Coding and Editing Policy - Professional & Facility

IMPORTANT NOTE ABOUT THIS CODING AND EDITING POLICY

Providers are responsible for submission of accurate claims. This coding and editing policy is intended to ensure that providers are reimbursed based on the code or codes that accurately describe the health care services provided so that proper editing can be applied by Piedmont.

This document serves as a general resource regarding Piedmont's coding and editing policy and does not address every aspect of its coding and editing procedures. In this policy reference is made to other resources for further information about such procedures. Accordingly, Piedmont may use reasonable discretion in interpreting and applying this policy to claims for health care services provided in each particular case.

Further, this policy does not address all issues related to reimbursement for health care services in professional and facility settings provided to Piedmont enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, the terms and conditions of participating provider agreements, the enrollee's benefit coverage documents, and/or Piedmont's other medical or drug policies.

The information presented in this policy is current as of the date of publication. Piedmont may modify this policy at any time by publishing a new version on Piedmont's website at www.pchp.net.

Application

Claims correct coding and editing will apply to all network and non-network physicians (and other qualified health care professionals) and facilities.

This policy applies to all Piedmont products.

This policy applies to all health care services billed on CMS 1500 forms, CMS 1450 and UB04 forms. It also includes electronic claim transactions for 837I (Institutional) and 837P (Professional). Coding methodology, industry standard reimbursement logic, regulatory requirements, benefit plan design and other factors are considered in developing this coding and editing policy.

The guidelines addressed in this policy are not all-inclusive. Please refer to the additional resources referenced below.

Policy

Claims Coding

Professional Claims - According to the Centers for Medicare and Medicaid Services (CMS), medical and surgical procedures should be reported with the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes that most comprehensively describe the services performed. Piedmont will use CMS' claim submission procedures, for all products, which can be found in the Medicare Claims Processing Manual – Chapter 26.

Institutional and Outpatient Claims – Piedmont will use CMS' Institutional and Outpatient claim submission guidelines, for all products, which can be found in Chapters 3 and 25 of the Medicare Claims Processing Manual.

Coding and editing methodology for Piedmont specific benefits will be incorporated in this policy when and if any should occur.

Edit Sources

Piedmont began using Burgess Source editing and its software tools on January 1, 2022 (the "***Implementation Date***"). Piedmont's list of standard CMS edits applies to the categories of services listed below (not an all-inclusive list). This list is also available on our website at www.pchp.net.

- Ambulance
- Anesthesia
- Billing Guidelines
- CPT/HCPCS
- Diagnosis
- DME
- Drug
- DRG
- ESRD
- Facility Type
- Global
- Hospice
- Imaging
- Modifier
- MPPR
- MUE
- NCCI
- NPI
- Pathology/Laboratory
- Provider type reimbursement levels
- Revenue Codes
- Substance Abuse
- Taxonomy Code
- Units

Questions and Answers

1. **Q:** When will the policy edits be applied?

   A: All applicable edits will be processed to claims with dates of service on and after the Implementation Date (as defined above).

2. **Q:** How often are the bundling rules updated in each system?

   A: Bundling edits are updated quarterly. Piedmont reserves the right to update edits more frequently as necessary.

3. **Q:** Since the bundling policy recognizes many modifiers, do all modifiers bypass bundling edits in every situation?

   A: No. There are many coding guidelines provided within credible third-party sources such as the CPT and HCPCS books, CMS NCCI Policy Manual, etc. that address situations in which a modifier applies. While the bundling policy recognizes many modifiers, modifiers only apply when they are used according to correct coding guidelines.

4. **Q:** Why are Evaluation and Management (E/M) services not reimbursed with certain codes in the CPT Medicine section when performed on the same date of service by the same individual provider?

   A: Consistent with CPT guidelines, E/M services will be considered included in many medicine codes in the 9xxxx section of CPT and will not be separately reimbursed. Modifier 25 should only be used to report a significant and separately identifiable E/M service that is above and beyond the other service provided.

5. **Q:** Why isn't the E/M service 99211 allowed when reported with hydration, therapeutic, prophylactic, or diagnostic IV infusion or injections?

   A: According to CPT, hydration, therapeutic, prophylactic, or diagnostic IV infusion or injection services typically require direct physician supervision. Since 99211 may be reported by qualified health care professionals other than physicians, Piedmont does not allow 99211 to be reimbursed separately when reported with these services whether or not a modifier is appended.

Resources
American Medical Association, *Current Procedural Terminology* (CPT®) and associated publications and services Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files