Summary
This policy describes reimbursement of laboratory panel and component codes, venipuncture and laboratory handling services, and other laboratory services.

Policy Statement

Laboratory Panels
Laboratory tests are often performed as groups or panels. The American Medical Association (AMA) has defined the components of numerous organ or disease-oriented laboratory panels for coding purposes. When the individual component codes are billed together, Medica will combine them into the more comprehensive panel code. All of the individual components in any of the panels must be billed in order for the charges to be bundled under a comprehensive panel code. If all components of a panel are not billed, the individual component codes will be reimbursed separately.

If individual codes overlap more than one panel, providers should report the panel that includes the most individual laboratory codes to fulfill the panel code definition, and report the remaining tests using individual test codes.

Venipuncture and Laboratory Handling
Medica allows reimbursement of one venipuncture code (CPT code 36415) per day, per member, per provider specialty. Lab handling (CPT codes 99000 and 99001) are not separately reimbursed.

Place of Service
The Place of Service (POS) identifies where the laboratory service was performed. Medica uses the codes indicated in the Centers for Medicare and Medicaid Services (CMS) Place of Service Codes for Professional Claims Database to determine if laboratory services are reimbursable:

- CMS POS Codes

Note: POS 81 = Independent Laboratory

Laboratory Services Performed in a Facility Place of Service
Medica 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 (CMS facility place of service codes: 19, 21, 22, 23, 26, 34, 51, 52, 55, 57 and 61).

- PC/TC indicator definitions:
  - 3 – Technical Component Only Codes
  - 9 – PC/TC Concept Not Applicable
Duplicate Laboratory Charges – Multiple Providers
Only one provider will be reimbursed when multiple providers bill identical services. Medica will reimburse the provider or entity that actually performed the test. Duplicate laboratory services are defined as identical or equivalent bundled laboratory codes.

Reference Laboratory and Non-Reference Laboratory Providers
If a reference laboratory and a non-reference laboratory provider both submit identical or equivalent bundled laboratory codes (excluding 82947 and 82948) for the same patient on the same date of service (plus or minus one business day), only the reference laboratory service is reimbursable, unless the 77 modifier is appended to codes from the non-reference laboratory provider.

Pathologist and Physician Laboratory Providers
If a pathologist and another physician or other qualified health care professional’s offices submit identical laboratory codes for the same patient on the same date of service, only the pathologist’s service is reimbursable.

Reference Laboratory and Unrelated Reference Laboratory Provider
If a reference laboratory and an unrelated reference laboratory provider submit identical codes for the same patient on the same date of service, both reference laboratories are reimbursable if one laboratory appends an appropriate modifier (Modifier 77 or 90) to the codes submitted.

Modifier 90
Medica will reimburse Reference laboratories reporting laboratory services with a modifier 90. 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 and perform laboratory testing will continue to be eligible for reimbursement as modifier 90 would not be reported for the laboratory service.

Duplicate Laboratory Charges – Same Provider
Charges are considered to be duplicate if claims are received from the same provider for the same patient for the same laboratory services on the same date of service. If repeat services are deemed necessary, laboratory codes or panel codes should be appended with the appropriate modifier.

Pathology Consultation
Pathology consultation codes are reimbursable services to pathologists, dermatologists, and reference laboratories:
- Clinical pathology consultation (80500 and 80502)
- Surgical pathology consultation (88321, 88323 and 88325)
A pathologist, at the request of an attending physician or other qualified health care professional, provides a clinical or surgical pathology consultation. Pathology consultation codes are considered included in Evaluation and Management (E/M) codes submitted by the same pathologist or reference laboratory for the same patient on the same date of service.

**Antinuclear Antibodies**
When CPT code 86039 (antinuclear antibodies [ANA]; titer) and CPT code 86038 (antinuclear antibodies [ANA]) are submitted by the same physician, other qualified health care professional, or laboratory on the same date of service for the same patient, only CPT code 86039 is a reimbursable service.

**Code Q0091**
HCPCS code Q0091 (screening Papanicolaou smear, obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory) is eligible for reimbursement for Medicare beneficiaries only. For all other products it is considered to be part of the E/M and Pap smear codes and is not eligible for separate reimbursement.

**Guidelines for Billing Units**
When submitting multiple units of one code, the guidelines are based on code descriptions:
- If the CPT or HCPCS code description contains "per" or "each" or another unit of measurement and multiple services are provided, providers should bill the code on one line with the appropriate number of units.
- If the code does not contain a measurement such as "per" or "each" in the description of the code, providers should report one unit for all services.
- If a CPT or HCPCS code description does not contain "per" or "each," and multiples of that service are provided, providers may bill the code on one line with multiple units, or with the appropriate repeat service modifier on separate lines:
  - The 76 modifier is used for repeat services
  - The 91 modifier is used for clinical diagnostic laboratory tests

Note: Codes billed with multiple units will be paid up to the maximum allowed per day. Refer to the Maximum Frequency Per Day policy for additional information.
Modifiers

**Modifier 59** – Distinct Procedural Service.

**Modifier 76** – Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional.

**Modifier 77** – Repeat Procedure by Another Physician or Other Qualified Health Care Professional.

**Modifier 90** – Reference (Outside) Laboratory.

**Modifier 91** – Repeat Clinical Diagnostic Laboratory Test.

**Modifier 92** – Alternative Laboratory Platform Testing.

**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.

Code Lists

- [Laboratory Panel and Component Code List](#)
- [Laboratory Rebundling E/M Code List](#)
- [Laboratory Codes with CMS PC/TC Indicator of 3 or 9 List](#)

Resources

- Centers for Medicare and Medicaid Services (CMS)
- Healthcare Common Procedure Coding System (HCPCS)
- National Physician Fee Schedule (NPFS)
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<tr>
<td>Revision Updates</td>
<td>08/01/2019 Duplicate Laboratory section updated</td>
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<tr>
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<tr>
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