healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Laboratory Procedures Reimbursement Policy		
Policy Number:	PO-RE-075v1		
Effective Date:	06/01/2023	**Last Approval Date:**	5/22/2023

I. Policy Description

To be considered for reimbursement, all outpatient laboratory claims should be submitted in accordance with:

- AMA CPT and HCPCS coding and ICD-10 diagnosis coding guidelines
- Other laboratory and pathology coding guidelines
- All applicable regulatory guidelines

This policy outlines additional requirements beyond the guidelines listed above that are required for reimbursement. Note that these guidelines are reviewed and updated periodically.

Modifier Guidelines/ Instructions

1. Technical, Professional, and Global services (TC, 26 modifiers)
   - Before using the 26 or TC modifiers, verify that these modifiers are allowable with the procedure code.
   - Do not append these modifiers to the procedure code when performing the global service.

2. Tests performed by a Reference laboratory
   - When laboratory procedures are performed by a party other than the treating or reporting physician to other qualified health care professionals, the procedure must be identified by adding modifier 90 to the claim line.
   - Only independent clinical laboratories may append modifier 90 to indicate that the service was referred to an outside laboratory.

Repeat Testing

- While treating a patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory

test performed can be identified by its usual procedure number and the addition of modifier 91.

- Modifier 91 may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required.
- Modifier 91 may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing).

Clinical Laboratory Improvement Amendments (CLIA) Waived Testing

- Laboratory tests which are CLIA-waived must have the QW modifier appended to the procedure code.

Place of Service Guidelines

In accordance with S61 1b of OBRA of 1989, a referring lab can bill for tests performed by a reference lab only if it meets any one of the following exceptions:

- The referring laboratory is in or is part of a rural hospital.
- The referring lab and the reference lab are 'subsidiary related.' That is:
  - The referring lab is a wholly owned subsidiary of the reference lab.
  - The referring lab wholly owns the reference lab.
  - Both the referring lab and reference lab are wholly owned subsidiaries of the same entity.

Non-Reimbursable CPT/HCPCS Codes

Some procedure codes will not be reimbursed due to their expiration or replacement with more appropriate codes.

- AMA drug assay codes 80320 to 80377 are not accepted and will not be reimbursed. Refer to policy PO-RE-066v1, Opioids Testing in Pain Management and Substance Abuse, for guidelines for submitting G0480 to G0483.
- Starting July 1, 2023, proprietary Laboratory Analyses (PLA) codes will not be reimbursed unless a laboratory policy specifically covers the PLA code.

Edit Types

Outpatient lab claims are consistently evaluated for reimbursement against several standard edit types using administrative information (e.g., claim information, historical claims). The specific edits are described below.

Additional Tests on the Date of Service

The presence or absence of additional tests on a single date of service (DOS) may trigger a reimbursement denial for a claim line. The exclusivity edit is based upon:

- A list of tests where Correct Coding Initiative (CCI) and/or AMA coding guidance identify that two procedure codes for the test are not permitted for the same patient at the same time because it is only appropriate to charge for one of those procedures.
- Clinical guidelines for testing preclude the simultaneous performing of two tests. For example, individual components of panel procedures codes will not be separately reimbursed when billed with the panel procedure code.
- Technically complex procedures which incorporate simple procedures will not be reimbursed for the same patient on the same DOS. For example, billing for multiple testing methodologies (e.g., direct, amplification, and quantitative testing) for the same microorganism codes is not reimbursed.

Thus, a denial based upon this edit is one that is based upon evaluation of universal, objective criteria related to how the test is being billed, not an assessment of a patient's condition to determine whether both codes were appropriate.

Incorrect Diagnosis Code

Select diagnosis and procedure code combinations are permitted or precluded depending on the nature of the policy.

The edit functions to identify those tests that are never appropriate unless the physician has first concluded that the patient presents with the indicated diagnosis. Although the edit is contingent upon the diagnosis of the individual patient, it is not conducting any clinical evaluation of whether the condition, in fact, exists. Rather, the inherent nature of the test (only being indicated for patients with the condition or contraindicated for the condition) and the question of whether the pre-requisite condition is present are the conditions for reimbursement.

Incorrect Patient Age

This edit addresses medical policies with coverage criteria, CPT/HCPCS codes, and diagnosis codes that are not reimbursable based on the patient's age on the DOS.

For example, testing on newborns must be associated with a member who is 28 days of age or younger.

Incorrect Place of Service

This edit is invoked when the Place of Service is identified as inappropriate with the laboratory test/service performed submitted on the claim.

Once per Lifetime Tests

This edit limits the frequency of applicable laboratory services/procedure codes to once in the patient's lifetime.

Certain laboratory services should only be performed once in a patient's lifetime as outlined in medical policy. If a once-per-lifetime test is submitted for reimbursement more than once, the subsequent submissions will not be reimbursed.

Unit Threshold Met (Daily and Historical)

These edits are invoked when the number of units billed for the procedure on a single DOS or over a period of time exceeds an allowed reimbursement quantity without considering any aspect of an individual's specific condition. Maximum units of service are determined by one or more of the following:

- The CPT or HCPCS code description defines the number of units per patient per DOS for a unique billing event.
- Laboratory Coverage Guidelines outlined in medical policy establish the number of units for a laboratory service.
- The service is anatomically or clinically limited to the number of procedures that may be performed and therefore units billed.
- Scientific or statistical analyses demonstrate a reasonable limitation of the number of units that should be performed within a period of time.
- Third parties such as Correct Coding Initiative or Centers for Medicare and Medicaid Services limit reimbursement to a specified number of units.

If a procedure code that is assigned a maximum unit value is reported with a greater unit count, the claim line will be reimbursed only for the number of units up to but not exceeding the allowed maximum.

In Scope Lines of Business:

Medicare with the exception of Senior Health Plan (SHP), Medicaid, HARP, Child Health Plus, Essential Plan, Qualified Health Plan, Commercial

II. Applicable Codes

Code	Description	Comment
Modifier QW	Is defined as a Clinical Laboratory Improvement Amendment (CLIA) waived test.	

Modifier TC	Is defined as “Technical Component” and should be appended to a procedure code when the provider rendered only the technical component of the service.	
Modifier 26	Is appended to billed codes to indicate that only the professional component of a service/procedure has been provided. It is generally billed by a physician.	
Modifier 90	Is used when laboratory procedures are performed by a party other than the treating. or reporting physician and the laboratory bills the physician for the service.	
Modifier 91	Is used when a clinical laboratory test must be repeated on the same date of service and the results are used to assist in managing the treatment of a patient.	

III. Definitions

Term	Meaning
AMA	American Medical Association
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedure Coding System
CCI	Correct Coding Initiative
POS	Place of Service
DOS	Date of service
PLA	Proprietary Laboratory Analyses
CLIA	Clinical Laboratory Improvement Amendments
SHP	Senior Health Plan

IV. Related Policies

Policy Number	Policy Description
PO-RE-066v1	Prescription Medication and Illicit Drug Testing in the Outpatient Setting

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

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html
American Medical Association, Current Procedural Terminology (CPT ®), Professional Edition
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf
CMS Pub. 100-04, chapter 16, section 40.1.1 external link (PDF, 497 KB)

VI. Revision History

Revision Date	Summary of Changes

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 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.