PAYMENT POLICIES

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

HMO/POS/PPO
Outpatient Services
• Testing must be based on a specific written request from an authorized treating prescriber 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 nursing homebound.
• Human papilloma virus (HPV) testing for approved diagnosis.
• Presumptive and definitive urine drug screening.

Harvard Pilgrim Does Not Reimburse

HMO/POS/PPO
• Amylase when billed with lipase
• 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 (They are included in the respective global payment. i.e., DRG, per diem, etc.)
• Handling charges
• Specimen collection
• Routine venipuncture charges made in conjunction with blood or related laboratory services or evaluation and management services
• Paternity blood tests

(continued)
• 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


- Modifier 26 or Modifier TC with procedure codes with a PC/TC Indicator of 9 since the concept does not apply
- 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 unless the following criteria are met:
  - Requested by the attending physician
  - Result is a written narrative report included in the patients' medical record
  - Require an exercise of medical judgment by the consulting physician

### Member Cost-Sharing

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

#### Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>0300–0309</td>
<td>Laboratory Revenue Codes</td>
<td>Bill with CPT/HCPCS code</td>
</tr>
<tr>
<td>0310–0319</td>
<td>Pathology Revenue Codes</td>
<td></td>
</tr>
<tr>
<td>36415</td>
<td>Venipuncture</td>
<td>Not reimbursed when billed with blood or related laboratory services or with E&amp;M services</td>
</tr>
<tr>
<td>36416</td>
<td>Collection of capillary blood specimen</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>80048–89240</td>
<td>Pathology and laboratory procedures</td>
<td></td>
</tr>
<tr>
<td>81500, 81503</td>
<td>Oncology (ovarian), biochemical assays</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>81506</td>
<td>Endocrinology (type 2 diabetes), biochemical assays of seven analytes</td>
<td></td>
</tr>
<tr>
<td>81508–81512</td>
<td>Fetal congenital abnormalities, biochemical assays</td>
<td></td>
</tr>
<tr>
<td>81504</td>
<td>Oncology (tissue of origin), microarray gene expression profiling of &gt;2000 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores</td>
<td></td>
</tr>
<tr>
<td>81507</td>
<td>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</td>
<td>Bill for tests reporting risk scores. Labs reporting results without a risk score should be billed using unlisted codes 84999 or 81599.</td>
</tr>
<tr>
<td>82150</td>
<td>Amylase</td>
<td>Not reimbursed when billed with lipase</td>
</tr>
<tr>
<td>87623–87625</td>
<td>Human Papilloma Virus (HPV)</td>
<td>[ICD-10 Covered Indications]</td>
</tr>
<tr>
<td>99000–99002</td>
<td>Handling charges</td>
<td>Not reimbursed</td>
</tr>
</tbody>
</table>
### Payment Policies

#### Laboratory and Pathology (cont.)

<table>
<thead>
<tr>
<th>Code</th>
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</tr>
</thead>
<tbody>
<tr>
<td>G0480-G0483</td>
<td>Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day.</td>
<td></td>
</tr>
<tr>
<td>G0659</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes.</td>
<td></td>
</tr>
<tr>
<td>P9603</td>
<td>Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient; prorated miles actually travelled.</td>
<td></td>
</tr>
<tr>
<td>Q0091</td>
<td>Specimen collection</td>
<td>Not reimbursed when billed with related laboratory tests or with E&amp;M services</td>
</tr>
</tbody>
</table>

#### Provider Billing Guidelines and Documentation

**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.

**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 prescriber
• 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 prescriber 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 prescriber 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 prescriber.

Related Policies
• Renal Prostatic Hypertrophy Medical Policy
• Cardiovascular Disease Risk Tests Medical Policy
• Continuous Glucose Monitoring Systems Medical Policy
• CPT and HCPCS Level Modifiers Payment Policy
• Emergency Care Payment Policy
• Evaluation and Management Payment Policy
• Fecal DNA Testing for Colorectal Cancer Medical Policy
• Helicobacter pylori (H. pylori) Testing Medical Policy
• Hepatic Fibrosis Medical Policy
• Human Leukocyte Antigen Testing Payment Policy
• Infertility CT Medical Policy
• Infertility MA Medical Policy
• In Vitro Chemosensitivity and Chemoresistance Assays Medical Policy
• Molecular Diagnostic Management Medical Policy
• Neutralizing Antibody Testing in Multiple Sclerosis Patients Medical Policy
• Non–covered Services Payment Policy
• Non–invasive Prenatal Testing for Fetal Trisomy Medical Policy
• Obsolete and Unreliable Procedures Payment Policy
• Platelet-rich Plasma Injections Medical Policy
• Preimplantation Genetic Testing Medical Policy
• Rehabilitation/Long Term Acute Care Payment Policy
• Serum Immunoglobulin G Allergy Testing Medical Policy
• Skilled Nursing Facility Payment Policy
• Umbilical Cord Blood Payment Policy
• Unlisted/Unspecified Procedure Codes Payment Policy
• Urine Drug Testing Medical Policy
• Urine Drug Testing Payment Policy
• Viral Hepatitis Serology Testing Payment Policy
• Vitamin B12 Screening and Testing Medical Policy
• Vitamin D Screening and Testing Medical Policy

PUBLICATION HISTORY
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
10/31/03 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

(continued)
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

1This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—Harvard Pilgrim Health Care of Connecticut, 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.

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