Laboratory and Pathology

Policy

Harvard Pilgrim reimburses contracted laboratory and pathology providers for services provided at approved/contracted clinical and diagnostic laboratories.

Policy Definition

Laboratory and Pathology Services include clinical studies and testing of materials, tissues or fluids obtained from a patient to study the nature and cause of disease.

Prerequisite(s)

Applicable Harvard Pilgrim referral, notification and authorization policies and procedures apply. Refer to *Referral, Notification and Authorization* for more information.

HMO/POS/PPO

- An order is required for laboratory and pathology services.
- A referral is required for outpatient specialist services for HMO and in-network POS members.

Open Access HMO and POS

For *Open Access HMO and Open Access POS* products, no referral is required to see a contracted specialist.

Harvard Pilgrim Reimburses[1]

HMO/POS/PPO

Outpatient Services

- Testing must be based on a specific written request from an authorized ordering, referring, and/or prescribing provider for the purpose of diagnosis, treatment, or an otherwise specified medically necessary reason.
- Panel codes, when all individual tests in the panel have been performed.
- Individual codes, when all components in a panel have not been performed.
- Pre-admission testing when applicable.
- Testing for medication levels — when part of an active treatment plan ordered and managed by a Harvard Pilgrim contracted provider.
- Routine screening labs.
- Clinical laboratory tests, when performed by a technician under physician supervision.
- Laboratory and pathology consultant opinions, when the test results are outside the normal expected range and the ordering physician requests additional outside testing.
- Traveling allowance when medically necessary laboratory specimen collection is drawn from members that are homebound or who are residents or custodial status at a skilled nursing facility or rehabilitation facility/LTAC hospital.
- Presumptive and definitive urine drug screening.
- The administration of blood and blood products, including typing, cross matching, processing/storage, and the transfusion procedure

Harvard Pilgrim Does *Not* Reimburse

HMO/POS/PPO

- Amylase when billed with lipase.
- CPT code 88305 for the analyses of prostate biopsies use HCPCS code G0416 for all prostate biopsies, regardless of the number of specimens.
- Laboratory and pathology services that are rendered in conjunction with an inpatient stay, observation stay, or during the course of Facility-Based Behavioral Health Program or authorized skilled nursing, rehabilitation facility /LTAC hospital admission. Laboratory services should be billed to the facility as they are included in the respective global payment (i.e., DRG, per diem, etc.).

- Handling charges.
- Specimen collection.
- Venipuncture charges (collection of blood) made in conjunction with blood or related laboratory services or evaluation and management services when reported on the same day by any provider reporting the same Federal Tax ID Number (TIN).
- Paternity blood tests.
- NAbFeron (IFNb) antibody test.
- Mandated drug testing (e.g., court-ordered, residential monitoring, non-medically necessary testing).
- Laboratory and pathology services submitted with unlisted CPT codes when an appropriate specific code is available.
- Laboratory and pathology services provided at no charge by state agencies, including but not limited to pertussis and rubella.
- Drugs, devices, treatments, procedures, laboratory and pathology tests that are experimental, unproven, or investigational and not supported by evidence-based medicine and established peer reviewed scientific data.
- Employment drug screening.
- NAB (neutralizing antibody testing) in multiple sclerosis patients.
- Lipoprotein subclass testing in the evaluation of cardiovascular disease.
- Definitive drug testing where there has been no underlying presumptive test or where the presumptive test is negative.
- Any PC /TC indicator 9 code when submitted with a professional or technical modifier or when such code is billed by more than one entity for the same patient and same test
- Any PC/TC indicator 6 code when submitted with a TC modifier or when submitted by more than one entity. Modifier 26 is not reimbursed for these codes
- HLA tissue typing for bone marrow registries beyond testing for A, B or DR antigens
- Lipoprotein subclass testing in the evaluation of cardiovascular disease.
- Payment to blood/blood product donors in exchange for their donation or the cost or transportation of blood and/or blood products
- Transfer factor for the treatment of multiple sclerosis

Member Cost-Sharing

Services subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible).

Provider Billing Guidelines and Documentation

Coding[2]

Code	Description	Comments
0300–0309	Laboratory Revenue Codes	Bill with CPT/HCPCS code
36405, 36406, 36410, 36415, 36416, 36420, 36425, 36591, 36592	Venipuncture	Not reimbursed separately when billed with blood or related laboratory services or with E&M services
81500, 81503	Oncology (ovarian), biochemical assays	Not reimbursed
81506	Endocrinology (type 2 diabetes), biochemical assays of seven analytes	
81508–81512	Fetal congenital abnormalities, biochemical assays	

Code	Description	Comments
81507	Fetal aneuploidy (Trisomy 21,18, and 13) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy	Bill for tests reporting risk scores. Labs reporting results without a risk score should be billed using unlisted codes 84999 or 81599
82150	Amylase	Not reimbursed when billed with lipase
99000–99002	Handling charges	Not reimbursed
Q0091	Specimen collection	Not reimbursed when billed with related laboratory tests or with E&M services or when billed by a facility

Modifiers

- Use the 26 modifier when the professional component is reported separately from the technical component. It is not appropriate to use the 26 modifier if the CPT code represents a procedure to which the technical and professional component concept does not apply (e.g., CPT code 85013).
- Use the TC modifier when the technical component is reported separately from the professional component. It is not appropriate to use the TC modifier if the CPT code represents a procedure to which the technical and professional component concept does not apply.
- Always report the 26 or TC modifier in the first modifier field when reporting with other modifiers.

Other Information

- Use appropriate CPT and/or HCPCS codes for laboratory and pathology services performed in a non-institutional setting.
- Submit unlisted CPT codes on a paper claim with supporting documentation.
- Use 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.
- Bill multiple same-day services on one line with a count representing the number of services rendered.
- Bill one unit of HCPCS code G0416 for all prostate biopsies CPT 88305 will not be reimbursed for pathology of prostate biopsies.

Harvard Pilgrim uses the Center for Medicare and Medicaid Services (CMS) Professional Component/Technical Component (PC/TC) indicators in the National Physician Fee Schedule (NPFS) Relative Value File to determine whether a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code is eligible for separate reimbursement for professional and technical services.

Required Documentation

Requests for laboratory services must be in writing to the lab and include the following information:

- Date of the request
- The name or any other means of identifying the member to be tested
- The name (legible) and address of the authorized ordering, referring, and/or prescribing provider
- The name of the specific laboratory tests to be performed
- The frequency for performing each laboratory test (applicable to standing orders only)
- The duration and maximum number of times each laboratory test or tests are to be performed (applicable to standing orders only)
- A statement by the authorized ordering, referring, and/or prescribing provider that such testing is required as part of the member's medical or drug treatment plan
- The Identification number of the specimen

- If the specimen is referred from another laboratory, the name of the referring laboratory
- The date the specimen was collected, the name of the authorized ordering, referring, and/or prescribing provider or other person who collected the specimen and the location of the collection
- The date on which the specimen was received by the laboratory
- The specific tests performed
- The date or dates on which each test was performed
- The results of each test, the name and address of all persons to whom the test result is reported, and the date of reporting
- The name and address of the laboratory to which the specimen was referred, if applicable

If a laboratory refers a specimen to a testing laboratory, the referring laboratory must forward the original request to perform the service to the testing laboratory. Both laboratories must keep a record of each request for laboratory services, each specimen and each test result for at least six years from the date on which the results were reported to the authorized ordering, referring, and/or prescribing provider.

Related Policies

Payment Policies

- CPT and HCPCS Level Modifiers
- Emergency Care
- Evaluation and Management
- Gynecology
- Inpatient Acute Medical Admissions
- Non–covered Services
- Obsolete and Unreliable Procedures
- Rehabilitation Facilities/Long-Term Acute Care Hospitals
- Skilled Nursing Facility
- Unlisted/Unspecified Procedure Codes
- Urine Drug Testing
- General Coding and Claims Editing

Clinical Policies

- Cardiovascular Disease Risk Tests
- Molecular Diagnostic Management
- New Technology Assessment and Non-Covered Services
- Urine Drug Testing
- Vitamin B12 Screening and Testing
- Vitamin D Screening and Testing

PUBLICATION HISTORY

01/01/01	original documentation
09/01/00	original documentation
06/01/01	inpatient authorization requirement changed to notification
11/01/02	added coding; added modifier and multiple same-day services billing information
04/01/03	annual review; 2003 coding update
10/31/04	annual review
04/30/05	coding review
1/31/06	annual review & coding update; removed premarital blood test (Massachusetts mandate repealed 01/28/05); added non–coverage of mandated drug testing
01/31/07	annual review; clarified venipuncture billing
10/31/07	annual review; added information related to denials for unlisted lab codes, services provided by state agencies at no charge, and experimental/investigational tests
01/31/08	annual coding update
10/31/08	annual review; added HPV testing with approved diagnosis (with table); added to the do not reimburse list: employment drug screening and NAB; added four new HPV diagnosis ranges, effective 10/01/08

01/31/09	annual coding update; 36416 not reimbursed; added existing non-coverage for Lipoprotein subclass testing CPTs and diags
10/15/09	annual review; added payable diag 622.10 for HPV; added HLA related policy
09/15/10	annual review; no changes
09/15/11	annual review; update to related policies
01/01/12	removed First Seniority Freedom information from header
10/15/12	added PC TC Indicator 6 and 9 reimbursement info & required documentation for urine testing documentation
01/15/13	annual coding update
06/15/13	added denial of amylase billed with lipase
08/15/13	annual review; CPT 80100,80101 and 80104 no longer reimbursed
12/15/13	updated HPV diag list and removed age criteria
01/15/14	annual coding update; added new CPT codes 81504, 81507, effective 01/01/14
06/15/14	added *Connecticut Open Access HMO* referral information to Prerequisites
09/15/14	annual review; administrative edits
01/15/15	annual coding update
07/15/15	ICD-10 coding update
09/15/15	annual review; updated related policies
01/15/16	annual coding update
04/15/16	updated policies to include Vitamin D Screening and Testing Medical Policy
09/15/16	annual review; administrative edit
01/15/17	annual coding update
09/15/17	annual review; administrative edits; removed "qualitative" and "quantitative" language and replaced with "definitive" and "presumptive;" added related medical policies
11/15/17	administrative edits
01/01/18	added Molecular Diagnostic Management Medical Policy as a related policy; updated Open Access Product referral information under Prerequisites
09/04/18	annual review; removed ICD-9 Covered Indications; administrative edits
12/03/18	removed lipoprotein subclass testing from coding grid
10/01/19	annual review; clarified definition of homebound members in the Harvard Pilgrim Reimburses section; clarified laboratory services should be billed to facility in the Harvard Pilgrim Does Not Reimburse section; added Inpatient Acute Medical Admissions Payment Policy to Related Policies section; clarified the definition of prescriber; administrative edits
04/01/20	added that CPT 88305 will no longer be reimbursed for pathology of prostate biopsies as of dos 06/01/20; removed archived medical policy, added U0001 & U0002 effective 02/04/20; added 87635 effective 03/13/20
08/03/20	added codes to venipuncture in coding grid, not reimbursed when reported by same TIN
09/01/20	annual review; administrative edits
03/01/21	added Q0091 not reimbursed when billed by a facility as of dates of service 5/1/2021
05/01/21	added Gynecology Payment Policy as a related policy
09/01/21	annual review; added HLA tissue typing, Lipoprotein testing, payment of blood/blood products in exchange for donation, Transfer factor for MS to not reimbursed section, added administration of blood and blood products to reimbursed section, other administrative edits
02/01/22	annual coding update
09/01/22	annual review; administrative edit
09/01/23	annual review; administrative edits, updates to related policies
08/30/24	annual review; administrative edit; updated Related Policies; removed HPV testing

[1]This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.

[2]The table may not include all provider claim codes related to laboratory/pathology.