

## LABORATORY and PATHOLOGY SERVICES

### Policy

Neighborhood Health Plan reimburses participating clinical laboratory and pathology providers for tests medically necessary for the diagnosis, treatment and prevention of disease, and for the maintenance of the health of NHP members. Services may be provided in NHP participating non-institutional settings such as an office or a free-standing facility, or in an institutional setting such as a hospital, skilled nursing facility or an outpatient rehabilitation facility.

### Policy Definition

Services include testing of materials, tissues or fluids obtained from a patient or clinical studies to determine the cause and nature of disease. Laboratory panels include hematology tests reported with a panel code when all individual components in that panel have been performed. If other hematology tests are performed in addition to those specified in the panel(s), NHP will separately reimburse those in addition to the panel code.

### Prerequisites

### Authorization, Notification and Referral

*Note: Please contact NHP directly for genetic testing authorization.*

Service	Requirement
Laboratory and Pathology Services for:	<ul style="list-style-type: none"> <li>No authorization, referral or notification required.</li> <li>An order is required from the referring, participating provider.</li> </ul>
Reproductive Medicine Laboratory Services	<b>Prior Authorization</b> required for Reproductive Medicine Services, including these laboratory services.
For HVMA Members	A referral number for most specialists is required for NHP members with a Harvard Vanguard Medical Associates PCP seeking non-emergency care outside of the Harvard Vanguard Medical Associates Network. Please verify that the member has the appropriate referral number prior to rendering care.

### Limitations

#### Reproductive Medicine Laboratory Procedures

For MassHealth and CommonwealthCare (CCHIP) members only, not a covered service. For Commercial and Commonwealth Choice members, coverage is dependent on the member's employer group.

## Exceptions to Policy Criteria

Any changes to the CPT panel descriptors or individual components will be adopted by reference, if not contained in amended versions of this NHP policy.

## Member Cost-Sharing

The provider is responsible for verifying at each encounter and when applicable for each day of care when the patient is hospitalized, coverage, available benefits, and member out-of-pocket costs; copayments, coinsurance, and deductible required, if any.

## Definitions

**Clinical Laboratory:** A facility that conducts microbiological, serological, chemical, hematological, biophysical, radiobioassay, cytological, immunohematological, immunological, pathological, or other examinations of materials derived from the human body, to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

**Genetic Testing Code Modifiers:** Appendix I, found in the appendices section of the CPT manual, lists modifiers for molecular genetics testing to enable providers to submit more complete and specific information for claims adjudication, as they provide more information on the purpose for molecular laboratory procedures without altering test descriptors. The modifier system is classified by gene mutation. The first (numeric) digit indicates the disease category, and the second (alpha) digit denotes gene type.

**Hospital Laboratory:** A clinical laboratory that is owned and operated by a hospital that is licensed by the Massachusetts Department of Public Health and is an approved Medicare provider.

**Independent Clinical Laboratory:** A freestanding clinical laboratory that is not affiliated with a hospital.

**Panel Test:** Any group of tests, whether performed manually, automated, or semi-automated, that are ordered for a specified member on a specified day and have at least one of the following characteristics:

- (1) The group of tests is designated as a panel by the current version of CPT published by the American Medical Association
- (2) The group of tests is performed by the clinical laboratory at a usual and customary fee that is lower than the sum of that laboratory's usual and customary fees for the individual tests in that group.

**Reproductive Medicine Laboratory Procedures:** Laboratory procedures available for practitioners utilizing assisted reproductive therapy (ART) to accurately describe the work being performed including: comprehensive semen analysis; sperm preparation procedures; cryopreservation protocols for semen, testicular and ovarian tissues and assisted reproduction (IVF/ICSI) techniques.

**Urinalysis:** A physical, chemical, and microscopic examination of urine.

## Neighborhood Health Plan Reimburses

- Panel codes when all individual tests in the panel have been performed.
- Individual codes when all individual tests in the panel have *not* been performed.
- Pre-admission testing when applicable.
- Routine screening labs.
- Clinical laboratory tests when performed by a technician under physician supervision.
- Urinalysis when medically necessary to evaluate signs or symptoms of a kidney/urinary tract disorder or condition that is known to affect the kidney/urinary tract.

**Neighborhood Health Plan Does *Not* Reimburse**

- Handling charges.
- Specimen collection.
- Routine venipuncture in conjunction with blood or related laboratory services or evaluation and management services.
- Employment drug screening.
- Paternity blood tests.
- Mandated drug testing (e.g. court-ordered).
- Laboratory and pathology services submitted with an unlisted CPT code when an appropriate specific code is available.
- Laboratory and pathology services provided at no charge by the Commonwealth of Massachusetts agencies, including but not limited to rubella.
- Devices, drugs, procedures, treatments, laboratory and pathology tests that are experimental, investigational or unproven and not supported by evidence based medicine and established peer reviewed scientific data.
- Routine urinalysis in the absence of signs or symptoms suggestive of kidney/urinary tract disorders or a condition that is known to affect the kidney/urinary tract.
- Physicians ordering lab tests since the lab test is not performed by the physician. (The physician’s obligation is to order the test, submit an ICD-9-CM code to the lab, and maintain documentation of the medical necessity in the patient’s medical record.)

**Procedures Codes Applicable to Guideline**

*Note: This list of codes may not be all-inclusive.*

Code	Descriptor	Comments
0300-0309	Laboratory Revenue Codes	Bill with CPT / HCPCS code detail
0310-0319	Pathology Revenue Codes	Bill with CPT / HCPCS code detail
36415	Venipuncture	Not reimbursed with blood or related lab services, or with E/M services
36416	Collection of capillary blood specimen	Not reimbursed
80047	Basic metabolic panel (Calcium ionized) (This panel must include the following: Calcium, ionized (82330), Carbon dioxide (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Potassium (84132), Sodium (84295), and Urea nitrogen (BUN) (84520).)	
80048	Basic metabolic panel (Calcium total) (This panel must include the following: Calcium; total (82310), Carbon dioxide (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Potassium (84132), Sodium (84295), and Urea nitrogen (BUN) (84520).)	

80050	General health panel (This panel must include the following: Comprehensive metabolic panel (80053), Blood count, complete (CBC), automated and automated differential (85025 or 85027 and 85004) or Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009), and Thyroid stimulating hormone (TSH) (84443).)	
80051	Electrolyte panel (This panel must include the following: Carbon dioxide (82374), Chloride (82435), Potassium (84132), and Sodium (84295).)	
80053	Comprehensive metabolic panel (This panel must include the following: Albumin (82040), Bilirubin, total (82247), Calcium; total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphatase, alkaline (84075), Potassium (84132), Protein, total (84155), Sodium (84295), Transferase, alanine amino (ALT) (SGPT) (84460), Transferase, aspartate amino (AST) (SGOT) (84450), and Urea nitrogen (BUN) (84520).)	
80055	Obstetric panel (This panel must include the following: Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) or Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009), Hepatitis B surface antigen (HBsAg) (87340), Antibody, rubella (86762), Syphilis test, qualitative (e.g., VDRL, RPR, ART) (86592), Antibody screen, RBC, each serum technique (86850), Blood typing, ABO (86900), and Blood typing, Rh (D) (86901).)	
80061	Lipid panel (This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), and Triglycerides (84478).)	
80069	Renal function panel (This panel must include the following: Albumin 982040), Calcium (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphorus inorganic (phosphate) (84100), Potassium (84132), Sodium (84295), and Urea nitrogen (BUN) (84520).)	
80074	Acute hepatitis panel (This panel must include the following: Hepatitis A antibody (HAAb), IgM antibody (86709), Hepatitis B core antibody (HBcAb), IgM antibody (86705), Hepatitis B surface antigen (HBsAg) (87340), and Hepatitis C antibody (86803).)	
80076	Hepatic function panel (This panel must include the following: Albumin (82040), Bilirubin, total (82247), Bilirubin, direct (82248), Phosphatase, alkaline (84075), Protein, total (84155), Transferase, alanine amino (ALT) (SGPT) (84460), and Transferase, aspartate amino (AST) (SGOT) (84450).)	
80100-89356	Pathology and Laboratory Procedures	
99000-	Handling charges	Not reimbursed

99002		
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### Modifiers Applicable to Guideline

Modifier	Descriptor	Comments
26	Professional component	Use with CMS identified codes with separate professional and technical components
TC	Technical component	Use with CMS identified codes with separate professional and technical components
91	Repeat clinical laboratory diagnostic test	Use to report laboratory tests performed more than once on the same date to obtain subsequent, <i>multiple</i> test results. Do <i>NOT</i> use when test is repeated due to specimen mishandling, insufficient sampling or re-confirmation.
Various	Genetic Testing Code Modifiers	Reference Appendix I of the current year CPT Manual for a complete listing. Use with molecular diagnostic codes (83890-83914) and cytogenetic studies (88230-88299). Do not append when testing for multiple genes with an individual procedure.

### Provider Payment Guidelines and Documentation

Submit multiple same-day services on one line with a count representing the number of services rendered.

Submit laboratory panel codes only when all individual tests included in the panel have been performed; if other tests are performed together with those specified in the panel, bill separately in addition to the panel code.

Submit genetic testing code modifiers with molecular diagnostic codes (83890-83914) and cytogenetic studies (88230-88299).

When applicable, report modifier -26 or -TC in the first modifier field.

### Related NHP Payment Guidelines

Evaluation and Management Services

NHP Prior Authorization Guideline posted on [www.NHP.org](http://www.NHP.org)

### References

AMA-CPT Coding Guidelines

Manual of Laboratory Tests and Services, Massachusetts Department of Public Health, Bureau of Laboratory Sciences, William A. Hinton State Laboratory Institute, Boston, Massachusetts; Fourth Edition, Volume 1 (December 2008)

MassHealth Transmittal Letter LAB-36, January 2011

NHIC (National Heritage Insurance Company) -New England, Provider Education: Reminder to Physicians Ordering Laboratory Tests

Official UB-04 Data Specifications Manual 2012

## Publication History

<b>Topic:</b> Laboratory and Pathology Services	<b>Owner:</b> Provider Network Management
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2009/07/24 *Original documentation*

2011/04/19 *Member cost-sharing language, reference, and disclaimer updated*

2012/02/01 *Exceptions to policy criteria and referral grid updated*

2012/03/16 *Referral grid updated*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Neighborhood Health Plan utilizes McKesson's claims editing software, ClaimCheck, a clinically oriented, automated program that identifies the "appropriate set" of procedures eligible for provider reimbursement by analyzing the current and historical procedure codes billed on a single date of service and/or multiple dates of service, and also audits across dates of service to identify the unbundling of pre and post-operative care. Please refer to Neighborhood Health Plan's Provider Manual Billing Guidelines section for additional information on NHP's billing guidelines and administration policies. Questions may be directed to Provider Network Management at [prweb@nhp.org](mailto:prweb@nhp.org).