Providence Health Plan

Coding Policy Alerts

March/April 2025

This is the March/April 2025 issue of Providence Health Plan's Coding Policy Alerts. The focus of this update is to communicate to providers new or revised coding policies, as well as general billing and coding information.

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CODING POLICY UPDATES

Clinical Documentation Requirements for Clinical Edit Appeals	PHP has noticed an increase in appeals with missing clinical documentation (e.g. office notes, operative/procedure notes, imaging reports, laboratory reports, etc.). Including chart notes is critical to ensure PHP has all the information needed to process an appeal without unnecessary delays. Appeals submitted with insufficient information to support the services billed will be returned to the provider.
HCPCS Code G2211 Not Covered for Commercial Plans (Repeat Article)	Effective for dates of service on or after November 1, 2024, HCPCS code G2211 will be denied as a bundled service for Commercial plans. PHP will continue to allow HCPCS code G2211 for Medicare Advantage plans. HCPCS code G2211 is used to report, "Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition." This is an add-on code that may be billed with office/outpatient evaluation and management (E/M) codes when ongoing care is provided for complex conditions. Coding Policy 13.0 (Bundled or Adjunct Services), which is available on ProvLink, has been updated to show this code will not be covered for Commercial plans for dates of service on or after November 1, 2024.
Billing Guidelines for Unlisted CPT and HCPCS Codes	Coding Policy 27.0 (Billing Guidelines for New or Unlisted CPT and HCPCS Codes), which is available on ProvLink, lists the information required to support billing an unlisted code. All documentation requirements listed on Coding Policy 27.0 must be met for an unlisted code to be paid. Providers are advised to review guidelines in this policy to avoid unnecessary delays in payment. Supporting documentation is required for all unlisted codes, even if the procedure has been prior authorized. Providers are required to include a **clear description of the nature and extent of the procedure or service**, underlining (not highlighting) the portion of the documentation that identifies the work for which the provider is billing an unlisted code. Providers are also encouraged to identify the code for a comparable procedure as a *suggestion* for pricing the unlisted code. As indicated on Coding Policy 27.0, when a comparable code is used for pricing an unlisted code, all edits that apply to the comparable code will apply to the unlisted code. If pricing cannot be established by using a comparable code, the service will default to payment by discount.

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GENERAL CODING GUIDELINES

Pre-Operative Visit Prior to Screening Colonoscopy **(Repeat Article)**	A visit prior to screening colonoscopy is included in payment for the colonoscopy and may not be reported separately, even if this visit is performed several weeks prior to the colonoscopy. This is addressed in Coding Policy 12.0 (Global Surgical Package Pre- and Post- Operative Care), which gives instructions for reporting Evaluation and Management (E/M) services with minor procedures. Minor procedures have a global period of 0 or 10 days. The 0- to 10-day global period includes obtaining a medical history and performing a brief exam prior to the procedure. This service is not separately billable, even if performed several days or weeks prior to the procedure.