UnitedHealthcare® Medicare Advantage
Reimbursement Policy
CMS 1500
Policy Number 2020R9017B

Laboratory Services Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

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 Medicare Advantage 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 (CMS 1450). 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 resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage 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 Medicare Advantage enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents**. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

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** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.

Application

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, and laboratory handling. 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.

Reimbursement Guidelines

Place of Service

UnitedHealthcare Medicare Advantage uses the codes indicated in the CMS Place of Service (POS) Codes for Professional Claims Database to determine if laboratory services are reimbursable.

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.

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.

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Within the UnitedHealthcare Medicare Advantage 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

Duplicate Laboratory Charges

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

Separate consideration will be given to repeat procedures (i.e., two laboratory procedures performed the same day) by the Same Individual Physician or Other Qualified Health Care Professional when reported with modifier 91.

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, or XU may be used when the same laboratory services are performed for the same patient on the same day. UnitedHealthcare Medicare Advantage will reimburse laboratory services reported with modifier 59, XE, XP, XS, or 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 #2, and #4.

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 Individual 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 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.

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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 #5

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 Medicare Advantage uses the Centers for Medicare and Medicaid Services (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

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 Medicare Advantage'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.

UnitedHealthcare Medicare Advantage 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 an Independent Laboratory, Reference Laboratory or Non-Reference Laboratory provider in a facility setting.

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

Modifiers

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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 (eg, 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

Organ or Disease-Oriented Laboratory Panel Codes

The Organ or Disease-Oriented Panels as defined in the CPT book are codes 80047, 80048, 80051, 80053, 80061, 80069, 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 Medicare Advantage uses CMS guidelines to define the components of each panel.

UnitedHealthcare Medicare Advantage 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

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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 1, 2020, laboratories shall bill the HCPCS panel test code and not unbundle the individual components if all components of the HCPCS panel are performed. Claims will be denied if the HCPCS panel test code is not billed. Providers and suppliers are required to submit all Automated Multi-Channel Chemistry (AMCC) laboratory test HCPCS for the same patient, performed on the same date of service on the same claim. This billing policy applies when:

a). Submitting a complete organ disease panel; or

b). Submitting individual component tests of an organ disease panel when all components of the panel were not performed.

Basic Metabolic Panel (Calcium, ionized), 80047		
Panel Code	**Component Code**	**Code Description**
80047		**Basic Metabolic Panel (Calcium, ionized), 80047**
	82330	Calcium; ionized
	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)

Basic Metabolic Panel (Calcium, total), 80048		
Panel Code	**Component Code**	**Code Description**
80048		**Basic Metabolic Panel (Calcium, total), 80048**
	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)
Electrolyte Panel, 80051		
Panel Code	**Component Code**	**Code Description**

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80051		**Electrolyte Panel**
	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		
Panel Code	**Component Code**	**Code Description**
80053		**Comprehensive Metabolic Panel**
	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)

Lipid Panel, 80061		
Panel Code	**Component Code**	**Code Description**
80061		**Lipid Panel**
	82465	Cholesterol, serum or whole blood; total
	84478	Triglycerides

Renal Function Panel, 80069		
Panel Code	**Component Code**	**Code Description**
80069		**Renal Function Panel**
	82040	Albumin; serum, plasma or whole blood
	82310	Calcium; total

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	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)

Hepatic Function Panel, 80076		
Panel Code	**Component Code**	**Code Description**
80076		**Hepatic Function Panel**
	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)

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.

Consistent with CMS, UnitedHealthcare Medicare Advantage 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.

UnitedHealthcare Medicare Advantage 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.

Consistent with CMS, specimen collection HCPCS code G0471 is reimbursable only when a Specimen is collected from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency.

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.

Definitions	
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

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	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.)
Component Codes	Identify individual tests that when performed together may comprise a panel.
Duplicate Laboratory Service	Identical or equivalent bundled 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.
Non-Reference Laboratory Provider	A physician or a Pathologist 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.
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.
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).
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.
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.
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 (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

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	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 Independent or 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 Individual 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 physicians 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 Individual Physician or Other Qualified Health Care Professional 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: • 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 each 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 absent of a physician(s) or other qualified health care professional(s) documentation or signed physician orders? **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.

Codes
CPT code section
National Physician Fee Schedule Relative Value File
Clinical Laboratory Fee Schedule

Resources
www.cms.gov Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

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

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

History	
11/1/2020	Version Change Deleted procedure code 84155 from Panel 80048 Added procedure code 82495 to Panel 80048 History section: Entries prior to 6/20/2018 archived
4/1/2020	Annual Anniversary Update and Version Change Update to add panel editing language
2/22/2019	Annual Anniversary Date and Version Change Updated definition section Title section: Removed Annual Approval information & moved policy # to the header
1/1/2019	Annual Approval Date and Version change FY 2019 Clinical Laboratory Fee Schedule link Updated
5/1/2018	Policy Implemented by UnitedHealthcare Medicare Advantage
12/13/2017	Policy approved by the Reimbursement Policy Oversight Committee

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