Commercial Reimbursement Policy

Subject: **Non-Patient Laboratory Services– Facility**	
Policy Number: **C-21001**	Policy Section: **Facilities**
Last Approval Date: **07/27/2022**	Effective Date: **01/01/2022**

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Anthem Blue Cross (Anthem) benefit plan. 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 as well as to the member's state of residence. 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. Our policies apply to both participating and non-participating professionals and facilities as indicated.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem 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These policies may be superseded by provider or state contract language, or state, federal requirements or mandates.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 recover claims payment to the effective date, in accordance with the policy. Anthem reserves the right to review and revise these policies periodically when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan does not allow reimbursement for non-patient laboratory services when reported on a UB-04 with type of bill 014X unless provider, state, or federal contracts and/or requirements indicate otherwise.

Note: This policy does not apply to pathology services billed on type of bill 014X.

Related Coding

Standard Correct Coding applies

Policy History

07/27/2022	Review approved 07/27/2022 effective 01/01/2022: added Note: This policy does not apply to pathology services billed on type of bill 014X.
10/01/2021	Initial policy committee approval 04/30/2021 and effective 01/01/2022.

References and Research Materials

This policy has been developed through consideration of the following:

- Centers for Medicare and Medicaid Services (CMS)
- Optum Encoder Pro for Professionals

Definitions

Non-Patient	A member that is neither an inpatient nor an outpatient of a hospital, but has a specimen that is submitted for analysis to a hospital and the member is not physically present at the hospital.
Type of Bill	A four-digit alphanumeric code provides three specific pieces of information after a leading zero. This three-digit alphanumeric code gives three specific pieces of information: the type of facility, the type of care and the sequence of this bill in the episode of care, also referred to as the 'frequency'.
General Reimbursement Policy Definitions	

Related Policies and Materials

None

Use of Reimbursement 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. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.