

Subject:	Non-Coverage of CPT Code 80050		
Policy Number:	PO-RE-166v1		
Effective Date:	07/01/2026	Last Approval Date:	03/16/2026

I. Policy Description

Effective July 1, 2026, Healthfirst will no longer reimburse for CPT code 80050 (General Health Panel). This decision aligns with current coverage determinations from:

- Centers for Medicare & Medicaid Services (CMS)
- New York State (NYS) Medicaid

Both CMS and NYS Medicaid do not separately cover CPT 80050. In accordance, Healthfirst will deny all claims submitted with this code

This policy applies to the following Lines of Business (LOB):

• Child Health Plus (CHP)	• Essential Plan (EP)
• Integrated Benefit Dual Plan (IB-Dual)	• Managed Long Term Care Plan (MLTCP – Senior Health Partners)
• Medicaid Managed Care (MMC)	• Medicaid Advantage Plus/MAP (CompleteCare)
• Medicare Advantage HMO	• Qualified Health Plan (QHP)
• Medicare PPO	• Personal Wellness Plan (HARP)

Definitions

Laboratory Panel - A laboratory panel is a collection of individual tests performed on the same date for a specific clinical purpose.

- These panels are requested with a single order and are completed using a single biological specimen.
- The panel test is represented by a single CPT or HCPCS code, although the individual tests within a panel typically have their own specific assigned CPT or HCPCS codes.

Policy Scope

This reimbursement policy applies to:

- All participating and non-participating providers submitting claims to Healthfirst
- All Healthfirst products and lines of business, unless otherwise required by federal or state regulation or specified in a provider contract
- All places of service
- All claims with dates of service on or after July 1, 2026

Note: This policy affects reimbursement only. It does not determine member benefit eligibility or coverage beyond state or federal requirements.

Reimbursement Guidelines

1. Non-Reimbursable Code

- Claims for CPT 80050 will be denied as non-covered.
- Applies regardless of place of service or provider status.

2. Component Billing

Providers may bill individual laboratory test components included within CPT 80050 when:

- The services are medically necessary
- The services are appropriately documented
- The services are covered under the members' benefit plan
- Billing complies with CMS, NYS Medicaid, and Healthfirst billing policies

3. Claim Processing

- Claims with CPT 80050 will be denied.
- If CPT 80050 is billed with its component codes, only the panel code will be denied.

Adjudication and Appeal Process

1. This reimbursement policy is intended to provide general billing and reimbursement guidance. It does not supersede applicable provider contracts, member benefit documents, federal or state laws, or regulatory requirements. In the event of a conflict, applicable laws, regulations, and contractual provisions will govern.
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
80050	General health panel This panel must include the following: Comprehensive metabolic panel (80053) 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) Thyroid stimulating hormone (TSH) (84443)	

III. Definitions

Term	Meaning

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IV. Related Policies

Policy Number	Policy Description
N/A	N/A

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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

Information Regarding the Final CY 2018 Private Payor Rate-Based Clinical Laboratory Fee Schedule (CLFS) Payment Rates

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.