Anthem Blue Cross and Blue Shield
Commercial Professional Reimbursement Policy

Subject: Laboratory and Venipuncture Services	
IN, WI Policy: 0029	**Effective: 01/01/2018**

Coverage is subject to the terms, conditions, and limitations of an individual member's programs or products and policy criteria listed below. This reimbursement policy also applies to Employer Group Retiree Medicare Advantage programs.

Description

Multiple Component Blood Tests

The first entry in the Pathology and Laboratory Section of the *Current Procedural Terminology* (CPT®′) codebook 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:

Code	Description
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:

Code	Description
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

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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 laboratory) for provider claims submitted on a CMS-1500, whether performed in a physician's office, a hospital laboratory, or an independent laboratory.

Policy

I. Laboratory Combination Editing for Component Codes

A. When 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) the Health Plan'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. 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).[1]"

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.
   - 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 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., laboratory) has been reported by a

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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 laboratory 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

In addition, when one provider reports a global procedure and a different provider reports the same procedure with a professional component (26) or a technical component(TC) modifier, only the first charge processed as approved by the Health Plan will be eligible for reimbursement and the subsequent charge processed will not eligible for separate reimbursement.

B. Laboratory Modifiers

- The Health Plan considers modifier 90 (reference (outside) laboratory) 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, the Health Plan's 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.

  Modifier 91 will not override component code editing for laboratory organ or disease oriented panels.

- 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.

See also our Modifier Rules reimbursement policy.

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III. Routine Venipuncture and the Collection of Blood Specimen

A. Routine Venipuncture/Capillary Blood Collection
Routine venipuncture CPT code 36415 and Healthcare Common Procedure Coding System (HCPCS Level II) code S9529 and capillary blood collection 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. (See also our Frequency Editing Reimbursement Policy.)

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 be eligible for separate reimbursement when reported with a laboratory service.

B. Collection of Blood Specimen from Access Device or Catheter
The Health Plan follows CPT coding guidelines which state that CPT codes 36591and 36592 should not be reported "…in conjunction with other services except a laboratory service.[2]" Therefore, CPT codes 36591 and 36592 are only eligible for separate reimbursement when reported with a laboratory service. See also our Bundled Services and Supplies Reimbursement Policy.

IV. Handling and/or Conveyance of Specimen, and/or Travel Allowance
The Health Plan considers the handling and 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 and 99001, P9603, and P9604 are not eligible for separate reimbursement. See also our Bundled Services and Supplies Reimbursement Policy.

Coding

The following tables are provided as an informational tools only to help identify some of the procedures described above. The inclusion or exclusion of a specific code does not indicate eligibility for reimbursement under all circumstances.

According to Health Plan policy, the following codes are eligible for separate reimbursement when reported with a laboratory service:

Code	Description
36415	Collection of venous blood by venipuncture
36416	Collection of capillary blood specimen (e.g., finger, heel, ear stick)
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

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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 (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)

According to Health Plan policy, the following codes are not eligible for separate reimbursement:

Code	Description
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

[1]Current Procedural Terminology *cpt*® 2017 Professional Edition, pg. 496
[2] Current Procedural Terminology *cpt*® 2017 Professional Edition, pg. 243

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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.

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