Priority Health	BILLING POLICY No. 213
Office Lab Policy	
Date of origin: 10/2026	**Review dates: NA**

POLICY OVERVIEW

This policy outlines billing and payment requirements associated with laboratory services performed by physicians and other qualified health care professionals in the office setting (Place of Service 11). Coverage is limited to laboratory tests that require a rapid turnaround time to support the timely diagnosis, evaluation, and treatment of a member's condition during an office encounter.

DEFINITION

The purpose of this policy is to define payment criteria for physicians and other qualified health professionals performing lab services requiring a short turnaround time in the office setting.
Office lab services are those performed during an in-office encounter where diagnostic lab testing is needed to establish a diagnosis and/or to select the most appropriate treatment option for the member's care. These tests require immediate results to manage urgent or emergent conditions and are designated for in-office settings.
This policy will outline the appropriate lab tests for office settings (place of service 11) to ensure specialized and high-quality laboratory tests are performed in the appropriate setting.
CLIA certificate requirements as defined by CMS are followed. Modifiers should be appended for applicable tests. Failure to append CLIA waived test modifier (QW) will result in a claim denial.
CLIA – Clinical laboratory improvement amendment of 1988 approves tests that are cleared by the FDA as simple, low-risk tests.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Payment for office laboratory services will be limited to those defined in the coding section of this document. Laboratory services that are not included in the list below or outlined in another policy within the provider manual, are not payable when performed in the office setting. These should be referred to and performed by an independent or facility-based lab provider.

- Lab services outlined in this policy do not guarantee coverage. Member benefits should be consulted for most up to date coverage detail.

Coding specifics

Code List	Code
General Code List	80047

General Code List	80048
General Code List	80053
General Code List	80305
General Code List	80306
General Code List	80307
General Code List	80324
General Code List	80325
General Code List	80326
General Code List	80327
General Code List	80328
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General Code List	80330
General Code List	80331
General Code List	80332
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General Code List	81002
General Code List	81003
General Code List	81005
General Code List	81015
General Code List	81025
General Code List	82043
General Code List	82044
General Code List	82247
General Code List	82270
General Code List	82271
General Code List	82272
General Code List	82465
General Code List	82565
General Code List	82731
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General Code List	82952
General Code List	82962
General Code List	83036

General Code List	83037
General Code List	83655
General Code List	83735
General Code List	83861
General Code List	83986
General Code List	83992
General Code List	84132
General Code List	84436
General Code List	84437
General Code List	84439
General Code List	84443
General Code List	84520
General Code List	84703
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General Code List	87905
General Code List	88174
General Code List	88175
General Code List	88305
General Code List	88342
General Code List	0202U
General Code List	0223U
General Code List	0224U
General Code List	0225U
General Code List	0226U
General Code List	C9803
General Code List	G0435
General Code List	G0480
General Code List	G0481
General Code List	G0659
General Code List	Q0111
General Code List	Q0112

General Code List	U0001
General Code List	U0002
Family Practice/Pediatrics	82248
Family Practice/Pediatrics	82247
Family Practice/Pediatrics	83655
Family Practice/Pediatrics	83036
Family Practice/Pediatrics	87184
Oncology/Hematology	86561
Oncology/Hematology	85097
Oncology/Hematology	85007
Oncology/Hematology	85060
Oncology/Hematology	88187
Oncology/Hematology	88188
Oncology/Hematology	88189
Reproductive Endocrinology	89300
Reproductive Endocrinology	89320
Reproductive Endocrinology	89330
Reproductive Endocrinology	89060
Reproductive Endocrinology	83036
Urology	89300
Ophthalmology	83516
Ophthalmology	83861

Modifiers

See modifier pages for repeated modifiers, technical and professional components, CLIA waived modifier at link below.

Provider Center: Provider office lab testing

Using modifiers | Priority Health

Place of service

11 Office - As defined by CMS: Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

Place of Service Code Set | CMS

Documentation requirements

Documentation should clearly indicate all tests ordered and performed. Medical records should be authenticated with physician's intent to order testing. Test results must be documented in the medical record to detail the test results.

Resources

Current Procedural Terminology (CPT)
HCPCS Level II

Related policies

- Provider Center: Provider office lab testing
- Reference labs billing | Provider | Priority Health
- Lab_and_pathology_coding_policy_downloadOriginal

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements are appropriate to procedure; diagnosis and frequency which are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
October 2026	New policy defining the laboratory services eligible for reimbursement when performed in the office setting (Place of Service 11), including applicable billing, documentation, and CLIA requirements.