Laboratory and Pathology
Payment Policy

MASSACHUSETTS

Policy

Blue Cross Blue Shield of Massachusetts (Blue Cross*) reimburses contracted providers for covered, medically necessary laboratory and pathology services provided at contracted clinical and diagnostic laboratories.

Services may be delivered in non-institutional settings, such as an office or a freestanding facility, and in institutional settings such as hospitals, skilled nursing facilities, and comprehensive outpatient rehabilitation facilities.

General benefit information

Covered services and payment are based on the member's benefit plan and provider Agreement. Providers and their office staff may use our online tools to verify effective dates and member copayments before providing services. Visit our eTools page for information on member eligibility and benefits. Member liability may include, but is not limited to: copayments, deductibles, and co-insurance. Members' costs depend on member benefits.

Certain services require prior authorization or referral.

In addition, Blue Cross maintains medical policies specific to medical necessity criteria for certain laboratory services. Medical policy information can be found on Provider Central.

Payment information

Blue Cross reimburses health care providers based on your contracted rates and member benefits.

Claims are subject to payment edits, which Blue Cross updates regularly.

Blue Cross reimburses:

- Clinical laboratory tests, when performed by a technician under physician supervision.
- Genetic testing, when the test rendered meets any applicable Blue Cross medical policy criteria for individual codes, when all components in a panel have not been performed.
- Presumptive and definitive drug screening (see Medical Policy # 674: Drug Testing in Pain Management and Substance Use Disorder Treatment for additional information).
- Automated multi-channel chemistry (AMCC) and organ or disease panel tests based on AMCC payment method.
    - All automated tests in any combination performed on the *same* day, for the *same* patient, by the *same* provider is regarded as a single panel test.
    - See the Billing Information section below for a list of codes eligible to be reimbursed according to the AMCC payment method.
- Routine screening labs.
- Testing for medication levels when part of an active treatment plan ordered and managed by a Blue Cross contracted provider (see Medical Policy # 674: Drug Testing in Pain Management and Substance Use Disorder Treatment for additional information).
    - 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.
- Traveling allowance when medically necessary laboratory specimen collection is drawn from members who are homebound or nursing homebound.

Blue Cross does not reimburse:

Service	1500 professional claims	UB-04 facility claims
• Lab handling charges	• For any type of lab service	• For any type of lab service
• Collection of capillary blood specimen	• For any service	• For any service
• Venipuncture	• With office visit or lab	• When billed with E/M, lab codes or codes with a J1, J2, S, T, V, Q1, Q2, Q3, or Q4 OPPS status indicator
• Urinalysis (81000 – 81005)	• Procedure codes 81002, 81003	• When billed with E/M codes • Effective 10/1/2018: When billed with codes with a J1, J2, S, T, V, Q1, Q2, or Q3 OPPS status indicator
• Lab procedure codes (with OPPS status indicator = N)	• Not applicable	• Effective 2/1/2020: Any lab procedure code with an OPPS status indicator = 'N' o Please refer to CMS guidelines Addendum B for additional information

Acute care hospitals

- Pathology-related services include the technical component. Hospitals may bill separately for the professional component with the appropriate professional revenue code. Physicians may also bill separately, if appropriate.
- All other outpatient laboratory services reimbursement is global. No additional reimbursement will be made to the hospital or other provider.

Maximum units

Laboratory and pathology services are subject to unit limits. Please see the Maximum Units Payment Policy for additional information.

Billing information

Specific billing guidelines

The list of codes below is included for *informational purposes only*. This may not be a complete list of all the codes related to this service. Whether or not a code is listed here does not guarantee coverage or reimbursement.

COVID-19 testing

The Centers for Medicare & Medicaid Services (CMS) recently announced new HCPCS codes for providers and laboratories to test patients for COVID-19. Blue Cross will begin accepting these codes on April 1, 2020 for claims with dates of service on or after February 4, 2020.

The American Medical Association (AMA) has announced a new CPT code to describe laboratory testing for COVID-19. Blue Cross will begin accepting this code for claims with dates of service on or after March 13, 2020.

Code	Service description	Comments
971	Professional fees, laboratory	Reimbursable when the hospital reimbursement covers only the technical portion.
36415	Collection of venous blood by venipuncture	**Professional** • Not reimbursed with office visit and lab procedures. **For facility only**

Code	Service description	Comments
		• Not reimbursed when billed with E/M codes, lab codes or codes with procedure codes with a J1, J2, S, T, V, Q1, Q2, Q3, or Q4 OPPS status indicator.
36416	Collection of capillary blood specimen	Not reimbursed.
81000-81005	Urinalysis	**Professional** • 81002 and 81003 not reimbursed to professional providers. **Facility outpatient** • Deny when billed with E/M codes. • *Effective 10/1/2018*: Deny when billed with procedure codes with a J1, J2, S, T, V, Q1, Q2, or Q3 OPPS status indicator.
99000	Handling or conveyance of specimen for transfer from the office to a laboratory	Not reimbursed.
99001	Handling or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)	
G0416	Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method	Bill only one unit regardless of the number of specimens collected.
U0001	CDC 2019 novel coronavirus (2019-ncov) real-time rt-pcr diagnostic panel	Reimbursable effective 4/1/2020 for claims with dates of service on or after 2/4/2020
U0002	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) using any technique, multiple types or subtypes (includes all targets), non CDC	Reimbursable effective 4/1/2020 for claims with dates of service on or after 2/4/2020
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique	Reimbursable for dates of service on or after 3/13/2020 Do not bill on the same day for the same patient as U0002

Automated multi-channel chemistry services (AMCC):
Any combination of the following tests, when performed on a single patient, on a single date of service, is regarded as a *single panel test* and reimbursed according to AMCC payment method.

Code	Service description	Number of tests	Comments
80047	Basic metabolic panel – calcium, ionized (consists of 82330, 82374, 82435, 82565, 82947, 84132, 84295, 84520)	8	
80048	Basic metabolic panel – calcium, total (consists of 82310, 82374, 82435, 82565, 82947, 84132, 84295, 84520)	8	
80051	Electrolyte panel (consists of 82374, 82435, 84132, 84295)	4	
80053	Comprehensive metabolic panel (consists of 82040, 82247, 82310, 82374, 82435, 82565, 82947, 84075, 84132, 84155, 84295, 84460, 84450, 84520)	14	
80061	Lipid panel (consists of 82465, 83718, 84478)	3	
80069	Renal function panel (consists of 82040, 82310, 82374, 82435, 82565, 82947, 84100, 84132, 84295, 84520)	10	
80076	Hepatic function panel (consists of 82040, 82247, 82248, 84075, 84155, 84460, 84450)	7	

Code	Service description	Number of tests	Comments
82040	Albumin, serum	1	
82247	Bilirubin, total	1	
82248	Bilirubin, direct	1	
82310	Calcium, total	1	
82330	Calcium, ionized	1	
82374	Carbon dioxide (bicarbonate)	1	
82435	Chloride, blood	1	
82465	Cholesterol, serum; total	1	
82550	Creatinine kinase CK, CPK; total	1	
82565	Creatinine, blood	1	
82947	Glucose, quantitative	1	
82977	Glutamyltransferase, gamma GGT	1	
83615	Lactate dehydrogenase LD, LDH	1	
84075	Alkaline phosphatase	1	
84100	Phosphorus, inorganic (phosphate)	1	
84132	Potassium, serum	1	
84155	Protein, total, except refractometry	1	
84295	Sodium, serum	1	
84450	Transferase, aspartate amino AST, SGOT	1	
84460	Transferase, alanine amino ALT, SGPT	1	
84478	Triglycerides	1	
84520	Urea nitrogen, quantitative	1	
84550	Uric acid, blood	1	

When submitting claims, report all services with:

- Up-to-date industry-standard procedure and diagnosis codes, and
- Modifiers that affect payment in the first modifier field, followed by informational modifiers

Related policies

Note: Log into Provider Central before clicking Payment Policy links.

Drug Testing
General Coding and Billing
Maximum Units

Medical Policy # 307: Saturation Biopsy for Diagnosis and Staging of Prostate Cancer
Medical Policy # 674: Drug Testing in Pain Management and Substance Use Disorder Treatment
Non-Reimbursable Services
Third Party Services

Policy update history

08/15/2014	Documentation of existing policy
02/17/2015	Addition of information on acute care hospitals reimbursement policy
05/18/2015	Template update, addition of information on prostate needle biopsy services
10/30/2015	Template update; annual review; edits for clarity; inclusion of information on billing guidelines for acute care hospitals, automated multi-channel chemistry and lab panel services, lab handling codes, venipuncture, and pap smear
05/01/2017	Template update; annual review; addition of information on automated multi-channel chemistry (AMCC) and organ or disease panel tests based on AMCC payment method effective 8/1/2017
06/30/2018	Annual review; removed effective date of AMCC; removed pap smear billing info; inclusion of OPPS status codes for facility venipuncture and urinalysis procedures
12/31/2018	Edits for clarity on facility venipuncture language and correction to lab panel codes.
02/01/2020	Updated to reflect changes to outpatient reimbursement effective 2/1/2020 to deny OPPS SI=N codes for facility claims; edits for clarity in coding grid
03/13/2020	Updated with COVID-19 information
03/18/2020	Updated with new COVID-19 CPT code

This document is for informational purposes only and is not an authorization, an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.

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Payment policies are intended to help providers obtain Blue Cross Blue Shield of Massachusetts' payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy development takes into consideration a variety of factors, including: the terms of the participating provider's contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

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