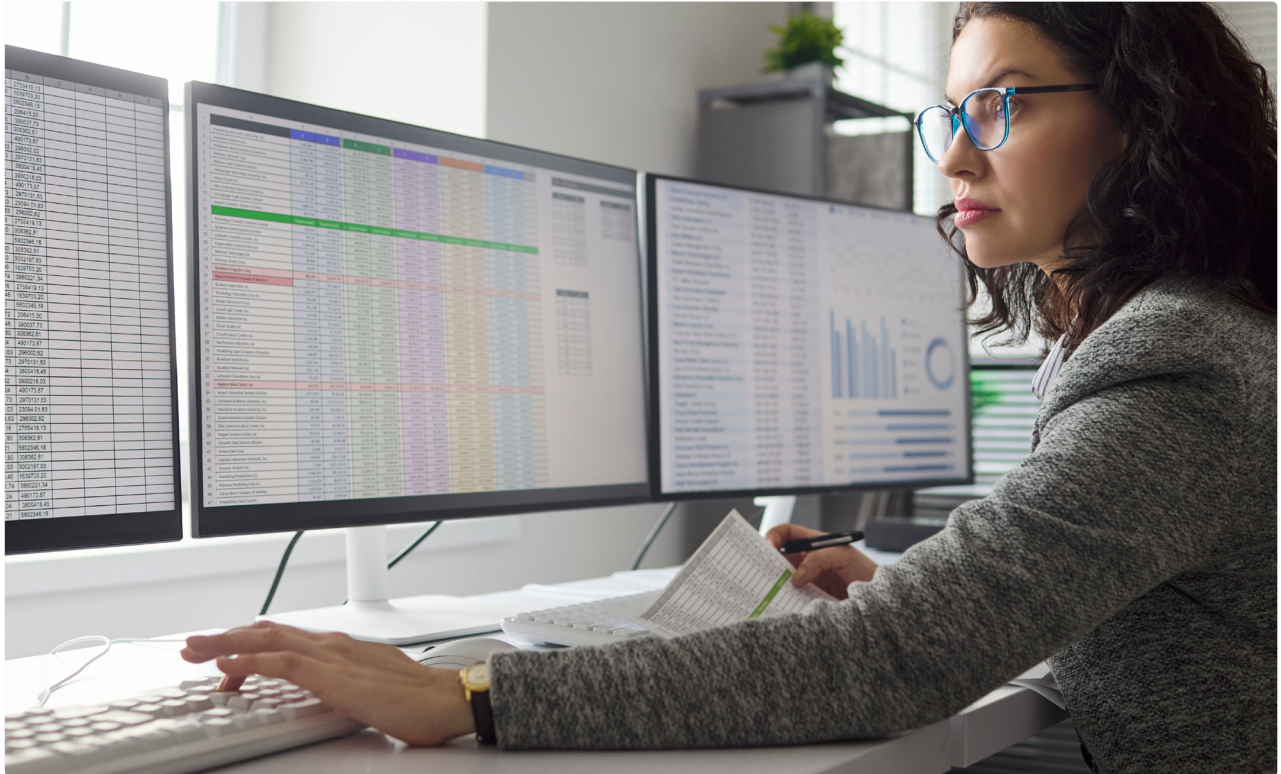


SHIFT



Outpace policy change: keeping your edit strategy up to speed

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Innovation and change is a good thing, right?

Healthcare changes constantly, and it should. These innovations in care delivery are improving patient outcomes and expanding access. New tech is streamlining back-office processes, reducing administrative burden, and helping payers manage an increasingly complex system more efficiently. The goals are universal - reduce costs and improve care in a landscape that is relentlessly getting more expensive and complex.

However, every wave of this positive change carries a downstream effect. Changes in how care is delivered reshape coverage, documentation and coding updates. New tech in provider workflows change how claims are submitted and coded. **JAMA recently reported** that providers utilizing AI scribes (leading to automated coding processes) are seeing a 6% increase in value delivered. Each of these shifts creates an obligation somewhere in the edit program - a policy to update, a code set to incorporate, a rule to revisit or care delivery to keep pace with.

For plans that rely on periodic review cycles to keep their edits current, every delay between policy change and edit deployment is a window where errors can build up or payments can pass through unchecked.

When edit programs fall behind, the consequences get real:

- Improper payments pass through undetected
- Edits misfire against codes or policies that have since changed
- Provider disputes build up without defensible rationale to resolve them
- Admin costs rise as teams manage disputes that better-timed edits would have prevented

What was once a pace plans could manage has now become a growing source of errors, losses and administrative burden for plans.



When policy moves faster than edit programs

Most edit programs were designed around a predictable cadence of change, one that the current policy environment has now outpaced. The standard update sequence (a policy changes, a team member identifies it, a coding expert interprets it, IT configures and tests the logic, and weeks or months later the edit deploys) was built for a slower environment. Everest Group researchers, who speak with 40 to 50 healthcare payers annually, consistently find that plans are responding to continuous change on a quarterly or annual basis, at best.

- CMS National and Local Coverage Determinations (NCD/LCD)
- Quarterly NCCI updates
- Annual CPT and ICD-10 code set revisions
- HCPCs updates
- Off-cycle code additions or deletions
- Medicaid state model contracts with plan-specific payment requirements
- Internal clinical guideline updates
- Emerging care delivery trends that push coverage boundaries

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No single team can monitor all of these sources manually at the pace needed to keep up. “Off-cycle” edit or policy updates are especially costly, where a new code added or policy adjustment issue wouldn’t surface until months of leakage have already built up.

The cost of edit drift

The concept of edit drift occurs when policy change and existing edit logic diverge far enough to matter financially and operationally. It is a condition that grows, not a one-off event - and for most programs, it shows up quietly.

The clearest way to spot drift is in trend data: spend increasing in a category without a clear driver, denial rates declining without improvements in provider billing accuracy, or dispute rates rising in a particular line of business. By the time these trends surface in a report, the underlying drift has likely been accumulating for months.

Improper payments are the most obvious sign, but operational costs become an equal threat to the plan:

- **Edit misfires.** When a policy change hasn’t been incorporated, the resulting denials often lack defensible rationale. Providers appeal, and when the basis for a denial can’t be clearly explained, the outcome is typically a reversal, plus the administrative cost of the appeal itself.
- **Dispute volume and staffing.** Rising appeal rates require clinical and administrative resources to handle any disputes. Plans may need to hire coding dispute staff specifically to manage the volume generated by edits that are out of sync with current policy.

- **Provider relationship strain.** Unexplainable decisions create ongoing friction. Over time, a pattern of poorly justified denials strains network relationships and can surface in contract negotiations.
- **Administrative burden on good providers.** Providers who are billing correctly under current policy but getting denied under outdated edit logic are then forced to resubmit, correct claims, or adjust behavior to accommodate rules that no longer reflect the actual policy.

Not all providers, or LOBs are treated equally.

Dr. Priscilla Alfaro, a strategic advisor for health plan cost adjudication and payment accuracy, describes this as a “peanut butter” approach to editing: applying (or spreading) the same rules broadly across an entire provider population. This evenly spread distribution creates two main risks:

- *Over-denial* of providers billing within accepted norms, generating unnecessary dispute volume
- *Under-detection* of providers whose coding behavior has shifted in ways that a broad rule won’t catch

Tracking how a specific provider’s billing patterns have evolved, what changes in their coding behavior might indicate, and whether a new pattern represents an error or a legitimate shift requires a level of granularity that manual programs struggle to sustain across a full provider network.

The plans most at risk are those operating reactively — updating their edit programs only when an audit finding, provider complaint, or visible leakage event forces the issue. In that model, the program is always addressing yesterday’s problem.

What modern edit governance actually looks like

The difference between edit programs that stay current and those that fall behind is rarely a technology deficit alone. It is almost always a governance oversight rooted in an absence of the structures, cadences, and decision rights that allow a program to move at the speed of change.

A four-level maturity framework

Outlined by Everest Group, a global research organization outlines a four-level maturity framework:

Level	Description	Characteristics
1 — Reactive	Edits touched only when something breaks	No cadence, no named owner; always in recovery mode
2 — Scheduled	Regular reviews with named ownership	Detection still manual and lagging; reacts to published policy, not actual provider behavior
3 — Proactive	Monitoring two signals simultaneously	Watches both policy changes and claims data; clear governance body with decision rights
4 — Adaptive	AI/agent layer continuously monitoring for change	Drafts potential edits, forecasts impact, presents to plan team for approval and deployment

According to Everest Group and other industry experts, most plans are operating at Level 1 or 2. Getting to Level 3. Building toward Level 4 requires rethinking both the technology and the organizational structure around the edit program.

Governance means having the right tech, but more importantly, the right people in the room.

An effective edit review brings together stakeholders beyond the clinical coding team:

- **Clinical coders and payment policy experts:** to validate that new edit logic accurately reflects the policy, and to catch misapplied code mappings that automated systems can miss
- **Network and contracting teams:** to flag when a technically correct edit conflicts with a fee schedule arrangement or provider-specific contract exclusion
- **Legal and compliance:** to confirm the policy basis for a denial is defensible before it goes live
- **Line-of-business representatives:** because coverage rules and code interpretation vary across commercial, Medicare, and Medicaid populations
- **Customer service stakeholders:** so front-line teams can support providers when decisions are questioned post-deployment

Visibility and traceability are non-negotiable for a defensible program. One of the most consistent issues in edit governance is the black-box problem - deploying edits through a vendor where the plan has limited visibility into how logic was generated or why a specific claim was flagged. When a provider appeals a denial and the plan can't produce a clear, policy-backed explanation, the outcome is almost always a reversal, plus the cost of the appeal process.

Governance requires transparency for every edit decision: what policy drove it, how the logic was codified, what claims it has touched. The ability to test a proposed edit against historical claims data before deployment adds another layer of confidence.

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It surfaces which providers would be affected, the estimated financial impact, and likely dispute volume before the edit goes live.

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How AI and agents are changing what's possible

AI in edit programs works best when it removes the manual bottlenecks that slow human judgment down — not as a replacement for that judgment.

Automated policy monitoring and ingestion is the most immediate application. Rather than relying on teams to manually track these policy sources, AI agents can continuously monitor key code sets, policy and other sources for changes and surfacing relevant policy text for review. This shifts the human role from research to validation.

AI-assisted edit generation accelerates the time from policy change to potential edits for programs. When a new policy is published, AI can transform the unstructured text into a structured edit — identifying relevant CPT and ICD-10 codes, flagging related conditions, and surfacing the specific policy sections that support the logic. Clinical coders and policy experts still validate the output; they are not performing the initial research.

Human + AI collaboration and oversight is essential.

AI-generated edit logic needs expert review — the context, nuance and application of field expertise is the final step that separates a misfired edit from one with true impact. ICD-10 codes can have clinical synonyms that don't appear in the policy text. A coding pattern that looks like an error may reflect a legitimate shift in care delivery. The reviewers who catch these nuances with their own inherent context (seasoned coders, medical directors, line-of-business experts) are what make an AI-assisted program successful. The goal is to give those reviewers better, faster inputs, not to bypass their judgment, and also use those outputs for continuous improvement of models.

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Building an edit program with AI and human expertise

For payment integrity leaders who know their edit programs are behind, the path forward can follow a consistent ramp regardless of team size or current maturity. It is a progression, and it starts with an honest look at where your program stands.

Step 1: Diagnose before you deploy. The assessment has to be organizational, not just technological. That means:

- Taking the highest-volume, highest-dollar edit categories and comparing current edit logic against both published policy and recent claims data
- Identifying areas where the program is most behind — categories where policy has moved but edits have not, coding areas where provider behavior has shifted without a program response
- Inventorying existing payment policies, because an edit without a policy basis is indefensible, and missing policies create blind spots in the edit program

Step 2: Start small and stay focused. Scope the first AI-assisted effort to a specific category where the diagnosis identified clear exposure. A successful pilot with measurable results builds both organizational confidence and the operational muscle to expand.

Step 3: Invest in change management as seriously as technology. Payment integrity teams often describe resistance less as opposition than as uncertainty — not knowing what their role looks like when AI is handling more of the initial research and codification. Dr. Alfaro has seen success with a “see one, do one, teach one” approach. When teams can observe the process, work through it themselves, and then bring that experience to their colleagues, adoption follows. The wins from a successful pilot are the most effective tool available.



Step 4: Deploy with traceability built in. When expanding beyond the pilot, ensure the governance infrastructure is in place before scaling. Defensibility at scale requires the same rigor that was applied in the pilot.

Step 5: Treat optimization as a continuous cycle.

As edits deploy and provider behavior evolves in response, new patterns will emerge. Governance needs to be designed to catch those patterns and update the program. The value of an adaptive program is that it doesn't require a new transformation initiative every time the policy environment changes.

The shift: from reactive to adaptive

The edit programs keeping pace today are not necessarily the biggest or best-resourced. They are the ones that have stopped treating policy change as

a periodic event to respond to and started building programs designed to absorb and adapt continuously.

That shift requires AI to handle the heavy lift of monitoring, research, and initial codification that human teams cannot sustain at volume, and it requires the human-in-the loop for expert context, final touch, ongoing governance, and great data to put that AI to productive use.

Start with an honest assessment of where the program stands, prove value in a specific area, and build from there. Plans that move on this now will be better positioned as the pace of change continues to accelerate.

Sources:

Menlo Ventures, "2025: The State of AI in Healthcare," October 2025
American Medical Association, CPT 2025 Code Set
Centers for Medicare & Medicaid Services, ICD-10 Code Updates
Everest Group, Healthcare Payer AI Adoption Research, 2025

About Shift Technology

Shift empowers health plans to strengthen payment integrity with speed, precision and transparency at critical steps of the claim lifecycle. With a continually optimized concept library, enriched data, and healthcare-trained AI, Shift detects errors, waste, abuse and potential fraud to prevent improper payments and maximize savings. Our agent-led solutions drive accelerated value and insightful decision-making, helping health plans reduce costs and enhance operational efficiency.

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