

Blood Counts

Date of origin: March 2026

Review dates: 03/2026

DEFINITION

A Complete Blood Count (CBC) is a common test used to evaluate and diagnose diseases relating to abnormalities of the blood or bone marrow. These include primary disorders such as anemia, leukemia, polycythemia, thrombocytosis, and thrombocytopenia.

MEDICAL POLICY

- *Reference PH current medical policy*

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**Screening is not covered:**

CBCs, hemoglobin, or hematocrit tests performed on asymptomatic patients or those without a condition expected to cause hematologic abnormalities are considered screening and are not reimbursable. Screening is not covered.

Hemoglobin or hematocrit only:

If the provider orders only hemoglobin or only hematocrit to assess oxygen carrying- capacity, the other CBC components are not covered and should not be billed.

ESRD patients:

When a CBC is obtained for an end stage renal disease (ESRD) patient outside the ESRD bundled rate, medical necessity must be documented and submitted with the claim.

Repeat testing:

A single CBC is generally sufficient for many symptoms or conditions.

Repeat CBCs are covered only if:

- initial results are abnormal, or
- the patient's clinical condition changes, or
- the patient has a condition with ongoing risk for hematologic abnormalities (in which case repeat testing is appropriate even if prior results were normal).

When repeat testing is justified, a more specific diagnosis code (e.g., anemia) should be used to support medical necessity.

Limitations

CBC testing is not covered when used as routine screening in asymptomatic patients or those without a condition expected to cause a blood abnormality. In some cases, only hemoglobin or hematocrit testing is appropriate; if only these are ordered, the other CBC components are not covered.

For ESRD patients, CBCs billed outside the ESRD bundle require documentation of medical necessity with the claim. A single CBC may be sufficient for certain conditions, and repeat testing is generally not covered unless results are abnormal or the patient's clinical condition changes. However, repeat testing may be medically necessary even with normal results in patients who remain at ongoing risk for developing hematologic abnormalities.

Detail any billing/coding requirements we want specified.

- *Reference medical policy but we do not want to re-iterate or define medical policy in our payment policies.*
- *Indications*
- *Limitations*
- *Indications to indicate code or associated code(s) that are not payable*

Our goal in these coding/billing policies is not to define medical necessity. This is driven by medical policy. Please confirm if content you find exists within one of our current medical policies and if so, we can include this in our discussions with our medical policy team.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information [in our Provider Manual](#).

Summary of pertinent information (if applicable).

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Summary of expected documentation within medical record.

Coding specifics

CPT Codes:

85004 – Blood Count, automated differential WBC count

85007 – Blood Count, blood smear, microscopic examination with manual differential WBC count

85008 – Blood Count, blood smear, microscopic examination without manual differential WBC count

85013 – Blood Count, spun microhematocrit

85014 – Blood count, hematocrit (Hct)

85018 – Blood count, hemaglobin (Hgb)

85025 – Blood count, complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count

85027 – Blood count, complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)

85032 – Blood count, manual cell count (erythrocyte, leukocyte, or platelet) each

85048 – Blood count, leukocyte (WBC), automated

85049 – Blood count, platelet, automated

If all diagnoses on claim line are not covered, the line will be denied. Not covered diagnosis codes can be found on CMS lab code list.

<http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsLCD10.html>

Modifiers

- 59, XE, XP, XU - Distinct Procedure Services
- 91 - Repeat Clinical Diagnostic Laboratory test

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

List any pertinent modifier detail

List any other applicable detail

FAQ

Include any FAQs here

Resources

- *Link to relevant resources here*

Related policies

- *Link to relevant related policies here*

Related denial language

Include any denial language here

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 appropriate to procedure, diagnosis and frequency 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, HCPCS, 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
March 2026	New Policy