University of Michigan Health Plan

PAYMENT REIMBURSEMENT POLICY

Title: PRP-19 Professional Laboratory Services

Category: UMHP_PAYMENT REIMBURSEMENT (PR)

Effective Date: 08/23/2024

1.0 Guidelines:

This policy applies to all network and non-network providers, including but not limited to the percent of charge contract providers. This policy does not guarantee benefits or solely determine reimbursement. Benefits are determined and/or limited by an individual member's benefit coverage document (COC, SPD, etc.). The Health Plan reserves the right to apply clinical edits to all medical claims through coding software and accuracy of claim submission according to industry billing standards. Clinical edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. The Health Plan may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid through CMS, but which are covered by the Health Plan to support covered benefits available through one of the Health Plan's products. Prior approval does not exempt adherence to the following billing requirements. The provider contract terms take precedence if there is a conflict between this policy and the provider contract.

2.0 Description:

This policy applies to billing and reimbursement of laboratory services billed in a professional setting. The policy applies to laboratory panels, individual component codes, specimen collection, and specimen handling. It is appropriate for labs to be performed in an office setting when the results are needed to make real-time care plan decisions. The services can be performed in an effective, accurate manner, and the services are medically necessary. The appearance of a code in this document does not guarantee reimbursement. Benefit coverage rules, prior authorization/approval requirements, limitations, and clinical edits such as bundling, MUEs, or incidental service logic may apply.

Coding and Billing:

Coding

The following lab procedures may be performed and billable in an office setting without referring the patient or the specimen to an independent laboratory. These codes are reviewed regularly in accordance with AMA CPT® code updates and Health Plan policy reviews.

Code	Description
80047	Basic metabolic panel (Calcium, ionized). This panel must include the following: Calcium, ionized (82330), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Potassium (84132), Sodium
80050	General health panel: Comprehensive metabolic panel, Blood count, complete (CBC), automated and automated differential WBC count OR Blood count, complete (CBC), automated and appropriate manual differential WBC count, Thyroid stimulating hormone
80076	Hepatic function panel: Albumin, Bilirubin, total, Bilirubin, direct, Phosphatase, alkaline, Protein, total, Transferase, alanine amino (ALT) (SGPT), Transferase, aspartate amino (AST) (SGOT)

Code	Description
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrate, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
81005	Urinalysis; qualitative of semiquantitative, except immunoassays
81007	Urinalysis; bacteriuria screen, except by culture or dipstick
81015	Urinalysis; microscopic only
81020	Urinalysis; 2 or 3 glass tests
81025	Urine pregnancy test, by visual color comparison methods
82040	Albumin; serum, plasma or whole blood
82044	Albumin; urine (e.g., microalbumin), semiquantitative (e.g., reagent strip assay)
82270	Blood, occult by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection).
82272	Blood, occult, by perioidase activity (e.g., guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening
82274	Blood occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
82550	Creatine kinase (CK), (CPK); total
82565	Creatinine; blood
82670	Estradiol; total
82947	Glucose; quantitative, blood (except reagent strip)
82948	Glucose; blood, reagent strip
82962	Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for

Code	Description
	home use
83001	Gonadotropin; follicle stimulating hormone (FSH)
83002	Gonadotropin; luteinizing hormone (LH)
83036	Hemoglobin; glycosylated (A1C)
83615	Lactate dehydrogenase (LD), (LDH);
83655	Lead
83861	Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity
83872	Mucin, synovial fluid (Ropes test)
83986	pH, body fluid, except blood
84075	Phosphatase, alkaline
84132	Potassium; serum, plasma or whole blood
84144	Progesterone
84146	Prolactin
84450	Transferase; aspartate amino (AST/SGOT)
84460	Transferase; alanine amino (ALT) (SGPT)
84520	Urea nitrogen; quantitative
84702	Human chorionic gonadotropin (HCG)
84703	Gonadotropin, chorionic (hCG); qualitative
85007	Blood count; blood smear, microscopic examination with manual differential WBC count
85013	Blood count; spun microhematocrit
85014	Blood count; hematocrit (Hct)
85018	Blood count; hemoglobin (Hgb)
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85048	Blood count; leukocyte (WBC), automated
85651	Sedimentation rate, erythrocyte; non-automated
85652	Sedimentation rate, erythrocyte; automated
86140	C-reactive protein
86308	Heterophile antibodies; screening
86317	Immunoassay for infectious agent antibody, quantitative, not otherwise specified
86328	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single-step method (e.g., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])
86329	Immunodiffusion; not elsewhere specified
86403	Particle agglutination; screen
86406	Particle agglutination; titer, each antibody
86408	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); screen
86409	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); titer
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) antibody, quantitative
86580	Skin test; tuberculosis, intradermal
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)

Code	Description
	(Coronavirus disease [COVID-19])
87081	Culture, presumptive, pathogenic organisms, screening only;
87205	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types
87210	Smear, primary source with interpretation; wet mount for infectious agents (e.g., saline, India ink, KOH preps)
87220	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (e.g., scabies)
87426	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV2 [COVID-19])
87427	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Shiga-like toxin
87428	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B
87430	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Streptococcus, group A
87502	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, first 2 types or sub-types
87634	Infectious agent detection by nucleic acid (DNA or RNA); respiratory syncytial virus, amplified probe technique
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
87636	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique
87651	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique
87804	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza
87807	Infectious agent antigen detection by immunoassay with direct optical observation; respiratory syncytial virus
87811	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
87880	Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group A

Code	Description
88304	Level III - Surgical pathology, gross and microscopic examination:
88305	Level IV - Surgical pathology, gross and microscopic examination
88312	Special stain including interpretation and report; Group I for microorganisms (e.g., acid fast, methenamine silver), each
88313	Special stain including interpretation and report; Group II, all other (e.g., iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry
88738	Hemoglobin (Hgb), quantitative, transcutaneous
89050	Cell count, miscellaneous body fluids (e.g., cerebrospinal fluid, joint fluid) except blood;
89051	Cell count, miscellaneous body fluids (e.g., cerebrospinal fluid, joint fluid), except blood; with differential count
89060	Crystal identification by light microscopy with or without polarizing lens analysis, tissue or any, body fluid (except urine)
89259	Cryopreservation; sperm
89260	Sperm isolation; simple prep (e.g. sperm wash and swim up) for insemination or diagnosis with semen analysis
89261	Sperm isolation; complex prep (e.g., Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis
89264	Sperm identification from testis tissue, fresh or cryopreserved
89300	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)
89310	Semen analysis; motility and count (not including Huhner test)
89320	Semen analysis; volume, count, motility, and differential
89322	Semen analysis; volume, count, motility, and differential using strict morphologic criteria (e.g., Kruger)
89325	Sperm antibodies
89330	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test
89331	Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)
89353	Thawing of cryopreserved; sperm/semen, each aliquot
0202U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected
0223U	Autoimmune (inflammatory bowel disease), mRNA, gene expression profiling by quantitative RT-PCR, 17 genes (15 target and 2 reference genes), whole blood, reported as a continuous risk score and classification of inflammatory bowel disease aggressiveness
0224U	Oncology (thyroid), mRNA, gene expression analysis of 593 genes (including BRAF, RAS, RET, PAX8, and NTRK) for sequence variants and rearrangements, utilizing fine needle aspirate, reported as detected or not detected
0240U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected or not detected
0241U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A,

Code	Description
	influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each pathogen reported as detected or not detected
U0001	CDC 2019 novel coronavirus (2019-ncov) real-time rt-PCR diagnostic panel
U0002	2019-ncov coronavirus, sars-cov-2/2019-ncov (covid-19), any technique, multiple types or subtypes (includes all targets), non-CDC
U0003	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R.
U0004	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R
U0005	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), amplified probe technique, CDC or non-CDC, making use of high throughput technologies, completed within 2 calendar days from date of specimen collection (list separately in addition to either HCPCS code u0003 or u0004) as described by cms-2020-01-r2

Billing

1. Place of service.

   The Health Plan requires providers to bill in accordance with the CMS place of service (POS) Codes.

   - When the lab is performed/resulted in the office setting, POS 11 for Office is reported.
   - When an independent lab receives the specimen and processes the lab, the independent lab should bill for the services with POS 81.

2. Specimen collection.

   - When a specimen is collected and not resulted in the office, the appropriate specimen collection, venipuncture, and/or handling code may be billable. The lab code is not separately reportable.

3. Laboratory modifiers.

   a. Modifier 59.

   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.

   b. Modifier 90.

- Used to report procedure performed by an outside laboratory, unrelated to treating/reporting physician.

- Do not report modifier 90 with anatomic pathology and lab services.

- Do not append modifier 90 for the drawing fee (36415).

c. Modifier 91.

- Used to report the same lab test when performed on the same patient, same date of service, to obtain subsequent test results.
- May not be used when there are standard HCPCS codes available that describe the series of results (e.g., glucose tolerance tests, evocative/suppression testing, etc.).

- May not be used when tests are rerun to confirm initial results due to testing problems with specimens and equipment; or for any other reason when a normal, one-time, reportable result is all that is required.

- Does not replace modifiers such as RT, LT, 50, E1-E4, FA, F1-F9, TA, and T1-T9.

4. PC/TC Indicator.

Health Plan claim processing uses the CMS National Physician Fee Schedule (NPFS) Professional Component/Technical Component (PC/TC) indicators. The following indicators apply to lab service billing.

- 4 = Global test only codes.

  This indicator identifies stand-alone codes that describe selected diagnostic tests for which there are associated codes that describe (a) the professional component of the test only and (b) the technical component of the test only.

  Modifiers 26 and TC cannot be used with these codes. The total RVUs for the global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for the global procedure only codes equal the sum of the total RVUs for the professional and technical components only codes combined.

- 6 = Laboratory physician interpretation codes.

  This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. The actual performance of the tests is paid for under the lab fee schedule.

  Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense, and malpractice expense.

- 8 = Physician interpretation codes.

  This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient.

This applies to CPT codes 88141, 85060, and HCPCS code P3001-26. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate.

No payment is recognized for CPT codes 88141, 85060 or HCPCS code P3001-26 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

- 9 = Not applicable.

  The concept of a professional/technical component does not apply.

4.0 Documentation Requirements:

1. Documentation of laboratory services must follow the general principles of medical record-keeping based on CMS and Health Plan Guidelines. Documentation requirements vary based on the service provided.

2. Documentation must be complete and legible.

   - Avoid handwritten acronyms that may not be an industry standard, or shorthand terms used by the office and may be unclear to an auditor.

   - Avoid copy and paste or autofill templates.

3. Documentation should include the following:

   - Progress notes or office notes that support the medical necessity of order.

   - Signed order or requisition listing the specific test.

   - Laboratory results.

   - Details to support specific coding such as specimen type, microscopic examination, chemical evaluation, automation, number of reagent strips, number, and type of assays, qualitative, quantitative, etc.

4. Certification.

   - Practice must maintain and provide any pertinent Clinical Laboratory Improvement Amendments (CLIA) certification for laboratory services that require certification when documentation is requested.

   - Practice must maintain and provide CLIA certification for Provider Performed Microscopy Procedures (PPMP) when documentation is requested.

5.0 Verification of Compliance

Claims are subject to audit, prepayment, and post payment, to validate compliance with the terms and conditions of this policy.

6.0 Terms & Definitions:

CLIA Certificate(s): Certificate(s) conferred by the Centers for Medicare and Medicaid Services, pursuant to Section 353 of the Public Health Services Act (42 U.S.C. § 263a) as amended by the Clinical Laboratory Improvement Amendments, authorizing the acceptance of human specimens for the purpose of performing laboratory examinations or procedures.

Independent Laboratory: A lab that is independent of a physician's office as well as a hospital or other facility.

Provider Performed Microscopy Procedures (PPMP): A CLIA Certificate for Provider-Performed Microscopy (PPM) procedures permits physicians and midlevel practitioners to perform a limited list of moderate complexity microscopic tests, as well as waived tests, as part of a patient's visit. PPM procedures require training and specific skills for test performance and must meet criteria. A CLIA certificate is required, and the testing site must meet the CLIA quality standard for moderate complexity testing.

Place of Service (POS): Designation of the location where a service the service was provided.

Reference Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician.

7.0 References, Citations & Resources:

Centers for Medicare & Medicaid Services Internet-Only Manual, Publication 100-04 and other CMS publications.

American Medical Association (AMA), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and associated publications.

8.0 Revision History:

Revision Date	**Reason for Revision**
11/21	Annual review, updates approved at CCSC meeting 12/7/2021
12/22	Annual review
2/23	Off-Cycle review
4/23	Off-Cycle review, added code
4/24	Annual review added codes 80305, 80306, 80307 eff. Retroactively 1/1/2023