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Originated Department	Medical Management

Standard Operating Procedure (SOP) – Sources for Coding Determinations

Audience
Medical Management, Claims

Purpose
<p>Medical policies provide general support for applying Mountain Health Co-Op member policy document coverage decisions and must reference the member-specific benefit plan document. The terms of the member-specific Policy document may differ from the standard benefit plan on which this medical policy is based. If there is a conflict between a member-specific policy document and the Mountain Health Co-Op medical policy, the member-specific policy document supersedes this medical policy. Any person(s) applying this medical policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this medical policy, including the existence of any state or federal guidance. Mountain Health Co-Op medical policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health Co-Op reserves the sole discretionary right to modify all policies and guidelines at any time.</p>

Definition
<p>The Sources for Coding Determinations will provide guidance as to the process used in determining coverage criteria for specific HCPCS, CPT, Revenue, DRG and similar coding used in submitting claims for medical and behavioral health Services.</p>

Policy/Procedure
<p>Commercial Plans</p> <p>Mountain Health Co-op Plans uses multiple resources to create coding and reimbursement coverage determinations. Mountain Health Co-op Plans uses the following hierarchy in determining its reimbursement coverage policies:</p>

- A. American Medical Association (AMA) Current Procedural Terminology (CPT®) Manual and Associated Coding Rules
- B. Centers for Medicare and Medicaid Services
- C. Physician Specialty Societies
- D. AHA coding Clinic
- E. Other Expert Sources

Generally, Mountain Health Co-op Plans will use CMS, AMA-CPT, and CCI coding rules as the primary source for all coverage determinations. As Mountain Health Co-Op sells Affordable Care Act plans supplemented by government funding and monitored by HHS/CMS, the Co-Op follows CMS coding guidelines first and then AMA CPT. If AMA-CPT or CMS does not provide guidance, physician specialty societies or other sources will be used. These guidelines are provided in policies and are available on our website or portals.

Mountain Health Co-op Plans may create policies that differ from the above sources due to local practice variations or other circumstances. In those instances, the Mountain Health Co-op Plans Policy will be used to audit and adjudicate claims.

If a state or federal law requires using a particular coding or reimbursement coverage determination, Mountain Health Co-op Plans will follow the state or federal law.

Rationale

CPT, HCPCS, and other coding tools, such as modifiers, are used by providers to submit claims for payment for their services. In many instances, providers have no clear rules regarding what claims to submit in various circumstances and what modifiers, units, etc., are appropriate. Additionally, the Mountain Health Co-op Plan must have a reliable, reproducible, and defensible approach to logic-based determinations that are not already precise based on code descriptions or other common sense rules well-known to providers. In determining the hierarchy of sources for coding determination, the plan wishes to be transparent and provide a vehicle for understanding the logic used in rendering its coverage policies that align with standard practice and intended coverage based on member policies.

The first source for determining coding setup and claims payment rules is the American Medical Association CPT® Coding Guidelines and their Correct Coding Initiative (CCI). Though this may be biased toward physician reimbursement, this tool has established rules for when specific CPT/HCPCS codes and modifiers are to be used and when codes are considered a part of another service and are being unbundled. Some coding circumstances may have a great deal of controversy among payers, providers, and/or physician specialty societies, and CMS regarding a specific matter. In these circumstances, CPT® guidelines may take precedence.

The second source for coding setup determination is the rules established by CMS for coverage. These may include National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or Local Coverage Articles (LCAs). Additionally, the weighing of physician services, pricing information, payment policy indicators, relative value units (RVUs),

and geographic practice code index (GPCI) are established by CMS in the Medicare Physician Fee Schedule (MPFS), and this may have a bearing on coding set up and policy. Medicare also provides its own National Correct Coding Initiative (NCCI) Coding Policy Manual (Coding Policy Manual).

Physician specialty societies, such as the American Academy of Orthopaedic Surgeons (AAOS) and the American Congress of Obstetricians and Gynecologists (ACOG), will sometimes provide coding guidance to their members. Though intended to assist in the billing process for their members, these sources can also provide advice and clinical background to coding that is not provided by other sources. Mountain Health Co-op Plans will look at what specialty societies state regarding CMS and CPT®. If these areas do not agree, then all views will be evaluated before making a decision.

Lastly, there may be other expert sources, including CPT® Assistant, CPT® Changes: An Insider's View, American Hospital Association Coding Clinic, and Optum360° Coders' Desk Reference for Procedures, evidence-based society practice guidelines available, which may impact code coverage setup. These will also be considered when determining reimbursement policy when other, more authoritative sources are not sufficient to reach a determination.

References

1. <https://www.ama-assn.org/amaone/cpt-current-procedural-terminology>
2. <https://www.cms.gov/medicare/coding/nationalcorrectcodinitiated/index.html>
3. <https://www.cms.gov/medicare/coverage/determinationprocess/>
4. <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/>
5. www.cms.gov/files/document/fy-2025-icd-10-cm-coding-guidelines.pdf

Vendors

- Health Plan Services (HPS)

Review/Revision/Approval History

Date	Description
01/01/2024	New Policy
01/01/2025	Added ICD10 ref.

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult appropriate healthcare providers for medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's benefit plan, effective when services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Including or excluding a procedure, diagnosis, or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as they apply to an individual member.

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