

Coding Policy

General Coding Policy

CODING POLICY NUMBER: 1

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SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”). **The full Company portfolio of current coding policies is available online and can be [accessed here](#).**

POLICY APPLICATION

- | | | |
|--|---|--|
| <input checked="" type="checkbox"/> Providence Health Plan Participating Providers | <input checked="" type="checkbox"/> All Service Areas | |
| <input checked="" type="checkbox"/> Commercial | <input checked="" type="checkbox"/> Medicaid/Oregon Health Plan | <input checked="" type="checkbox"/> Medicare |

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Coding policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

POLICY STATEMENT

- I. Coding policies help establish coding and billing standards that support uniform and consistent reimbursement of health care services. This information is to be used as a reference and is not intended to address every aspect of coding matters. Reasonable discretion may be used by Company in applying coding policy to individual situations.

- II. Coding policies are derived from the following sources:
- A. Standards developed by Company directives
 - B. Centers for Medicare and Medicaid Services (CMS) written policy
 - C. Local Carrier and National Carrier Determinations (LCD, NCD)
 - D. Medicare's Resource Based Relative Value System (RBRVS)
 - E. National Correct Coding Initiative (NCCI) Policy Manual
 - F. Medicare Physician Fee Schedule Data Base (MPFSDB)
 - G. CMS Medically Unlikely Edits (MUE)
 - H. American Medical Association (AMA) coding guidelines for CPT codes
 - I. AMA CPT Assistant newsletter articles
 - J. American Hospital Association (AHA) Coding Clinic
 - K. HCPCS Manual, including code definitions and associated text
 - L. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) official guidelines for coding and reporting
 - M. Coding guidelines from medical specialty associations

In cases where discrepancies exist between the sources listed above Company has sole discretion to determine which guideline to use in the development of Coding Policy.

- III. Coding policies may contain fee information but do not establish contracted rates.
- IV. Health Insurance Portability and Accountability Act (HIPAA) requires that providers use the most current code sets for billing services.
- V. Company uses the most current published service codes for coverage issues and pricing.
- VI. Service code sets include:
- A. Current Procedural Technology (CPT) codes
 - B. HCPCS National Level II codes
 - C. ICD-10-CM codes
 - D. ICD-10-PCS codes
 - E. Diagnosis-Related Group (DRG)
 - F. Revenue codes
 - G. Place of Service (POS) codes
 - H. National Drug Codes (NDC)
- VII. Systematic implementation of approved service codes is effective January 1st of each year.
- VIII. Contract-specific exceptions may apply.

POLICY DEVELOPMENT & MAINTENANCE

Company does not hold a coding policy to address every billing situation. When no applicable published Company policy exists, claims are to be coded appropriately according to industry standard coding guidelines. Information included in authoritative coding sources (e.g. AMA, CMS, NCHS, etc.) will generally not be duplicated in a separate Company policy. If Company coding policies and/or edits differ from other sources (including CCI edits and CPT guidelines), Company policies will take precedence.

The following factors are included in the development of coding policies:

- Compliance with government programs
- Customer service
- Clinical appropriateness
- Overall cost versus benefit
- Impact on provider community
- Operational ease of administration
- Compatibility with payment systems

Coding policies are developed with input from the following departments:

- Health Care Services/Medical Management
- Medical Directors
- Provider Relations
- Provider Contracting
- Operations
- Systems Administration
- Finance
- Regulatory Compliance and Government Affairs [ad hoc]

Coding policies are reviewed annually at a minimum. Company monitors updates to the claims code editing system annually when new codes are released for the following year, as well as periodically throughout the year as needed. National Correct Coding Initiative (NCCI) edit updates are reviewed and implemented quarterly as published by the Centers for Medicare and Medicaid Services (CMS).

Coding policies are reviewed, finalized, and approved by Coding & Reimbursement Policy Committee (CRPC).

PROVIDER NOTIFICATION

Coding policy changes are communicated to providers through *Coding Policy Alerts* on ProvLink, special communications, and/or through the contracting process.

Coding policies are published on the Providence Health Plan ProvLink website.

Changes to Company coding edits or coding policies that could have a negative financial impact on providers will be communicated to providers in Coding Policy Alerts on ProvLink at least 60 days prior to implementation.

There will be no notification to providers prior to implementation of coding edits based on CPT guidelines, ICD-10 guidelines, or NCCI Policy Manual guidelines.

CORRECT CODING GUIDELINES

Company utilizes code editing to enhance reimbursement and reporting accuracy and efficiency. Clinical edits detect coding errors (e.g. unbundling, frequency limitations, up-coding, duplication, invalid codes, mutually exclusive procedures, laterality inconsistencies, status indicator inconsistencies, place of service inconsistencies, etc.) by analyzing reported code sets (e.g. CPT, HCPCS, ICD-10, modifiers, place of service, revenue codes, etc.). Code edit rules are based on generally accepted correct coding guidelines and methodologies. Company will continue to enhance its editing system to automate edits that support correct coding.

Reimbursement will not be made for incorrectly reported or unsupported services. Providers must adhere to proper coding conventions including, but not limited to, complete and accurate reporting of the appropriate code sets; correct application of bundling, MUE, and status indicator rules; and documentation requirements.

Company reserves the right to perform postpayment review of claims and clinical documentation.

If Claims are not compliant with coding guidelines from nationally recognized sources (e.g. AMA, NCHS, CMS), or if documentation is not submitted upon request for an episode of care, Company may:

- Reject the claim,
- Deny payment of the service(s), or
- Recoup payment(s) already made for the service(s).

SERVICE CODE SETS

Code sets are implemented in accordance with Health Insurance Portability and Accountability Act (HIPAA) rules and regulations. Submitted codes must be complete, valid, and effective for the date of service. If conflicting information is submitted within or between code sets (for example, the CPT description indicates an emergency department service was performed, but the place of service for urgent care was reported), it may result in the denial of services.

Accepted code sets for claims include:

Current Procedural Terminology (CPT)

- Level I HCPCS codes and modifiers used to report medical, surgical, and diagnostic procedures.
- Maintained by AMA.
- Updated annually, effective January 1st; Category III codes are updated biannually, effective six months after release.

Health Care Common Procedure Coding System (HCPCS)

- Level II HCPCS codes and modifiers describing materials, injections, and services that do not have an assigned CPT code.
- Maintained by CMS.
- Updated quarterly throughout the year.
- See Coding Policy 22.0 (HCPCS S-Codes and H-Codes).

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

- ICD-10-CM codes are used to report symptoms, illnesses, injuries, or other circumstances which influence an individual's health status.
- Maintained by NCHS in collaboration with WHO.
- Updated annually, effective October 1st.
- See Coding Policy 02.0 (Diagnosis Coding).

International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)

- ICD-10-PCS codes are used to report procedures in hospital inpatient healthcare settings.
- Maintained by CMS.
- Updated annually, effective October 1st.

Diagnosis-Related Group (DRG)

- DRG codes are used to classify diagnoses in which patients demonstrate similar resource consumption and length-of-stay patterns. Individual DRGs are calculated and assigned to inpatient admissions claims based on the diagnoses, procedures performed, age, sex, discharge, and length of stay.
- Maintained by CMS.
- Groupings are updated annually, typically effective October 1st.

Revenue Codes

- Revenue Codes are used to categorize the type of service or location where a patient received care in the hospital setting.
- Published by the National Uniform Billing Committee (NUBC).

Place of Service (POS) Codes

- POS codes are used to report the location where a healthcare service was provided.
- Maintained by CMS.
- See Coding Policy 11.0 (Place of Service for Diagnostic Tests).

National Drug Code (NDC)

- NDCs are used to identify the manufacturer, product information, and packaging of drugs.
- Assigned by the FDA.

CROSS REFERENCES

- Coding Policy 22.0 (HCPCS S-Codes and H-Codes)
- Coding Policy 02.0 (Diagnosis Coding)
- Coding Policy 11.0 (Place of Service for Diagnostic Tests)

REFERENCES

1. American Medical Association (AMA) (ama-assn.org)
2. Centers for Medicare & Medicaid Services (CMS) (cms.gov)
3. State and Federal Regulations
4. Health Insurance Portability and Accountability Act (HIPAA)
5. Providence Health Plan Clinical Edits
6. National Correct Coding Initiative (NCCI) (cms.gov)
7. AHA Coding Clinic (codingclinicadvisor.com)

POLICY REVISION HISTORY

Date	Revision Summary
1/2023	Annual review (converted to new template 5/2023). Original policy effective date: 3/1990
1/2024	Annual review with no changes.
1/2025	Removed statement saying CPRC reports to MEMC.
8/2025	Interim Update. Merged Coding Policy 19.0 (Service Code Policy) and reorganized content. Additional sources used for policy decisions. Noted coding policies are not all-encompassing. New "Correct Coding Guidelines" section. Added revenue, POS, and NDC code set information.
05/2026	Annual review. Corrected ICD-10-PCS maintained organization to state by CMS.