Subject: Laboratory and Venipuncture Services


Coverage is subject to the terms, conditions, and limitations of an individual member’s programs or products and policy criteria listed below.

DESCRIPTION

Multiple Component Blood Tests

The first entry in the Pathology and Laboratory Section of the Current Procedural Terminology (CPT®) Manual 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. The blood panels are:

- 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

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

- 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)

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. Please refer to the coding section of this policy for the CPT code most applicable to the method of blood withdrawal.

This policy addresses the Health Plan’s reimbursement policies pertaining to clinical laboratory and related laboratory services (e.g., venipuncture and the handling and conveyance of the specimen to the...
POLICY

I. Laboratory Combination Editing for Component Codes

A. If the Health Plan 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) ClaimsXten® 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.

B. The Health Plan follows CPT reporting guidelines which state: “Do not report two or more panel codes that include any of the 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…”

C. 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.
   • If 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, ClaimsXten 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.

II. Modifiers

A. Technical/Professional Modifiers TC/26
   1. 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.

   2. 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. radiology, laboratory, or diagnostic) has been
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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.

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 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.

4. A global 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.

B. Laboratory Modifiers
The Health Plan considers modifiers 90 (reference (outside) laboratory) and 92 (alternative laboratory platform testing) to be informational only and they do not affect the reimbursement of the laboratory code. 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. Refer to our Modifier Rules Reimbursement Policy and Frequency Editing Reimbursement Policy.

III. Routine Venipuncture and the Collection of Blood Specimen
A. Routine Venipuncture/Capillary Blood Collection
Routine venipuncture CPT codes 36415 and S9529 and capillary blood collection code 36416, are eligible for reimbursement when billed with an E/M and/or a laboratory service. Unless an additional routine venipuncture/capillary blood collection is clinically necessary, this service is only eligible for reimbursement once per member, per provider, per date of service.

B. Collection of Blood Specimen
The Health Plan follows the 2013 CPT coding guidelines which state that CPT 36591-36592 should not be reported “…in conjunction with other services except a laboratory service.” Therefore, these codes are only eligible for separate reimbursement when billed 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, and P9604 are not eligible for separate reimbursement. See also our Bundled Services and Supplies Reimbursement Policy.

CODING
Codes eligible for separate reimbursement when billed with a laboratory service:

- 36415: collection of venous blood by venipuncture
- 36416: collection of capillary blood specimen (e.g., finger, heel, ear stick)
- S9529: routine venipuncture for collection of specimen(s), single home bound, nursing home, or skilled nursing facility patient
- 36591: collection of blood specimen from a completely implantable venous access device
- 36592: collection of blood specimen using established central or peripheral venous catheter

Codes not eligible for separate reimbursement:

- 99000: handling and/or conveyance of specimen for transfer from the physician's 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
- P9603: Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient; prorated miles actually travelled
- P9604: Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient; prorated trip charge

POLICY HISTORY

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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.

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