healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Diagnostic Laboratory		
Policy Number:	PO-RE-162v1		
Effective Date:	5/1/2026	**Last Approval Date:**	1/20/2026

I. Policy Description

This policy outlines Healthfirst's standards and requirements for the reimbursement of diagnostic laboratory services. It applies to claims for services billed under the Pathology and Laboratory Procedures sections of the CPT®/HCPCS Manuals, including:

- Pathology and Laboratory Procedures (CPT Codes 80000 Series)
- Multianalyte Assays with Algorithmic Analyses (MAAA), (M codes)
- Proprietary Laboratory Analyses (PLA), (U codes)
- Level II Healthcare Common Procedure Coding System (HCPCS) codes related to laboratory services

Note: Inclusion of a code within the scope of this policy does **not** guarantee coverage or reimbursement. Coverage is subject to medical necessity and specific plan benefits.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Medicare Advantage
- Medicare PPO
- Essential Plan (EP)
- Medicaid Advantage Plus/MAP (CompleteCare)
- Qualified Health Plan (QHP)
- Personal Wellness Plan (HARP)

Reimbursement Guidelines

1. Billing Requirements
   Providers must meet the following requirements when submitting claims for laboratory services:
   - The specific test ordered and performed, matching the requisition and result.
   - Complete and accurate ordering and rendering provider information must be on the claim.
   - Diagnosis codes (ICD) that are specific and appropriate, per the International Classification of Diseases (ICD) coding system created by the World Health Organization (WHO)[2], avoid general 3-digit ICD codes as they may lack specificity to determine coverage in some instances and may be denied for insufficient specificity

- Service date and place of service, with appropriate Place of Service (POS) codes to identify outpatient, inpatient, or emergency settings.

Note: Claims missing required information may be denied.

2. Coding Requirements
   Coding practices must adhere to:
   - AMA CPT® guidelines
   - CMS National Correct Coding Initiative (NCCI) Manual

   Key provisions include:
   - Procedure codes must reflect the test attributes, not based on the member's diagnosis or clinical indication.
   - If the laboratory has obtained an approved Proprietary Laboratory Analyses (PLA) code or the test has a Multianalyte Algorithmic Assay (MAAA) code, the PLA/MAAA code must be used to bill for the service.
   - Proprietary codes may be used to bill only for the specific test to which the code is assigned.
   - Billing codes may be used when the date of service falls after the listed effective date and prior to the date of retirement.
   - Coding of a procedure shall follow the rules set forth in the CMS NCCI Manual. In cases of conflict, NCCI guidance takes precedence over CPT code descriptors.
   - If a test qualifies for panel code(s), the panel code(s) must be used.
     - Per the NCCI Manual, Chapter 10, Section F-8, if one laboratory procedure evaluates multiple genes using a next generation sequencing procedure, the laboratory shall report only one unit of service of one genomic sequencing procedure code.
     - If a test evaluates multiple analytes (e.g. drugs, pathogens, metabolites, genes) using a procedure that consolidates at least one part of the testing process (e.g., tandem mass spectrometry), and an appropriate panel code exists, the laboratory shall report only one unit of service of one appropriate level II HCPCS, CPT, or PLA code.
     - If a code descriptor, as defined in the American Medical Association's CPT® Codebook, addresses multiple analytes, it is inappropriate to bill separately for the subcomponents of that panel code without the use of an appropriate modifier.
   - If a panel code is not appropriate, a limited number of individual components from multi-gene tests may be billed.
   - To account for economies of scale associated with panel testing and avoid redundant billing for the wet lab components of the test, Modifier 52 can be used to indicate that additional wet lab procedures were not performed.
     - Similarly, when interpretation of existing data resulting from a separate test is conducted, the provider should use Modifier 52 to indicate that additional wet lab procedures were not performed.
   - Only one unit of the miscellaneous, non-specific codes 81479 and 81599 may be billed per test.
   - Modifier codes should be used when billing multiple service units of a code is appropriate. This includes but is not limited to repeat testing, testing performed on multiple specimens, and testing for multiple species

- Use of the professional component modifier (26) and the technical component modifier (TC) is restricted to specific codes identified by the Centers for Medicare & Medicaid Services (CMS) as valid for separate component billing. These codes are indicated in the CMS Physician Fee Schedule[5].
    - Modifier 26 should only be used with codes that have a Technical Component Professional Component (TCPC) indicator of 1 or 6.
    - Modifier TC should only be used with codes that have a TCPC indicator of 1.

3. NCCI Procedure-to-Procedure (PTP) and Medically Unlikely Edit **(**MUE) Requirements
   All providers billing for laboratory services must be billed according to the recommendations of the National Correct Coding Initiative (NCCI) manual, or claims may be denied:
   - If a code(s) falls under a NCCI PTP edit[6], the code must be billed in alignment with the edit. PTP edits prohibit certain codes from being billed in presence of other codes as they are "mutually exclusive procedures".
   - If a code(s) falls under an NCCI PTP edit, modifiers must ONLY be used when appropriate and Modifier 59 may be used only if no other appropriate modifier describes the service.
   - If a code(s) falls under an MUE[7], the billed units must not exceed the maximum units of service allowed. Per the NCCI Manual, MUEs define the maximum units of service (UOS) typically reported for a HCPCS/CPT code by the same provider/supplier for the same patient on the same date of service. Not all HCPCS/CPT codes include MUE

4. Genetic and Molecular Testing Requirements
   For CPT codes 81105–81479, 81490–81599, and applicable PLA codes, all Providers must follow these requirements when submitting claims and prior authorization:
   - Concert registration is required: https://www.concert.co/join-healthfirst
     - Register lab test catalog
     - Complete quality profile
     - Access and use Concert GTUs (Genetic Testing Units) in billing and prior authorization
   - To support accurate and timely payment of your claim:
     - For *non-specific codes* (e.g. 81479), a procedure description is **required,** with use of the Concert GTU being **strongly recommended** (e.g. “GTU-6V98G” or “6V98G”).
     - For *all other codes impacted by this policy*, including the Concert GTU in the procedure description is **recommended**.
   - Prior authorization requests must also include the Concert GTU.

Adjudication and Appeal Process

1. Reimbursement for diagnostic laboratory testing will be determined based on the provider’s scope of services and the reimbursement rates outlined in the provider’s contract with Healthfirst.
2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

3. This policy applies only to the line(s) of business (LOB) identified at the beginning of the policy and does not apply to other LOBs. For policies applicable to other lines of business, please visit www.hfproviders.org.

4. This policy is a provider resource for understanding Healthfirst's reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.

5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

For any questions or further clarification regarding this policy, providers are encouraged to reach out to their designated contact within our organization

II. Applicable Codes

Code	Description	Comment

III. Definitions

Term	Meaning
Diagnostic Laboratory Services	Clinical laboratory tests and pathology services performed on specimens such as blood, urine, tissue, or other bodily materials for the purpose of diagnosis, screening, monitoring, prevention, or treatment of disease.
CPT® Codes (Current Procedural Terminology)	A standardized coding system developed and maintained by the American Medical Association (AMA) to describe medical, surgical, and diagnostic services for billing and reporting purposes.
HCPCS Level II Codes	Alphanumeric codes maintained by the Centers for Medicare & Medicaid Services (CMS) that identify products, supplies, and services not included in CPT®, including certain laboratory tests.
Pathology and Laboratory	CPT® codes that describe laboratory analyses of specimens, including chemistry, hematology, microbiology, immunology, and pathology services.

Procedures (80000 Series)	
Multianalyte Assays with Algorithmic Analyses (MAAA)	Laboratory tests that measure multiple analytes and use an algorithm to generate a single patient-specific result, reported using CPT® MAAA codes.
Proprietary Laboratory Analyses (PLA)	CPT® codes assigned to proprietary clinical laboratory tests developed by a single laboratory or manufacturer and performed only by that entity or its designated laboratories.
Medical Necessity	Services or supplies that are reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, in accordance with accepted standards of medical practice and applicable benefit coverage.
National Correct Coding Initiative (NCCI)	A CMS program that promotes correct coding methodologies and controls improper coding that may result in inappropriate payment, including Procedure-to-Procedure (PTP) edits and Medically Unlikely Edits (MUEs).
Procedure-to-Procedure (PTP) Edit	An NCCI edit that prevents payment for certain combinations of CPT®/HCPCS codes that should not be reported together because they represent overlapping or mutually exclusive services.
Medically Unlikely Edit (MUE)	An NCCI edit that defines the maximum number of units of service that are typically reported for a CPT®/HCPCS code for a single patient on a single date of service.
Panel Code	A CPT® or HCPCS code that represents a grouping of individual laboratory tests commonly performed together and reported as a single code.
Modifier 52 (Reduced Services)	A modifier used to indicate that a service or procedure was partially reduced or eliminated at the provider's discretion, including instances where wet lab components were not performed.
Modifier 26 (Professional Component)	A modifier appended to a CPT® code to report only the professional component of a service when the technical component is billed separately, as permitted by CMS.
Modifier TC (Technical Component)	A modifier appended to a CPT® code to report only the technical component of a service when the professional component is billed separately, as permitted by CMS.
Next Generation Sequencing (NGS)	High-throughput laboratory technology that allows for the simultaneous sequencing of multiple genes or genomic regions, commonly used in molecular and genetic testing.
Concert Genetic	A unique identifier assigned through Concert to describe a specific genetic test, used to support billing accuracy and prior authorization for genetic and

Testing Unit (GTU)	molecular testing services.
Ordering Provider	The licensed practitioner who requests or orders a diagnostic laboratory test for a member.
Rendering Provider	The laboratory or healthcare professional that performs the diagnostic laboratory service and submits the claim for reimbursement.

IV. Related Policies

Policy Number	Policy Description
PO-RE-075	Reimbursement Policy Laboratory Procedures

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

[2] World Health Organization. (2019). International statistical classification of diseases and related health problems (11th ed.). ICD-11
[5] Centers for Medicare and Medicaid Services, "PFS Relative Value Files" PFS Relative Value Files | CMS
[6] Centers for Medicare and Medicaid Services, "Medicare NCCI Procedure to Procedure (PTP) Edits" Medicare NCCI Procedure to Procedure (PTP) Edits | CMS
[7] Centers for Medicare and Medicaid Services, "Medically Unlikely Edits" Medicare NCCI Medically Unlikely Edits | CMS
PLA Code List- Diagnostic Benefit Program - Concert

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.