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Coding & Reimbursement Policy Changes

INPATIENT SEPSIS DRG BILLING – LENGTH OF STAY REQUIREMENT

This policy has been rescinded, and The Plan will no longer be implementing this claim edit.

~~***Tentatively Effective 7/1/2026***~~
~~**Applies to:** Inpatient Facility Claims~~
~~**Lines of Business:** Medicare and Commercial~~

~~**SUMMARY**~~

~~Providence Health Plan will deny inpatient facility claims billed with certain sepsis MS-DRGs when the length of stay is less than 3 days and the patient is discharged to home.~~

~~**IMPACTED DRGS**~~

~~The following MS-DRGs are impacted by this policy:~~

- ~~**MS-DRG 871** – Septicemia or Severe Sepsis without Mechanical Ventilation >96 Hours with MCC~~
- ~~**MS-DRG 872** – Septicemia or Severe Sepsis without Mechanical Ventilation >96 Hours without MCC~~

~~**DENIAL CRITERIA**~~

~~Inpatient facility claims will be denied when all of the following apply:~~

- ~~Billed with MS-DRG 871 or 872, and~~
- ~~Length of stay is less than 3 days, and~~
- ~~Discharge disposition is to home~~

~~Claims that do not meet the clinical severity and resource intensity expected for these DRGs may require rebilling under a more appropriate DRG.~~

~~**PROVIDER REMINDER**~~

- ~~MS-DRGs 871–872 represent high-severity sepsis cases that typically require extended inpatient care.~~
- ~~DRG assignment must be supported by clear physician documentation and clinical severity consistent with the billed DRG.~~
- ~~Accurate documentation and coding help prevent claim denials and payment delays.~~

CRITICAL CARE SERVICES BILLED IN THE EMERGENCY DEPARTMENT

Tentatively Effective 7/1/2026
Applies to: Facility Outpatient Emergency Department Claims
Lines of Business: Medicare and Commercial

SUMMARY

Providence Health Plan will deny facility-billed critical care services when critical care is reported in the emergency department (ED) and the patient is discharged to home.

Critical care services are reserved for patients who are critically ill or critically injured and require highly complex medical decision-making and continuous care. Discharge to home from the ED generally does not support the use of critical care codes.

IMPACTED CODES

The following CPT codes are impacted:

- **99291** – Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes
- **99292** – Critical care, each additional 30 minutes (add-on code)

DENIAL CRITERIA

Facility claims will be denied at the line level when all of the following apply:

- Critical care services (99291 and/or 99292) are billed,
- Services are rendered in the emergency department, and
- The discharge disposition is to home (status code 01).

In these situations, reporting an appropriate ED evaluation and management (E/M) level may be more appropriate.

IMPORTANT NOTES

- This edit applies to facility billing only.
- ED visits resulting in inpatient admission are not impacted.
- Critical care services must meet all CPT requirements, including clinical severity and documentation support.

SURGICAL PROCEDURE ANATOMICAL MODIFIER REQUIREMENTS

Effective 7/1/2026

Applies to: Professional and Facility Claims
Lines of Business: All

SUMMARY

Providence Health Plan will deny surgical procedure lines when required anatomical modifiers are missing, incorrect, or inappropriate for procedures where laterality or anatomical site is necessary to support accurate billing.

Anatomical modifiers are essential to correctly identify the location or laterality of a surgical procedure and to support proper claims processing.

IMPACTED SERVICES

This edit applies to CPT codes 10000–69999 that:

- Are bilateral-eligible under the Medicare Physician Fee Schedule, and
- Require identification of anatomical site or laterality when applicable.

DENIAL CRITERIA

Claims will be denied at the line level when:

- A surgical procedure requires an appropriate anatomical modifier (e.g., RT, LT, E1–E4, F1–F9, T1–T9, LC, RC), and
- The modifier is missing, incorrect, or substituted with a non-specific modifier (such as modifier 59 or XS) when a more specific anatomical modifier is required.

Non-specific modifiers should only be used when no more specific anatomical modifier accurately describes the service performed.

PROVIDER REMINDER

- Anatomical modifiers must accurately reflect the site or laterality of the procedure performed.
- Modifier 59 or XS should not be reported when a more specific anatomical modifier is available.
- Proper modifier use helps prevent duplicate billing issues, frequency edit conflicts, and claim denials.

ANESTHESIA SERVICES: PHYSICAL STATUS MODIFIERS

Effective 6/1/2026

Applies to: Professional Claims
Lines of Business: Commercial Only

UPDATED REIMBURSEMENT POLICY

Effective for dates of service on or after June 1, 2026, Providence Health Plan will no longer reimburse additional units associated with anesthesia physical status modifiers P3, P4, or P5 for commercial lines of business.

POLICY BACKGROUND

Under Reimbursement Policy RP26 – Anesthesia Services, anesthesia reimbursement for commercial products is based on:

- Applicable base units
- Time units (reported as total anesthesia time)
- Eligible payment modifiers, as outlined in the policy

With this policy change, physical status modifiers P3, P4, and P5 will no longer result in additional reimbursable units for commercial plans, even when appropriately reported. These modifiers may continue to be reported for clinical documentation purposes; however, no additional payment will be made for these modifiers.