Priority Health	BILLING POLICY No. 015
LAB AND PATHOLOGY	
Effective date: July 15, 2025 **Date of origin: July 2024**	**Review dates: 9/2024, 12/2024, 2/2025, 5/2025, 6/2025, 8/2025, 11/2025, 3/2026, 04/2026, 8/2026**

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual and industry standards. This policy describes the reimbursement methodology for lab and lab-related services. The policy outlines billing guidelines for place of services, duplicates, multiple tests per day and diagnosis coding.

DEFINITIONS

The place of service (POS) designation identifies the location where the laboratory service was collected. For example, if the specimen is obtained:

- Independent Laboratory or a Reference Lab (POS 81)
- Office/clinic or other non-facility setting (POS 11)
- Outpatient/Inpatient facility setting (Professional claim would not be appropriate)

For additional information on labs in the provider office, see the Provider office lab testing page in our Provider Manual.

MEDICAL POLICY

- **Markers for Digestive Disorders (#91583)**
- **Genetics: Counseling, Testing and Screening (#91540)**
- **Allergy Testing / Immunotherapy (#91037)**

POLICY SPECIFIC INFORMATION

Global, professional and technical component billing

We align to the Centers for Medicare and Medicaid Services (CMS) for component billing of lab services. PC/TC status indicators may identify if a service is reimbursed for the professional, technical or global based on modifier use and/or POS.

- Reimbursement is made for only one global service unless appropriate modifiers are appended for repeated services.
- POS may determine if a service is payable for a global, professional, or technical component. For example, professional claims billed with POS 19, 22, 23 won't be reimbursed for the technical component of a service.
- Services may be denied if a global, TC or PC component is billed, and this component of the service isn't payable for a defined location.

Confirm appropriate status indicators defined by CMS.

Provider-based departments should append the appropriate modifiers to labs performed as defined in our Provider-based billing policy.

All entities billing for laboratory services should append identifying modifiers (i.e., 90), when appropriate, in accordance with correct coding.

Reference laboratory providers

We recognize reference labs. Any test you aren't qualified to perform should be referred to a participating hospital lab or Quest Diagnostics for West and Northern Michigan, or Joint Venture Hospital Lab in Eastern Michigan. If reference labs are non-participating, the participating provider is responsible for paying for the non-participating facility.

- Participating facilities/providers should bill Priority Health for all member laboratory services, including those requested from non-participating labs.
    - Append **modifier 90** to indicate the procedure was performed by a party other than the treating or reporting provider.
    - Include the CLIA of both the referring and the reference laboratory on the claim.

Duplicate laboratory charges

Same group physician or other qualified health care professional

Only one laboratory service is reimbursed on a date of service.

- Repeated services should be coded with the appropriate modifier.
- Professional and technical components should be coded with the appropriate modifier to avoid duplicate denials.
- Global services received by one billing provider and component codes by another provider will result in a denial based on first claim received. Ensure component or global services are accurately reported when duplicate laboratory services are submitted from the same group physician or other qualified health care professional.
- Separate consideration will be given to repeat procedures (i.e., two laboratory procedures performed the same day) when reported with modifier 91. Modifier 91 is appropriate when the repeat laboratory service is performed by a different individual in the same group with the same Federal Tax Identification number.
    - According to CMS and CPT guidelines, modifier 91 is appropriate to identify repeated lab services when the course of treatment indicates additional testing. This may include different intervals for testing or repeating a test for updated results based on clinical indications. According to CPT coding guidelines, modifier 59 may not be the most descriptive modifier when coding for repeated services.
    - According to CMS guidelines, the –X {EPSU} modifiers are more selective versions of modifier 59, so it would be incorrect to include both modifiers on the same line. Please refer to the "Modifiers" section for a complete listing of modifiers and their descriptions.
    - According to the AMA, it is inappropriate to append modifier 76 or 77 for repeated lab services.
    - Modifier 91 should be applied only when the identical service is repeated on the same date of service by the same provider or provider group. Use of this modifier without meeting these criteria will result in denial of the service.
    -

In alignment with industry standards outlined above, we will only recognize laboratory services reported with modifier 59, XE, XP, XS, XU for different species or strains and to identify specimens from distinctly separate anatomic sites.

Venipuncture and specimen collection

Consistent with CMS, only one collection fee for each type of specimen per patient encounter, regardless of the number of specimens drawn, will be allowed.

- A collection fee will be reimbursed only to the entity or provider for collecting the specimen.
- Venous blood collection by venipuncture and capillary blood collection (CPT codes 36415 and 36416) will be reimbursed once per patient per date of service for the entity or provider collecting the specimen. When both CPT codes 36416 and 36415 are billed by the same entity/provider, only CPT code 36415 is payable. No modifier overrides will exempt CPT code 36416 from bundling into CPT code 36415.
- P9603 or P9604 (Travel allowance one way in connection with medically necessary laboratory specimen) should be coded with a specimen collection code. When these services are coded without a specimen collection, code P9603 and P9604 will be denied.

Pathology coding for outpatient and professional claims

We require services to be coded to the highest level of specificity. This applies to diagnosis of coding pathology services when billing for diagnostic interpretation of these services. The pathologist or interpreting provider billing for the pathology service is confirming results with a definitive diagnosis. This should be reported as such on the claim.

- In billing for the global pathology services or the interpretation of the pathology services, it is expected that signs and symptoms would not be defined as the primary or principal diagnosis in these cases.
- Services reported from the ICD-10 code range for signs and symptoms (commonly beginning with R codes) instead of a definitive diagnosis as the primary for these diagnostic services.
- Signs and symptoms should only be coded when the definitive diagnosis is not available. These can be listed as additional diagnosis codes but should not be primary.
- Based on the CPT, ICD-10-CM and guidelines from the Centers for Disease Control and Prevention, the pathologist should report a first-listed diagnosis based on the gross/microscopic examination.

For more information, see the Diagnosis coding and documentation page in our Provider Manual.

Panel codes

We will begin requiring the panel code 87800 (direct probe tests) or 87801 (amplified probe tests) for infectious agent detection by nucleic acid (DNA or RNA) when multiple organisms are tested (three or more individual tests). This includes codes that fall within the code ranges 87468 and 87799. This is not an all-inclusive list.

87800	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique
87801	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique.
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
87494	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis and Neisseria gonorrhoeae, multiplex amplified probe technique
87591	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique.
87661	Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, amplified probe technique

**If 87491 and 87591 are performed together, report 87494.*

According to standard coding guidelines, panel codes should be used when all tests defined in the panel description are performed.

- If a group of tests overlap two or more panels performed, the panel with the greatest number of tests should be reported. Codes falling outside that panel should be coded individually. Both panel codes shouldn't be reported.
- Tests defined as a component of panel shouldn't be coded separately. If individual tests within a panel are repeated through a separate specimen collection, these should be coded with the appropriate modifiers to reflect separate lab services.

Our Medicare product aligns to CMS guidelines for billing panel codes. Review CMS guidelines for reimbursement and coverage guidelines. Medicaid would align to MDHHS policy guidelines.

80047	Basic metabolic panel (Calcium, ionized) This panel must include the following: Calcium, ionized (82330) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea Nitrogen (BUN) (84520)
80048	Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)
80050	General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443)
80051	Electrolyte panel This panel must include the following: Carbon dioxide (bicarbonate) (82374) Chloride (82435) Potassium (84132) Sodium (84295)
80053	Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520)
80055	Obstetric panel This panel must include the following: Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Hepatitis B surface antigen (HBsAg) (87340) Antibody, rubella (86762) Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART) (86592) Antibody screen, RBC, each serum technique (86850) Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)
80069	• Renal function panel This panel must include the following: Albumin (82040) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphorus inorganic (phosphate) (84100) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)
80074	Acute hepatitis panel. This panel must include the following: Hepatitis A antibody (HAAb), IgM antibody (86709); Hepatitis B core antibody (HBcAb), IgM antibody (86705); Hepatitis B surface antigen (HBsAg) (87340); Hepatitis C antibody (86803)
80076	Hepatic function panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Bilirubin, direct (82248) Phosphatase, alkaline (84075) Protein, total (84155) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450)

80081	Obstetric panel (includes HIV testing)

Celiac Disease Testing

Celiac disease is a genetic autoimmune disorder where eating gluten triggers an immune response that damages the small intestine, reducing nutrient absorption. A simple blood test can detect celiac disease by measuring certain antibodies that rise when gluten is consumed.

All reimbursable testing must be:

- Ordered by the treating physician.
- Medically reasonable and necessary for the management of the patient's specific medical condition.

Below is a non-comprehensive listing of codes that may be applicable to this policy. Inclusion of a code does not guarantee coverage and/or reimbursement for a service or procedure.

81376	HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each
81377	HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each
81382	HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each
81383	HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each
82784	Gammaglobulin (immunoglobulin); IgA, IgD, IgG, IgM, each
83516	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method
84436	Thyroxine; total testing
84439	Thyroxine; free testing
84443	Thyroid stimulating hormone (TSH) testing
84479	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR) testing
86231	Endomysial antibody (EMA), each immunoglobulin (Ig) class
86255	Fluorescent noninfectious agent antibody; screen, each antibody
86256	Fluorescent noninfectious agent antibody; titer, each antibody
86258	Gliadin (deamidated) (DGP) antibody, each immunoglobulin (Ig) class
86364	Tissue transglutaminase, each immunoglobulin (Ig) class

Molecular pathology tests (Tier 1 and 2) may be covered if:

- No other clear diagnostic tests are available.
- The test is clinically valid and supported by peer-reviewed research.
- The test is FDA-approved or has documented analytical and clinical validity if lab-developed.
- Results directly impact the patient's treatment or management.
- For multi-gene panels, only necessary tests for treatment decisions are covered.
- The individual hasn't had prior genetic testing for the same condition, unless repeat testing is needed for treatment planning.

In general, a Tier 1 or Tier 2 molecular pathology CPT code shouldn't be reported along with other genomic or molecular test codes if they cover the same analyte. The procedures billed together must be medically necessary and ordered by the treating physician to manage the patient's specific condition.

For individuals with celiac disease, follow-up antibody testing depends on IgA status:

- **IgA sufficient**: Use IgA anti-TTG tests at 3–6 months after diagnosis,
- every 6 months until levels normalize,
- then every 12–24 months.
- **IgA deficient**: Use IgG-based tests (endomysial, deamidated gliadin peptide, or TTG) on the same schedule.

Modifiers

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

Diagnosis requirements

Codes for prostate specific antigen testing require specific diagnosis code combinations. Please see diagnosis list on NCD 190.31

Codes for glycated hemoglobin/glycated protein testing require specific diagnosis code combinations. Please see diagnosis list on NCD 190.21

Frequency

CPT Code	Coverage Limit
84436	2 per year
84439	2 per year
84443	2 per year
84479	2 per year

Documentation requirements

The ordering practitioner's documentation must support the test(s) ordered. Each lab service ordered should be documented in the member's medical record and detailed on the lab order. The medical records should also detail the reasons each test is indicated and ordered to support management of the member's specific medical condition. Such documentation must indicate how the test results will impact clinical care.

- Custom panel tests shouldn't be referenced on the written lab order; only panel tests defined by CMS or CPT are acceptable.
- Orders must be signed and dated by the ordering practitioner.
- Standard orders and/or routine screenings as part of a practitioner protocol aren't payable without supporting documentation to support members' specific medical assessment and treatment.
- Our preventive health guidelines detail services that are considered preventive health services; provider defined protocols may not align are subject to applicable benefit and supporting documentation requirements.

Medical records may be requested to support accurate coding and support testing ordered. Although we don't expect billing labs to obtain medical records from ordering providers and submit them upon request, it's expected that at a minimum the lab order, requisition and results will be submitted. This requisition must contain the following:

- Signed, valid requisition from the ordering provider that specifically outlines the tests being ordered
- Specific lab being tested
- Member specific information

- Ordering provider (full name and credentials) and ordering provider NPI
- Legible signature (photocopy, stamp, or signature on file is not accepted)
- Facility/location where specimen was collected
- Sample type (urine, blood, etc.)
- Date sample collected
- Time sample collected
- Individual who collected sample
- Date/time received at the lab facility
- Diagnostic reason for the testing

Final reports for lab results must contain the following:

- Complete detail for entity performing the lab service (name, address, CLIA)
- Patient full name
- Patient date of birth
- Ordering full name and NPI
- Facility name if different from above
- Date sample was collected
- Date sample was received at facility
- Date results were reported
- Detail of complete test results for each test performed
- Final diagnostic findings
- Claims submitted with insufficient documentation to support lab services will be denied. The provider submitting the claim will receive a denial if there is insufficient documentation to support all services reported.
- Submitting orders or requested information alone does not guarantee that services will be reimbursed. Supporting documentation from both lab and order provider must support requirements detailed in both payment and medical policy.

Related Billing Policies

Genetic Counseling, Testing and Screening No. 11

Related denial language

- u84 – Sign or Symptoms Reported as primary Dx
- E5N - Price of Lab Panel Components Exceed Lab
- U86 – denied for incorrect CPT/HCPCS

REFERENCES

- Celiac Disease: Symptoms & How It's Treated
- Celiac Disease Screening | Celiac Disease Foundation
- Celiac Disease Testing AHS - G2043 | Providers | Blue Cross NC
- Celiac Disease Screening | Celiac Disease Foundation
- Recommendation: Celiac Disease: Screening | United States Preventive Services Taskforce
- LCD - Molecular Pathology Procedures (L35000)
- Prostate Specific Antigen 190.31
- Glycated Hemoglobin/ Glycated Protein

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, 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	Update(s) made
Sept. 10, 2024	Effective Nov. 11, 2024, we'll require providers to append panel codes (87899 or 87801) when billing three or more infectious agent lab tests. Impacted lab tests include 87468-87799. This update is in alignment with CMS guidelines associated with the panel code verses of individual code reporting.
Dec. 23, 2024	Specified existing practices for participating and non-participating reference labs
Feb. 5, 2025	Added "Disclaimer" section
May 13, 2025	Added billing guidance for P9603 and P9604 under "Venipuncture and specimen collection"
June 19, 2025	• Clarifications added to support coding to the highest degree of specificity: The lab requisition must include the diagnostic reason for the testing. Additionally, final reports for lab results must include final diagnostic findings.

	• Added “Related denial language” section and prism denial code for applicable clinical edits:
	  ○ u84 - Sign or Symptoms Reported as primary Dx
	  ○ E5N - Price of Lab Panel Components Exceed Lab

Aug. 14, 2025	Added information on celiac disease testing including: • Frequency of testing • Modifiers • Information on Tier 1 and Tier 2 testing
Nov. 2025	Added clarification on Chlamydia trachomatis Neisseria gonnorrhoeae testing Added related denial language u86 – denied for incorrect CPT/HCPCS code
March. 2026	• Added NCD language for Prostate Specific Antigen (190.31), including a link to the CMS website with applicable diagnosis requirements. • Updated NCD Thyroid Testing (190.22) made a chart to include frequency and code limitations for 84436, 84439, 84443, and 84479. • Included CMS NCD chart link for Glycated Hemoglobin/Glycated Protein (190.21). • Added guidance regarding the appropriate use of Modifier 91.
April 2026	Added new code 87494
August 2026	viewed- No Changes Needed