EmblemHealth

Payment Policy:
Laboratory/Venipuncture
(Commercial, Medicare & Medicaid)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RP20220018	Commercial/Medicare: 7/01/2020 Medicaid: 7/01/2022	**RPC (Reimbursement Policy Committee)**

Reimbursement Guideline Disclaimer: EmblemHealth has 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. EmblemHealth will inform you of new policies or changes in policies through updates to the Provider Manual and/or provider news. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in EmblemHealth's 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, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by EmblemHealth due to programming or other constraints; however, EmblemHealth strives to minimize these variations.

EmblemHealth follows 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. EmblemHealth uses industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how EmblemHealth handles specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, EmblemHealth may deny the claim and/or recoup claim payment.

Overview:

This policy addresses the EmblemHealth's reimbursement policies pertaining to clinical laboratory and related laboratory services (e.g., venipuncture and the handling and conveyance of the specimen to the laboratory) for provider claims submitted on a CMS-1500, whether performed in a physician's office, a hospital laboratory, or an independent laboratory.
Note this policy does not address reimbursement for all laboratory codes. Coding relationships for laboratory topics not included within this policy are administered through EmblemHealth's administrative and reimbursement policies. All services described in this policy may be subject to additional reimbursement policies.

If you are a physician, practitioner, or medical group, you may only bill for services that you or your staff perform. Pass-through billing is not permitted and may not be billed to our members. We only reimburse for laboratory services that you are certified to perform through the Federal Clinical Laboratory Improvement Amendments (CLIA). You must not bill our members for any laboratory services for which you lack the applicable CLIA certification.
To validate whether a test requires CLIA visit CMS/FDA websites.

Policy Statement:

Duplicate Laboratory Charges – Multiple Providers

Only one provider will be reimbursed when multiple providers bill identical services. EmblemHealth will reimburse the provider or entity that actually performed the test. Duplicate laboratory services are defined as identical or equivalent bundled laboratory codes.
Note: For the purpose of this policy, CPT codes 82947 and 82948 are not considered to be

equivalent codes:
- 82947 - Glucose; quantitative, blood (except reagent strip)
- 82948 - Glucose; blood, reagent strip

Pathologist and Physician Laboratory Providers
If a pathologist and another physician or other qualified health care professional's offices submit identical laboratory codes for the same patient on the same date of service, only the pathologist's service is reimbursable.

Place of Service
The Place of Service (POS) identifies where the laboratory service was performed. EmblemHealth uses the codes indicated in the Centers for Medicare and Medicaid Services (CMS) Place of Service Codes for Professional Claims Database to determine if laboratory services are reimbursable.
Examples:

- If the physician bills for lab services performed in his/her office, the POS code 11 for "Office" is reported.
- If an independent laboratory bills for a test on a sample drawn on an inpatient or outpatient of a hospital, the POS code 81 for "Independent Laboratory" is reported.

Laboratory Panels
Individual laboratory codes, which together make up a laboratory panel code, will be combined into and reimbursed as the more comprehensive laboratory panel code as described under the specific laboratory panel headings below.

EmblemHealth also considers an individual component code included in the more comprehensive panel code when reported on the same date of service by the same individual physician or other qualified health care professional. The Professional Edition of the CPT book, Organ or Disease-Oriented Panel section states: "Do not report two or more panel codes that include any of the same constituent tests performed from the same patient collection. If a group of tests overlaps two or more panels, report the panel that incorporates the greater number of tests to fulfill the code definition and report the remaining tests using individual test codes."

In addition, it is not appropriate for a laboratory panel to be split amongst multiple laboratories or office/laboratory settings. This is also considered unbundling of a laboratory panel.
Laboratory panels that have been split billed, or unbundled are not reimbursable.

Venipuncture and Specimen Collection
Specimen collection fees are not reimbursed when billed by the same provider who is rendering blood or related laboratory services.

Consistent with CMS, only one collection fee for each type of specimen per patient encounter, regardless of the number of specimens drawn, will be allowed. A collection fee will not be reimbursed to anyone who did not extract the specimen.

Venous blood collection by venipuncture and capillary blood specimen collection (CPT codes 36415 and 36416) will be reimbursed once per patient per date of service when reported by the Same Individual Physician or Other Qualified Health Care Professional. When CPT code 36416 is submitted with CPT code 36415, CPT code 36415 is the only venipuncture code considered eligible for reimbursement. No modifier overrides will exempt CPT code 36416 from bundling into CPT code 36415.

Consistent with CMS, EmblemHealth considers collection of a specimen from a completely implantable venous access device and from an established catheter (CPT codes 36591 and 36592) to be bundled into services assigned a CMS NPFS Status Indicator of A, R or T provided on the same date of service by the Same Individual Physician or Other Qualified Health Care Professional, for which payment is made. When CPT code 36591 is submitted with CPT code 36592, CPT code 36592 is the only venipuncture code considered eligible for reimbursement. No modifier overrides will exempt CPT code 36591 from bundling into CPT code 36592.

EmblemHealth considers venipuncture code S9529 (Routine venipuncture for collection of Specimen(s), single homebound, nursing home, or skilled nursing facility patient) a non-reimbursable service. The description for S9529 focuses on place of service for a service that is more precisely represented by CPT code 36415 and reported with the appropriate CMS place of service code.

Consistent with CMS, specimen collection HCPCS code G0471 is reimbursable only when a Specimen is collected from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency.

Laboratory Handling Laboratory handling and conveyance

CPT codes 99000 and 99001 and HCPCS code H0048 are included in the overall management of a patient and are not separately reimbursed when submitted with another code, or when submitted as the only code on a claim for the same date of service.

Code Q0091
HCPCS code Q0091 (screening Papanicolaou smear, obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory) is eligible for reimbursement for Medicare beneficiaries only. For all other products it is considered to be part of the E/M and Pap smear codes and is not eligible for separate reimbursement.

Guidelines for Billing Units
When submitting multiple units of one code, the guidelines are based on code descriptions:

- If the CPT or HCPCS code description contains "per" or "each" or another unit of measurement and multiple services are provided, providers should bill the code on one line with the appropriate number of units.
- If the code does not contain a measurement such as "per" or "each" in the description of the code, providers should report one unit for all services.

Modifiers

Technical/Professional Modifiers TC/26

- Technical/Professional Component Billing identifies proper coding of professional, technical, and global procedures. Modifier 26 signifies the professional component of a procedure, and Modifier TC signifies the technical component.
- When the Centers for Medicare & Medicaid Services (CMS) National Physician Fee Schedule Relative Value File (NPFSRVF) designates that modifier 26 is applicable to a procedure code (PC/TC indicator of 1 or 6), and the procedure (e.g., laboratory) has been reported by a professional provider with a facility place of service, the procedure code must be reported with modifier 26 or it will not be eligible for reimbursement.
- When the NPFSRVF designates that the concept of a separate professional and technical component does not apply to a laboratory procedure (PC/TC indicator of 3 or 9), and a professional provider has reported the laboratory procedure code with a modifier 26 the laboratory procedure code will not be eligible for reimbursement. When a laboratory procedure with a PC/TC indicator of 3 or 9 is reported by a professional provider with a facility place of service, the laboratory procedure code will not be eligible for reimbursement since, in this case, the facility will bill for performing the laboratory procedure.
- A global laboratory procedure code includes reimbursement for both the professional and technical components.
    - When both components are performed by the same provider, the appropriate code must be reported without the 26/TC modifiers.
    - When a provider has reported a global procedure and also reported the same procedure with a professional (26) or technical component (TC) modifier on a different line or claim, the procedure reported with the 26 or TC modifier will not be eligible for reimbursement.
    - When a professional provider bills the global code (no modifiers) with a facility place of service, the code will not be eligible for reimbursement.
- CPT instructions state that modifier 59 should not be used when a more descriptive modifier is available. CMS guidelines cite that the –X {EPSU} modifiers are more selective versions of modifier 59 so it would be incorrect to include both modifiers on the same line. According to CMS and CPT coding guidelines, modifier 59, XE, XP, XS, or XU may be used when the same laboratory services are performed for the same patient on the same day. EmblemHealth will reimburse laboratory services reported with modifier 59, XE, XP, XS, or XU for different species or strains, as well as Specimens from distinctly separate anatomic sites.

Codes:

Separate Reimbursement will not be provided for the following services when performed by a nurse other ancillary staff:

CPT Codes	Description
36591	Collection of blood specimen from a completely implantable venous access device
36592	Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified

Separate Reimbursement will not be provided for the following:

CPT Codes	Description
99000	Handling and/or conveyance of specimen for transfer from the office to a laboratory
99001	Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory (distance may be indicated)
99002	Handling, conveyance, and/or any other service in connection with the implementation of an order involving devices (eg, designing, fitting, packaging, handling, delivery or mailing) when devices such as orthotics, protectives, prosthetics are fabricated by an outside laboratory or shop but which items have been designed and are to be fitted and adjusted by the attending physician or other qualified health care professional
S3600	Stat laboratory request (situations other than S3601)

CLIA (Clinical Laboratory Improvement Amendment) ID Requirement: The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S. through CLIA. Congress passed CLIA in 1988 to establish quality standards, strengthen Federal oversight of clinical laboratories, and ensure the accuracy and reliability of patient test results.

CLIA applies to all laboratories that examine "materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings." (42 U.S.C. § 263a(a)).

CLIA mandates nearly all laboratories, including those in physician offices, must meet applicable Federal requirements and have a current CLIA certificate. CLIA applies to all entities providing clinical laboratory services including those that do not file Medicare test claims.

For purposes of this policy, a valid CLIA Certificate Identification number will be required for reimbursement of clinical laboratory services reported on a1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent.

Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete and rejected or denied. Claim line edits will also be applied if the lab certification level does not support the billed service code.

Laboratory service providers who do not meet the reporting requirements and/or do not have the appropriate level of CLIA certification for the services reported will not be reimbursed.

Additional information regarding CLIA, applying for or renewing a certificate, or regarding assigned test complexity levels can be found at the following website.
Clinical Laboratory Amendments (CLIA) Website

In-Office Testing

The tests listed in the table below are laboratory testing/procedure codes that EmblemHealth will consider for reimbursement to its network physicians when performed in their office. This list represents the only laboratory testing/procedures that EmblemHealth network physicians may provide in their offices for our Commercial, Medicare and/or Medicaid members.

Please continue to direct all other tests to Quest Diagnostics (EmblemHealth's preferred free-standing laboratory) or another applicable EmblemHealth participating laboratory. Reimbursement will be made according to contracted fee schedules. EmblemHealth will continue to prohibit members from being balanced billed for these services. If you have questions, please contact EmblemHealth Provider Customer Service at 866-447-9717.

Covered in-office tests/procedures by plan – "X" indicates whether a specific service is covered for that specific plan. A blank indicates that the service is not covered for that plan. Please make note of Specialty limitations that may apply. If the Specialty is listed, it means only those providers may perform the test in-office.

Specialty	Laboratory/Pathology CPT Code(s)	Commercial/Medicare/ Medicaid* *Medicaid services prior to 7/01/2022	Medicaid *Effective 7/01/2022*
All Practitioners/All Specialties *Note: Those codes listed under "All Specialties" will not appear under each specific specialty heading, but do apply.*	81000	X	X
	81001		X
	81002	X	X
	81003	X	X

Specialty	Laboratory/Pathology CPT Code(s)	Commercial/Medicare/ Medicaid* *Medicaid services prior to 7/01/2022	Medicaid *Effective 7/01/2022*
	81015		X
	81025	X	X
	82270	X	
	82272	X	
	82274	X	
	82803	X	
	82947	X	
	82948	X	
	82962	X	
	83655	X	
	84132	X	
	85013		X
	85041		X
	85048		X
	85610	X	
	86403	X	
	86485	X	X
	86486	X	X
	86490		X
	86510	X	X
	86580	X	X
	86701	X	X
	86702	X	
	86703	X	X
	87081		X
	87210	X	
	87220	X	X
	87426	X	X

Specialty	Laboratory/Pathology CPT Code(s)	Commercial/Medicare/ Medicaid* *Medicaid services prior to 7/01/2022	Medicaid *Effective 7/01/2022*
	87428		X
	87430	X	
	87535	X	X
	87536	X	X
	87651	X	X
	87804	X	
	87806	X	X
	87880	X	X
	G0475	X	
	G0476	X	
	Q0115	X	
Hematology / Oncology	85007	X	X
	85014	X	
	85027	X	
	85060	X	
Hematology / Oncology / Pediatrics	85018	X	X
	85025	X	X
Infectious Disease, Allergy / Immunology	86735	X	
OB/GYN/ Maternal Fetal Medicine/Reproductive Endocrinology	82670	X	
Obstetrics/ Gynecology/ Urology/ Reproductive Endocrinology	89320	X	
Ophthalmology	83516	X	
	83861	X	
	85651	X	X
	85652	X	X
Orthopedics / Rheumatology	89060	X	

Specialty	Laboratory/Pathology CPT Code(s)	Commercial/Medicare/ Medicaid* *Medicaid services prior to 7/01/2022	Medicaid *Effective 7/01/2022*
Pediatrics	82247	X	
	82248	X	
Urology / Reproductive Endocrinology	89250	X	
	89251	X	
	89254	X	
	89255	X	
	89257	X	
	89258	X	
	89259	X	
	89260	X	
	89261	X	
	89264	X	
	89268	X	
	89272	X	
	89290	X	
	89300	X	
	89310	X	
	89321	X	
	89322	X	
	89330	X	
	89335	X	
	89337	X	
	89342	X	
	89344	X	
	89346	X	
	89352	X	
	89353	X	
	89354	X	

Specialty	Laboratory/Pathology CPT Code(s)	Commercial/Medicare/ Medicaid* *Medicaid services prior to 7/01/2022	Medicaid *Effective 7/01/2022*
	89356	X	

Laboratory Modifiers

Modifier	Description
90	• Reference (outside) laboratory. Modifier 90 indicates pass through billing for a service that was not performed by the billing provider. • EmblemHealth will only reimburse providers for procedures that are performed by the same provider. • *EmblemHealth does not reimburse modifier 90*
91	• Modifier 91 is appropriate when the repeat laboratory service is performed by a different individual in the same group with the same Federal Tax Identification number. • According to CMS and CPT guidelines, Modifier 91 is appropriate when, during the course of treatment, it is necessary to repeat the same laboratory test for the same patient on the same day to obtain subsequent test results, such as when repeated blood tests are required at different intervals during the same day
92	• Alternative Laboratory Platform Testing. When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701-86703, and 87389). • The test does not require permanent dedicated space; hence by its design it may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.
QW	• CLIA Waived Test

Ordering MD Claim Requirements:

EmblemHealth may pend or deny your claim if you do not list the ordering provider. Diagnostic claims such as labs and/or radiology must include the ordering physician's name and NPI as well as TIN.

Definitions:

Term	Definition
CLIA (Clinical Laboratory Improvement Amendments)	The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). In total, CLIA covers approximately 251,000 laboratory entities. The Division of Laboratory Services, within the Survey and Certification Group, under the Center for Clinical Standards and Quality (CCSQ) has the responsibility for implementing the CLIA Program. More information is available at: Clinical Laboratory Amendments (CLIA) Website
CLIA Waived Test	As defined by CLIA, waived tests are categorized as "simple laboratory examinations and procedures that have an insignificant risk of an erroneous result." https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/waivetbl.pdf
Venipuncture	Venipuncture is the process of withdrawing a sample of blood for the purpose of analysis or testing. There are several different methods for the collection of a blood sample. The most common method and site of venipuncture is the insertion of a needle into the cubital vein of the anterior forearm at the elbow fold.
Multiple Component Blood Tests/Panels	The first entry in the Pathology and Laboratory Section of the Current Procedural Terminology (CPT®′) codebook is labeled "Organ or Disease Oriented Panels." Under the code for each blood panel is an inclusive list of each component code which when grouped together comprise the entire blood panel. CPT indicates that these panels were developed for coding purposes only.
Duplicate Laboratory Service	Identical or equivalent bundled laboratory Component Codes, submitted for the same patient on the same date of service on separate claim lines or on different claims regardless of the assigned Maximum Frequency per Day (MFD) value.
Non-Reference Laboratory Provider	A physician reporting laboratory procedures performed in their office or a pathologist.
Physician Office Laboratory	A laboratory maintained by a physician or group of physicians for performing diagnostic tests in connection with the physician practice.
Independent Laboratory	An Independent Laboratory is one that is independent both of an attending or consulting physician's office and of a hospital that meets at least the requirements to qualify as an emergency hospital. An Independent Laboratory must meet Federal and State requirements for certification and proficiency testing under the Clinical Laboratories Improvement Act (CLIA). Independent Laboratory providers must append modifier 90 to all reported laboratory services.

Term	Definition
Reference Laboratory	A Reference Laboratory that receives a Specimen from another, Referring Laboratory for testing and that actually performs the test is often referred to as an Independent Laboratory. Reference Laboratory providers must append modifier 90 to all reported laboratory services.
Referring Laboratory	A Referring Laboratory is one that receives a specimen to be tested and that refers the specimen to another laboratory for performance of the laboratory test. Referring Laboratory providers must append modifier 90 to all reported laboratory services.
Specimen	Tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathological diagnosis. Two or more such Specimens from the same patient (eg, separately identifiable endoscopic biopsies, skin lesions) are each appropriately assigned an individual code reflective of its proper level of service.
Date of Service	The date of service (DOS) on a claim for a laboratory test is the date the Specimen was collected and if collected over 2 calendar days, the DOS is the date the collection ended.

References

1. https://www.cms.gov/files/document/mm11640.pdf
2. https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/SubjecttoCLIA.pdf
3. https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index
4. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CLIABrochure.pdf
5. https://www.cms.gov/files/document/mm12131.pdf

Revision history

DATE	REVISION
2/2022	• Updated policy to align with Medicaid Fee Schedule **effective 7/01/2022** • Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number
5/2022	• Updated policy title to include Medicare • Updated In-Office Testing Table to include effective dates for clarification