Commercial Reimbursement Policy

Subject: **Laboratory and Venipuncture Services - Professional and Facility**	
Policy Number: **C-21010**	Policy Section: **Laboratory**
Last Approval Date: **04/01/2024**	Effective Date: **07/01/2024**

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 Blue Cross (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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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, Anthem will publish the most current policy to the website.

Policy

The Health Plan 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 the Health Plan 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) the Health Plan's claim-editing system will bundle those separate tests together into the appropriate comprehensive CPT® code listed in the Related Coding section

below. This claim editing is based on CPT® reporting guidelines. Modifiers will not override this edit.

ii. The Health Plan 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. The Health Plan'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 the Health Plan receives a claim for two or more of the individual laboratory procedures codes that are part of a comprehensive blood panel/CBC code the Health Plan'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 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: The Health Plan 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, the Health Plan 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 Section II of the Related Coding section.

ii. Laboratory Modifiers

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

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.
- If routine venipuncture CPT® code 36415 is reported with Evaluation and Management (E&M) office visit codes (99202-99205 and 99211-99215) then the routine venipuncture code is included in the reimbursement for office visit E&M services and not reimbursed separately.
- Modifiers will not override the edit.

ii. Collection of Blood Specimen from Access Device or Catheter
- The Health Plan follows CPT® coding guidelines, which state that CPT® codes 36591 and 36592 should not be reported in conjunction with other services except laboratory service. Therefore, CPT® codes 36591 and 36592 are only eligible for separate reimbursement when reported with a laboratory service.

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

The Health Plan 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

The Health Plan 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.

Related Coding

Description	Coding Grids
Professional Section I: Panel Codes & Global Codes for Complete Blood Counts	Professional Section I: Panel Codes and 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

Policy History

04/01/2024	Initial approval 04/01/2024 and effective 07/01/2024: policy number C-10001: Laboratory and Venipuncture Services-Professional was retired and consolidated with codes 99000-99001, H0048 removed from the Bundled Services and Supplies-Professional policy (C-08003) Section 1; policy applies to professional and facility providers; facilities will not allow separate reimbursement for select specimen-handling CPT/HCPCS codes 99000 – 99001, H0048, P9603 and P9604; policy applies to professional and facility providers

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 Rules - Professional
Modifier 26 and TC: Professional and Technical Component - 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.