

Laboratory Services Policy, Professional for Louisiana

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines.

References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication. CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

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Policy

Overview

This policy describes the reimbursement methodology for laboratory panels and individual Component Codes, as well as reimbursement for venipuncture services, laboratory services performed in a facility setting, laboratory handling, surgical pathology and clinical pathology consultations. The policy also addresses place of service and date of service relating to laboratory services.

Duplicate laboratory code submissions by the same or multiple physicians or other health care professionals, as well as certain laboratory services provided in a facility place of service, are also addressed in this policy.

Note this policy does not address reimbursement for all laboratory codes. Coding relationships for laboratory topics not included within this policy are administered through the UnitedHealthcare Community Plan "Rebundling" and "CCI Editing" policies.

Reimbursement Guidelines

Place of Service

UnitedHealthcare Community Plan uses the codes indicated in the Centers for Medicare and Medicaid Services (CMS) Place of Service (POS) Codes for Professional Claims Database to determine if laboratory services are reimbursable.

[CMS Place of Service Database](#)

The POS designation identifies the location where the laboratory service was provided, except in the case of an Independent or a Reference Laboratory. An Independent or Reference Laboratory must show the place where the sample was taken (if drawn in an Independent Lab or a Reference Lab, POS 81 is reported; if drawn in a hospital inpatient setting, the appropriate inpatient POS is reported). All entities billing for laboratory services should append identifying modifiers (e.g., 90), when appropriate, in accordance with correct coding. For example:

- If the physician bills for lab services performed in his/her office, the POS code for "Office" is reported.
- If the physician bills for a lab test furnished by another physician who maintains a lab in his/her office, the code for "Other Place of Service" is reported.
- If the physician bills for a lab service furnished by an independent lab, the code for "Independent Laboratory" is reported.

- If an independent lab bills, the place where the sample was taken is reported. An independent laboratory taking a sample in its laboratory shows "81" as place of service.
- If an independent laboratory bills for a test on a sample drawn on an inpatient or outpatient of a hospital, it reports the code for the inpatient (POS code 21) or outpatient hospital (POS code 22), respectively.

For additional information, refer to the [Questions and Answers](#) section, Q&A #1.

Date of Service

The date of service (DOS) on a claim for a laboratory test is the date the Specimen was collected and if collected over 2 calendar days, the DOS is the date the collection ended.

Refer to the UnitedHealthcare Community Plan "Professional/Technical Component Policy" for guidelines on reporting the date of service for laboratory tissue Specimens collected during a surgical procedure, stored Specimens and chemotherapy sensitivity testing on live tissue samples.

Provider Specialties Eligible for Reimbursement of Laboratory Services

Reference Laboratory and Non-Reference Laboratory Providers:

- Aligning with CMS, Reference Laboratories reporting laboratory services appended with modifier 90 are eligible for reimbursement.
- Non-reference laboratory physicians or other qualified health care professionals reporting laboratory services appended with modifier 90 are not eligible for reimbursement.
- Physicians or other qualified health care professionals who own laboratory equipment (Physician Office Laboratory) and perform laboratory testing report the laboratory service without appending modifier 90. These laboratory services are eligible for reimbursement.
- A valid Federal Clinical Laboratory Improvement Amendments (CLIA) Certificate Identification number is required for reimbursement of clinical laboratory services reported on a CMS 1500 Health Insurance Claim Form or its electronic equivalent.

Within the UnitedHealthcare Provider Administrative Guide it states, "If you are a physician, practitioner, or medical group, you may only bill for services that you or your staff perform. Pass-through billing is not permitted and may not be billed to our members. We only reimburse for laboratory services that you are certified to perform through the Federal Clinical Laboratory Improvement Amendments (CLIA). You must not bill our members for any laboratory services for which you lack the applicable CLIA certification."

For more complete information refer to the [UnitedHealthcare Provider Administration Guide](#)

For additional information, refer to the Questions and Answers section, Q&A #2

For more complete information regarding CLIA requirements refer to the UnitedHealthcare "Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Reimbursement Policy."

Duplicate Laboratory Charges

Same Group Physician or Other Health Care Professional

Only one laboratory service is reimbursable when Duplicate Laboratory Services are submitted from the Same Group Physician or Other Health Care Professional. CPT codes 82947 and 82948 are excluded from Duplicate Laboratory Services.

Separate consideration will be given to repeat procedures (i.e., two laboratory procedures performed the same day) by the Same Group Physician or Other Health Care Professional when reported with modifier 91. Modifier 91 is appropriate when the repeat laboratory service is performed by a different individual in the same group with the same Federal Tax Identification number.

According to CMS and CPT guidelines, Modifier 91 is appropriate when, during the course of treatment, it is necessary

to repeat the same laboratory test for the same patient on the same day to obtain subsequent test results, such as when repeated blood tests are required at different intervals during the same day.

CMS has established four new HCPCS modifiers (referred to collectively as the –X {EPSU} modifiers) to define specific subsets of modifier 59. Modifiers XE, XP, XS, and XU will be recognized under this reimbursement policy effective 1/1/2015. According to CMS guidelines and if appropriate, the provider should report one of these modifiers or modifier 59, but not both. Please refer to the “Modifiers” section for a complete listing of modifiers and their descriptions.

According to CMS and CPT coding guidelines, modifier 59, XE, XP, XS, XU may be used when the same laboratory services are performed for the same patient on the same day. UnitedHealthcare will reimburse laboratory services reported with modifier 59, XE, XP, XS, XU for different species or strains, as well as Specimens from distinctly separate anatomic sites.

For additional information, refer to the [Questions and Answers](#) section, Q&A #3, and #5.

According to the AMA and CMS, it is inappropriate to use modifier 76 or 77 to indicate repeat laboratory services. Modifiers 59, XE, XP, XS, XU or 91 should be used to indicate repeat or distinct laboratory services when reported by the Same Group Physician or Other Health Care Professional. Separate consideration for reimbursement will not be given to laboratory codes reported with modifier 76 or 77.

Multiple Physicians or Other Health Care Professionals

Only one laboratory provider will be reimbursed when multiple individuals report Duplicate Laboratory Services. Multiple individuals may include, but are not limited to, any physician or other health care professional, Reference Laboratory, Referring Laboratory or pathologist reporting duplicate services. CPT codes 82947 and 82948 are excluded from Duplicate Laboratory Services.

For additional information, refer to the [Questions and Answers](#) section, Q&A #5.

Reference Laboratory and Non-Reference Laboratory Providers:

If a Reference Laboratory and a Non-Reference Laboratory Provider submit Duplicate Laboratory Services only the Reference Laboratory service is reimbursable.

Independent Laboratory, Reference Laboratory and Referring Laboratory:

Laboratory services billed with modifier 90 by a Referring Laboratory are reimbursable if a duplicate claim has not been received from an Independent Laboratory or Reference Laboratory. Duplicate services are not reimbursable, unless one laboratory appends modifier 91 to the code(s) submitted.

Pathologist and Physician Office Laboratory Providers:

If a pathologist and Physician Office Laboratory provider submit Duplicate Laboratory Services, only the pathologist's service is reimbursable, unless the Physician Office Laboratory provider appends a modifier 91 to the codes submitted.

For additional information, refer to the [Questions and Answers](#) section, Q&A #6

Anatomic Pathology Services and Purchased Diagnostic Services:

UnitedHealthcare Community Plan reimburses Purchased Diagnostic Tests that are subject to the professional/technical concept submitted with modifier 90 by a physician or pathologist. If both the purchaser and supplier who performed the service bill Duplicate Laboratory Services, only one service is reimbursable, unless modifier 59, XE, XP, XS, XU or 91 is appended. Purchased Diagnostic Tests do not apply to automated or manual laboratory tests. UnitedHealthcare Community Plan uses the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFSS) Professional Component/Technical Component (PC/TC) indicators 1, 6, and 8 to identify laboratory services that are eligible as Purchased Diagnostic Tests.

PC/TC Indicator 1: Physician Service Codes (modifier TC and 26 codes)

PC/TC Indicator 6: Laboratory Physician Interpretation Codes

PC/TC Indicator 8: Physician Interpretation Codes

[2019A UnitedHealthcare Community Plan Purchased Laboratory Eligible Codes](#)

For more complete information regarding when a professional or technical component is billed, refer to the UnitedHealthcare Community Plan "Professional/Technical Component" policy. Refer to the UnitedHealthcare Community Plan "Maximum Frequency per Day" policy for additional information on assigned MFD values.

Documentation Requirements for Reporting Laboratory Services

According to CMS, the physician or other qualified health care professional who is treating the patient must order all diagnostic laboratory tests, using these results in the management of the patient's condition. Tests not ordered by the physician or other qualified health care professional are not reasonable and necessary.

The physician's or other qualified health care professional's documentation should clearly indicate all tests to be performed. For example, "run labs" or "check blood" by itself does not support intent to order.

The documentation must include the following:

- Progress notes or office notes signed by the physician or other qualified health care professional
- Physician or other qualified health care professional order/intent to order
- Laboratory results

For additional information, refer to the Questions and Answers section, Q&A #7

Laboratory Services Performed in a Facility Setting

The established policy for reimbursement of laboratory services performed in a facility setting is consistent with UnitedHealthcare Community Plan's policy not to pay for duplicative laboratory services.

Manual and automated laboratory services submitted by a reference or Non-Reference Laboratory Provider with a CMS facility POS 19, 21, 22, 23, 26, 34, 51, 52, 55, 56, 57 or 61 will not be reimbursable. These services are reimbursable to the facility. When facilities obtain manual or automated laboratory tests for patients under arrangements with a Reference Laboratory or pathology group, only the facility may be reimbursed for the services.

Note: UnitedHealthcare Community Plan will make an exception to this policy for reproductive laboratory medicine procedures 89250-89398 when the facility laboratory is not equipped to perform these specialized services and refers them to a reproductive laboratory. In the event that both a facility and a Reference Laboratory report the same service on the same day for the same member, only the facility reproductive laboratory services may be reimbursed.

UnitedHealthcare Community Plan uses the CMS National Physician Fee Schedule (NPFS) Professional Component/Technical Component (PC/TC) indicators 3 and 9 to identify laboratory services that are not reimbursable to a reference or non-reference provider in a facility setting.

- PC/TC indicator 3: Technical Component Only Codes
- PC/TC indicator 9: PC/TC Concept Not Applicable

[2019A UnitedHealthcare Community Plan Laboratory Codes with a PC/TC Status Indicator of 3 or 9](#)

For more complete information on when a professional or technical component is billed refer to the UnitedHealthcare Community Plan "Professional/Technical Component Policy."

Modifiers

Modifier	Description
Modifier 59	-Distinct Procedural Service Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are

	appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.
Modifier 90	-Reference (Outside) Laboratory When laboratory procedures are performed by a party other than the treating or reporting physician, or other qualified health care professional, the procedure may be identified by adding the modifier 90 to the usual procedure number.
Modifier 91	-Repeat Clinical Diagnostic Laboratory Test In the course of treatment of the 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. Note: This modifier 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. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.
Modifier 92	-Alternative Laboratory Platform Testing When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701-86703, and 87389). The test does not require permanent dedicated space; hence by its design it may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.
Modifier XE	Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
Modifier XP	Separate Practitioner, A Service That Is Distinct Because It Was Performed by A Different Practitioner
Modifier XS	Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
Modifier XU	Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

Laboratory Panels

Individual laboratory codes, which together make up a laboratory Panel Code, will be denied. The provider will be required to submit the more comprehensive laboratory Panel Code as described under the specific laboratory panel headings below.

Organ or Disease-Oriented Laboratory Panel Codes

The Organ or Disease-Oriented Panels as defined in the CPT book are codes 80047, 80048, 80050, 80051, 80053, 80055, 80061, 80069, 80074, and 80076. According to the CPT book, these panels were developed for coding purposes only and are not to be interpreted as clinical parameters. UnitedHealthcare Community Plan uses CPT coding guidelines to define the components of each panel.

UnitedHealthcare Community Plan also considers an individual component code included in the more comprehensive Panel Code when reported on the same date of service by the Same Individual Physician or Other Health Care Professional. The Professional Edition of the CPT® book, Organ or Disease-Oriented Panel section states: "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."

For reimbursement purposes, UnitedHealthcare Community Plan differs from the CPT book's inclusion of the specific

number of Component Codes within an Organ or Disease-Oriented Panel. UnitedHealthcare Community Plan will deny the individual Component Codes and require the provider to submit the more comprehensive Panel Code. as set forth more fully in the tables below. The tables for CPT codes 80047, 80048, 80050, 80051, 80053, 80061, 80069, 80074 and 80076 identify the Component Codes that UnitedHealthcare Community Plan will require the submission of the specific panel.

Basic Metabolic Panel (Calcium, ionized), 80047

CPT coding guidelines indicate that a Basic Metabolic Panel (Calcium, ionized), CPT code 80047 should not be reported in conjunction with CPT code 80053. If a submission includes CPT 80047 and CPT 80053, both codes will be denied; the services will need to be resubmitted with CPT 80053 to be reimbursed.

There are 2 configurations for a Basic Metabolic Panel, CPT code 80047:

1. A submission that includes CPT code 82330 plus 4 or more of the following laboratory Component Codes by the Same Individual Physician or Other Health Care Professional for the same patient on the same date of service is a reimbursable service as a Basic Metabolic Panel (Calcium, ionized), CPT code 80047.

Panel Code	Component Code	Code Description
80047		Basic Metabolic Panel (Calcium, ionized), 80047
		Includes the following:
	82330	Calcium; ionized
		Plus 4 or more of the following Component Codes for the same patient on the same date of service:
	82374	Carbon Dioxide (bicarbonate)
	82435	Chloride; blood
	82565	Creatinine; blood
	82947	Glucose; quantitative, blood (except reagent strip)
	84132	Potassium; serum, plasma or whole blood
	84295	Sodium; serum, plasma or whole blood
	84520	Urea nitrogen (BUN)

2. A submission that includes an Electrolyte Panel, CPT code 80051 plus 1 or more of the following laboratory Component Codes by the Same Individual Physician or Other Health Care Professional for the same patient on the same date of service is a reimbursable service as a Basic Metabolic Panel (Calcium, ionized) CPT code 80047.

Panel Code	Component Code	Code Description
80047		Basic Metabolic Panel (Calcium, ionized), 80047
		Includes the following panel:
	80051	Electrolyte Panel
		Plus, the following component code:
	82330	Calcium; ionized
		Plus at least one of the following Component Codes for the same patient on the same date of service:
	82565	Creatinine; blood
	82947	Glucose; quantitative, blood (except reagent strip)
	84520	Urea nitrogen (BUN)

Basic Metabolic Panel (Calcium, total), 80048

CPT coding guidelines indicate that a Basic Metabolic Panel (Calcium, total), CPT code 80048 should not be reported in conjunction with 80053. If a submission includes CPT 80048 and CPT 80053, only CPT 80053 will be reimbursed. There are 2 configurations for a Basic Metabolic Panel (Calcium, total), CPT code 80048:

1. A submission that includes 5 or more of the following laboratory Component Codes by the Same Individual Physician or Other Health Care Professional for the same patient on the same date of service is a reimbursable service as a Basic Metabolic Panel (Calcium, total), CPT code 80048.

Panel Code	Component Code	Code Description
80048		Basic Metabolic Panel (Calcium, total), 80048
		Must contain 5 or more of the following Component Codes for the same patient on the same date of service
	82310	Calcium; total
	82374	Carbon Dioxide (bicarbonate)
	82435	Chloride; blood
	82565	Creatinine; blood
	82947	Glucose; quantitative, blood (except reagent strip)
	84132	Potassium; serum, plasma or whole blood
	84295	Sodium; serum, plasma or whole blood
	84520	Urea nitrogen (BUN)

2. A submission that includes an Electrolyte Panel, CPT code 80051 plus 1 or more of the following laboratory Component Codes by the Same Individual Physician or Other Health Care Professional for the same patient on the same date of service is a reimbursable service as a Basic Metabolic Panel (Calcium, total) CPT code 80048.

Panel Code	Component Code	Code Description
80048		Basic Metabolic Panel (Calcium, total), 80048
		Includes the following panel:
	80051	Electrolyte Panel
		Plus 1 or more of the following Component Codes for the same patient on the same date of service:
	82310	Calcium; total
	82565	Creatinine; blood
	82947	Glucose; quantitative, blood (except reagent strip)
	84520	Urea nitrogen (BUN)

General Health Panel, 80050

A submission that includes a Comprehensive Metabolic Panel, CPT code 80053, a Thyroid Stimulating Hormone, CPT code 84443 and one of the following CBC or combination of CBC Component Codes, either CPT codes 85025 or 85027 + 85004 or 85027 + 85007 or 85025 + 85009 by the Same Individual Physician or Other Health Care Professional for the same patient on the same date of service is a reimbursable service as a General Health Panel, CPT code 80050.

Panel Code	Component Code	Code Description
80050		General Health Panel
		Includes the following panel:
	80053	Comprehensive Metabolic Panel
		Includes the following component code:
	84443	Thyroid Stimulating Hormone (TSH)
		Plus, one of the following CBC or combination of CBC Component Codes for the same patient on the same date of service:
	85025	Blood Count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
	85027 + 85004	Blood Count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) AND Blood count; automated differential WBC count
	85027 + 85007	Blood Count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) AND Blood count; blood smear, microscopic examination with manual differential WBC count
	85027 + 85009	Blood Count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) AND Blood count; manual differential WBC count, buffy coat

When Hepatic Function Panel code 80076 is submitted on the same date of service by the Same Individual Physician or Other Health Care Professional for the same patient as General Health Panel code 80050, CPT code 80076 will not be separately reimbursed.

Comprehensive Metabolic Panel code 80053, a component of Panel Code 80050, includes all components of Hepatic Function Code 80076 except for code 82248 (bilirubin, direct).

Electrolyte Panel, 80051

A submission that includes 2 or more of the following laboratory Component Codes by the Same Individual Physician or Other Health Care Professional for the same patient on the same date of service is a reimbursable service as an Electrolyte Panel, CPT code 80051.

Panel Code	Component Code	Code Description
80051		Electrolyte Panel
		Includes two or more of the following individual Component Codes for the same patient on the same date of service:
	82374	Carbon Dioxide (bicarbonate)
	82435	Chloride; blood
	84132	Potassium; serum, plasma or whole blood
	84295	Sodium; serum, plasma or whole blood

Comprehensive Metabolic Panel, 80053

There are 3 configurations for a Comprehensive Metabolic Panel, CPT code 80053:

1. A submission that includes 10 or more of the following laboratory Component Codes by the Same Individual Physician or Other Health Care Professional for the same patient on the same date of service is a reimbursable service as a Comprehensive Metabolic Panel, CPT code 80053.

Panel Code	Component Code	Code Description
80053		Comprehensive Metabolic Panel
		Must contain 10 or more of the following Component Codes for the same patient on the same date of service:
	82040	Albumin; serum, plasma or whole blood
	82247	Bilirubin; total
	82310	Calcium; total
	82374	Carbon dioxide (bicarbonate)
	82435	Chloride; blood
	82565	Creatinine; blood
	82947	Glucose quantitative, blood (except reagent strip)
	84075	Phosphatase, alkaline
	84132	Potassium; serum, plasma or whole blood
	84155	Protein, total, except by refractometry; serum, plasma or whole blood
	84295	Sodium; serum, plasma or whole blood
	84450	Transferase, aspartate amino (AST) (SGOT)
	84460	Transferase, alanine amino (ALT) (SGPT)
	84520	Urea Nitrogen (BUN)

2. A submission that includes a Basic Metabolic Panel (Calcium, total), CPT code 80048, and 2 or more of the following laboratory Component Codes by the Same Individual Physician or Other Health Care Professional for the same patient on the same date of service is a reimbursable service as a Comprehensive Metabolic Panel, CPT code 80053.

Panel Code	Component Code	Code Description
80053		Comprehensive Metabolic Panel
		Includes the following panel:
	80048	Basic Metabolic Panel (Calcium, total)
		Plus 2 or more of the following Component Codes for the same patient on the same date of service:
	82040	Albumin; serum, plasma or whole blood
	82247	Bilirubin; total
	84075	Phosphatase, alkaline
	84155	Protein, total

	84450	Transferase, aspartate amino (AST) (SGOT)
	84460	Transferase; alanine amino (ALT) (SGPT)

3. A submission that includes an Electrolyte Panel, CPT code 80051, and 6 or more of the following laboratory Component Codes by the Same Individual Physician or Other Health Care Professional for the same patient on the same date of service is a reimbursable service as a Comprehensive Metabolic Panel, CPT code 80053.

Panel Code	Component Code	Code Description
80053		Comprehensive Metabolic Panel
		Includes the following panel:
	80051	Electrolyte Panel
		Plus 6 or more of the following Component Codes for the same patient on the same date of service:
	82040	Albumin; serum, plasma or whole blood
	82247	Bilirubin; total
	82310	Calcium; total
	82565	Creatinine; blood
	82947	Glucose; quantitative, blood (except reagent strip)
	84075	Phosphatase, alkaline
	84155	Protein, total, except by refractometry; serum, plasma or whole blood
	84450	Transferase, aspartate amino (AST) (SGOT)
	84460	Transferase; alanine amino (ALT) (SGPT)
	84520	Urea nitrogen (BUN)

When the Same Individual Physician or Other Health Care Professional reports CPT 80053 with CPT 80048 or CPT 80076 for the same patient on the same date of service, neither CPT 80048 nor CPT 80076 will be reimbursed separately.

CPT Panel Code 80053 includes all of the components of CPT Panel Code 80048 and all the components of CPT Panel Code 80076, except for CPT 82248 (bilirubin, direct). Therefore, when performed with all of the components of CPT 80053, report CPT 82248 separately.

Obstetric Panel, 80055

A submission that includes one of the following CBC or combination of CBC Component Codes, either CPT codes 85025 or 85027 + 85004 or CPT codes 85027 + 85007 or 85027 + 85009 and each component CPT code Syphilis, non-treponemal antibody 86592, Antibody, Rubella, 86762, RBC antibody screen, 86850, Blood typing ABO, 86900, Blood typing RH (D), 86901 and Hepatitis B surface antigen (HBsAg), 87340 by the Same Individual Physician or Other Health Care Professional for the same patient on the same date of service is a reimbursable service as an Obstetric Panel, CPT code 80055.

NOTE: The Hepatitis B Surface Antigen (87340) is a component code of both the Obstetric Panel (80055) and the Acute Hepatitis Panel (80074). The Obstetric Panel takes Precedence.

Panel Code	Component Code	Code Description
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80055		Obstetric Panel
		Includes one of the following CBC or combination of CBC Component Codes for the same patient on the same date of service:
	85025	Blood Count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
	85027 + 85004	Blood count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) Hemogram and platelet count, automated complete differential WBC count (CBC) AND Blood count; automated differential WBC count
	85027 + 85007	Blood count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) Hemogram and platelet count, automated complete differential WBC count (CBC) AND Blood count; blood smear, microscopic examination with manual differential WBC count
	85027 + 85009	Blood count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) Hemogram and platelet count, automated complete differential WBC count (CBC) AND Blood count; manual differential WBC count, buffy coat
		Plus, each of the following Component Codes for the same patient on the same date of service:
	86592	Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART)
	86762	Antibody; Rubella
	86850	RBC, antibody screen
	86900	Blood typing; ABO
	86901	Blood typing; Rh (D)
	87340	Hepatitis B surface antigen (HBsAg)

Lipid Panel, 80061

A submission that includes all of the following laboratory Component Codes by the Same Individual Physician or Other Health Care Professional for the same patient on the same date of service is a reimbursable service as a Lipid Panel, CPT code 80061.

Panel Code	Component Code	Code Description
80061		Lipid Panel
		Includes all of the following Component Codes for the same patient on the same date of service:
	82465	Cholesterol, serum or whole blood; total
	83718	Lipoprotein direct measurement high density cholesterol (HDL cholesterol)
	84478	Triglycerides

Renal Function Panel, 80069

A submission that includes 6 or more of the following laboratory Component Codes by the same individual physician or health care professional for the same patient on the same date of service is a reimbursable service as a Renal Function Panel, CPT code 80069.

NOTE: Renal Function Panel, 80069, includes the Basic Metabolic Panel, CPT code 80048, submitted by the Same Individual Physician or Other Health Care Professional for the same patient on the same date of service.

Panel Code	Component Code	Code Description
80069		Renal Function Panel
		Includes 6 or more of the following Component Codes for the same patient on the same date of service:
	82040	Albumin; serum, plasma or whole blood
	82310	Calcium; total
	82374	Carbon dioxide (bicarbonate)
	82435	Chloride; blood
	82565	Creatinine; blood
	82947	Glucose; quantitative, blood (except reagent strip)
	84100	Phosphorus inorganic (phosphate)
	84132	Potassium; serum, plasma or whole blood
	84295	Sodium; serum, plasma or whole blood
	84520	Urea nitrogen (BUN)

Acute Hepatitis Panel, 80074

A submission that includes all of the following laboratory Component Codes by the Same Individual Physician or Other Health Care Professional for the same patient on the same date of service is a reimbursable service as an Acute Hepatitis Panel, CPT code 80074.

NOTE: Hepatitis B Surface Antigen (87340) is a Component Code for both the Obstetric Panel, CPT code 80055, and the Acute Hepatitis Panel, CPT code 80074. The Obstetric Panel, CPT code 80055, takes Precedence.

Panel Code	Component Code	Code Description
80074		Acute Hepatitis Panel
		Includes all of the following Component Codes for the same patient on the same date of service:
	86705	Hepatitis B core antibody IgM (HBcAb)
	86709	Hepatitis A antibody (HAAb), IgM
	86803	Hepatitis C antibody
	87340	Hepatitis B surface antigen (HBsAg)

Hepatic Function Panel, 80076

A submission that includes 4 or more of the following laboratory Component Codes by the Same Individual Physician or Other Health Care Professional for the same patient on the same date of service is a reimbursable service as a Hepatic Function Panel, CPT code 80076.

Panel Code	Component Code	Code Description
80076		Hepatic Function Panel

		Includes 4 or more of the following Component Codes for the same patient on the same date of service:
	82040	Albumin; serum, plasma or whole blood
	82247	Bilirubin, total
	82248	Bilirubin, direct
	84075	Phosphatase, alkaline
	84155	Protein, total, except by refractometry; serum, plasma or whole blood
	84450	Transferase, aspartate amino (AST) (SGOT)
	84460	Transferase, alanine amino (ALT) (SGPT)

Surgical Pathology

Surgical Pathology CPT codes 88300-88309 describe gross and microscopic examination and pathologic diagnosis of Specimen(s) submitted. Two or more Specimens separately identified from the same patient are each assigned an individual code reflective of its proper level of service. Under certain circumstances, the physician may need to report the same surgical pathology code for multiple Specimens for the same patient on the same date of service.

Pathology Specimens from the same anatomic site reported with the same Surgical Pathology CPT code may be reported on one line with multiple units.

Duplicate pathology Specimens reported with the same Surgical Pathology CPT code must be reported with a modifier 59, XE, XP, XS, XU or 91 to receive separate consideration.

Venipuncture and Specimen Collection

Consistent with CMS, only one collection fee for each type of Specimen per patient encounter, regardless of the number of Specimens drawn, will be allowed. A collection fee will not be reimbursed to anyone who did not extract the Specimen.

Venous blood collection by venipuncture and capillary blood Specimen collection (CPT codes 36415 and 36416) will be reimbursed once per physician or other health care professional per patient per date of service. When CPT code 36416 is submitted with CPT code 36415, CPT code 36415 is the only venipuncture code considered eligible for reimbursement. No modifier overrides will exempt CPT code 36416 from bundling into CPT code 36415.

Consistent with CMS, UnitedHealthcare Community Plan considers collection of a Specimen from a completely implantable venous access device and from an established catheter (CPT codes 36591 and 36592) to be bundled into services assigned a CMS NPFS Status Indicator of A, R or T provided on the same date of service by the Same Individual Physician or Other Health Care Professional, for which payment is made. When CPT code 36591 is submitted with CPT code 36592, CPT code 36592 is the only venipuncture code considered eligible for reimbursement. No modifier overrides will exempt CPT code 36591 from bundling into CPT code 36592.

UnitedHealthcare Community Plan considers venipuncture code S9529 (Routine venipuncture for collection of Specimen(s), single homebound, nursing home, or skilled nursing facility patient) a non-reimbursable service. The description for S9529 focuses on place of service for a service that is more precisely represented by CPT code 36415 and reported with the appropriate CMS place of service code.

UnitedHealthcare Community Plan considers CPT code 36416 an integral part of an E&M service when performed on the same date of service by the same provider. When CPT code 36416 is submitted with an E&M service, only the E&M service will be considered for reimbursement. No modifier overrides will exempt CPT code 36416 from bundling into an E&M service.

Laboratory Handling

Laboratory handling and conveyance CPT codes 99000 and 99001 and HCPCS code H0048 are included in the overall management of a patient and are not separately reimbursed.

Clinical and Surgical Pathology Consultations (80500 – 80502 and 88321 – 88325)

CPT codes 80500, 80502, and 88321 – 88325 are reimbursable services only to Reference Laboratories and to providers whose primary specialty is pathology or dermatology.

UnitedHealthcare Community Plan considers clinical and surgical pathology consultation codes as included in an Evaluation and Management (E/M) service provided for the same patient on the same date of service. If billed with an E/M service, codes 80500-80502 and/or 88321-88325 are not separately reimbursable.

[2019A UnitedHealthcare Community Plan E & M Codes for the Laboratory Services Policy](#)

Drug Assay Codes: Not applicable for UnitedHealthcare Community Medicaid Plans

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Definitions	
Component Codes	Identify individual tests that when performed together may comprise a panel.
CMS NPFS Status A	Active Code. These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.
CMS NPFS Status R	Restricted Coverage. Special coverage instructions apply. If covered, the service is carrier priced. (NOTE: The majority of codes to which this indicator will be assigned are the alpha-numeric dental codes, which begin with "D". We are assigning the indicator to a limited number of CPT codes which represent services that are covered only in unusual circumstances.)
CMS NPFS Status T	Injections. There are RVUS and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. (NOTE: This is a change from the previous definition, which states that injection services are bundled into any other services billed on the same date.)
Duplicate Laboratory Service	Identical or equivalent laboratory Component Codes, submitted for the same patient on the same date of service on separate claim lines or on different claims regardless of the assigned Maximum Frequency per Day (MFD) value.
Independent Laboratory	An Independent Laboratory is one that is independent both of an attending or consulting physician's office and of a hospital that meets at least the requirements to qualify as an emergency hospital. An Independent Laboratory must meet Federal and State requirements for certification and proficiency testing under the Clinical Laboratories Improvement Act (CLIA). Independent Laboratory providers must append modifier 90 to all reported laboratory services.





Non-Reference Laboratory Provider	A physician reporting laboratory procedures performed in their office or a pathologist.
Panel Codes	Identify, for coding purposes, a group of tests commonly performed as a group or profile.
Physician Office Laboratory	A laboratory maintained by a physician or group of physicians for performing diagnostic tests in connection with the physician practice.
Precedence	The fact, state, or right of preceding priority; priority claimed because of pre-eminence or superiority.
Purchased Diagnostic Tests	When one component (technical or professional) of a diagnostic test is purchased from a laboratory supplier by a physician or laboratory. Purchased Diagnostic Tests include laboratory or pathology services that are listed in the (CMS) National Physician Fee Schedule with a PC/TC indicator 1, 6, or 8. Purchased services do not apply to automated or manual laboratory services. When billed by the purchaser, the purchased service is identified with a modifier 90.
Reference Laboratory	A Reference Laboratory that receives a Specimen from another, Referring Laboratory for testing and that actually performs the test is often referred to as an Independent Laboratory. Services billed by a Reference Laboratory should use modifier 90 to identify the Reference Laboratory services.
Referring Laboratory	A Referring Laboratory is one that receives a specimen to be tested and that refers the specimen to another laboratory for performance of the laboratory test. Referring Laboratory providers must append modifier 90 to all reported laboratory services.
Same Group Physician or Other Health Care Professional	All physicians and/or other health care professionals of the same group reporting the same Federal Tax Identification number.
Same Individual Physician or Other Health Care Professional	The same individual rendering health care services reporting the same Federal Tax Identification number.
Specimen	Tissue or tissues that is or are submitted for individual and separate attention, requiring individual examination and pathological diagnosis. Two or more such Specimens from the same patient (e.g., separately identifiable endoscopic biopsies, skin lesions) are each appropriately assigned an individual code reflective of its proper level of service.

Questions and Answers

1	<p>Q: What place of service should an Independent or Reference Laboratory report when billing?</p> <p>A: When billing, the place of service reported should be the location where the Specimen was obtained, For example, a specimen removed from a hospitalized patient and sent to the laboratory would be reported with Place of Service (POS) 21 or 22; a sample taken at a physician's office and referred to the laboratory would be reported with POS 11; if the reference laboratory did the blood drawing in its own setting, it should report POS 81.</p>
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2	<p>Q: What provider specialty is eligible to report and receive reimbursement for Laboratory services?</p> <p>A: As stated in the UnitedHealthcare Provider Administration Guide you may only bill for services that you or your staff perform. If your provider specialty is a Reference Laboratory, report laboratory services appended with modifier 90 to indicate a Reference (Outside) Laboratory.</p>
3	<p>Q: Will identical or equivalent laboratory Component Codes submitted on the same day for the same patient by the Same Group Physician or Other Health Care Professional be denied as Duplicate Laboratory Services?</p> <p>A: No, identical or equivalent laboratory Component Codes are reimbursable when the appropriate repeat laboratory procedure modifier (modifier 59, XE, XP, XS, XU or 91) is appended to the code(s) submitted.</p>
4	<p>Q: Will consecutive or serial tests provided on the same day to the same patient by either physicians of the same group or multiple providers be denied as a Duplicate Laboratory Service?</p> <p>A: No, consecutive or serial tests are reimbursable when the appropriate repeat laboratory procedure modifier (modifier 91) is appended to the codes submitted.</p>
5	<p>Q: In what circumstance(s) is it appropriate to report modifier 59 with a laboratory service?</p> <p>A: When identifying procedures/services that are performed by the same or multiple individuals or other health care professionals for the same patient on the same day, modifier 59, XE, XP, XS, or XU is appropriate. Multiple individuals may include, but are not limited to, any physician or other health care professional, Reference Laboratory, Referring Laboratory or pathologist. Circumstances include:</p> <ul style="list-style-type: none"> • Mutually exclusive procedures (e.g., a Panel Code and one of its individual Component Codes reported together). • Repeat laboratory services on Specimens from distinctly separate anatomic sites. • Repeat laboratory services for different species or strains.
6	<p>Q: If a pathologist and a treating physician report identical codes for the same individual on the same date of service, how will the claim be reimbursed?</p> <p>A: Only the pathologist will be reimbursed. The treating physician may also be reimbursed if modifier 59, XE, XP, XS, XU, or 91 is appropriately reported with the code(s) submitted to distinguish that it was a distinct or repeat laboratory service.</p>
7	<p>Q: Can laboratory tests be performed in the absent of a physician(s) or other qualified healthcare professional(s) documentation or signed physician orders?</p> <p>A: No, physicians or other qualified health care professionals who order laboratory services for patients must maintain documentation of the order/intent of the service(s) or signed progress notes or office notes.</p>
8	<p>Q: Why is code 83992 (Phencyclidine (PCP)) added to the Drug Assay Testing section code range 80320 - 80377?</p> <p>A: CPT code 83992 (Phencyclidine (PCP)) which was resequenced, is included in the Drug Assay Testing code range, 80320-80377. In CPT, code 83992 has been placed between 80365 and 80366, which falls into the Drug Assay Testing code range.</p>

Attachments: Please right-click on the icon to open the file.

 UnitedHealthcare Community Plan EM Codes for the Laboratory Services Policy	<p>A list of evaluation and management codes applicable to the Laboratory Services Policy.</p>
 UnitedHealthcare Community Plan Laboratory Codes with a PC/TC Status Indicator of 3 or 9	<p>A list of codes that have been assigned a Professional Component/ Technical Component (PC/TC) Indicator of 3 or 9. PC/TC Indicator 3: Technical Component Only code PC/TC Indicator 9: The concept of a professional/technical component does not apply These services are not reimbursable to a Reference Laboratory or Non-Reference Laboratory Provider in a facility setting.</p>
 UnitedHealthcare Community Plan Purchased Laboratory Eligible Codes	<p>A list of laboratory codes that have been assigned a Professional Component/ Technical Component (PC/TC) Indicator of 1, 6, or 8. PC/TC Indicator 1: Physician Service Codes (modifier TC and 26 codes) PC/TC Indicator 6: Laboratory Physician Interpretation Codes PC/TC Indicator 8: Physician Interpretation Codes These services are reimbursable as Purchased Diagnostic Tests when billed with a modifier 90.</p>
 Lab Status Indicator A R T codes	<p>A list of codes that have a CMS NPFS Status Indicator of A, R or T.</p>

Resources

Individual state Medicaid regulations, manuals & fee schedules

American Medical Association, *Current Procedural Terminology (CPT®) Professional Edition* and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

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History

2/15/2021	<p>Policy Version Change Removed reference to other state exceptions</p>
5/26/2019	<p>Policy Version Change Table of Contents Updated Removed Molecular Diagnostic Laboratory and Proprietary Laboratory Analyses Services section Attachment Section: Removed Molecular Diagnostic Laboratory Codes and Proprietary Laboratory Analyses Code lists Resources Section Updated</p>
3/31/2019	<p>Policy Version Change Attachment Section: Laboratory Status Indicator A R T Codes</p>

	Molecular Diagnostic Laboratory and Proprietary Laboratory Analyses Services Section: Added Oncology to the allowed specialties
3/3/2019	Reimbursement Guidelines section updated: Laboratory Handling verbiage updated State Exception section updated: Iowa Attachments section updated: MDL & PLA code lists added
1/13/2019	State Exception section updated: Iowa
1/1/2019	Annual Policy Version Change Table of Contents Updated Definitions section updated Questions and Answers section updated History section: Entries prior to 1/1/2017 archived
11/11/2018	State Exception section updated: added MO & WA
7/2/2018	Policy Change: Provider Specialties Eligible for Reimbursement of Laboratory Services section added; Duplicate Charges section updated Exceptions section updated Definition section updated Q&A: #2 added and remaining section updated and renumbered Attachments update: A R T Codes
4/1/2018	Annual Policy Version Change Attachment Updates: Evaluation and Management Codes, Laboratory Codes with a PC/TC Indicator 3 or 9, and Laboratory Status Indicator A R T Codes History/Updates Section: Entries prior to 1/1/2016 archived
3/14/2018	Policy Approval Date Change, No New Version
12/11/2017	Added Documentation Requirements for Reporting Laboratory Services section Questions and Answers section: added question 6
11/26/2017	State Exceptions Section: updated DE & OH
11/17/2017	Policy Section: Laboratory Services Performed in a Facility Setting section changed
10/1/2017	Attachments Section: Updated E&M Codes, PC/TC Status Indicator of 3 or 9 & Lab Status Indicator A R T attachments
7/15/2017	Application Section: Removed UnitedHealthcare Community Plan Medicare products as applying to this policy. Added location for UnitedHealthcare Community Plan Medicare reimbursement policies. Drug Assay Section: Policy verbiage change to state not applicable for Medicaid products Exceptions Section: Policy verbiage removed for UnitedHealthcare Community Plan Medicare Organ or Disease-Oriented Laboratory Panel Codes exception
5/21/2017	State Exception section updated: New Mexico
3/20/2017	Annual Policy Version Change State Exception section updated: Iowa
3/3/2017	Drug Assay Codes Section: Removed code 80305-80507
01/01/2017	Annual Policy Version Change Application Section: Verbiage change; no change to intent History Section: Entries prior to 1/1/15 archived

01/01/2016	Annual Policy Version Change Laboratory Services Performed in a Facility Setting POS 19 added Policy Attachment Updates: Evaluation and Management Codes, Laboratory Codes with a PC/TC Indicator 3 or 9, and Purchased Laboratory Eligible Codes History/Updates Section: Entries prior to 1/1/2014 archived
09/20/2015	Policy Verbiage Addition to the following sections: Application, Place of Service, Organ or Disease-Oriented Laboratory Panel Codes, Venipuncture and Specimen Collection, Drug Assay Codes, Exceptions, Definition, and Attachments.
06/1/2015	Policy Verbiage Update: Table of Contents Section, Policy Verbiage Addition: Drug Assay Codes Section Added for Community Plan Medicare products.
05/16/2015	Policy Verbiage Update: Table of Contents Section, Application Section, Place of Service Section, Duplicate Laboratory Charges Section, Laboratory Services Performed in a Facility Setting Section, Venipuncture and Specimen Collection Section, Definitions Section and Q&A #1.
3/11/2015	Annual Approval Date Change Approved by Section: Replaced United HealthCare Community & State Payment Policy Committee with Payment Policy Oversight Committee
1/1/2015	Annual Policy Version Change Application Section: Verbiage change; no change to intent Policy and Verbiage Changes: Venipuncture Section updated, Removal of the Qualitative Laboratory Services Section (80100, 80101, or 80104) Policy Attachment Updates: Purchased Laboratory Eligible Codes, Laboratory Codes with a PC/TC Indicator 3 or 9 and Evaluation and Management Codes for the Laboratory Services Policy History/Updates section - Entries prior to 1/1/2013 archived