CODING POLICY	19.0 Service Code Policy
Effective Date: 01/2023 **Original Effective Date: 01/1994**	Coding Policy Number: MC 19.0
Approved by: Coding Policy Review Committee	Committee Approved Date: **03/02- 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 01/21, 01/22, 01/23**

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").

APPLIES TO:

Health Plan Providers
All Lines of Business

POLICY STATEMENT

Company uses the most current published service codes for coverage issues and pricing. These service codes are published in the Current Procedural Terminology (CPT), ICD-10-CM, HCPCS (National Level II codes) and Diagnostic Related Groupings (DRG) books. Systematic implementation of approved service codes and rates is effective January 1st of each year. Health Insurance Portability and Accountability Act (HIPAA) requires that providers use the most current code sets for billing services.

PROCEDURE

Company monitors updates or changes to the claims code editing system annually when new codes are released for the following year, as well as periodically throughout the year as new codes are published. Coding policies and edits are updated as required. Changes to edits and/or policies are communicated to providers in the newsletter *Coding Policy Alerts* on ProvLink.

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.

National Correct Coding Initiative (NCCI) edit updates are reviewed and implemented quarterly as published by CMS. There will be no notification to providers prior to implementation of NCCI edits or edits based on CPT guidelines or NCCI Policy Manual guidelines.

Code sets are implemented in accordance with Health Insurance Portability and Accountability Act (HIPAA) rules and regulations.

DEFINITIONS

- CPT procedure codes and modifiers (also known as Level I HCPCS codes) are defined in the current edition of CPT as published by the American Medical Association. These service codes are updated during the year and published annually in the last quarter of the year.

- HCPCS codes (also known as Level II HCPCS codes) are defined by CMS. Level II HCPCS codes and modifiers are used for describing materials, injections and services rendered that are not assigned a CPT (Level I HCPCS) code. Updates of the Level II HCPCS are controlled by CMS. Updates are done throughout the year.

- ICD-10-CM codes are defined in the current edition of the International Classification of Diseases, 10th Revision, Clinical Modification. Codes are updated annually in September and effective in October.

- Diagnostic Related Groupings (DRG) are defined by CMS. DRG are classifications of diagnoses in which patients demonstrate similar resource consumption and length-of-stay patterns. Individual DRGs are assigned to inpatient admissions by the hospitals, utilizing the diagnoses, procedures performed, age, sex, discharge, and length of stay to calculate. Groupings are updated annually, typically effective October 1st.

- Company clinical edits are developed using information from Providence Health Plan Medical Directors, medical specialty societies, CPT guidelines, and/or CMS National Correct Coding Initiative policy guidelines. These edits may differ from CCI edits and/or CPT guidelines and will take precedence over CCI edits or CPT guidelines when that is the case.

REFERENCES

1. Providence Health Plan Provider Contracts
2. Providence Health Plan Coding Policies