blue of california

Payment Policy

Laboratory Panel	
Original effect date:	Revision date:
07/08/2017	08/03/2018

IMPORTANT INFORMATION

Blue Shield of California payment policy may follow industry standard recommendations from various sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT) and/or other professional organizations and societies for individual provider scope of practice or other coding guidelines. The above referenced payment policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms or their electronic equivalent. This information is intended to serve only as a general reference regarding Blue Shield's payment policy and is not intended to address every facet of a reimbursement situation. Blue Shield of California may use sound discretion in interpreting and applying this policy to health care services provided in a particular case. Furthermore, the policy does not address all payment attributes related to reimbursement for health care services provided to a member. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy such as coding methodology, industry-standard reimbursement logic, regulatory/legislative requirements, benefit design, medical and drug policies. Coverage is subject to the terms, conditions and limitation of an individual member's programs benefits.

Application

Automated test panels are individual laboratory tests that clinical laboratories typically perform at the same time on the same automated equipment. CPT describes these laboratory tests as Organ or Disease-oriented Panels and identifies the component tests that make up a particular panel.

Policy

This policy is applied to claims with date of service on or after July 8, 2017.

BlueShield of California will bundle individual laboratory procedure codes that are part of a lab panel grouping together into a more comprehensive CPT code. The individual codes will be denied and the closest code representing the comprehensive procedure will be added to the claim for reimbursement.

Example:
Laboratory tests 83718, 84478, and 82465 are reported for the same date of service. This combination of tests is unique to lab panel 80061.

Laboratory components 83718, 84478, and 82465 are recommended for denial because their summed value exceeds the value of the all-inclusive panel. Panel 80061 is added to the claim for payment. If the sum of the individual values of the components had not exceeded the value of the panel, each individual laboratory test would have been allowed for payment

Modifiers –59 (Distinct procedural service) and –91 (Repeat clinical diagnostic test) are taken into account and may potentially override the recommendation for denial.

Rationale

Automated test panels are individual laboratory tests that clinical laboratories typically perform at the same time on the same automated equipment. CPT describes these laboratory tests as Organ or Disease-oriented Panels and identifies the component tests that make up a particular panel. Therefore, when multiple components of a lab panel are reported on the same date of service, the payment for the individual components should not exceed the payment amount of the panel itself.

Reimbursement Guideline

Blue Shield of California will reference national or regional industry standards, such as Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and MUE (Medically Unlikely Edits) rules, and American Medical Association's (AMA) CPT guidelines, as coding standards and as guidance for payment policy. In claims payment scenarios where CMS and/or CPT reference is lacking or insufficient, the Payment Policy Committee (PPC) may develop customized payment policies that are based on other accepted or analogous industry payment standards and or expert input.

Resources

- **American Medical Association** http://www.ama-assn.org/ama
- **Centers for Medicare & Medicaid Services**

http://www.cms.gov/

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Payment Policy.

Effective Date	Action	Reason
07/08/2017	New Policy Adoption	Payment Policy committee
08/03/2018	Maintenance	Payment Policy Committee

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.