General Coding and Billing

Policy

The terms of this policy set forth the guidelines for reporting the provision of care rendered by Mass General Brigham Health Plan participating providers, including but not limited to, use of standard diagnosis and procedure codes in compliance with HIPAA (Health Information Portability and Accountability Act) medical transaction code set standards.

Reimbursement

Providers are reimbursed in accordance with the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan Payment Policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include but are not limited to copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. This is the General Coding and Billing PPG. All claims are subject to audit, and Mass General Brigham Health Plan may request medical records from the provider.

Mass General Brigham Health Plan utilizes industry standard coding for claims processing.

CPT Codes

A set of five-digit codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers, uniquely identified by the American Medical Association (AMA) Current Procedural Terminology (CPT) nomenclature.

- Category I Codes – Procedures
- Category II Codes – Performance Management
- Category III Codes – Emerging Technology

DRG Codes

Diagnosis-related groups (DRGs) are a patient classification scheme which provides a means of relating the type of patient a hospital treats to the costs incurred by the hospital and provides a framework for Medicare's hospital reimbursement system. Please see Mass General Brigham Health Plan's Inpatient Hospital Admissions PPG for further guidance.

Global Period

The period of time immediately prior to or after a surgical procedure in which all routine pre and follow up care is included in the global surgery fee. The global period assigned to a procedure, 0, 10, or 90 days, is assigned by CMS based on the complexity of the procedure.

HCPCS Level II Codes

A set of alpha-numeric codes, consisting of a single alphabetical letter followed by four numeric digits, used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a provider's office.

ICD-10-CM (Diagnoses)

The International Classification of Diseases, Tenth Edition, Clinical Modification. This code set replaced ICD-9-CM codes to report medical diagnoses on or after October 1, 2015.

- Diseases
- Injuries
- Impairments

- Other health problems and their manifestations
- Causes of injury, disease, impairment, or other health problems

ICD-10-PCS (Procedures)

The International Classification of Diseases, Tenth Edition, Clinical Modification, Procedure Coding System. This code set replaced ICD-9-CM (Volume 3) to report procedures performed only in U.S. hospital inpatient health care settings on or after October 1, 2015.

- Prevention
- Diagnosis
- Treatment
- Management

Modifiers

Modifiers indicate that a service was altered in some way from the stated code descriptor without changing the definition. The American Medical Association (AMA) CPT modifiers are two-digit numeric codes listed after a procedure code and separated from the CPT code by a hyphen. The HCPCS Level II modifiers are two-alpha character codes listed after a procedure code and separated from the HCPCS code by a hyphen.

NDC Codes

National Drug Codes as maintained and distributed by HHS.

PC/TC Indicator 5 Codes (CMS National Physician Fee Schedule RVU File)

This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision.

Revenue Codes

Four-digit codes configured to identify specific accommodations, ancillary services, and billing calculations as determined by the National Uniform Billing Committee reported in conjunction with the UB 04 (facility) uniform billing form. HCPCS/CPT codes must be reported in conjunction with specific revenue codes to describe the services rendered. The COBRA act of 1986 requires hospital outpatient billing (acute-care, long-term care, rehabilitation and psychiatric hospitals, and hospital-based rural

health clinics) to make use of HCPCS coding. The following revenue codes are the only revenue codes exempt from the additional specificity requirement of a HCPCS/CPT code.

Revenue Codes	Description
0250-0259	Pharmacy
0270-0273	Medical/Surgical Supplies and Devices
0275-0279	Medical/Surgical Supplies and Devices
0620-0622	Medical/Surgical Supplies
0710,0719	Recovery Room

Coding Guidelines

Note: This list of codes may not be all-inclusive. Inclusion of a code does not imply or guarantee reimbursement for that code. For a comprehensive list of related and required codes, refer to the most current CPT, HCPCS Level II, and ICD-10-CM manuals.

- Adhere to proper CPT/HCPCS and other nationally recognized coding and billing guidelines.
- Code to the most appropriate level of specificity as a general standard of practice (CPT, ICD10). Mass General Brigham Health Plan may audit the provider at any point for over-coding and/or similar billing practices related to Fraud, Waste, and Abuse.

For professional services, use the following code sets:

CPT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. To ensure proper and timely reimbursement, codes must be effective on the date of service (DOS) for which the procedure or service was rendered and not the date of submission.

Professional Services Codes	Service
CPT-4, Category I codes must be used as the first line of coding when an appropriate code exists	Professional services and uniquely identified by CPT such as surgery, radiology, laboratory, pathology, therapies
HCPCS Level II codes	Ambulance, durable medical equipment (DME), pharmacy and other specifically approved services. Do not report with a HCPCS code when an

Professional Services Codes	Service
	equivalent or similar CPT code exists describing the same service or procedure, unless directed otherwise in a specific policy
CPT-D – when appropriate CPT code does not exist for oral surgery	Dental services (when available, report oral surgery with a CPT code)

For facility (technical) services, use the following code sets:

Facility (Technical) Service Codes	Service
Revenue (REV) codes	Facility (technical) services
CPT-4 codes	Professional services and uniquely identified by CPT such as surgery, radiology, laboratory, pathology, therapies
Diagnosis Related Groupings (DRG) codes	As contractually required

Category II CPT Codes (XXXXF)

This code set is a set of supplemental tracking codes that can be used for performance measurement and are intended to facilitate data collection for quality of care. Use of these codes is optional, not required for correct coding, and may not be used as a substitute for Category I codes.

Category III CPT Codes (XXXXT)

This code set are temporary codes allows physicians and other qualified healthcare professionals, insurers health services researchers and health policy experts to identify emerging technology, services, and service paradigms. Use of these codes is optional, not required for correct coding, and may not be used as a substitute for Category I codes.

C Codes

C codes are temporary HCPCS codes established by CMS for use under the Hospital Outpatient Prospective Payment System (OPPS). The reimbursement of C codes is dependent on the provider's contract.

D Codes

D Codes are Dental procedure**s**. Generally, Mass General Brigham Health Plan do not accept "D" codes. The reimbursement of D codes is dependent on the provider's contract.

Diagnosis Codes

For diagnosis codes on all claims, including but not limited to inpatient admissions and outpatient services, use the following code sets:

Diagnosis Codes	Service
ICD-10-CM codes	A diagnosis code with every claim
ICD-10-CM "Z" codes	Per ICD-10-CM guidelines
ICD-10-CM "V" codes	Required on all motor vehicle, worker's compensation, and other accident claims

Global Surgical Period

The fee schedule for most surgical procedures allows a global payment that includes the surgery and all routine pre-operative and post-operative care. The provider's inpatient hospital visits during an inpatient stay are included in the global allowance. The global fee allowable for the surgeon includes the following:

Service	Global Period	Comments
Routine Pre-operative Care	Visit up to 1 day prior to the procedure	Additional reimbursement allowed for evaluation and management service resulting in decision for major surgery when submitted on the same day as, or the day prior to a major surgical procedure, identified by appendage of modifier 57 (decision for surgery) to the appropriate level E&M service
Surgery		Includes the surgical procedure itself, local, topical or digital metacarpal block anesthesia, and any biopsy related to the surgery on the same day as the surgery
Routine Post-operative Care	10 days (minor surgery) or 90 days (major surgery)	Includes follow up visits within the global period; each procedure is assigned a specific global period

Incidental Global Procedures or 'Status B' Codes

Incidental global procedures are procedures that clinical practices standards suggest are normally included as part of the definitive procedure and would not be separately reimbursed. CMS refers to these procedures as 'Status B' codes. All codes defined by CMS as 'Status B' will be denied as such by Mass General Brigham Health Plan and are not separately reimbursable.

J Codes

These are Drugs Administered Other than Oral Method codes. Unlisted, NOC and NOS drug codes may be accepted with an NDC Number. See "Unlisted Codes", below.

Modifiers

A Modifier provides the means by which the reporting physician/service can indicate that a service or procedure that has been performed has a specific circumstance but not changed in its definition or code.

Multianalyte Assays

Multianalyte assays with Algorithmic Analysis not assigned to a Category I CPT code are not reimbursable.

PC/TC Indicators

Mass General Brigham Health Plan will deny "Incident To" codes identified with a CMS PC/TC indicator 5 in the National Physician Fee Schedule Relative Value File when reported in a facility and reported by a physician. If reported incorrectly, PC/TC indicator will deny with provider liability. Please refer to CMS guidelines for additional information.

Proprietary Laboratory Analyses (PLA) Codes

PLA are alpha-numeric CPT codes with a corresponding descriptor, for labs or manufacturers to more specifically identify their test. The reimbursement of PLA codes is dependent on the provider's contract.

S Codes

These are temporary National Codes (Non-Medicare). The reimbursement of S codes is dependent on the provider's contract.

T Codes

These are National T Codes established for State Medicaid Agencies. The reimbursement of T codes is dependent on the provider's contract.

Unbundling

Unbundling occurs when two or more procedures are reported separately when a single, comprehensive code exists that accurately describes the services performed. Unbundled procedure services will be denied or re-bundled and processed as the more accurate, single, comprehensive procedure code.

Unlisted Services and Procedures

Unlisted/NOC/NOS/NES CPT and HCPCS codes are not recognized by Mass General Brigham Health Plan. Mass General Brigham Health Plan will deny all codes categorized by CPT and HCPCS as Unlisted/NOC/NOS/NES. If a given procedure does not have a valid CPT code, please submit the Unlisted Special Report form, and supply all required information
Unlisted NOC/NOS/NES Special Report.
Complete all fields on the form; incomplete submissions will result in claim(s) denial.

Submit the Unlisted Special Report form to Mass General Brigham Health Plan via https://mft.nhp.org/EFTClient/Account/Login.htm. Please do not attach any medical records.

Unlisted Drug Codes (J Codes)

Unlisted, NOC and NOS drug codes may be accepted with an NDC Number. See below.

HCPCS	Descriptor	Comment
J0220	Injection, alglucosidase alfa, 10 mg, not otherwise specified	NDC# required.
J0256	Injection, alpha 1-proteinase inhibitor (human), not otherwise specified, 10 mg	NDC# required.
J0833	Injection, cosyntropin, not otherwise specified, 0.25 mg	NDC# required.
J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg	NDC# required.

HCPCS	Descriptor	Comment
J1599	Injection, immune globulin, intravenous, nonlyophilized (e.g., liquid), not otherwise specified, 500 mg	NDC# required.
J3301	Injection, triamcinolone acetonide, not otherwise specified, 10 mg	NDC# required.
J3490	Drugs unclassified injection	NDC# required.
J3590	Unclassified biologics	NDC# required.
J3591	Unclassified drug or biological used for ESRD on dialysis	NDC# required.
J7192	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	NDC# required.
J7195	Injection, factor ix (antihemophilic factor, recombinant) per iu, not otherwise specified	NDC# required.
J7199	Hemophilia clotting factor not otherwise classified	NDC# required.
J7599	Immunosuppressive drug not otherwise classified	NDC# required.
J7699	NOC drugs, inhalation solution administered through DME	NDC# required.
J7799	NOC drugs, other than inhalation drugs, administered through DME	NDC# required.
J7999	Compounded drug not otherwise classified	NDC# required.
J8498	Antiemetic drug, rectal/suppository, not otherwise specified	NDC# required.
J8499	Prescription drug, oral, nonchemotherapeutic, NOS	NDC# required.
J8597	Antiemetic drug, oral, not otherwise specified	NDC# required.
J8999	Prescription drug, oral, chemotherapeutic, NOS	NDC# required.

HCPCS	Descriptor	Comment
J9020	Injection, asparaginase, not otherwise specified, 10,000 units	NDC# required.
J9999	Not otherwise classified, antineoplastic drugs	NDC# required.

Related Mass General Brigham Health Plan Payment Guidelines

Inpatient Hospital Admissions
Modifiers

References

American Medical Association (AMA) Current Procedural Terminology (CPT)
CMS/HIPAA Information Series
HCPCS Level II
ICD-10-CM

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July 24, 2009	*Original documentation*
April 19, 2011	*References and disclaimer updated*
September 2, 2015	*Updated with ICD-10 references*
April 1, 2017	*Unlisted code submission details and unlisted code list*
November 18, 2017	*Template update; addition of guidance for PT/TC indicator; reorganization of Coding categories*
January 1, 2019	*Document restructure; code descriptor, add J3591 and references*
June 12, 2020	*Added Category III, D-Codes with definitions. Updated definition of C-Codes, J-Codes, Modifiers, Proprietary Laboratory Analyses (PLA) Codes, S-Codes, and T Codes*
January 1, 2023	*Document rebrand*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

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