Reimbursement Policy:

CPT and HCPCS Billing Guidelines (Commercial and Medicaid)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC202200030	EmblemHealth: 1/01/2018 ConnectiCare: 1/1/2015	**RPC (Reimbursement Policy Committee)**

Reimbursement Guideline Disclaimer: We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. We will inform you of new policies or changes in policies through postings to the applicable Reimbursement Policies webpages on emblemhealth.com and connecticare.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in our policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. 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, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Overview:

The Current Procedural Terminology (CPT®) codes offer physicians and other health care professionals a uniform language for coding medical services and procedures to streamline reporting, increase accuracy and efficiency.

Current Procedural Terminology (CPT®) codes are maintained by the American Medical Association (AMA). CPT codes are one of the most commonly used code sets and are further divided into several categories.

- Category I – These are the most commonly used codes by medical coders to report medical services and procedures. Category I codes are five-digit numeric codes only, ranging from 00100 to 99499. (CPT codes for Pathology Billing are listed above).
- Category II – This category comprises codes for performance measurement. Category II codes are supplemental tracking codes. These alphanumeric codes comprise four digits ending with an "F." These codes are optional, meaning they are not required for proper medical coding.
- Category III – This code set comprises temporary codes for emerging technology, procedures, and services. They are alphanumeric codes, four digits ending with a "T.

According to the AMA (American Medical Association) instructions for the CPT Code Set, select the names of the procedure/service that accurately identifies the service performed. *Do not select a CPT code that merely approximates the service provided.*

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The term HCPCS stands for Healthcare Common Procedure Coding System and is comprised of three levels.

- Level I: Level I codes are the ones maintained and published by the American Medical Association (AMA), i.e., CPT® codes. These codes describe medical, surgical, and diagnostic services provided by healthcare physicians or providers.
- Level II: This level comprises codes that are non-physician services or procedures. Level II HCPCS codes represent services like
    - Ambulance services
    - Wheelchairs
    - Durable medical equipment
    - And other medical services
- Level III: HCPCS codes are the local codes and are not nationally accepted. HCPCS Level III codes are alphanumeric codes, starting with an alpha character, X or Z.

"G" and "S" HCPCS Codes Reimbursement

EmblemHealth Medicaid plans only reimburse "G" and/or "S" HCPCS codes if they are found on the Medicaid fee schedules. Codes that are not included on the Medicaid fee schedule(s) will be denied.

Effective 1/1/2024, EmblemHealth/ConnectiCare Commercial Plans **will not** reimburse "G" and/or "S" HCPCS codes and will deny these codes if reported on a claim, unless otherwise noted in a policy.

HCPCS Code	Definition
"G" Codes- (G0008-G9987)	• HCPCS codes used to identify professional health care services and medical services that could otherwise be coded in CPT®-4 (the current version of CPT codes) but for which CMS has determined that a Level II code should be issued. CMS does not have an application process for G codes, as they are established by CMS typically through notice and comment rulemaking specifically to support Medicare policy and claims processing needs. • HCPCS codes used to report information about the beneficiary's functional status at the outset of the PT, OT, or SLP therapy episode of care, including projected goal status, at specified points during treatment, and at the time of discharge.
"S" Codes- (S0012-S9999)	Temporary HCPCS codes created by private health plan and state agencies to report drugs, services, and supplies for which national codes do not exist but are needed to implement policies, programs, or support claims processing.

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"H" and "T" HCPCS Codes Reimbursement

EmblemHealth Medicaid plans only reimburse H" and/or "T" HCPCS codes if they are found on the Medicaid fee schedules. Codes that are not included on the Medicaid fee schedule(s) will be denied.

Effective 3/22/2024, EmblemHealth/ConnectiCare Commercial Plans **will not** reimburse "H" and/or "T" HCPCS codes and will deny these codes if reported on a claim, unless otherwise noted in a policy.

HCPCS Code	Definition
"H" Codes- (H0001-H2037)	Distinctive HCPCS codes that indicate mental health services and are utilized by Medicaid State Agencies. The range includes HCPCS codes for alcohol and drug abuse treatment, pre-natal care, medication administration training, and foster care. These codes are used to report medical procedures and services to Medicare, Medicaid, and other health insurance programs.
"T" Codes- (T1000-T5999)	Codes that indicate items for which there are no permanent national codes and, like "H" HCPCS codes, are used by Medicaid State Agencies. The range contains HCPCS codes for nursing assessment, clinic visits, administration of medication, non-emergency transportation, non-emergency vehicle, and air ambulance. "T" HCPCS codes may be used by private insurance programs, but they are not payable by Medicare.

References:

1. American Medical Association, Current Procedural Terminology (CPT®) Professional Edition and associated publications and services
2. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
3. Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
4. Centers for Medicare and Medicaid Services, MLN Educational Tool- MLN908924, March 2019, "Quick Reference Chart: Descriptors of G-codes and Modifiers for Therapy Functional Reporting," https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/g-codes-chart-908924-text-only.pdf
5. Centers for Medicare and Medicaid Services, CMS Guide For Medical Technology Companies and Other Interested Parties, "Overview of Coding and Classification Systems," https://www.cms.gov/cms-guide-medical-technology-companies-and-other-interested-parties/coding/overview-coding-classification-systems

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Revision History

Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	7/3/2024	• Updated definition for “G” HCPCS codes for clarity
EmblemHealth ConnectiCare	3/14/2024	• **Medicaid:** Updated to clarify reimbursement guidance on “G” and “S” HCPCS codes • **Commercial:** Updated to clarify reimbursement guidance on “G” and “S” HCPCS codes **effective 1/1/2024**
EmblemHealth ConnectiCare	1/20/2024	• **Medicaid:** Updated to clarify reimbursement guidance on “H” and “T” HCPCS codes • **Commercial:** Updated to clarify reimbursement guidance on “H” and “T” HCPCS codes **effective 3/22/2024**
EmblemHealth ConnectiCare	10/2022	• Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number