Coding Guidelines for Claims Editing (Line-Item Bill Auditing)

Lines of Business	*Document Type*
Commercial, Medicaid, Medicare	Policy, Procedure
Who This Applies To	***States***
Health Services	Idaho, Montana, Oregon, Washington

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Providers are responsible for accurately, completely, and legibly documenting the services they perform. The billing office is expected to submit claims for services rendered using valid codes from HIPAA approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including, but not limited to: UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS National Correct Coding Initiative (NCCI) Policy Manual, NCCI Table Edits and MUEs (units), and other CMS guidelines).

PacificSource follows CMS's Provider Reimbursement Manual Part I, chapter 22, section 2202.6, for definition of **"routine services**" as those services included by the provider in a daily service charge—sometimes referred to as the "room and board" charge. Routine services are comprised of two broad components: (1) general routine service, and (2) special care units (SCU), including coronary care units (CCU) and intensive care units (ICU). Included in routine services are the regular room/observation room, dietary services, nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not applicable"

In addition, current procedural terminology (CPT) is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers.

Procedural CPT code(s) and charges include all supplies and related services. Supplies/equipment are ineligible for separate reimbursement when billed in combination with the procedure CPT code. In the case of DRG payment structures, supplies, equipment, and services that are not eligible for separate reimbursement are not eligible to be included in outlier calculation.

The purpose of this policy is to set forth standards for the review of the itemized claim for covered medical and surgical services and supplies in the Inpatient/Outpatient, Observation, and Ambulatory Care settings. Routine equipment, supplies, and services are not separately reimbursable as they are considered to be included in the room and board charges or are part of another more comprehensive procedure or service. Determination of disallowed claim lines based on coding regulations and policy will be made by the assigned clinical and support staff. Determination of disallowed claim lines based on medical necessity will be made by the Medical Director.

Procedure

On identified claims, an itemized bill of incurred charges and supporting documentation will be requested. The itemized bill will be reviewed by clinical and non-clinical staff for appropriate billing practices. In addition, any questions of medical necessity will be forwarded to a PacificSource Medical Director for determination.

In the event that disallowed claim lines are identified, the information is communicated to the Claims Department for further processing.

Providers are granted rights to appeal coverage decisions. See the applicable (Commercial or Government) Provider Appeal policies for details.

Criteria

- **Medical Equipment/Supplies (Capital Equipment)** – Routine medical equipment/supplies are not eligible for separate reimbursement as they are packaged in the procedure or facility charge respectively (Federal Register). Medical equipment/supplies include but are not limited to: (*commonly associated revenue codes 260-269, 270, 279, 410, 412*)

▪ Ambu bags ▪ Beds, commodes, scales, overhead frame, over-bed table, room furniture ▪ Cameras/video recording devices ▪ Cell Saver equipment and related supplies ▪ Crash cart, defibrillator ▪ Digital recording equipment i.e., EKG, CO2 ▪ Fetal monitors ▪ Flow meters ▪ Fluoroscopy and/or Ultrasound in OR	▪ Microscopes (digital or other microscopes) ▪ Monitors (cardiac, oximetry, fetal, arterial, neurology [IONM], etc.) ▪ NIBP machines/monitors ▪ Perfusion equipment and supplies in OR ▪ Pill splitter or crusher ▪ Pressure bags/pressure infusion equipment ▪ Procedure specific tool kits/instruments/trays ▪ Pumps (IV, Bio, syringe, blood warmer, suction, feeding, PCA, etc.)

▪ Glucometer ▪ Infant warmer ▪ Incentive Spirometer ▪ Linens – reusable sheets, blankets, pillowcases, draw sheets, under pads, washcloths, towels ▪ Lasers ▪ Machines (anesthesia, bladder scanner, blood pressure, cautery, humidifier, CPAP, ventilator, heating/cooling, hemodynamic, etc.)	▪ Rental equipment (wound vac, bariatric bed, etc.) ▪ Scopes (bronc, colon, endo) ▪ Stethoscopes, pin lights, flashlights (including disposable) ▪ Traction equipment ▪ Transport monitors, isolates, ventilators ▪ Thermometers ▪ Vascular closure devices

- **Routine Medical/Surgical Supplies** – are to be included in the general cost of the procedure or the facility. These items are considered floor stock and are generally available to all patients receiving services. Routine Supplies are not separately reimbursable. (Commonly associated revenue codes 250, 270–279)
    - When coding for services or supplies, the most specific and comprehensive code available is to be selected to report the service or item. Unspecified codes (i.e., 99070) and any use of "miscellaneous" charge items will not be eligible for separate reimbursement consideration.

▪ Alcohol swabs/pads ▪ Baby powder ▪ Basin ▪ Bandages/dressings (Band-Aids, 4X4, sponges, etc.) *does not include wound vac supplies ▪ Batteries ▪ Bedpans ▪ Blood pressure cuff ▪ Breast pumps ▪ Cold/hot packs ▪ Cotton balls (sterile or non-sterile) ▪ Diapers ▪ Drapes ▪ Food thickeners ▪ Gloves ▪ Heat lights or pads ▪ Irrigating solution ▪ IV arm boards ▪ IV solutions 50 mL – 250 mL used as vehicle to administer medication (bundled in the J code)	▪ Masks (patient or staff) ▪ Meal trays (including guest) ▪ Mouth care kits (excludes chlorhexidine used for VAP) ▪ Odor eliminator/room deodorizer ▪ Oxygen ▪ Oxygen masks, cannula, tubing ▪ Personal items (soap, toothpaste, razors, deodorant, socks, etc.) ▪ Preparation kits ▪ Reusable equipment or items ▪ Skin cleansing solutions (betadine, chlorhexidine) ▪ Socks/slippers ▪ Sterile water ▪ Stock or bulk supplies ▪ Syringes and needles ▪ Tape ▪ Tubing (IV, blood, etc.) ▪ Wall suction ▪ Water pitcher (measuring) ▪ Items used to obtain specimens or

▪ IV saline and/or heparin flushes ▪ IV tubing, extenders, dressings ▪ Lemon glycerin swabs ▪ Lubricant jelly	complete a diagnostic or therapeutic procedure (arterial blood gas kit, urine collection kits, mucus traps, etc.)

- **Nursing Care/Services** – is performed by the primary bedside nurse (RN and/or LPN), respiratory therapists, certified nursing assistants, or technicians within the scope of their daily duties. Routine services are bundled under the room and board charge and not separately reimbursable. Normal scope of services include but are not limited to (Standards and Scope of Practice). (*Commonly associated revenue codes 260, 300, 309, 361, 391, 460, 510, 761*)
    - Routine care/services **DO NOT** apply to specialty trained/certified nurses' providing such services as PICC insertion or wound debridement

▪ Administration of blood or any blood product including Intraoperative Autologous Transfusion (product is billed under laboratory services). This excludes Massive Transfusion Protocol ▪ Administration or application of any medication, chemotherapy, and/or IV fluids including TPN ▪ Accessing indwelling IV catheter or port ▪ Assisting physician or other licensed personnel in performing any procedure regardless of setting (patient room, treatment room, surgical suite, endoscopy suite, cardiac cauterization lab, or x-ray) when performed as part of the routine care provided in the specific facility region/unit ▪ Cardiopulmonary resuscitation (management or participation in arrest event – see code blue activation below) ▪ Dressing changes/ostomy appliances ▪ Enterostomal services ▪ Incentive spirometer ▪ Incremental nursing care (1:1, 2:1 in ICU, sitter [see incremental nursing below]) ▪ Insertion, discontinuation, maintenance of nasogastric tubes ▪ IV hydration at TKO/KVO rate ▪ IV peripheral line insertions/discontinuation (including use of local anesthesia) ▪ IV maintenance (flushes, dressing changes) of peripheral or central lines	▪ Medical records documentation ▪ Mixing, preparing, and dispensing medications (IV fluids, nutrition, etc.) ▪ Monitoring of cardiac monitors (CVP, Swan-Ganz, arterial readings) ▪ Neurological status checks ▪ Quantitative Pupillometry/Pupillography ▪ Obtaining/monitoring vital signs (blood pressure, temperature, respirations, pulse, pulse oximetry) ▪ Obtaining any bodily fluid specimen (urine, stool, sputum, blood [finger-stick glucose], venipuncture, arterial draw, line draw) ▪ Patient/family education ▪ Personal hygiene ▪ Personal safety/quality care (turning) ▪ Preoperative care ▪ Point-of-care testing (glucose, urine dip, ABG, electrolyte) obtained at the bedside with a handheld device ▪ Pulse oximetry (single or continuous) ▪ Respiratory/nebulizer treatments administered by Nursing staff ▪ Set up and/or take down of IV pumps, suction, flow meters, heating/cooling pumps, over-bed frames, traction equipment, monitoring equipment. ▪ Scanning of the bladder for urinary retention ▪ Suctioning or lavaging ▪ Tracheostomy care

▪ Maintenance or flushing of J-tubes, PEG tubes, or feeding tubes of any kind ▪ Maintenance of chest tubes (dressing change, discontinuation)	▪ Transporting, ambulating, range-of-motion, transfers from surface to surface ▪ Urinary catheterization ▪ Venipuncture (venous or arterial)

- **Surgery/Procedures** – to include surgical suites, major or minor treatment rooms, endoscopy labs, cardiac catheterization labs, x-ray, pulmonary, and cardiology procedure rooms. Minor procedures can also be performed at the bedside. In addition to the above list of equipment, supplies, and nursing personnel services, the following list of services are included in the surgical room rate (not all inclusive) (*commonly associated revenue codes 27X, 270-279, 300- 370*)
    - When coding for services or supplies, the most specific and comprehensive code available is to be selected to report the service or item. Unspecified codes (i.e., 99070) and any use of "miscellaneous" charge items will not be eligible for separate reimbursement consideration.

▪ Air conditioning and filtration ▪ All reusable instruments charged separately (e.g., forceps/scissors) ▪ Anesthesia equipment and monitors ▪ Anesthesia gases ▪ Any automated blood pressure/vital sign equipment (e.g., Dinamap) ▪ Blankets (e.g., Bair Hugger) ▪ Batteries for any equipment ▪ Cardiac monitors ▪ Cardiopulmonary bypass equipment ▪ Cautery Equipment monopolar and bipolar electrosurgical/bovie ▪ Cell Saver equipment and supplies ▪ CO2 monitors ▪ Crash carts ▪ Digital recording equipment and printouts ▪ Fracture tables ▪ Grounding pads ▪ Hemochron/supplies ▪ Hemoconcentrator ▪ Laparoscopes, bronchoscopes, endoscopes and accessories ▪ Lights; Light handles; light cord, fiber optic Microscopes ▪ Local anesthesia ▪ Midas Rex (high speed pneumatic drill)	▪ Procedure-specific reusable tools/instruments (broaches, extractors, drill, drill bits, osteotomes, reamers, retractors, etc.) ▪ Power equipment ▪ Robotic-assisted techniques listed in the procedure code will be covered at contract rates, to include MAKO (exceptions for LEHP – see specific policy). Robotic-assisted techniques billed as an add-on code will be denied ▪ Room heating and monitoring equipment ▪ Room set-ups of equipment and supplies ▪ Saline infusion sonogram (SIS equipment) ▪ Saline slush machine ▪ Solution warmer ex. warms IV fluid or solution used to warm scopes ▪ Surgeons' loupes or other visual assisting devices ▪ Surgical Cultures (swabs) ▪ Surgical closures and dressings ▪ Surgical imaging and/or ultrasound guidance during surgery or procedure ▪ Trocars ▪ Transport monitor to include intra hospital transport and bedside monitoring ▪ Video camera and tape ▪ Wall suction equipment

▪ Multiple levels of care for the same procedure ▪ Obtaining laboratory specimens (biopsies, tissue samples, cultures, etc.)	– **in addition, when a procedure CPT code is billed, all usual and customary supplies/equipment required to complete the procedure is considered bundled to the procedure and is not separately reimbursable.

- **Ambulatory Surgery Center (ASC)/Emergency Department (ED)**
  - Hydration/Drug administration are not separately reimbursable when provided in a facility setting such as an ASC, hospital outpatient, or emergency department. (*Commonly associated codes 250, 258,260, 636, 771)* https://www.cms.gov/files/document/chapter11cptcodes90000-99999final11.pdf
    - Intravenous Infusion, hydration; initial, 31 minutes to 1 hour
    - Intravenous Infusion, hydration; each additional hour
    - IV infusion, for therapy, prophylaxis, or diagnosis
    - Infusions of non-chemotherapeutic drugs
    - Injection and Intravenous Infusion Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration
    - Initial filling and maintenance of a portable or implantable pump
    - Irrigation of implanted venous access device for drug delivery system
  - **Emergency charges**
    - No separate reimbursement will be provided for callback, emergency, standby, urgent attention, ASAP, STAT, or portable services
    - Procedures bundled in the E/M level of care are not separately reimbursable.

- **Blood Product Processing**
  - The following are considered included in the revenue code for the blood product and not separately reimbursable (*commonly associated rev codes 390, 392, 399*)
    - Blood product collection
    - Safety testing (including but not limited to Hep C, Hep B, HIV, Viral and Bacterial testing, blood typing, retyping, crossmatching, adverse reaction testing)
    - Pooling
    - Irradiating
    - Leukocyte-reducing
    - Freezing
    - Thawing
    - Cost of delivery, monitoring, or storage
    - Splitting

- **C-codes**
    - PacificSource utilizes CMS/NCCI designation for consideration of C-code reimbursement(s). C-codes are temporary 5-digit HCPC codes assigned to certain new medical devices by CMS. The outpatient prospective payment system (OPPS) allows for a temporary (2 -3 years) pass-through code to allow for payment while collecting data on the product.
    - Non-OPPS (inpatient) providers are not eligible for passthrough payments.
    - OPPS (outpatient) providers **ARE** eligible for pass-through payments on items or services that qualify for pass-through payments. (See CMS Payment Addendums)
    - C-codes with a dollar amount assigned **ARE**:
        - Eligible for reimbursement at the contracted benefit level UNLESS:
            - There is a valid CPT or HCPCS code
            - The C-code is considered experimental, investigational, or unproven
        - C-codes with **NO** dollar amount assigned are:
            - **NOT** eligible for separate reimbursement as they are considered "bundled" services. New C-codes not yet on Addendum B are **NOT** eligible for separate reimbursement.
    - Device-intensive procedures are defined as procedures that involve the surgical implantation or insertion of an implantable device that is assigned a CPT or HCPCS code (including single-use devices) and has a device offset amount that exceeds 30 percent of the procedure's mean cost:
        - Device intensive procedure require the c-codes(s) be listed but not necessarily separately reimbursable.
        - Provider is to use modifier 74 for the additional payment/compensation.
- **Code Blue activation**
    - Advanced Life support (CPT 99288) is allowable when accompanied by documentation to support the patient received at least 30 minutes of critical care (CPT 99291).
- **Computer aided navigation** is considered bundled into the primary procedure and not eligible for separate reimbursement.
- **Imaging**
    - Low-osmolar imaging contrast is included in the imaging charge (i.e., CT abdomen w/contrast).
    - Chest x-ray to confirm placement of central lines is packaged into the insertion procedure code and is not separately reimbursable.
    - 3D rendering is considered a packaged service with the primary imaging study and is not separately reimbursable.
    - 3D functional mapping is considered a packaged service with the primary imaging study and is not separately reimbursable.

- **Implants** (commonly associated revenue code 272-278)
    - Will require an implant log (or similar documentation) that clearly indicates the vendor, the implant description, and units used.
    - May require a vendor's invoice to support supplies used that correspond to the services rendered.
    - If supplies are purchased in bulk, the units that apply to the claim billed must be noted on the invoice.
    - If not specifically approved by prior authorization (PA), will be reviewed for experimental, investigational, or unproven (E/I/U) designation.
- **Incremental Nursing** (commonly associated revenue code 023x)
    - Is allowable when accompanied by documentation supporting extraordinary service that goes above and beyond the customary and routine care of the primary nurse.
    - Payment for incremental nursing charges will take into consideration the average usual and customary room and board charges for the specific region in which the care was provided. Routine nursing charges unbundled from standard room and board will not be reimbursed.
    - There is no reimbursement for a 1:1 sitter
- **Frequency Edits or Units Billed**
    - Medically Unlikely Edits (MUE) for Government outpatient services can be found at: https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-medically-unlikely-edits
    - Multiple Frequency per day (MFD) for Commercial outpatient services is housed within the Optum 360 Medical Reference Engine (MRE) product:
        - Maximum Frequency Per Day CPT List
        - Maximum Frequency Per Day HCPC List
- **Unbundling**
    - Unbundling: Procedure code that is a component of the primary procedure code. https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits
        - Unbundling occurs when a provider bills in multiple parts for a procedure that would typically be reported under a single comprehensive code.
    - PacificSource applies clinical edits to claims to align with industry-standard guidance, including but not limited to guidance from CMS's National Correct Coding Initiative (NCCI) to both in-network and out-of-network providers. Listed below are some examples and definitions of edits that providers/facilities may encounter. These are strictly for example purposes, are not exhaustive, and are subject to change.

        - **Mutually Exclusive**: Codes that cannot reasonably be done in the same session, or the coding combination represents two methods of performing the same service.
        - **Incidental**: Includes procedures that can be performed along with the primary procedure but are not essential to complete the procedure. They do not typically have a significant impact on the work and time of the primary procedure. Incidental procedures are not separately reimbursable when performed with the primary procedure.
        - **OCE/CCI**: Based on coding conventions defined in the AMAs CPT Manual, current standards of medical and surgical coding practice, input from specialty societies, and analyses of current coding practice. Edits always consist of pairs of HCPCS codes using the correct coding edits table and the mutually exclusive edit table.

- **Multiple procedures**
    - Multiple procedure rule assigns a lesser payment for the second and subsequent procedures performed during the same patient encounter than would be allowable when the procedures have been performed under separate encounters (laparoscopic cholecystectomy/umbilical hernia, MRI/MRA, CT/CTA).

- **Pharmacy**
    - Disposable drug delivery systems (CPT A4305, A4306) are considered a packaged service and not separately reimbursable.

- **Respiratory** (commonly associated revenue codes 410, 412, 419, 460)
    - Ventilator or CPAP (facility owned) management charges are allowed one (1) unit per day. Ventilatory or CPAP management includes:
        - System set up, system checks, O2, CPAP, PEEP changes, endotracheal suctioning, weaning, extubation, circuit change
        - Respiratory assessment
        - Carbon dioxide end tidal system setup and/or monitoring
        - Tracheostomy, tracheostomy tube, and/or trach collar care
        - More than one type of support i.e., mechanical ventilation AND CPAP and the same time
        - Patient transport by respiratory therapy
    - Patient's own CPAP/BiPAP machine services
- Pressurized or non-pressurized inhalation treatment for acute airway obstruction describes either treatment of acute airway obstruction with inhaled medication or the use of an inhalation treatment to induce sputum for diagnostic purposes. CPT code 94640 shall only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered. (bundled into the J code) https://www.cms.gov/ncci-medicare/medicare-ncci-policy-manual

- **Room & Board**
    - Post-operative surgical or procedural recovery services are performed in the ICU setting (outside the PACU), the critical care daily room charge will cover the recovery services charges.
    - Room and board charges will be for a semi-private room unless medically indicated (isolation).
- **Trauma team activation**
    - Activation of Trauma teams is allowable when:
        - Billed by a designated trauma center;
        - CPT 99291 must be included on the claim if greater than or equal to 30 minutes of critical care were provided to the patient;
        - Documentation requirements:
            a. Commercial: May require documentation at submission or upon request and may deny claims if documentation is not provided or does not support services
            b. Medicaid/Medicare: Documentation is not required at submission, and claims may not be denied solely for its absence, but remain to pre- or post-payment review with denial only if documentation when requested, does not support billed services

Definitions

Ancillary Services – Includes laboratory, radiology, pharmacy, delivery room (including maternity labor room), operating room (including post-anesthesia and post-operative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge.

Nursing services - Health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by state law. Certified Nursing Assistants and technicians provide nursing services under the direction and supervision of the professional nurse.

Medical Equipment/Supplies - Any device that is used in the rendering of patient care to include: capital, minor, and other hardware (tools, machinery, instruments, apparatuses) that is owned (leased, rented, or purchased) for diagnostic or therapeutic purposes.

Maximum Frequency per Service - For HCPCS/CPT code, is the highest number of units eligible for reimbursement for services on a single date of served with the same individual physician or qualified health care professional.

Medically Unlikely Edits (MUE) - For a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date.

Routine Services - Services to be included in the room and board charges. Routine services are composed of two components:

1. general routine services; and
2. special care units (SCU, CCU, ICU, and NICU). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customary.

Unbundling - Occurs in a couple of ways:

1. Submission of revenue codes for payment of routine supplies/equipment/nursing care that are considered "bundled" into the room and board charges; and
2. Submission of revenue codes for payment for individual parts of a procedure in addition to charges for CPT procedure code.

Related Policies

****** In the event of conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides services to eligible member(s) and/or plans, the provider contract will govern.**

Durable Medical Equipment Prosthetic, Orthotics and Supplies (DMEPOS)

Enteral Nutrition Support and Supplies

Global Period

Hospital Observation Services Reimbursement

Inhaled Nitric Oxide (iNO)

Intraoperative Neurophysiologic Monitoring

Neonatal Levels of Care and Inpatient Management

New and Emerging Technologies – Coverage

Status Provider Appeals – Commercial

Provider Appeals - Government

Robotic – Assisted Surgery

References

American Medical Association (AMA). "Introduction – Instructions for Use of the CPT codebook"

Centers for Medicare & Medicaid Services (CMS). Code Sets Overview (HIPAA approved code sets)

Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual. Chapter(s) 1, 6

Centers for Medicare & Medicaid Services (CMS). Coding and Billing Guidelines

Centers for Medicare & Medicaid Services (CMS). Costs related to Patient Care. Chapter(s) 21

Centers for Medicare & Medicaid Services (CMS). (2026). Medicaid NCCI Edit Files. https://www.cms.gov/medicare/coding-billing/ncci-medicaid/medicaid-ncci-edit-files

Centers for Medicare & Medicaid Services (CMS). Medically Unlikely Edits (MUEs)

Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual. Chapter(s) 4, 10, 16, 20, 21

Centers for Medicare & Medicaid Services (CMS). (2026). Medicare NCCI Procedure to Procedure (PTP) Edits. https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ptp-edits

Centers for Medicare & Medicaid Services (CMS). Centers for Medicare & Medicaid Services (CMS).

Centers for Medicare & Medicaid Services (CMS). National Correct Coding Initiative Policy Manual. Chapter(s) 1, 9, 11, 12

Centers for Medicare & Medicaid Services (CMS). Physicians/Non-physician Practitioners Medicare Claims Processing Manual. Chapter 12.

Centers for Medicare & Medicaid Services (CMS). Provider Reimbursement Manual Part I, chapter 22

Centers for Medicare & Medicaid Services (CMS). Provider Reimbursement Manual, Determination of Cost of Services to Beneficiaries. Chapter(s) 22

Centers for Medicare & Medicaid Services (CMS). Centers for Medicare & Medicaid Services. HCPCS Code G0390, Trauma response team associated with hospital critical care service.

Federal Register, Health Care Financing Administration (HCFA, 65 FR 18433, Medical Devices.

Joint Commission International, Point of Care Testing

Medicare Desk Reference for Hospitals

Multiple Frequency per day (MFD) list

Noridian Administrative Services – Routine Hospital Supplies and Services (Not Separately Billable)

Nurse Practice Act. Standard and Scope of Practice. Montana, Oregon, Idaho & Washington State Board of Nursing

Oregon Health Authority. Hospital Services Provider Guide. Chapter 410, Division 130.

Optum360 Medical ReferenceEngine.com. Optum360, LLC, 2022.

OR Manager Inc. How surgery departments charge for OR time.

PacificSource Provider Manual: Commercial, Medicaid, and Medicare. https://pacificsource.com/sites/default/files/2023-08/PRV1_0823_ProviderManual.pdf

Washington Apple Health. Inpatient Hospital Services Billing Guide

Appendix A. Document Control – update the Property Wizard to change the appendix

Version 2 **of Doc #** 187

Effective Date: 08/20/2026

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Owner:

Business Owner: Claims, Health Services

Applicable regulation(s):

- N/A

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Policy Function: Posted to PacificSource.com - Clinical Policy

External entities affected: N/A

LOBO Committee Review completed: 08/20/2026