

## Laboratory Services Policy, Professional

### **IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY**

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage reimbursement policies use Current Procedural Terminology (CPT®\*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design, and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Medicare Advantage enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents\*\*. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

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*\*\* For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.*

### **Application**

This reimbursement policy applies to all Medicare Advantage products and for services reported using the 1500 Health Insurance Claim Form (a/k/a CMS 1500) or its electronic equivalent or its successor form. This policy applies to all network physicians and other qualified health care professionals.

### **Policy**

#### **Overview**

This policy describes the reimbursement methodology for laboratory panels and individual Component Codes, as well as reimbursement for venipuncture services, laboratory services performed in a facility setting, and laboratory handling. The policy also addresses place of service and date of service relating to laboratory services. Duplicate laboratory code

submissions by the same or multiple Physicians or Other Qualified Health Care Professionals, as well as certain laboratory services provided in a facility place of service, are also addressed in this policy.

**Reimbursement Guidelines**

**Place of Service**

UnitedHealthcare Medicare Advantage uses the codes indicated in the CMS Place of Service (POS) Codes for Professional Claims Database to determine if laboratory services are reimbursable. For the purposes of this policy, a facility POS is considered POS 19, 21, 22, 23, 24, 26, 31,34, 51, 52, 55, 56, 57 and 61. All other POS (e.g., 11, 81, etc.) are considered non-facility.

[CMS Place of Service Database](#)

The POS designation identifies the location where the laboratory specimen was collected. For example, if the specimen is obtained:

- In an Independent Laboratory or a Reference Laboratory, POS 81 is reported.
- In an office/clinic or other non-facility setting, the appropriate non-facility POS is reported.
- In a facility setting, the appropriate facility POS is reported (e.g., patient is inpatient [POS 21] or outpatient [POS 22]).
- In a laboratory setting maintained by another physician or other qualified health care professional in their office/clinic, the POS code 99 for "Other Place of Service" is reported.

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

For additional information, refer to the Questions and Answers section, Q&A #1.

**Date of Service**

The date of service (DOS) on a claim for a laboratory test is the date the Specimen was collected and if collected over 2 calendar days, the DOS is the date the collection ended.

Note: United Healthcare will make an exception to the DOS policy for Advanced Diagnostic Laboratory Testing (ADLT) and molecular pathology tests excluded from Outpatient Prospective Payment System (OPPS) packaging policy

- DOS for ADLTs and molecular pathology tests excluded from OPPS packaging policy may be noted as **the date the test was performed** if certain conditions are met:
  - (1) The test is performed following the date of a hospital outpatient’s discharge from the hospital outpatient department
  - (2) The specimen was collected from a hospital outpatient during an encounter
  - (3) It was medically appropriate to have collected the sample from the hospital outpatient during the hospital outpatient encounter
  - (4) The results of the test do not guide treatment provided during the hospital outpatient encounter; and
  - (5) The test was reasonable and medically necessary for the treatment of an illness.

**Provider Specialties Eligible for Reimbursement of Laboratory Services**

**Reference Laboratory and Non-Reference Laboratory Providers:**

- Aligning with CMS, Reference Laboratories reporting laboratory services appended with modifier 90 are eligible for reimbursement.

- Non-reference laboratory Physicians or Other Qualified Health Care Professionals reporting laboratory services appended with modifier 90 are not eligible for reimbursement.
- Physicians or Other Qualified Health Care Professionals who own laboratory equipment (Physician Office Laboratory) and perform laboratory testing report the laboratory service without appending modifier 90. These laboratory services are eligible for reimbursement.
- A valid Federal Clinical Laboratory Improvement Amendments (CLIA) Certificate Identification number is required for reimbursement of clinical laboratory services reported on a CMS 1500 Health Insurance Claim Form or its electronic equivalent.

Within the UnitedHealthcare Medicare Advantage Provider Administrative Guide it states, “If you are a physician, practitioner, or medical group, you may only bill for services that you or your staff perform. Pass-through billing is not permitted and may not be billed to our members. We only reimburse for laboratory services that you are certified to perform through the Federal Clinical Laboratory Improvement Amendments (CLIA).

You must not bill our members for any laboratory services for which you lack the applicable CLIA certification. “

For more complete information refer to the [UnitedHealthcare Provider Administration Guide](#)

For additional information, refer to the Questions and Answers section, Q&A #2

### **Duplicate Laboratory Charges**

#### **Same Individual Physician or Other Health Care Professional**

Only one laboratory service is reimbursable when Duplicate Laboratory Services are submitted from the Same Individual Physician or Other Health Care Professional.

Separate consideration will be given to repeat procedures (i.e., two laboratory procedures performed the same day) by the Same Individual Physician or Other Qualified Health Care Professional when reported with modifier 91.

According to CMS and CPT guidelines, Modifier 91 is appropriate when, during the course of treatment, it is necessary to repeat the same laboratory test for the same patient on the same day to obtain subsequent test results, such as when repeated blood tests are required at different intervals during the same day.

CPT instructions state that modifier 59 should not be used when a more descriptive modifier is available. CMS guidelines cite that 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.

According to CMS and CPT coding guidelines, modifier 59, XE, XP, XS, or XU may be used when the same laboratory services are performed for the same patient on the same day. UnitedHealthcare Medicare Advantage will reimburse laboratory services reported with modifier 59, XE, XP, XS, or XU for different species or strains, as well as Specimens from distinctly separate anatomic sites

For additional information, refer to the Questions and Answers section, Q&A #2, and #4.

According to the AMA and CMS, it is inappropriate to use modifier 76 or 77 to indicate repeat laboratory services. Modifiers 59, XE, XP, XS, XU, or 91 should be used to indicate repeat or distinct laboratory services when reported by the Same Individual Physician or Other Qualified Health Care Professional. Separate consideration for reimbursement will not be given to laboratory codes reported with modifier 76 or 77.

#### **Multiple Physicians or Other Qualified Health Care Professionals**

Only one laboratory provider will be reimbursed when multiple individuals report Duplicate Laboratory Services. Multiple individuals may include, but are not limited to, any physician or other health care professional, Independent Laboratory, Reference Laboratory, Referring Laboratory or pathologist reporting duplicate services.

For additional information, refer to the Questions and Answers section, Q&A #4.

**Reference Laboratory and Non-Reference Laboratory Providers:**

If a Reference Laboratory and a Non-Reference Laboratory Provider submit Duplicate Laboratory Services only the Reference Laboratory service is reimbursable.

**Independent Laboratory, Reference Laboratory and Referring Laboratory:**

Laboratory services billed with modifier 90 by a Referring Laboratory are reimbursable if a duplicate claim has not been received from an Independent Laboratory or Reference Laboratory. Duplicate services are not reimbursable, unless one laboratory appends modifier 91 to the code(s) submitted.

**Pathologist and Physician Office Laboratory Providers:**

If a pathologist and Physician Office Laboratory provider submit Duplicate Laboratory Services, only the pathologist's service is reimbursable, unless the Physician Office Laboratory provider appends a modifier 91 to the codes submitted.

For additional information, refer to the Questions and Answers section, Q&A #5

**Anatomic Pathology Services and Purchased Diagnostic Services:**

If both the purchaser and supplier who performed the service bill Duplicate Laboratory Services, only one service is reimbursable, unless modifier 59, XE, XP, XS, XU or 91 is appended. Purchased Diagnostic Tests do not apply to automated or manual laboratory tests.

UnitedHealthcare Medicare Advantage uses the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFs) Professional Component/Technical Component (PC/TC) indicators 1, 6, and 8 to identify laboratory services that are eligible as Purchased Diagnostic Tests.

PC/TC Indicator 1: Physician Service Codes (modifier TC and 26 codes)

PC/TC Indicator 6: Laboratory Physician Interpretation Codes

PC/TC Indicator 8: Physician Interpretation Codes

**Documentation Requirements for Reporting Laboratory Services**

According to CMS, the physician or other qualified health care professional who is treating the patient must order all diagnostic laboratory tests, using these results in the management of the patient's condition. Tests not ordered by the physician or other qualified health care professional are not reasonable and necessary and may not be considered for reimbursement.

The physician's or other qualified health care professional's documentation should clearly indicate all tests to be performed. For example, "run labs" or "check blood" by itself does not support intent to order.

**Documentation of an order or intent to order may include for example:**

- A signed order or requisition listing the specific test(s), or
- An unsigned order or requisition listing the specific test(s), and an authenticated medical record (e.g., progress notes or office notes) supporting the physician's intent to order the tests (for example, "order labs", "check blood", "repeat urine," or
- An authenticated medical record (e.g., office notes or progress notes) supporting the physician intent to order specific test(s), or
- Electronic requisitions are acceptable when the laboratory can demonstrate the order(s) was received through a standardized electronic process.

The medical record should include the documentation described above, as well as a copy of the test results.

For additional information, refer to the Questions and Answers section, Q&A #7

**Laboratory Services Performed in a Facility Setting**

The established policy for reimbursement of laboratory services performed in a facility setting is consistent with UnitedHealthcare Medicare Advantage's policy not to pay for duplicative laboratory services.

Manual and automated laboratory services submitted with a CMS facility POS 19, 21, 22, 23, 26, 34, 51, 52, 55, 56, 57 or 61 will not be reimbursable. These services are reimbursable to the facility. When facilities obtain manual or automated laboratory tests for patients under arrangements with an Independent Laboratory, Reference Laboratory or pathology group, only the facility may be reimbursed for the services.

Note: UnitedHealthcare Medicare Advantage will make an exception to this policy for molecular pathology laboratory procedures, Genomic Sequencing Procedures and Other Molecular Multianalyte Assays, and proprietary laboratory analysis procedures when the facility laboratory is not equipped or would not be expected to perform these specialized services and refers them to an appropriate laboratory. In the event that both a facility and an Independent Laboratory or Reference Laboratory report the same service on the same day for the same member, only the facility reproductive laboratory services may be reimbursed.

UnitedHealthcare Medicare Advantage uses the CMS National Physician Fee Schedule (NPF) Professional Component/Technical Component (PC/TC) indicators 3 and 9 to identify laboratory services that are not reimbursable to an Independent Laboratory, Reference Laboratory or Non-Reference Laboratory provider in a facility setting.

- PC/TC indicator 3: Technical Component Only Codes
- PC/TC indicator 9: PC/TC Concept Not Applicable

**Modifiers**

59	90	91	92	XE	XP	XS	XU
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**Laboratory Panels**

**Organ or Disease-Oriented Laboratory Panel Codes**

The Organ or Disease-Oriented Panels as defined in the CPT book are codes 80047, 80048, 80051, 80053, 80061, 80069, and 80076. According to the CPT book, these panels were developed for coding purposes only and are not to be interpreted as clinical parameters. UnitedHealthcare Medicare Advantage uses CMS guidelines to define the components of each panel.

UnitedHealthcare Medicare Advantage also considers an individual component code included in the more comprehensive Panel Code when reported on the same date of service by the Same Individual Physician or Other Qualified Health Care Professional. The Professional Edition of the CPT® book, Organ or Disease-Oriented Panel section states: "Do not report two or more panel codes that include any of the same constituent tests performed from the same patient collection. If a group of tests overlaps two or more panels, report the panel that incorporates the greater number of tests to fulfill the code definition and report the remaining tests using individual test codes."

Effective for claims with dates of service on or after April 1, 2020, laboratories shall bill the HCPCS panel test code and not unbundle the individual components if all components of the HCPCS panel are performed. Claims will be denied if the HCPCS panel test code is not billed. Providers and suppliers are required to submit all Automated Multi-Channel Chemistry (AMCC) laboratory test HCPCS for the same patient, performed on the same date of service on the same claim. This billing policy applies when:

- a). Submitting a complete organ disease panel; or

b). Submitting individual component tests of an organ disease panel when all components of the panel were not performed.

<b>Panel Code: 80047</b>				
82330	82374	82435	82565	82947
84132	84295	84520		

<b>Panel Code: 80048</b>				
82310	82374	82435	82565	82947
84132	84295	84520		

<b>Panel Code: 80051</b>				
82374	82435	84132	84295	

<b>Panel Code: 80053</b>				
82040	82247	82310	82565	82947
84075	84155	84450	84460	84520
82435	82374	84132	84295	

<b>Panel Code: 80061</b>				
82465	84478	83718		

<b>Panel Code: 80069</b>				
82040	82310	82374	82435	82565
82947	84100	84132	84295	84520

<b>Panel Code: 80076</b>				
82040	82247	82248	84075	84155
84450	84460			

**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 not be reimbursed to anyone who did not extract the Specimen.

Consistent with CMS, UnitedHealthcare Medicare Advantage considers collection of a Specimen from a completely implantable venous access device and from an established catheter (CPT codes 36591 and 36592) to be bundled into services assigned a CMS NPF Status Indicator of A, R or T provided on the same date of service by the Same Individual Physician or Other Qualified Health Care Professional, for which payment is made.

UnitedHealthcare Medicare Advantage considers venipuncture code S9529 a non-reimbursable service. The description for S9529 focuses on place of service for a service that is more precisely represented by CPT code 36415 and reported with the appropriate CMS place of service code.

Consistent with CMS, specimen collection HCPCS code G0471 is reimbursable only when a Specimen is collected from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency.

<b>Laboratory Handling</b>
Laboratory handling and conveyance CPT codes 99000 and 99001 and HCPCS code H0048 are included in the overall management of a patient and are not separately reimbursed.

<b>Definitions</b>	
<b>CMS NPFS Status A</b>	<b>Active Code.</b> These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.
<b>CMS NPFS Status R</b>	<b>Restricted Coverage.</b> Special coverage instructions apply. If covered, the service is carrier priced. (NOTE: The majority of codes to which this indicator will be assigned are the alpha-numeric dental codes, which begin with "D". We are assigning the indicator to a limited number of CPT codes which represent services that are covered only in unusual circumstances.)
<b>CMS NPFS Status T</b>	<b>Injections.</b> There are RVUS and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. (NOTE: This is a change from the previous definition, which states that injection services are bundled into any other services billed on the same date.)
<b>Component Codes</b>	Identify individual tests that when performed together may comprise a panel.
<b>Duplicate Laboratory Service</b>	Identical or equivalent bundled laboratory Component Codes, submitted for the same patient on the same date of service on separate claim lines or on different claims regardless of the assigned Maximum Frequency per Day (MFD) value.
<b>Non-Reference Laboratory Provider</b>	A physician or a Pathologist reporting laboratory procedure performed in their office or a pathologist.
<b>Panel Codes</b>	Identify, for coding purposes, a group of tests commonly performed as a group or profile.
<b>Physician Office Laboratory</b>	A laboratory maintained by a physician or group of physicians for performing diagnostic tests in connection with the physician practice.
<b>Purchased Diagnostic Tests</b>	When one component (technical or professional) of a diagnostic test is purchased from a laboratory supplier by a physician or laboratory. Purchased Diagnostic Tests include laboratory or pathology services that are listed in the (CMS) National Physician Fee Schedule with a PC/TC indicator 1, 6, or 8. Purchased services do not apply to automated or manual laboratory services.
<b>Independent Laboratory</b>	An Independent Laboratory is one that is independent both of an attending or consulting physician's office and of a hospital that meets at least the requirements to qualify as an emergency hospital. An Independent Laboratory must meet Federal and State requirements for certification and proficiency testing under the Clinical Laboratories Improvement Act (CLIA).
<b>Reference Laboratory</b>	A Reference Laboratory that receives a Specimen from another, Referring Laboratory for testing and that actually performs the test is often referred to as an Independent Laboratory.
<b>Referring Laboratory</b>	A Referring Laboratory is one that receives a specimen to be tested and that refers the specimen to another laboratory for performance of the laboratory test.

<b>Same Individual Physician or Other Qualified Health Care Professional</b>	The same individual rendering health care services reporting the same National Provider Identifier (NPI) number.
<b>Specimen</b>	Tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathological diagnosis. Two or more such Specimens from the same patient (e.g., separately identifiable endoscopic biopsies, skin lesions) are each appropriately assigned an individual code reflective of its proper level of service.

**Questions and Answers**

1	<p><b>Q:</b> What place of service should an Independent or Reference Laboratory report when billing?</p> <p><b>A:</b> When billing, the place of service reported should be the location where the specimen was obtained, For example, a specimen removed from a hospitalized patient and sent to the laboratory would be reported with (POS) 21 or 22; a sample taken at a physician's office and referred to the laboratory would be reported with POS 11; if the Independent or Reference Laboratory did the blood drawing in its own setting, it should report POS 81.</p>
2	<p><b>Q:</b> What provider specialty is eligible to report and receive reimbursement for Laboratory services?</p> <p><b>A:</b> As stated in the UnitedHealthcare Provider Administration Guide you may only bill for services that you or your staff perform. If your provider specialty is a Reference Laboratory, report laboratory services appended with modifier 90 to indicate a Reference (Outside) Laboratory.</p>
3	<p><b>Q:</b> Will identical or equivalent laboratory Component Codes submitted on the same day for the same patient by the Same Individual Physician or Other Qualified Health Care Professional be denied as Duplicate Laboratory Services?</p> <p><b>A:</b> Yes, identical, or equivalent laboratory Component Codes are denied unless the appropriate repeat laboratory procedure modifier (modifier 59, XE, XP, XS, XU, or 91) is appended to the code(s) submitted.</p>
4	<p><b>Q:</b> Will consecutive or serial tests provided on the same day to the same patient by either physicians of the same group or multiple providers be denied as a Duplicate Laboratory Service?</p> <p><b>A:</b> Yes, consecutive, or serial tests are denied unless the appropriate repeat laboratory procedure modifier (modifier 91) is appended to the codes submitted.</p>
5	<p><b>Q:</b> In what circumstance(s) is it appropriate to report modifier 59 with a laboratory service?</p> <p><b>A:</b> When identifying procedures/services that are performed by the same or multiple individuals or Same Individual Physician or Other Qualified Health Care Professional for the same patient on the same day, modifier 59, XE, XP, XS, or XU is appropriate. Multiple individuals may include, but are not limited to, any physician or other health care professional, Reference Laboratory, Referring Laboratory or pathologist. Circumstances include:</p> <ul style="list-style-type: none"> <li>• Mutually exclusive procedures (e.g., a Panel Code and one of its individual Component Codes reported together).</li> <li>• Repeat laboratory services on Specimens from distinctly separate anatomic sites.</li> <li>• Repeat laboratory services for different species or strains.</li> </ul>
6	<p><b>Q:</b> If a pathologist and a treating physician report identical codes for the same individual on the same date of service, how will each claim be reimbursed?</p> <p><b>A:</b> Only the pathologist will be reimbursed. The treating physician may also be reimbursed if modifier 59, XE, XP, XS, XU, or 91 is appropriately reported with the code(s) submitted to distinguish that it was a distinct or repeat laboratory service.</p>
7	<p><b>Q:</b> Can laboratory tests be performed in the absence of a physician(s) or other qualified health care professional(s) signed orders?</p> <p><b>A:</b> Yes, laboratory tests will be considered for reimbursement when they meet CMS's documentation requirements. The patient's medical record must include either a signed order from the physician or other health</p>

	care professional or must document a clear intent for the test to be performed. For example, “run labs” or “check blood” by itself does not support intent to order. The physician’s or other qualified health care professional’s documentation, showing the order or intent to order (electronic requisition is acceptable as noted above), should clearly indicate all tests to be performed.
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<b>Codes</b>
<b>CPT code section</b>
<a href="#">National Physician Fee Schedule Relative Value File</a>
<a href="#">Clinical Laboratory Fee Schedule</a>

<b>Resources</b>
<p><a href="http://www.cms.gov">www.cms.gov</a></p> <p>American Medical Association (AMA) Current Procedural Terminology (CPT®)</p> <p>Centers for Medicare and Medicaid Services: CMS Clinical Laboratory Fee Schedule, CMS Place of Service Code Set, PFS Relative Value Files</p> <p>Medicare Benefit Policy Manual - Chapter 06 - Hospital Services Covered Under Part B: Section 20.2</p> <p>Medicare Claims Processing Manual - Chapter 03 - Inpatient Hospital Billing: Section 10.4 and 40.3</p> <p>Medicare Claims Processing Manual - Chapter 04 - Part B Hospital (Including Inpatient Hospital Part B and OPPS): Section 10.12 and 250.6</p> <p>Medicare Claims Processing Manual - Chapter 12 - Physicians/Nonphysician Practitioners: Sections 20.2 and 60</p> <p>Medicare Claims Processing Manual - Chapter 16 - Laboratory Services Sections: 10.1,40.1, 40.8, 50.3.1, 60.1.1 90.1.1,90.2, 90.3, 90.3.1, 90.3.2 and 100.5.1</p> <p>Medicare Claims Processing Manual - Chapter 23 - Fee Schedule Administration and Coding Requirements Sections 30.2.2, 40, 40.1, 40.2,</p> <p>Medicare Claims Processing Manual - Chapter 26 - Completing and Processing Form CMS-1500 Data Set: Section 10.5</p> <p>National Correct Coding Initiative Edits: Modifier 59</p> <p>The Medicare Learning Network (MLN Matters): MM9112, MM8572, ICN 909221, MM9112, MM8572, ICN 909221</p> <p>CMS Place of Service Code Set</p>

<b>History</b>	
6/1/2026	Policy Version Change Resource Section: Updated History Section: Entries prior to 6/1/2024 archived
6/1/2025	Policy Version Change



	History Section: Entries prior to 6/1/2023 archived
6/1/2024	Policy Version Change Resource Section: Updated History Section: Entries prior to 6/1/2022 archived
12/13/2017	Policy approved by the Reimbursement Policy Oversight Committee