Commercial Reimbursement Policy

Subject: **Laboratory and Venipuncture Services - Professional and Facility**	
Policy Number: **C-21010**	Policy Section: **Laboratory**
Last Approval Date: **08/06/2024**	Effective Date: **08/06/2024**

Disclaimer

These reimbursement 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 an Anthem member's 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. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. 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. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem identifies conditions for reimbursement for professional and facility providers of laboratory and venipuncture services, which will be applied to submitted claims unless provider, state, or federal contracts and/or mandates indicate otherwise.

Professional:

I. Laboratory Combination Editing for Component Codes

i. When Empire receives a claim for all of the individual laboratory procedure codes that are part of a blood panel grouping (or other multiple-component laboratory tests) Empire's claim-editing system will bundle those separate tests together into the appropriate comprehensive CPT® code listed in the "Related Coding" section below (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.

ii. Empire 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)."

iii. Empire's total reimbursement 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 Empire receives a claim for two or more of the individual laboratory procedures codes that are part of a comprehensive blood panel/CBC code Empire'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 eligible for reimbursement and the individually reported codes will be denied.

NOTE: Anthem requires providers to submit a valid Clinical Laboratory Improvement Amendment (CLIA) certificate identification number for reimbursement of clinical laboratory services reported on a CMS-1500. If the required information is not submitted, Empire will reject or deny the claim as incomplete.

II. Modifiers

i. Technical/Professional Modifiers TC/26

- If applicable, a laboratory procedure code must be billed with the correct modifier (TC or 26) to receive reimbursement. If a professional provider performed both the technical and professional components of a global procedure, then the global procedure is eligible for reimbursement only if billed without a modifier (TC/26) and without a facility Place of Service.
- For additional details, see the related "Modifier 26 and TC Professional and Technical Component" policy and Section II of the "Related Coding" section below.

ii. Laboratory Modifiers

- For conditions of reimbursement for laboratory modifiers (90, 91, and 92), see comments in Section II of the "Related Coding" section below.

III. Routine Venipuncture and the Collection of Blood Specimen

i. Routine Venipuncture/Capillary Blood Collection

- Healthcare Common Procedure Coding System (HCPCS Level II) code S9529 and capillary blood collection CPT® code 36416, are eligible for separate reimbursement when reported with an E/M and/or a laboratory service. 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.
- Routine venipuncture CPT® code 36415, when reported with Evaluation and Management (E/M) office visit codes (99202-99205 and 99211-99215), is eligible for separate reimbursement.
- Modifiers will not override the edit.

ii. Collection of Blood Specimen from Access Device or Catheter
- Anthem follows CPT® coding guidelines, which state that CPT® codes 36591 and 36592 should not be reported in conjunction with other services except laboratory service. If CPT® codes 36591 and 36592 are reported with Evaluation and Management (E/M) codes (99202-99205, 99211-99215, 99222-99226, or 99242-99255) the E/M service will not be reimbursed separately. CPT® codes 36591 and 36592 are only eligible for separate reimbursement when reported with a laboratory service.

iii. Specimen Collection, any source
- Specimen Collection for SARS-CoV-2 code C9803 reported by a professional provider will be denied. Obtaining the sample is integral to performing the laboratory analysis when reported by the same provider.

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

Anthem 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, P9603, P9604, and H0048 are not eligible for separate reimbursement.

Facility:

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

Anthem 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, P9603, P9604, and H0048 are not eligible for separate reimbursement.

II. Routine Venipuncture and the Collection of Blood Specimen

i. Routine Venipuncture/Capillary Blood Collection.
- Venipuncture CPT® codes 36400, 36405, 36406, 36410, 36415, and 36416 reported by an outpatient facility will be denied. These codes will be included in the facility payment and not allowed for separate reimbursement.
- Modifiers will not override the edit.

ii. Collection of Blood Specimen from Access Device or Catheter
- Collection of blood specimen CPT® codes 36591 and 36592 reported by an outpatient facility will be denied. These codes will be included in the facility payment and not allowed for separate reimbursement.

iii. Specimen Collection, any source

- Specimen Collection for SARS-CoV-2 code C9803 reported by an outpatient facility will be denied. This code will be included in the facility payment and not allowed for separate reimbursement.

Related Coding

Description	Coding Grids
Professional Section I: Panel Codes & Global Codes for Complete Blood Counts	Professional Section I: Panel Codes & Global Codes for Complete Blood Counts
Professional Section II: Modifiers	Professional Section II: Modifiers
Professional Section III: Routine Venipuncture and the Collection of Blood Specimen	Professional Section III: Routine Venipuncture and the Collection of Blood Specimen
Professional Section IV: Handling, Conveyance of Specimen, and/or Travel Allowance	Professional Section IV: Handling, Conveyance of Specimen, and/or Travel Allowance - Professional
Facility Section I: Handling, Conveyance of Specimen, and/or Travel Allowance	Facility Section I: Handling, Conveyance of Specimen, and/or Travel Allowance - Facility
Facility Section II: Routine Venipuncture and the Collection of Blood Specimen	Facility Section II: Routine Venipuncture and the Collection of Blood Specimen

Policy History

08/06/2024	Review approved and effective: added clarifying language to Professional Section III and to the code list for codes 36591 and 36592
10/25/2023	Review approved 10/25/2023 and effective 06/15/2024: added Facility Section II code list to not allow 36400, 36405, 36406, 36410, 36415, 36416, 36591, 36592 in an outpatient facility, removed *modifiers* from Definition section; added back inadvertently removed language from the Modifier 26 comment in the Section II: Modifiers code list to not allow indicator 3 or 9 to be reimbursed in a facility setting
06/13/2023	Review approved: no changes
12/22/2021	Review approved 12/21/2021 and effective 10/01/2022: • Codes 99000 – 99001, H0048, P9603 and P9604 were removed from the Bundled Services and Supplies Section 1

	coding professional policy and added to the Laboratory and Venipuncture Services – Professional & Facility • Policy expanded to include facility: facilities will not allow separate reimbursement for select specimen-handling CPT/HCPCS codes 99000 – 99001, H0048, P9603 and P9604 • Policies added to the "Related Policies" section: Expenses Included in Facility Services and Modifier 26 and TC: Professional and Technical Component; removed deleted code 99201
08/07/2020	Revised: updated policy language; modifier 90 no longer reimbursable when reported in Place of Service 11 (Office Visit)
06/24/2020	Review approved: updated policy language and added modifier definitions; removed definitions from the policy body, retained edit language under laboratory Modifier 92
01/17/2020	Revised: Policy language updated to require providers to submit a CLIA certificate ID number for clinical laboratory claims submitted on a CMS-1500 and a Modifier QW with a CLIA certificate ID for laboratory services that require a CLIA waiver.
06/01/2019	Revised: Removed description section and added definition section
08/03/2018	Revised: Modifier 92 language updated: "Laboratory services reported with modifier 92 (alternative laboratory platform testing) will not be eligible for reimbursement" ○ Exceptions: Procedure codes 86701-86703 and 87389 will be eligible for reimbursement when reported with modifier 92 • Removed modifier 92 information for Cotiviti for 10/22/2017
06/01/2018	Revised: New York to allow separate reimbursement for venipuncture code 36415.
03/01/2018	Revised: New York will no longer allow separate reimbursement for venipuncture code 36415.
08/01/2017	Revised: Added bracketed language for modifier 92 (Alternative Laboratory Platform Testing) that only HIV testing 86701-86703, and 87389 are allowed to be reported with modifier 92; all other lab codes will not be eligible for reimbursement based on invalid modifier; correct coding based on CPT® and "Coding with Modifiers"
02/07/2017	Revised: Updated information that modifier 91 will not override the denial of component laboratory codes for the laboratory panel bundling edit
04/05/2016	Revised: Removed reference to drug screen testing for modifier 91 section (section II B); we do not allow modifier override for any of the lab tests listed in frequency editing
05/05/2015	Revised: • CPT® manual is being updated to CPT® "codebook" to be in line with industry language

	• Added 80076 – Hepatic Function Panel – to the blood panel list
	• Added language, to describe a new edit, under section 2.A.4.:
	  ○ "when one provider reports a global procedure and a different provider reports the same procedure with a professional (26) or technical (TC) component modifier, only the first charge processed as approved by Empire will be eligible for reimbursement and the subsequent charge processed will not be eligible for separate reimbursement."
	• Added information under section 3.A.: HCPCS code G0471 is eligible for separate reimbursement when reported with a laboratory service and billed by a professional on a CMS-1500 form.
	  ○ "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 be eligible for separate reimbursement when reported with a laboratory service and billed by a professional on a CMS-1500 Form."
	  ○ This code is also being added to the coding table which lists eligible services when reported with laboratory services along with language "according to Health Plan policy, the following code are either eligible or not eligible for separate reimbursement."

02/03/2015	Review with Revisions: • Minor language updates which do not change the policy position such as adding reference to our Bundled Services policy
02/04/2014	Review with Revisions: • Annual review with minor language/grammar/punctuation updates • We are adding enhanced language on pg. 3 regarding frequency limit information to support a future "procedure to procedure frequency shell rule" (slated for later this year) that will allow editing across the same/similar type of service, similar codes; in this instance blood collection services with any combo of 36415, 36416, and S9529—the frequency limit is 1 per member per provider on the same date of service same code or codes within this grouping ○ 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.

02/05/2013	Revised: • Pg. 2, section II A.: Updated “will be denied” to “not eligible for reimbursement” • Pg. 3, section B: Modifier 91 language updated ○ When modifier 91 (repeat clinical diagnostic laboratory test) is appended to a reported laboratory procedure code, our claims editing system will override a frequency edit and allow separate reimbursement for the repeat clinical diagnostic laboratory test except as described in our Frequency Editing Reimbursement Policy related to drug screen testing • Other minor language updates throughout the policy
01/08/2013	Revised: • Pg. 2, policy section II, A. 2.: Removing reference to effective date • Pg. 3: Adding travel allowance to policy section IV along with the codes P9603 and P9604 not separately reimbursed • Pg. 4: Added codes P9603 and P9604 to the coding section as not eligible for separate reimbursement
06/05/2012	Annual review with revisions: • Pg. 3: B. Collection of Blood Specimen • Therefore, these codes are only eligible for separate reimbursement when billed with a laboratory service • Pg. 3: Under the Coding section: Codes eligible for separate reimbursement when billed with a laboratory service • Added descriptions to modifiers coding section 2B on pg. 3 and removed “Modifiers” section • Updated the effective date, revision date, and copyright year
06/07/2011	Revised: • Policy language was changed “more than one will be denied” since frequency editing never was put in place to deny more than one. • Policy now indicates more than one is allowed when clinically necessary. • Page 3 middle: Section III A. “Capillary collection” was added to distinguish the description for 36416.
01/04/2011	Revised: Sections III A.+B. were revised to distinguish between: • routine venipuncture (A), which will pay with an E/M; and • Blood Collection 36591-36592 (B), which will not; effective 01/01/2011, will pay with another lab service. The coding section was also revised to indicate 36591-36592 is eligible for reimbursement with another lab service.
11/02/2010	Revised:

	• On page three under II. Modifiers B. The word “Informational” in the heading was replaced with “Laboratory.” • Modifier 91 was removed as informational and an explanation of the effect on claims processing was added.
05/04/2010	Revised: Removed the word “comprehensive” from subject
02/20/2010	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- CMS National Physician Fee Schedule Relative Value File (NPFSRVF)
- Optum EncoderPro 2023

Definitions

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

Related Policies and Materials

Bundled Services and Supplies - Professional
Expenses Included in Facility Services - Professional
Frequency Editing - Professional
Modifier Usage - Professional
Modifiers 26 and TC - Professional

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.