

## Corporate Medical Policy

### Laboratory Procedures Medical Policy AHS - R2162

**File Name:** laboratory\_procedures\_medical\_policy  
**Origination:** 01/01/2019  
**Last Review:** 07/2021

#### Description of Procedure or Service

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To be considered for reimbursement, all outpatient laboratory claims should be submitted in accordance with:

- AMA CPT and HCPCS coding and ICD-10 diagnosis coding guidelines
- Other laboratory and pathology coding guidelines
- All applicable regulatory guidelines

This policy outlines additional requirements beyond the guidelines listed above that are required for reimbursement. Note that these guidelines are reviewed and updated periodically.

#### Policy

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**BCBSNC will provide reimbursement for laboratory procedures based on the guidelines listed below.**

#### Benefits Application

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This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

#### Policy Guidelines

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##### Modifier Guidelines/Instructions

##### **Technical, Professional, and Global services (TC, 26 modifiers)**

- Before using the 26 or TC modifiers, verify that these modifiers are allowable with the procedure code.
- Do not append these modifiers to the procedure code when performing the global service.

##### **Tests performed by a Reference laboratory**

- When laboratory procedures are performed by a party other than the treating or reporting physician to other qualified health care professionals, the procedure must be identified by adding modifier 90 to the claim line.

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- Only independent clinical laboratories may append modifier 90 to indicate that the service was referred to an outside laboratory.

## **Repeat Testing**

- While treating a patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91.
- Modifier 91 may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required.
  - Modifier 91 may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing).

## **Clinical Laboratory Improvement Amendments (CLIA) Waived Testing**

- Laboratory tests which are CLIA-waived must have the QW modifier appended to the procedure code.

## **Place of Service Guidelines**

In accordance with S611b of OBRA (Omnibus Budget Reconciliation Act) of 1989, a referring lab can bill for tests performed by a reference lab only if it meets any one of the following exceptions:

- The referring laboratory is in or is part of a rural hospital
- The referring lab and the reference lab are 'subsidiary related.' That is:
  - The referring lab is a wholly owned subsidiary of the reference lab
  - The referring lab wholly owns the reference lab
  - Both the referring lab and reference lab are wholly owned subsidiaries of the same entity.

## **Genetic Counseling**

Reimbursement is allowed for genetic counseling, when required, only when performed by a provider who is NOT an employee or contractor of the rendering lab. Genetic counseling should be independent of the laboratory rendering the testing to prevent conflict of interest. Genetic counseling documentation consists of written documentation of the counseling elements provided to the member (may include: risks, benefits, care guidance, and follow-up plans). Any genetic counseling provided, whether a covered benefit or not, will be considered during review of health plan laboratory policy where counseling is a required component.

## **Non-Reimbursable CPT/HCPCS Codes**

Some procedure codes will not be reimbursed due to their expiration or replacement with more appropriate codes.

- AMA drug assay codes 80320 to 80377 are not accepted and will not be reimbursed. Refer to policy T2015, Opioids Testing in Pain Management and Substance Abuse, for guidelines for submitting G0480 to G0483.
- Proprietary Laboratory Analyses (PLA) codes will not be reimbursed unless a laboratory policy specifically covers the PLA code.
- Unlisted codes (81479, 81599, 84999) will not be accepted if a specific Tier 1, Tier 2, GSP, or MAAA code exists.

## **Panel Reimbursement**

**Reimbursement for genetic panel testing is as follows:**

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- If a procedure code is available for the multi-gene panel test, then this code is to be utilized (eg., 81442 Noonan spectrum disorders genomic sequence analysis panel).
- If there is not a specific next generation sequencing (NGS) procedure code that represents the requested test, the procedure may be represented by a maximum of ONE unit of 81479 [unlisted molecular pathology procedure] (i.e., 81479 X 1 should account for all remaining gene testing) OR all genes tested on the panel must be represented by ALL appropriate Molecular Pathology Tier 1 or 2 procedure codes (with exception of 81479 x 1 only being listed once if it appropriately represents more than one gene in the panel).
- ALL gene tests in the panel must be listed on the request and rationale for the clinical utility for the gene test must come from the ordering provider.
- If ALL codes that represent the testing of the panel are not submitted, reimbursement is not allowed due to incorrect coding process, as neither laboratory or clinical reviewer should assign meaning to incomplete unspecified panel codes.
- Concurrent ordering of multi-gene panel tests for a specific condition is strictly prohibited; only one multi-gene panel test may be ordered at a time for a specific condition.

### **Edit Types**

Outpatient lab claims are consistently evaluated for reimbursement against several standard edits types using administrative information (e.g., claim information, historical claims). The specific edits are described below.

#### **Additional Tests on the Date of Service**

The presence or absence of additional tests on a single date of service (DOS) may trigger a reimbursement denial for a claim line.

The exclusivity edit is based upon:

- A list of tests where Correct Coding Initiative (CCI) and/or AMA coding guidance identify that two procedure codes for the test are not permitted for the same patient at the same time because it is only appropriate to charge for one of those procedures.
- Clinical guidelines for testing preclude the simultaneous performing of two tests. For example, individual components of panel procedures codes will not be separately reimbursed when billed with the panel procedure code.
- Technically complex procedures which incorporate simple procedures will not be reimbursed for the same patient on the same DOS. For example, billing for multiple testing methodologies (e.g., direct, amplification, and quantitative testing) for the same microorganism codes is not reimbursed.

Thus, a denial based upon this edit is one that is based upon evaluation of universal, objective criteria related to how the test is being billed, not an assessment of a patient's condition to determine whether both codes were appropriate.

#### **Incorrect Diagnosis Code**

Select diagnosis and procedure code combinations are permitted or precluded depending on the nature of the policy.

The edit functions to identify those tests that are never appropriate unless the physician has first concluded that the patient presents with the indicated diagnosis. Although the edit is contingent upon the diagnosis of the individual patient, it is not conducting any clinical evaluation of whether the condition, in fact, exists. Rather, the inherent nature of the test (only being indicated for patients with the condition or contraindicated for the

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condition) and the question of whether the pre-requisite condition is present are the conditions for reimbursement.

## **Incorrect Patient Age**

This edit addresses medical policies with coverage criteria, CPT/HCPCS codes, and diagnosis codes that not are reimbursable based on the patient's age on the DOS.

For example, testing on newborns must be associated with a member who is 28 days of age or younger.

## **Incorrect Place of Service**

This edit is invoked when the Place of Service is identified as inappropriate with the laboratory test/service performed submitted on the claim.

## **Once per Lifetime Tests**

This edit limits the frequency of applicable laboratory services/procedure codes to once in the patient's lifetime.

Certain laboratory services should only be performed once in a patient's lifetime as outlined in medical policy. If a once-per-lifetime test is submitted for reimbursement more than once, the subsequent submissions will not be reimbursed.

## **Unit Threshold Met (Daily and Historical)**

These edits are invoked when the number of units billed for the procedure on a single DOS or over a period of time exceed an allowed reimbursement quantity without considering any aspect of an individual's specific condition. Maximum units of service are determined by one or more of the following:

- The CPT or HCPCS code description defines the number of units per patient per DOS for a unique billing event.
- Laboratory Coverage Guidelines outlined in medical policy establish the number of units for a laboratory service.
- The service is anatomically or clinically limited to the number of procedures that may be performed and therefore units billed.
- Scientific or statistical analyses demonstrate a reasonable limitation of the number of units that should be performed within a period of time.
- Third-parties such as Correct Coding Initiative or Centers for Medicare and Medicaid Services limit reimbursement to a specified number of units.

If a procedure code that is assigned a maximum unit value is reported with a greater unit count, the claim line will be denied, and the provider will be responsible for resubmitting the claim only for the number of units up to but not exceeding the allowed maximum.

## **Billing/Coding/Physician Documentation Information**

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This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at [www.bcbssc.com](http://www.bcbssc.com). They are listed in the Category Search on the Medical Policy search page.

*Applicable service codes: 0331U, 0341U, 0342U, 0351U, 0355U, 0357U, 0361U, 0372U, 0375U, 0376U, 0378U, 0381U, 0382U, 0383U, 0384U, 0385U, 0389U, 0390U, 0393U, 0394U, 0407U, 0418U, 0421U, 0427U, 0430U, 0431U, 0432U, 0449U.*

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BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

## Scientific Background and Reference Sources

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Centers for Medicare and Medicaid Services, “Medically Unlikely Edits”  
<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html>

American Medical Association, Current Procedural Terminology (CPT ®), Professional Edition  
CMS Pub. 100-04, chapter 16, section 40.1.1 external link (PDF, 497 KB)  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf>

Specialty Matched Consultant Advisory Panel review 7/2021

Medical Director review 7/2021

## Policy Implementation/Update Information

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### For policy titled: Laboratory Procedures Reimbursement Policy AHS – R2162

- 1/1/19 New reimbursement policy developed. Reimbursement for laboratory procedures will be based on the guidelines noted in the policy. Medical Director review 1/1/2019. Policy noticed 1/1/2019 for effective date 4/1/2019. (an)
- 1/14/20 Routine policy review. Senior Medical Director approved 12/2019. No changes to policy statement. (an)
- 6/9/20 Revised final statement in the Guidelines section to read: If a procedure code that is assigned a maximum unit value is reported with a greater unit count, the claim line will be denied, and the provider will be responsible for resubmitting the claim only for the number of units up to but not exceeding the allowed maximum. (bb)
- 7/28/20 Reviewed by Avalon 2nd Quarter 2020 CAB. Medical Director review 7/2020. Added Genetic Counseling and Panel Reimbursement sections to Policy Guidelines. (bb)
- 12/31/20 Routine policy review. Medical Director approved 12/2020. No changes to policy statement. (eel)

### For policy titled: Laboratory Procedures Medical Policy AHS – R2162

- 5/4/21 Reviewed by Avalon 1<sup>st</sup> Quarter 2021 CAB. Title changed from Laboratory Procedures Reimbursement Policy to “Laboratory Procedures Medical Policy”. Changed “Policy Scope” to “Description”. The following statement was added to the section on reimbursement for genetic panel testing: “Concurrent ordering of multi-gene panel tests for a specific condition is strictly prohibited: only one multi-gene panel test may be ordered at a time for a specific condition. Medical Director review 4.2021. (jd)
- 9/7/21 Specialty Matched Consultant Advisory Panel review 7/2021. Medical Director review 7/2021. (jd)
- 7/1/22 The following PLA code was added to the Billing/Coding section: 0331U. (jd)

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- 9/30/22 Added codes 0341U, 0342U and 0351U to Billing/Coding section. (tm)
- 12/30/22 Updated Billing/Coding section to add 0355U, 0357U, 0361U effective 1/1/2023. (tm)
- 3/31/23 Updated Billing/Coding section to add codes 0372U, 0375U, 0376U, 0378U, 0381U, 0382U, 0383U, 0384U and 0385U effective 4/1/2023. (tm)
- 6/30/23 Codes 0389U, 0390U, 0393U, 0394U added to Billing/Coding section, effective 7/1/23. (tm)
- 12/29/23 Updates to Billing/Coding section: codes 0407U and 0418U added, effective 10/1/23 and codes 0421U, 0427U, 0430U, 0431U and 0432U added, effective 1/1/24. (tm)
- 4/17/24 Code 0449U added to Billing/Coding section, effective 4/1/24. (tm)

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Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.