Laboratory and Pathology

Reimbursement Policy ID: RPC.0050.01CH

Recent review date: 07/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

The health plan reimbursement guidelines described in this policy apply to both professional and facility claims submitted to for clinical diagnostic and pathology services and procedures.

Exceptions

N/A

Reimbursement Guidelines

The intent of the health plan Laboratory and Pathology reimbursement policy is to address only the components of laboratory and pathology reimbursement listed below.

- Duplicate Laboratory Services — Facility
- Duplicate Laboratory Services — Independent Laboratory/Provider Office
- CLIA Certification
- Laboratory Panels
- Venipuncture

Duplicate Laboratory Services — Facility

CMS Medicare Claims Processing Manual Chapter 4 section 20.2 states, “In cases where there are separate codes for the technical component, professional component, and/or complete procedure, hospitals should report the code that represents the technical component for their facility services. If there is no separate technical component code for the service, hospitals should report the code that represents the complete procedure.”

Consistent with the CMS, the health plan deems the submission of multiple claims for the same professional or technical portion (as indicated by modifiers 26 or TC) or for a global (i.e., complete procedure) code billing a diagnostic procedure inappropriate except when the code(s) reported for professional service component are appended with the appropriate modifier.

Duplicate Laboratory Services – Independent Laboratory/Provider Office

When both an Independent Laboratory and a Provider Office submit claims for the same laboratory code on the same date of service, the health plan will deny the second claim received as a duplicate service when the place of service (POS) on one claim is Office (POS 11) and the place of service on the other claim is Independent Laboratory (POS 81).

Clinical Laboratory Improvement Amendments (CLIA) Certification

The health plan requires professional and independent laboratory providers to include a valid CLIA number on claims submitted for laboratory services, including CLIA waived tests. CLIA regulatory requirements vary according to the type of test(s) each laboratory conducts. All entities that meet the definition of a “Laboratory” under CLIA statutes and regulations must obtain an appropriate CLIA certificate prior to conducting patient testing. The health plan will deny Laboratory and Pathology claims where the CLIA certificate number is absent, incorrect, invalid or inappropriate for the performed test.

Laboratory Panels

Individual laboratory codes which when reported concurrently constitute a Laboratory Panel HCPCS or CPT code, are not eligible for reimbursement. The provider should submit the comprehensive laboratory panel code as described in the HCPCS or CPT section guidelines and code definition.

Venipuncture

CPT Code 36410 Venipuncture, age 3 years or older, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture) is not eligible for reimbursement by the health plan unless reported with a diagnosis that supports the need for “physician skill.”

The health plan follows Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), International Statistical Classification of Diseases and Related Health Problems (ICD), and associated publications for reimbursement of laboratory and pathology services.

Definitions

Clinical Laboratories Improvement Amendments (CLIA)
Clinical Laboratory Improvement Amendments (CLIA) regulate laboratory testing and require clinical laboratories to be certified by the Centers for Medicare and Medicaid Services (CMS) before they can accept human samples for diagnostic testing.

Independent Laboratory
A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a provider's office.

Venipuncture
A procedure in which a needle is used to take blood from a vein, usually for laboratory testing. Venipuncture may also be done to remove extra red blood cells from the blood, to treat certain blood disorders. Also called blood draw and phlebotomy.

Edit Sources

I. Current Procedural Terminology (CPT).
II. Healthcare Common Procedure Coding System (HCPCS).
III. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
IV. Clinical Laboratory Improvement Amendments (CLIA) Law and Regulations, https://www.cdc.gov/clia/law-regulations.html.
V. Centers for Medicare and Medicaid Services (CMS),
VI. The National Correct Coding Initiative (NCCI)
VII. Corresponding health plans Clinical Policies.
VIII. Applicable health plans provider manual.
IX. Commonwealth of Pennsylvania Children's Health Insurance Program guidance.
X. Commonwealth of Pennsylvania Medicaid Program fee schedule(s).

Attachments

N/A

Associated Policies

RPC.0048.01CH Professional/Technical Components (Modifiers 26,TC)

Policy History

09/2026	• Removed the next review date • Replaced the plan name with "the health plan"
07/2026	Reimbursement Policy Committee Approval
06/2026	Annual Review • Added Venipuncture Definition • Added Associated Policy
06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval