Professional Pricing Policy

Subject: **Laboratory and Venipuncture Services**	
Policy Number: HLLP-0001	Policy Section: **Laboratory**
Last Approval Date: September 1, 2020	Effective Date: October 17, 2020

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for allowed amounts for HealthLink members. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines are not followed, HealthLink and/or its Payors may:

- *Reject or deny the claim*
- *Recover and/or recoup claim payment*

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates.

We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or adjust pricing accordingly to the effective date. HealthLink reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to the website. Note: medical claim pricing and processing services provided by HealthLink are available to a payor; however not all payors purchase such services for the benefit plans they sponsor.

Policy

I. Laboratory Combination Editing for Component Codes

A. When HealthLink receives a claim for all of the individual laboratory procedures codes that are part of a blood panel grouping (or other multiple component laboratory tests), HeathLink's claim editing system will bundle those separate tests together into the appropriate comprehensive CPT code listed above (i.e. organ or disease oriented panel codes; CBC codes). This claim editing is based on CPT reporting guidelines. Modifiers will not override this edit.

B. HealthLink follows CPT reporting guidelines, which state: "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 (e.g., do not report 80047 in conjunction with 80053)."

C. HealthLink's total allowance for individual laboratory codes that are part of a comprehensive blood panel/CBC code will not exceed the allowance for such comprehensive blood panel/CBC code.

- When HealthLink receives a claim for two or more of the individual laboratory procedures codes that are part of a comprehensive blood panel/CBC code, HealthLink's claim editing system will bundle those separate tests together into the appropriate comprehensive blood panel/CBC code. The comprehensive blood panel/CBC code will be added to the claim regardless of whether or not the provider bills all of the individual codes that make up the comprehensive blood panel/CBC code.

- The laboratory comprehensive blood panel/CBC code will be allowed, and the individually reported codes will be denied.

Related Coding		
Code	**Description**	**Comment**
80047	Basic metabolic panel (calcium, ionized)	
80048	Basic metabolic panel (calcium, total)	
80050	General health panel	
80051	Electrolyte panel	
80053	Comprehensive metabolic panel	
80055	Obstetrical panel	
80061	Lipid panel	
80069	Renal function panel	
80074	Acute hepatitis panel	
80076	Hepatic Function Panel	
80081	Obstetric panel (includes HIV testing)	

In addition to the blood panels listed above, the global codes for a complete blood count (85025 and 85027) also have multiple code components:

Related Coding		
Code	**Description**	**Comment**
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	

II. Modifiers

A. Technical/Professional Modifiers TC/26

1. Technical/Professional Component Billing identifies proper coding of professional, technical, and global procedures. Modifiers 26 signifies the professional component of a procedure and Modifier TC signifies the technical component.
2. When the 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.
3. 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 allowed. 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 allowed since, in this case, the facility will bill for performing the laboratory procedure.
4. A global laboratory procedure code includes allowance 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 allowed.

- When a professional provider bills the global code (no modifiers) with a facility place of service, the code will not be allowed.

B. Laboratory Modifiers

HealthLink considers modifiers 90 and 92 to be informational only and they do not affect the allowance of the laboratory code.

When modifier 91 is appended to a reported laboratory procedure code, HealthLink's claims editing system will override a frequency edit and allow separate repeat clinical diagnostic laboratory test except as described in our Frequency Editing Reimbursement Policy.
Modifier 91 will not override component code editing for laboratory organ or disease oriented panels.

III. Routine Venipuncture and the Collection of Blood Specimen

A. Routine Venipuncture/Capillary Blood Collection

Healthcare Common Procedure Coding System (HCPCS Level II) code S9529, are separately allowed when reported with an E&M service. a Unless an additional routine venipuncture/capillary blood collection is clinically necessary, the frequency limit for any of these services is once per member, per provider, per date of service. The frequency limit will also apply to any combination of these codes reported on the same date of service for the same member by the same provider.

If routine venipuncture CPT code 36415 is reported with Evaluation and Management (E/M) office visit codes (99201-99205 and 99211-99215) then the routine venipuncture code is allowed separately.

Routine venipuncture CPT 36415 is not allowed separately when reported with a laboratory service.

In addition, HCPCS code G0471 for the collection of venous blood by venipuncture or urine sample by catheterization from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA) collected by a laboratory technician that is employed by the laboratory that is performing the test will not be allowed separately when reported with a laboratory service.

IV. Handling, Conveyance of Specimen, and/or Travel Allowance

HealthLink considers the handling, conveyance, and/or travel allowance for the pick up of a laboratory specimen, to be included in a provider's management of a patient. Therefore codes 99000, 99001 are not separately allowed.

According to HealthLink policy, the following codes are not allowed separately when reported with a laboratory service:

Related Coding

Code	Description	Comment
36415	Collection of venous blood by venipuncture	Not allowed separately when reported with a laboratory service Is allowed with an office visit
G0471	Collection of venous blood by venipuncture or urine sample by catheterization from an individual in a SNF or by a laboratory on behalf of a HHA	Not allowed separately when reported with a laboratory service

Code	Description	Comment
S9529	Routine venipuncture for collection of specimen (s), single home bound, nursing home, or skilled nursing facility patient	Not allowed separately when reported with a laboratory service
36591	Collection of blood specimen from a completely implantable venous access device (when reported with a laboratory service)	allowed separately when reported with a laboratory service
36592	Collection of blood specimen using established central or peripheral catheter, venous, not elsewhere specified (when reported with a laboratory service)	allowed separately when reported with a laboratory service

According to HealthLink policy, the following codes are not separately allowed:

Related Coding

Code	Description	Comment
36416	Collection of capillary blood specimen (e.g., finger, heel, ear stick)	not separately allowed
99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory	not separately allowed
99001	Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory	not separately allowed

Exemptions

Definitions

Venipuncture	Process of withdrawing a sample of blood for the purpose of analysis or testing.
General Professional Pricing Policy Definitions	

Related Policies and Materials

Bundled Services and Supplies
Frequency Editing
Modifier Rules

References and Research Materials

This policy has been developed through consideration of the following

- American Medical Association (AMA) Current Procedural Terminology (CPT)

Use of Pricing Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Pricing Policy is constantly evolving and we reserve the right to review and update these policies periodically.