

Laboratory & Pathology Services

Policy

Mass General Brigham Health Plan reimburses participating clinical laboratory and pathology providers for medically necessary services for the diagnosis, treatment, and prevention of disease, and for the maintenance of the health of Mass General Brigham Health Plan members.

Mass General Brigham Health Plan partners with eviCore for authorization requirements on certain high technology imaging services, ultrasound services, and cardiac studies. In addition, authorization through eviCore is required for radiation therapy and certain lab services.

Effective dates for the eviCore partnership and prior authorization process are as follows:

- **8/1/2016** for Genetic-molecular genomic testing.

Prior authorization for genetic-molecular genomic testing must be obtained by: [eviCore](#)

Provider portals for online prior authorization requests can be found here:

- Genetic-molecular genomic testing:
 - www.carecorenational.com

Contact eviCore toll-free at **888-693-3211** between the hours of **8:00am – 9:00pm EST**

Laboratory requests may **not** be requested via fax.

Reimbursement

Providers are reimbursed according to 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, and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include, but are not limited to, copayments, deductible, and/or co-insurance, and will be applied dependent upon the member's benefit plan.

Provider Payment Guidelines

Various services and procedures require referral and/or authorization. Referral and 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. Please refer to [Coding Provider Payment Guidelines](#) for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Mass General Brigham Health Plan Reimburses

- Certain screening labs
- Clinical laboratory tests when performed by a technician under physician supervision
- Individual codes when all components within a panel code have not been performed
- Panel codes when all individual tests within the panel have been performed
- COVID-19 specimen collection (Separately reimbursable during the Covid-19 State of Emergency only)

Mass General Brigham Health Plan Does *Not* Reimburse

- Devices, drugs, procedures, treatments, laboratory and pathology tests that are experimental, investigational as referenced in [Experimental and Investigational](#) medical policy
- Employment drug screening
- Handling fees
- Laboratory and pathology services provided at no charge by the Commonwealth of Massachusetts agencies
- Laboratory and pathology services submitted with an unlisted CPT code when a valid, specified code is available
- Mandated drug testing (i.e. court-ordered, DCF, residential monitoring aka “sober house” testing)
- Paternity blood testing

Provider Payment Guidelines

- Routine venipuncture in conjunction with blood or related laboratory services or evaluation and management services
- Specimen Collection
- PLA codes (Proprietary Lab Analyses)
- Lab tests conducted in the home for personal convenience

Provider Payment Guidelines and Documentation

- Submit multiple same day services on one line with a count representing the number of services rendered
- Submit laboratory panel codes only when individual tests included in the panel have been performed; if other tests are performed in conjunction with those specified in the panel, bill separately in addition to the panel code
- Submit genetic testing code modifiers with molecular diagnostic codes and cytogenetic studies
- When applicable, report modifier “26” or “TC” in the first modifier field. Claims with these modifiers in the second field are subject to audit and / or denial

Procedure Codes

Please refer to the following eviCore link for the CPT codes that adhere to the guideline and authorization requirement: [eviCore Utilization Management Program](#)

Note: This list of codes may not be all-inclusive.

Code	Descriptor	Comments
0300-0309	Laboratory Revenue Codes	Bill with appropriate CPT/HCPCS code
0310-0319	Pathology Revenue Codes	Bill with appropriate CPT/HCPCS code
36415	Collection of venous blood by venipuncture	Not reimbursable with blood or related lab services or with E/M services
36416	Collection of capillary blood specimen (e.g. finger, heel, ear stick)	Not reimbursable
99000-99002	Handling charges	Not reimbursable
G2023-G2024	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]),	Separately reimbursable during the Covid-19 State of Emergency only

Provider Payment Guidelines

Code	Descriptor	Comments
C9803	Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]),	Separately reimbursable during the Covid-19 State of Emergency only
P9603	Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient; prorated miles travelled	Not reimbursable
P9604	Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient; prorated trip charge	

Unlisted Services and Procedures

Mass General Brigham Health Plan does not allow submission of Unlisted Codes.

See [Unlisted Code Requirement](#)

Related Documents

[Mass General Brigham Health Plan Referral and Authorization Guide](#)

[Experimental and Investigational Medical Policy](#)

[General Coding and Billing](#)

[Outpatient Drug Screening and Testing Medical Policy](#)

[Preimplantation Genetic Testing Medical Policy](#)

[Vitamin D Screening and Testing in Adults Medical Policy](#)

[Unlisted Special Report Form](#)

[Urine Drug Testing](#)

[COVID-19 Payment Policy](#)

References

AMA-CPT Coding Guidelines

[CMS Medicare Claims Processing Manual, Chapter 16 - Laboratory Services](#)

[CMS Complying with Laboratory Services Documentation Requirements, MLN909221, December 2020](#)

Provider Payment Guidelines

[Manual of Laboratory Tests and Services, Massachusetts Department of Public Health, Bureau of Laboratory Sciences, William A. Hinton State Laboratory Institute, Boston, Massachusetts; Fourth Edition, Volume 1 \(December 2008\) and Sixth Edition, \(July 2014\)](#)

Publication History

Topic: Laboratory & Pathology Services	Owner: Network Management
---	----------------------------------

July 24, 2009	<i>Original documentation</i>
April 19, 2011	<i>Member cost sharing language, reference, and disclaimer updated</i>
March 19, 2013	<i>Authorization grid updated</i>
August 1, 2016	<i>Removed definitions, removed modifiers/cost sharing table, added new reimbursement language, updated guidelines, and added Mass General Brigham Health Plan relationship with eviCore and the new authorization process</i>
July 15, 2017	<i>Annual review; updated "Related Documents" section; updated guidance regarding Unlisted codes; addition of information on non-reimbursed services</i>
January 8, 2018	<i>Document review; removal of outdated text; addition of Urine Drug Testing PPG link</i>
January 1, 2019	<i>Document restructure; codes, code descriptor and references updated</i>
June 01, 2020	<i>Added COVID19 specimen collection codes G2023-G2024 and C9803. (Separately reimbursable during the Covid-19 State of Emergency only). Added Reimburse COVID-19 specimen collection (Separately reimbursable during the Covid-19 State of Emergency only)</i>
October 12, 2020	<i>Added P9603 and P9604</i>
March 10, 2021	<i>Updated "Does Not Reimburse" list</i>
January 1, 2023	<i>Document rebrand; updated references</i>

Provider Payment Guidelines

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.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Insurance Company.