In the event of a conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents.

In the event of a conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup. The billing office is expected to submit claims for services rendered using valid codes from the Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code auditing protocols for services/procedures billed.

Laboratory Panel Billing Guideline

Policy Number: CPCP021

Version 4.0

Clinical Payment and Coding Policy Committee Approval Date: 03/25/2019

Plan Effective Date: 05/24/2019

Description

This policy is to provide a guideline on the appropriate billing for laboratory procedures or services that belong to a panel when billed on the same date of service for a patient. This policy is consistent with the existing CPT coding guidelines and is not a new concept.

Reimbursement Information

Laboratory panels outlined below were developed for coding purposes only and are defined by AMA and published in the CPT® codebook under Pathology and Laboratory, Organ or Disease-Oriented Panels. Orders for laboratory tests, must be patient-specific and include the rationale/need for the test requested and must be signed and dated by the ordering health care professional. Provider-defined ("custom") panels are not recognized as nationally defined panels. To facilitate benefit processing, the codes for the individual tests in the "custom" panel must be reported. Reimbursement is provided for tests that are performed in a panel if they are reasonable, medically necessary under the applicable medical policy, and otherwise reimbursable under the terms of the member's plan. The plan reserves the right to rebundle individual codes that belong to a panel. If a claim is submitted with individual codes that belong

to a panel, our claim reviewers and/or correct coding software logic may rebundle the procedure codes for appropriate reimbursement. If the medical documentation submitted with a claim shows that a panel was ordered and performed but the claim submitted shows the individual components of the panel, claim reviewers may rebundle the codes into the appropriate panel for reimbursement. CPT states the following:

- Tests performed in addition to those specifically indicated for a particular panel should be reported separately from the panel code

  Example, If the Electrolyte panel (80051) is billed, individual tests such as 82947 (Assay Glucose Blood Quant), 84520 (Assay of Urea Nitrogen), 82565 (Assay of Creatinine) and 82550 (Assay of CK (CPK)) should be billed separately from the panel.

- Do not report two or more panel codes that include the same constituent tests performed from the same patient collection

  Example, If the Comprehensive Metabolic Panel (80053) is billed, the Basic Metabolic Panel (80047) cannot be billed.

- If a group of tests overlaps two or more panels, you must use the panel that incorporates the greatest number of tests and report the remaining individual tests

  Example, if 82374 (Assay of Blood Carbon Dioxide), 82435 (Assay of Blood Chloride), 84132 (Assay of Serum Potassium), 84295 (Assay of Serum Sodium), 84520 (Assay of Urea Nitrogen), and 82947 (Assay Glucose Blood Quant) are billed, two panel codes overlap. The Basic Metabolic Panel (80047) and the Electrolyte Panel (80051) include codes 82374 (Assay of Blood Carbon Dioxide), 82435 (Assay of Blood Chloride), 84132 (Assay of Serum Potassium) and 84295 (Assay of Serum Sodium). The Electrolyte Panel should be billed.

- The panel code should be billed when all individual tests in the panel have been performed and should not be billed separately

  Example, If the Lipid Panel (80061) is billed, then procedures 82465 (Assay BLD/Serum Cholesterol), 83718 (Assay of Lipoprotein) and 84478 (Assay of Triglycerides) should have been performed.

The following panels will be used when determining appropriate billing:

80047	**Metabolic Panel Ionized-** CA
82330	Assay of Calcium
82374	Assay Blood Carbon Dioxide
82435	Assay of Blood Chloride

82565	Assay of Creatinine
82947	Assay Glucose Blood Quant
84132	Assay of Serum Potassium
84295	Assay of Serum Sodium
84520	Assay of Urea Nitrogen

80048	**Metabolic Panel Total- CA**
82310	Assay of Calcium
82374	Assay Blood Carbon Dioxide
82435	Assay of Blood Chloride
82565	Assay of Creatinine
82947	Assay Glucose Blood Quant
84132	Assay of Serum Potassium
84295	Assay of Serum Sodium
84520	Assay of Urea Nitrogen

80050	**General Health Panel**
80053	Comprehensive Metabolic Panel
84443	Assay Thyroid Stim Hormone
85025	Complete CBC w/Auto Diff WBC; **OR**
85027 & 85004	• Complete CBC Automated • Automated Differential WBC Count
OR 85027	Complete CBC Automated **AND**
85007 or 85009	• BL Smear w/Diff WBC Count • Manual Differential WBC Count, B-Coat

80051	**Electrolyte Panel**
82374	Assay Blood Carbon Dioxide
82435	Assay of Blood Chloride

84132	Assay of Serum Potassium
84295	Assay of Serum Sodium

80053	**Comprehensive Metabolic Panel**
82040	Assay of Serum Albumin
82247	Bilirubin Total
82310	Assay of Calcium
82374	Assay Blood Carbon Dioxide
82435	Assay of Blood Chloride
82565	Assay of Creatinine
82947	Assay Glucose Blood Quant
84075	Assay Alkaline Phosphatase
84132	Assay of Serum Potassium
84155	Assay of Protein Serum
84295	Assay of Serum Sodium
84460	Alanine Amino (ALT) (SGPT)
84450	Transferase (AST) (SGOT)
84520	Assay of Urea Nitrogen

80055	**Obstetric Panel**
87340	Hepatitis B Surface AG IA
86762	Rubella Antibody
86592	Syphilis Test Non-Trep Qual
86850	RBC Antibody Screen
86900	Blood Typing Serologic ABO **AND**
86901	Blood Typing Serologic RH(D)
85025	Complete CBC w/Auto Diff WBC Count; **OR**
85027 & 85004	• Complete CBC Automated • Automated Diff WBC Count

OR 85027	Complete CBC Automated **AND**
85007 or 85009	• BL Smear w/ WBC Count • Manual Diff WBC Count, B-Coat

*CPT manual instructs when syphilis screening is conducted using a treponemal antibody approach- CPT code 86780, do not use CPT code 80055. Use the individual codes for the tests performed in the obstetric panel.

80061	**Lipid Panel**
82465	Assay BLD/Serum Cholesterol
83718	Assay of Lipoprotein
84478	Assay of Triglycerides

80069	**Renal Function Panel**
82040	Assay of Serum Albumin
82310	Assay of Calcium
82374	Assay Blood Carbon Dioxide
82435	Assay of Blood Chloride
82565	Assay of Creatinine
82947	Assay Glucose Blood Quant
84100	Assay of Phosphorus
84132	Assay of Serum Potassium
84295	Assay of Serum Sodium
84520	Assay of Urea Nitrogen

80074	**Acute Hepatitis Panel**
86709	Hepatitis A IGM Antibody
86705	HEP B Core Antibody IGM
87340	Hepatitis B Surface AG IA
86803	Hepatitis C AB Test
80076	**Hepatic Function Panel**
82040	Assay of Serum Albumin

82247	Bilirubin Total
82248	Bilirubin Direct
84075	Assay Alkaline Phosphatase
84155	Assay of Protein Serum
84460	Alanine Amino (ALT) (SGPT)
84450	Transferase (AST) (SGOT)

80081	**Obstetric Panel**
87340	Hepatitis B Surface AG IA
86762	Rubella Antibody
86592	Syphilis Test Non-Trep Qual
86850	RBC Antibody Screen
86900	Blood Typing Serologic ABO **AND**
86901	Blood Typing Serologic RH(D)
87389	HIV-1 AG w/HIV-1 & HIV-2 AB
85025	Complete CBC w/Auto Diff WBC; **OR**
85027 & 85004	• Complete CBC Automated • Automated Diff WBC Count
OR 85027	Complete CBC Automated **AND**
85007 or 85009	• BL Smear w/ Diff WBC Count • Manual Differential WBC Count, B-Coat

*CPT manual instructs when syphilis screening is conducted using a treponemal antibody approach- CPT code 86780, do not use CPT code 80081. Use the individual codes for the tests performed in the Obstetric panel.

Repeat Testing

Claims submitted for the same patient from the same provider for the same service(s) on the same date of service may be reviewed for appropriate coding. If a clinical review determines possible inappropriate coding, medical records may be requested to determine the necessity. If repeat services performed are deemed necessary, the services should be submitted with an appropriate modifier appended.

Providers are responsible for conducting laboratory services in an efficient manner. Modifier 91 should be appended to claims for repeat testing for the treatment of a patient when testing is required at different periods throughout the day. Claims may be denied for failure to append

modifier 91 or if a medical record review determines repeat testing did not meet standard guidelines.

Licensing and Certifications

Any provider that perform laboratory testing on a patient for a health assessment or the diagnosis, prevention or treatment of a disease are regulated under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). For additional information refer to the Provider Manual on the plans provider website.

Blue Cross Blue Shield New Mexico (BCBSNM) Addendum

Orders

Orders for diagnostic tests, including laboratory tests, must be patient-specific and include the rationale/need for the test requested. Panel testing is restricted to panels published in the current CPT manual. Orders must be signed and dated by the ordering health care professional. "Custom" panels are not specific to a particular patient and are not allowed. Further, the following are not reimbursable: Routine screenings, including quantitative (definitive) panels, performed as part of a clinician's protocol for treatment, without documented individual patient assessment; Standing orders, which are routine orders given to a population of patients and may result in testing that is not individualized, not used in the management of the patient's specific medical condition; and Validity testing, which is an internal process to affirm that the reported results are accurate and valid.

Note: For more details, please refer to CPCP020 Drug Testing Clinical Payment and Coding Policy

References

Policy Update History

HCSC Approval Date	Description	BCBSNM Approval Date	BCBSNM Effective Date	BCBSNM End Date
11/21/2018	New policy	12/18/2018	02/09/2019	05/23/2019
03/25/2019	Annual Review and CPT Code descriptors update	05/08/2019	05/24/2019	

Date	Summary of Changes
5/8/2019	Under section labeled Reimbursement Information, wording revised but concepts remain the same and more details provided for the examples. CPT descriptions were shortened. Obstetric Panel 80081 moved further down in the document to be in numerical order. Addition of section labeled Blue Cross Blue Shield New Mexico Addendum, Orders.