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 reimbursement policies may 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's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare 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 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, 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 due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations. UnitedHealthcare 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.

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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. This policy also applies to laboratories, including, but not limited to, independent, reference and referring laboratories.

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, clinical pathology consultations and drug assay codes. 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 “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 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. 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 specimen was collected. For example, if the specimen is obtained:

- In an Independent Laboratory or a Reference Laboratory, 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.

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, "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 CLIA. You must not bill our members for any laboratory services if you don't have 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, or 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, 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 #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 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 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

These services are reimbursable as Purchased Diagnostic Tests when billed with a modifier 90.

Purchased Laboratory Eligible Codes

83020	84165	84166	84181	84182	85060	85390	85576	86153	86255
86256	86320	86325	86327	86334	86335	87164	87207	88104	88106
88108	88112	88120	88121	88125	88160	88161	88162	88172	88173
88177	88182	88199	88300	88302	88304	88305	88307	88309	88311
88312	88313	88314	88319	88323	88331	88332	88333	88334	88341
88342	88344	88346	88348	88350	88355	88356	88358	88360	88361
88362	88364	88365	88366	88367	88368	88369	88371	88372	88373
88374	88377	88380	88381	88387	88388	88399	89060	G0416	G0452

For more complete information regarding when a professional or technical component is billed, refer to the UnitedHealthcare "Professional/Technical Component" policy. Refer to the UnitedHealthcare “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.

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'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 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 an Independent Laboratory or Reference Laboratory report the same service on the same day for the same member, only the facility reproductive laboratory services may be reimbursed.

UnitedHealthcare 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

Laboratory Codes with a PC/TC Indicator 3 or 9

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

Modifiers

59	90	91	92	XE	XP	XS	XU

Organ or Disease-Oriented Laboratory Panel Codes

Individual laboratory codes, which together make up an organ or disease-oriented laboratory Panel Code, will be combined into and reimbursed as the more comprehensive laboratory Panel Code as described under the specific laboratory panel headings below. These panels are defined in the CPT book as codes 80047, 80048, 80050, 80051, 80053, 80055, 80061, 80069, 80074, 80076, and 80081. According to the CPT book, they were developed for coding purposes only and are not to be interpreted as clinical parameters. UnitedHealthcare uses CPT coding guidelines to define the components of each panel.

UnitedHealthcare 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 (e.g., do not report 80047 in conjunction with 80053)."

When all components comprising a lab panel as described in CPT are submitted by the Same Individual Physician or Other Qualified Health Care Professional for the same patient on the same date of service, UnitedHealthcare will bundle them to the appropriate panel code. If a provider submits fewer than all the component codes that make up a panel, the component codes will be considered individually for reimbursement.

Panel 80047

There are 2 configurations for Panel CPT code 80047:

Configuration 1
Includes Component Codes: 82330, 82374, 82435, 82565, 82947, 84132, 84295, 84520.

Configuration 2
Includes the following Panel Code: 80051
Plus the following Component Codes:

82330, 82565, 82947 and 84520

Panel 80048

There are 2 configurations for Panel CPT code 80048:

Configuration 1
Includes Component Codes: 82310, 82374, 82435, 82565, 82947, 84132, 84295, 84520

Configuration 2
Includes the following Panel Code: 80051
Plus the following Component Codes: 82310, 82565, 82947, 84520

Panel 80050

There are 2 configurations for Panel CPT code 80050:

Configuration 1				
Includes the following Component Codes: 82040, 82247, 82310, 82374, 82435, 82565, 82947, 84075, 84132, 84155, 84295, 84443, 84450, 84460, 84520				
Plus one of the following CBC or combination of CBC Component Codes:				
85025	85027 + 85004	85027 + 85007	85027 + 85009	

Configuration 2				
Includes the following Panel Code: 80053				
Plus the following Component Code: 84443				
Plus one of the following CBC or combination of CBC Component Codes:				
85025	85027 + 85004	85027 + 85007	85027 + 85009	

Panel 80051

Configuration 1
Includes the following Component Codes: 82374, 82435, 84132, 84295

Panel 80053

There are 3 configurations for Panel CPT code 80053:

Configuration 1
Includes the following Component Codes: 82040, 82247, 82310, 82374, 82435, 82565, 82947, 84075, 84132, 84155, 84295, 84450, 84460, 84520

Configuration 2
Includes the following Panel Code: 80048
Plus the following Component Codes: 82040, 82247, 84075, 84155, 84450, 84460

Configuration 3
Includes the following Panel Code: 80051
Plus the following Component Codes: 82040, 82247, 82310, 82565, 82947, 84075, 84155, 84450, 84460, 84520

Panel 80055

Configuration 1				
Includes the following component codes: 86592, 86762, 86850, 86900, 86901, 87340				
Plus one of the following CBC or combination of CBC Component Codes:				
85025	85027 + 85004	85027 + 85007	85027 + 85009	

NOTE: The CPT code 87340 is a component code of both the Panel CPT codes 80055 or 80081 and the Panel CPT code 80074. The Panel CPT codes 80055 or 80081 takes precedence.

Panel, 80061

Configuration 1
Includes the following Component Codes: 82465, 83718, 84478

Panel 80069

There are 2 configurations for Panel CPT code 80069:

Configuration 1
Includes the following Component Codes: 82040, 82310, 82374, 82435, 82565, 82947, 84100, 84132, 84295, 84520

Configuration 2
Includes the following Panel Code: 80048
Plus the following Component Codes: 82040, 84100

Panel 80074

Configuration 1
Includes the following Component Codes: 86705, 86709, 86803, 87340

NOTE: CPT code 87340 is a Component Code for both the Panel 80055 or 80081 and the Panel 80074. The Panel 80055 or 80081 takes precedence.

Panel 80076

Configuration 1
Includes the following Component Codes: 82040, 82247, 82248, 84075, 84155, 84450, 84460

Panel 80081

There are 2 configurations for Panel CPT code 80081:

Configuration 1				
Includes the following Component Codes: 86592, 86762, 86850, 86900, 86901, 87340, 87389				
Plus one the following CBC or combination of CBC Component Codes:				
85025	85027 + 85004	85027 + 85007	85027 + 85009	

Configuration 2
Includes the following Panel Code: 80055
Plus the following Component Code: 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.

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 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 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.

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.

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 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.

Evaluation and Management Codes for Laboratory Services

92002	92004	92012	92014	99024	99091	99202	99203	99204	99205
99211	99212	99213	99214	99215	99217	99218	99219	99220	99221
99222	99223	99224	99225	99226	99231	99232	99233	99234	99235
99236	99238	99239	99241	99242	99243	99244	99245	99251	99252
99253	99254	99255	99281	99282	99283	99284	99285	99288	99291
99292	99304	99305	99306	99307	99308	99309	99310	99315	99316
99318	99324	99325	99326	99327	99328	99334	99335	99336	99337
99339	99340	99341	99342	99343	99344	99345	99347	99348	99349
99350	99354	99355	99356	99357	99358	99359	99360	99366	99367
99368	99374	99375	99377	99378	99379	99380	99381	99382	99383
99384	99385	99386	99387	99391	99392	99393	99394	99395	99396
99397	99401	99402	99403	99404	99406	99407	99408	99409	99411
99412	99415	99416	99417	99421	99422	99423	99429	99439	99441
99442	99443	99446	99447	99448	99449	99450	99451	99452	99453
99454	99455	99456	99457	99458	99460	99461	99462	99463	99464
99465	99466	99467	99468	99469	99471	99472	99473	99474	99475
99476	99477	99478	99479	99480	99483	99484	99485	99486	99487
99489	99490	99491	99492	99493	99494	99495	99496	99497	99498
99499	G0101	G0245	G0246	G0396	G0397	G0402	G0406	G0407	G0408
G0425	G0426	G0427	G0438	G0439	G0463	G0508	G0509	G0513	G0514
G2010	G2011	G2012	G2064	G2065	G2211	G2212	G2214	G2250	G2251
G2252	G9685	S0273	S0274	S0280	S0281	S0285	S0610	S0612	S0613
S0620	S0621								

Drug Assay Codes
Consistent with CMS, Drug Assay CPT codes 80320-80377 are considered non-reimbursable. These services may be reported under an appropriate HCPCS code. For additional information, refer to the Questions and Answers section, Q&A #8
Surgical Pathology for Prostate Needle Biopsy
In alignment with CMS, UnitedHealthcare requires surgical pathology for prostate needle biopsy specimens (including gross and microscopic examination) to be reported with HCPCS code G0416, rather than 88305. Code G0416 represents 1 unit of service regardless of the number of specimens examined. Code 88305 will not be reimbursed for prostate needle biopsy surgical pathology.
Respiratory Viral Panel Testing
Consistent with CMS Local Coverage Determinations, UnitedHealthcare does not consider multiplex Polymerase Chain Reaction (PCR) respiratory viral panels of 6 or more pathogens eligible for reimbursement, and codes 0115U, 0151U, 0202U, 0223U, 0225U, 87632 and 87633 will be denied. For additional information, refer to the Questions and Answers section, Q&A #10

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 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.
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.
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 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 (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 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 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 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 Group 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 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 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 absence of a physician(s) or other qualified health care 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 clearly 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.
10	**Q:** Are respiratory viral panels with fewer than 6 pathogen targets reimbursable under this policy? For example, can lab charges be submitted with the appropriate code(s) for 5 or less targets?

	A: Yes, respiratory viral panels of 5 or less targets may be considered for reimbursement, when appropriate.

Attachments	
Laboratory Codes with a PC/TC Indicator 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.

Resources
American Medical Association, *Current Procedural Terminology (*CPT®) 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, Health care Common Procedure Coding System, HCPCS Release and Code Sets

History	
7/1/2021	Policy Version Change Policy Section Changed: Organ or Disease-Oriented Laboratory Panel Codes section updated
6/27/2021	Policy Version Change Policy List Update: Laboratory Codes with a PC/TC Indicator 3 or 9
6/1/2021	Policy Version Change Policy Section Changed: Place of Service; Documentation Requirements for Reporting Laboratory Services; Q&A #7 Policy Section Added: Respiratory Viral Panel Testing; Q&A #10 History/Updates Section: Entries prior to 5/26/2019 archived
5/13/2021	Policy Version Change Attachments Section: Removed attachment(s) and provided link to source document
3/28/2021	Policy Version Change Policy List Update: Laboratory Status Indicator A R T Codes lists updated
2/14/2021	Policy Version Change Policy List Update: Laboratory Codes with a PC/TC Indicator 3 or 9
1/1/2021	Policy Version Change Surgical Pathology for Prostate Needle Biopsy section added Policy List Update: Evaluation and Management Codes for the Laboratory Services Policy, Laboratory Codes with a PC/TC Indicator 3 or 9, Laboratory Status Indicator A R T Codes lists updated History/Updates Section: Entries prior to 1/1/2019 archived
9/27/2020	Policy Version Change Policy List Update: Evaluation and Management Codes for the Laboratory Services Policy, Laboratory Codes with a PC/TC Indicator 3 or 9
6/28/2020	Policy Version Change Attachment Section: Laboratory Codes with a PC/TC Indicator 3 or 9
5/12/2020	Policy Version Change

	Attachment Section: Laboratory Codes with a PC/TC Indicator 3 or 9 and Laboratory Status Indicator A R T Codes
3/29/2020	Policy Version Change Added the word “Commercial” to the policy header Attachment Section: Laboratory Status Indicator A R T Codes list updated Modifier Section Updated: Modifier descriptions removed Panel Code Section Updated: Code descriptions removed Venipuncture and Specimen Collection Section Updated: Code descriptions removed Q&A Section Updated: Code descriptions removed
01/1/2020	Policy Version Change Attachment Section: Evaluation and Management Codes for the Laboratory Services Policy, Laboratory Codes with a PC/TC Indicator 3 or 9, Laboratory Status Indicator A R T Codes History/Updates Section: Entries prior to 1/1/2018 archived
9/3/2019	Policy Version Change Q&A: #9 added
5/26/2019	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
5/27/1999	Policy Approved by the Payment Policy Group
8/31/1998	Policy implementation by UnitedHealthcare Employer and Individual