Laboratory Services Policy, Professional

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 uses 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.

Table of Contents

Application
Policy
Overview
Reimbursement Guidelines
- Place of Service
- Date of Service
- Provider Specialties Eligible for Reimbursement of Laboratory Services
- Duplicate Laboratory Charges
- Documentation Requirements for Reporting Laboratory Services
- Laboratory Services Performed in a Facility Setting
- Modifiers
- Laboratory Panels
- Organ or Disease-Oriented Laboratory Panel Codes
  - Panel, 80047
  - Panel, 80048
  - Panel, 80050
  - Panel, 80051
  - Panel, 80053
  - Panel, 80055
  - Panel, 80061
  - Panel, 80069
  - Panel, 80074
  - Panel, 80076
  - Panel, 80081
  - Surgical Pathology
  - Venipuncture
  - Laboratory Handling

Clinical and Surgical Pathology Consultations (80503-80506 & 88321-88325)
Drug Assay Codes

Definitions
Questions and Answers
Attachments
Resources
History

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.

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 qualified 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. All services described in this policy may be subject to additional UnitedHealthcare reimbursement policies including, but not limited to, the Rebundling and CCI Editing Policy, the CLIA Policy and the Professional/Technical Component Policy.

Reimbursement Guidelines

Place of Service

UnitedHealthcare Community Plan uses the codes indicated in the CMS Place of Service (POS) Codes for Professional Claims Database to determine if laboratory services are reimbursable. For the purposes of this policy, a facility POS is considered POS 19, 21, 22, 23, 26, 34, 51, 52, 55, 56, 57 and 61. All other POS (e.g., 11, 81, etc.) are considered non-facility.

CMS Place of Service Database

The POS designation identifies the location where the laboratory service was collected. For example, if the specimen is obtained:

- In an Independent Laboratory or a Reference Lab, POS 81 is reported
- In an office/clinic or other non-facility setting, the appropriate non-facility POS is reported
- In a facility setting, the appropriate facility POS is reported (e.g., patient is inpatient [POS 21] or outpatient [POS 22]).
- In a laboratory setting maintained by another physician or other qualified health care professional in their office/clinic, the POS code 99 for “Other Place of Service” is reported.

All entities billing for laboratory services should append identifying modifiers (e.g., 90), when appropriate, in accordance with correct coding.

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.

Note: United Healthcare will make an exception to the DOS policy for Advanced Diagnostic Laboratory Testing (ADLT) and molecular pathology tests excluded from Outpatient Prospective Payment System (OPPS) packaging policy

- DOS for ADLTs and molecular pathology tests excluded from OPPS packaging policy may be noted as **the date the test was performed** if certain conditions are met:
  (1) The test is performed following the date of a hospital outpatient's discharge from the hospital outpatient department;
  (2) The specimen was collected from a hospital outpatient during an encounter;
  (3) It was medically appropriate to have collected the sample from the hospital outpatient during the hospital outpatient encounter;
  (4) The results of the test do not guide treatment provided during the hospital outpatient encounter; and
  (5) The test was reasonable and medically necessary for the treatment of an illness.

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 Qualified Health Care Professional
Only one laboratory service is reimbursable when Duplicate Laboratory Services are submitted from the Same Group Physician or Other Qualified Health Care Professional.

Separate consideration will be given to repeat procedures (i.e., two laboratory procedures performed the same day) by the Same Group Physician or Other Qualified 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.

CPT instructions state that modifier 59 should not be used when a more descriptive modifier is available. CMS guidelines cite that the –X {EPSU} modifiers are more selective versions of modifier 59 so it would be incorrect to include both modifiers on the same line. 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 American Medical Association (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 Qualified Health Care Professional. Separate consideration for reimbursement will not be given to laboratory codes reported with modifier 76 or 77.

Multiple Physicians or Other Qualified 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 Qualified Health Care Professional, Independent Laboratory, Reference Laboratory, Referring Laboratory, or pathologist reporting duplicate services.
For additional information, refer to the Questions and Answers section, Q&A #4.

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:
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 CMS National Physician Fee Schedule (NPFS) 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

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 and may not be considered for reimbursement.

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.

Documentation of an order or intent to order may include for example:

- A signed order or requisition listing the specific test(s), or
- An unsigned order or requisition listing the specific test(s), and an authenticated medical record (e.g., progress notes or office notes) supporting the physician's intent to order the tests (for example, "order labs", "check blood", "repeat urine," or
- An authenticated medical record (e.g. office notes or progress notes) supporting the physician intent to order specific test(s), or
- Electronic requisitions are acceptable when the laboratory can demonstrate the order(s) was received through a standardized electronic process.

The medical record should include the documentation described above, as well as a copy of the test 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 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 an Independent Laboratory, 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 molecular pathology laboratory procedures, Genomic Sequencing Procedures and other Molecular- Multianalyte Assays and proprietary laboratory analysis procedures when the facility laboratory is not equipped or would not be expected to perform these specialized services and refers them to a reproductive laboratory. In the event that both a facility and an Independent Laboratory or Reference Laboratory report the same service on the same day for the same member, only the facility laboratory services may be reimbursed.

UnitedHealthcare Community Plan uses the CMS NPFS 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

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

59	90	91	92	XE	XP	XS	XU

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, 80076 and 80081. 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 Qualified 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."

Effective for claims with dates of service on or after April 18, 2020, if a provider submits fewer than all the component codes that make up a panel, the component codes will be considered individually for reimbursement. Claims will be denied when all components found on the lab panel list are submitted.

Panel, 80047- There are 2 configurations for Panel CPT code 80047:

1.

Panel Code: 80047				
Includes Component Codes:				
82374	82435	82565	82947	84132
84295	84520	82330		

2.

Panel Code: 80047				
Includes the following Panel Codes:				
82565	82947	84520	80051	82330

Panel, 80048- There are 2 configurations for Panel CPT code 80048:

1.

Panel Code: 80048				
82310	82374	82435	82565	82947
84132	84295	84520		

2.

Panel Code: 80048				
82310	82565	82947	84520	80051

Panel, 80050- Panel CPT code 80053, Panel CPT code 84443 and one of the following Component Codes, either CPT codes 85025 or 85027 + 85004 or 85027 + 85007 or 85027 + 85009.

80053	84443	85025	OR
85027 + 85004	85027 + 85007	85027 + 85009	

Panel, 80051

Panel Code: 80051				
82374	82435	84132	84295	

Panel, 80053- There are 3 configurations for Panel CPT code 80053:

1.

Panel Code: 80053				
82040	82247	82310	82374	82435
82565	82947	84075	84132	84155
84295	84450	84460	84520	

2.

Panel Code: 80053				
Includes the following Panel Code: 80048				
82040	82247	84075	84155	84450
84460				

3.

Panel Code: 80053				
Includes the following Panel Code: 80051				
82040	82247	82310	82565	82947
84075	84155	84450	84460	84520

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 86592, 86762, 86850, 86900, 86901 and 87340

Panel Code: 80055				
85025	85027 + 85004	85027 + 85007	85027 + 85009	86592
86762	86850	86900	86901	87340

Panel, 80061

Panel Code: 80061				
82465	83718	84478		

Panel, 80069

Panel Code: 80069				
82040	82310	82374	82435	82565
82947	84100	84132	84295	84520

Panel, 80074

Panel Code: 80074				
86705	86709	86803	87340	

Panel, 80076

Panel Code: 80076				
82040	82247	82248	84075	84155
84450	84460			

Panel, 80081- A submission that includes one of the following Component Codes, either CPT codes 85025 or 85027 + 85004 or CPT codes 85027 + 85007 or 85027 + 85009 and each component CPT code 86592, 86762, 86850, 86900, 86901 and 87340 and 87389

NOTE: The CPT code 87340 is a component code of both the Panels 80055 or 80081 and the Panel 80074. The Panel 80055 or 80081 (which includes HIV testing) takes Precedence.

Panel Code: 80081				
85025	85027 + 85004	85027 + 85007	85027 + 85009	
86592	86762	86850	86900	86901
87340	87389			

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 patient per date of service when reported by the Same Individual Physician or Other Qualified Health Care Professional. 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 Qualified 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.

Laboratory Status Indicator A R T codes
The edits administered by this policy may be found on the following link using the appropriate year and quarter referencing the “Status Code” column:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

UnitedHealthcare Community Plan considers venipuncture code S9529 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 Healthcare Common Procedure Coding Systems (HCPCS) code H0048 are included in the overall management of a patient and are not separately reimbursed.

Clinical and Surgical Pathology Consultations (80503 – 80506 and 88321 – 88325)

CPT codes 80503 – 80506 and 88321 – 88325 are reimbursable services only to Reference Laboratories and to providers whose primary specialty is pathology or dermatology.

UnitedHealthcare 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 80503 – 80506 and/or 88321 - 88325 are not separately reimbursable.

UnitedHealthcare Community Plan E & M Codes for the Laboratory Services Policy

Drug Assay Codes: Please refer to the UnitedHealthcare Community Plan Drug Testing Policy

Exceptions	
California	Per California State Regulations, when a general health panel is performed (80050) the provider must bill the individual components of the panel, code 80050 is not covered.
Kansas	Per Kansas State Regulations, when a general health panel is performed (80050) the provider must bill the individual components of the panel, code 80050 is not covered. Per Kansas State Regulations, modifier 90 is covered.
Maryland	Maryland allows payment of CPT 36416 when billed with an Evaluation and Management service. Per Maryland State Regulations, when a general health panel is performed (80050) the provider must bill the individual components of the panel, code 80050 is not covered.
Minnesota	Minnesota allows payment of CPT 36416 when billed with Evaluation and Management Services.
Mississippi	Per Mississippi State Regulations, when a general health panel is performed (80050) the provider must bill the individual components of the panel, code 80050 is not covered
Missouri	Per Missouri State Regulations, when a general health panel is performed (80050) the provider must bill the individual components of the panel, code 80050 is not covered
Ohio	Per State requirements: Ohio allows payment of CPT 36416 when billed with an Evaluation and Management service. Ohio allows code H0048 under their Redesign product for lab services. Ohio Medicaid and MME plans require that certain lab codes cannot be submitted with a modifier, the list of codes is included in the policy. Per Ohio State Regulations, when a general health panel is performed (80050) in POS 81 the provider must bill the individual components of the panel, code 80050 is not covered in POS 81
Tennessee	Per Tennessee State Regulations: Tennessee allows payment of HCPC codes H0014HG, H0016HG, H0033HG, and H0049HG when services are received in facility place of service as part of the BESMART Program.
Texas	Texas allows reimbursement for CPT code 99000 & 99001.

Washington	Washington allows payment of CPT 36416 when billed with an Evaluation and Management service (codes 99381-99397 and 99401-99412); and even in the presence of a preventative medicine CPT code 99429, and HCPCS code G0402.
Wisconsin	Wisconsin allows payment of CPT 36416 when billed with an Evaluation and Management service for members ages 6 and under. Wisconsin allows reimbursement for CPT code 99000 & 99001. Manual and automated laboratory services submitted with a CMS facility POS 57 will be reimbursable.

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 Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group reporting the same Federal Tax Identification number.
Same Individual Physician or Other Qualified 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 (eg, separately identifiable endoscopic biopsies, skin lesions) are each appropriately assigned an individual code reflective of its proper level of service.

Questions and Answers	
1	**Q:** What place of service should an Independent or Reference Laboratory report when billing? **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.
2	**Q:** What provider specialty is eligible to report and receive reimbursement for Laboratory services? **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.
3	**Q:** Will identical or equivalent laboratory Component Codes submitted on the same day for the same patient by the Same Group Physician or Other Qualified Health Care Professional be denied as Duplicate Laboratory Services? **A:** Yes, identical or equivalent laboratory Component Codes are denied unless the appropriate repeat laboratory procedure modifier (modifier 59, XE, XP, XS, XU, or 91) is appended to the code(s) submitted.

4	**Q:** Will consecutive or serial tests provided on the same day to the same patient by either physician of the same group or multiple providers be denied as a Duplicate Laboratory Service? **A:** Yes, consecutive or serial tests are denied unless the appropriate repeat laboratory procedure modifier (modifier 91) is appended to the codes submitted.
5	**Q:** In what circumstance(s) is it appropriate to report modifier 59 with a laboratory service? **A:** When identifying procedures/services that are performed by the same or multiple individuals or Same Group Physician or Other Qualified 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 qualified health care professional, Reference Laboratory, Referring Laboratory or pathologist. Circumstances include: • 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	**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? **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.
7	**Q:** Can laboratory tests be performed in the absence of a physician(s) or other qualified healthcare professional(s) documentation or signed physician orders? **A:** Yes, laboratory tests will be considered for reimbursement when they meet CMS's documentation requirements. The patient's medical record must include either a signed order from the physician or other health care professional or must document a clear intent for the test to be performed. For example, "run labs" or "check blood" by itself does not support intent to order. The physician's or other qualified health care professional's documentation, showing the order or intent to order (electronic requisition is acceptable as noted above), should clear indicate all tests to be performed.
8	**Q:** Why is code 83992 added to the Drug Assay Testing section code range 80320 - 80377? **A:** CPT code 83992 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.
9	**Q:** Is a separate collection of the specimen and order necessary for the appropriate use of modifier 91? **A:** Yes, a separate collection with appropriate order is required for proper use of modifier 91. The order may be part of a sequential order or may be a standalone order for the same test, same day and same patient. **For Example**: Cardiac enzymes CPT code 82550 may be drawn at different times on the same date of service (DOS). Reporting 82550-91 for each additional blood draw would be an appropriate use of modifier 91. The 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.

Attachments	
Evaluation and Management Codes for Laboratory Services	A list of evaluation and management codes applicable to the Laboratory Services Policy.

Laboratory Codes with a PC/TC Status Indicator of 3 or 9	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.
Purchased Laboratory Eligible Codes	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.
Ohio No Modifier List	A list of codes that cannot be submitted with a modifier for Ohio Medicaid and MME plans.

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

History

4/14/2024	Policy Version Change State Exceptions Section: Updated Mississippi
3/31/2024	Policy Version Change State Exceptions Section: Updated Tennessee
2/25/2024	Policy Version Change Attachment Section: Updated E&M Codes History Section: Entries prior to 2/25/22 archived
1/1/2024	Policy Version Change Attachment Section: Updated E&M Codes and Laboratory Code with a PC/TC Indicator 3 or 9 History Section: Entries prior to 1/1/21 archived
10/08/2023	Policy Version Change State Exceptions Section: Updated Minnesota History section: Entries prior to 10/8/2021 archived
6/18/2023	Policy Version Change Logo Update State Exceptions Section: Updated Ohio History Section: Entries prior to 6/18/21 archived
1/1/2023	Policy Version Change Attachment Section: Updated E&M Codes for the Laboratory Services Policy, Laboratory Codes with a PC/TC Indicator 3 or 9 and Laboratory Status Indicator A R T Codes

	History section: Entries prior to 1/1/2021 archived
12/11/2022	Policy Version Change State Exceptions Section: Updated Washington
10/9/2022	Policy Version Change Reimbursement Guidelines Section: Date of service and Laboratory Services Performed in a Facility Setting updated State Exceptions Section: Updated Texas History section: Entries prior to 10/9/2020 archived
1/30/2006	Policy Implemented by UnitedHealthcare Community & State