If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for the submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from the Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry-standard coding guidelines including, but not limited to Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Laboratory Panel Billing Guideline

Policy Number: CPCP021

Version 5.0

Clinical Payment and Coding Policy Committee Approval Date: 5/5/2020

Plan Effective Date: September 1, 2020 (Blue Cross and Blue Shield of Texas Only)

Description

This policy is to provide a guideline on the appropriate billing for laboratory procedures or services that belong to a panel when billed on the same date of service for a member. This policy is consistent with the existing CPT coding guidelines and is not a new concept.

Reimbursement Information:

Laboratory panels outlined below were developed for coding purposes only and are defined by AMA and published in the CPT® codebook under Pathology and Laboratory, Organ or Disease-Oriented Panels. Orders for laboratory tests, must be member-specific and include the rationale/need for the test requested and must be signed and dated by the ordering health care professional. Provider-defined ("custom") panels are not recognized as nationally defined panels. To facilitate benefit processing, the codes for the individual tests in the "custom" panel must be reported. Reimbursement is provided for tests that are performed in a panel if they are reasonable, medically necessary under the applicable medical policy, and otherwise reimbursable under the terms of the member's plan. The plan reserves the right to rebundle individual codes that belong to a panel. If a claim is submitted with individual codes that belong to a panel, our claim reviewers and/or correct coding software logic may rebundle the procedure codes for appropriate reimbursement. If the medical documentation submitted with a claim shows that a panel was ordered and performed but the claim submitted shows the individual components of the panel, claim reviewers may rebundle the codes into the appropriate panel for reimbursement. CPT states the following:

- Tests performed in addition to those specifically indicated for a particular panel should be reported separately from the panel code

  Example, If the Electrolyte panel (80051) is billed, individual tests such as 82947 (Assay Glucose Blood Quant), 84520 (Assay of Urea Nitrogen), 82565 (Assay of Creatinine) and 82550 (Assay of CK (CPK)) should be billed separately from the panel.

- Do not report two or more panel codes that include the same constituent tests performed from the same patient collection

  Example, If the Comprehensive Metabolic Panel (80053) is billed, the Basic Metabolic Panel (80047) cannot be billed.

- If a group of tests overlaps two or more panels, you must use the panel that incorporates the greatest number of tests and report the remaining individual tests

  Example, if 82374 (Assay of Blood Carbon Dioxide), 82435 (Assay of Blood Chloride), 84132 (Assay of Serum Potassium), 84295 (Assay of Serum Sodium), 84520 (Assay of Urea Nitrogen), and 82947 (Assay Glucose Blood Quant) are billed, two panel codes overlap. The Basic Metabolic Panel (80047) and the Electrolyte Panel (80051) include codes 82374 (Assay of Blood Carbon Dioxide), 82435 (Assay of Blood Chloride), 84132 (Assay of Serum Potassium) and 84295 (Assay of Serum Sodium). The Electrolyte Panel should be billed.

- The panel code should be billed when all individual tests in the panel have been performed and should not be billed separately

> Example, If the Lipid Panel (80061) is billed, then procedures 82465 (Assay BLD/ Serum Cholesterol), 83718 (Assay of Lipoprotein) and 84478 (Assay of Triglycerides) should have been performed.

The following panels will be used when determining appropriate billing:

80047	Metabolic Panel Ionized- CA
82330	Assay of Calcium
82374	Assay Blood Carbon Dioxide
82435	Assay of Blood Chloride
82565	Assay of Creatinine
82947	Assay Glucose Blood Quant
84132	Assay of Serum Potassium
84295	Assay of Serum Sodium
84520	Assay of Urea Nitrogen

80048	Metabolic Panel Total- CA
82310	Assay of Calcium
82374	Assay Blood Carbon Dioxide
82435	Assay of Blood Chloride
82565	Assay of Creatinine
82947	Assay Glucose Blood Quant
84132	Assay of Serum Potassium
84295	Assay of Serum Sodium
84520	Assay of Urea Nitrogen

80050	General Health Panel
80053	Comprehensive Metabolic Panel
84443	Assay Thyroid Stim Hormone

85025	Complete CBC w/Auto Diff WBC; **OR**
85027 & 85004	• Complete CBC Automated • Automated Differential WBC Count
OR 85027	Complete CBC Automated **AND**
85007 or 85009	• BL Smear w/Diff WBC Count • Manual Differential WBC Count, B-Coat

80051	**Electrolyte Panel**
82374	Assay Blood Carbon Dioxide
82435	Assay of Blood Chloride
84132	Assay of Serum Potassium
84295	Assay of Serum Sodium

80053	**Comprehensive Metabolic Panel**
82040	Assay of Serum Albumin
82247	Bilirubin Total
82310	Assay of Calcium
82374	Assay Blood Carbon Dioxide
82435	Assay of Blood Chloride
82565	Assay of Creatinine
82947	Assay Glucose Blood Quant
84075	Assay Alkaline Phosphatase
84132	Assay of Serum Potassium
84155	Assay of Protein Serum
84295	Assay of Serum Sodium
84460	Alanine Amino (ALT) (SGPT)
84450	Transferase (AST) (SGOT)
84520	Assay of Urea Nitrogen

80055	Obstetric Panel
87340	Hepatitis B Surface AG IA
86762	Rubella Antibody
86592	Syphilis Test Non-Trep Qual
86850	RBC Antibody Screen
86900	Blood Typing Serologic ABO **AND**
86901	Blood Typing Serologic RH(D)
85025	Complete CBC w/Auto Diff WBC Count; **OR**
85027 & 85004	• Complete CBC Automated • Automated Diff WBC Count
OR 85027	Complete CBC Automated **AND**
85007 or 85009	• BL Smear w/ WBC Count • Manual Diff WBC Count, B-Coat

*CPT manual instructs when syphilis screening is conducted using a treponemal antibody approach- CPT code 86780, do not use CPT code 80055. Use the individual codes for the tests performed in the obstetric panel.

80061	Lipid Panel
82465	Assay BLD/Serum Cholesterol
83718	Assay of Lipoprotein
84478	Assay of Triglycerides

80069	Renal Function Panel
82040	Assay of Serum Albumin
82310	Assay of Calcium
82374	Assay Blood Carbon Dioxide
82435	Assay of Blood Chloride
82565	Assay of Creatinine
82947	Assay Glucose Blood Quant
84100	Assay of Phosphorus
84132	Assay of Serum Potassium

80069 (cont.)	**Renal Function Panel** (cont.)
84295	Assay of Serum Sodium
84520	Assay of Urea Nitrogen

80074	**Acute Hepatitis Panel**
86709	Hepatitis A IGM Antibody
86705	HEP B Core Antibody IGM
87340	Hepatitis B Surface AG IA
86803	Hepatitis C AB Test
80076	**Hepatic Function Panel**
82040	Assay of Serum Albumin
82247	Bilirubin Total
82248	Bilirubin Direct
84075	Assay Alkaline Phosphatase
84155	Assay of Protein Serum
84460	Alanine Amino (ALT) (SGPT)
84450	Transferase (AST) (SGOT)

80081	**Obstetric Panel**
87340	Hepatitis B Surface AG IA
86762	Rubella Antibody
86592	Syphilis Test Non-Trep Qual
86850	RBC Antibody Screen
86900	Blood Typing Serologic ABO **AND**
86901	Blood Typing Serologic RH(D)
87389	HIV-1 AG w/HIV-1 & HIV-2 AB
85025	Complete CBC w/Auto Diff WBC; **OR**
85027 & 85004	• Complete CBC Automated • Automated Diff WBC Count

OR 85027	Complete CBC Automated **AND**
85007 or 85009	• BL Smear w/ Diff WBC Count • Manual Differential WBC Count, B-Coat

*CPT manual instructs when syphilis screening is conducted using a treponemal antibody approach- CPT code 86780, do not use CPT code 80081. Use the individual codes for the tests performed in the Obstetric panel.

Repeat Testing

Claims submitted for the same member from the same provider for the same service(s) on the same date of service may be reviewed for appropriate coding. If a claim review determines inappropriate coding, medical records may be requested. If repeat services performed are deemed necessary, the services should be submitted with an appropriate appended modifier.

Providers are responsible for conducting laboratory services in an efficient manner. Modifier 91 should be appended to claims for repeat testing for the treatment of a member when testing is required at different periods throughout the day. Claims may be denied for failure to append modifier 91 or if a review determines repeat testing did not meet standard guidelines.

Licensing and Certifications

Any provider that performs laboratory testing on a member for a health assessment or the diagnosis, prevention or treatment of a disease are regulated under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). For additional information refer to the Provider Manual on the plans provider website.

References:

Policy Update History:

Approval Date	Description
11/21/2018	New policy
03/25/2019	Annual Review and CPT Code descriptors update
05/05/2020	Annual Review, updated disclaimer, policy language update