

# Test Specific Guidelines

# Laboratory Claim Reimbursement

**MOL.CS.105.A**  
**v1.0.2023**

## Procedures Addressed

The inclusion of any procedure code in this table is provided for informational purposes and is not a guarantee of coverage nor an indication that prior authorization is required.

<u>Procedures addressed by this guideline</u>	<u>Procedure codes</u>
<u>Molecular Pathology</u>	<u>81105 - 81479</u>
<u>Molecular Multianalyte Assays with Algorithmic Analyses (MAAA)</u>	<u>81490 - 81599; Molecular* administrative MAAA codes (ending in M)</u>
<u>Molecular Proprietary Laboratory Analyses (PLA)</u>	<u>Molecular* PLA codes (ending in U)</u>
<u>Molecular Infectious Testing</u>	<u>Molecular tests* within range 87149 – 87912</u> <u>0500T</u> <u>G0476</u>
<u>Molecular HCPCS Codes</u>	<u>S3800 - S3870</u> <u>G0452, G0327, G9143</u> <u>U0001-U0004</u>
<u>Molecular Cytopathology Procedures (Flow Cytometry, In Situ Hybridization)</u>	<u>88120 - 88121</u> <u>88182 - 88199</u>
<u>Cytogenetics</u>	<u>88230 - 88299</u>
<u>Molecular Surgical Pathology Procedures (Immunohistochemistry, In Situ Hybridization)</u>	<u>88341 - 88344</u> <u>88360 - 88361</u> <u>88364 –88377</u> <u>88380 - 88388</u>

<u>Procedures addressed by this guideline</u>	<u>Procedure codes</u>
<u>Other Molecular Codes</u>	<u>84999</u>
	<u>86152</u>
	<u>86153</u>

---

Note \*Generally defined as codes that include “DNA”, “RNA”, “nucleic acid”, “genotype”, “phenotype” or related language in the code description.

---

### Description

eviCore manages claims payment for our subscribing Health Plans. Procedure codes (CPT, HCPCS, PLA) are adjudicated against claims review and payment rules. Payment and coverage adjustments may be made in addition to those outlined in this policy.

The following claim reimbursement policies provide general guidance on what forms of review may be employed. They are intended to augment other clinical and administrative policies and do not represent all possible claim treatments.

## Criteria: Claims Reimbursement

### Introduction

All procedure codes included in the Laboratory Management Program may be subject to claims review and payment policies. The table at the top of this document provides general guidance; see the Health Plan's managed procedure code list for details. The following policies define many, but not all, of the most commonly applied claim edits performed under this program.

### Authorization Check

#### Required Authorization

Procedure codes that require medical necessity authorization are defined in published Plan procedure code management lists, which are generally available on the Health Plan's website or at eviCore.com. All claims will be reviewed for the presence of any procedure code that requires authorization. When required, the following process is employed:

The procedure code(s) requiring authorization will be checked against an authorization database.

The procedure code will be released for further adjudication if an approved authorization is on file for all units of that procedure code and the code is billed with any stipulated additional information (e.g., modifier, unique test identifier).

If any of the following are true, the Plan's authorization requirements will be enforced.

A denied authorization is on file for the billed procedure code, or

An authorization is not on file for all units of the billed procedure code, or

The stipulated modifier is not appended to the code, or

The authorization is not valid for the date of service.

### Pre-Service Review of Procedures That Do Not Require Prior Authorization

When a prior authorization request is submitted for a group of procedure codes and at least one procedure code requires prior authorization, all submitted procedure codes that are under management by the Program (in any form) will be reviewed regardless of the authorization requirements for each code. The determinations for each reviewed procedure code, approved or denied, will be fully enforced during claim adjudication.

### Substitutable Codes

An authorization for a procedure code may be used to approve coverage for a DIFFERENT billed procedure code that is substantially similar in clinical intent and coverage requirements to the authorized code (e.g., an authorization to perform CPT 81228 is substitutable if CPT 81229 is billed). Clinically reasonable substitution rules are automatically applied through the claims adjudication process. When substitution rules are invoked, the billed procedure code is the paid procedure code. A list of substitutable codes is available on request.

### Post-Service Medical Necessity Determination

Many lab tests that are in scope for the Lab Management Program are not managed through mandatory authorization requirements. Appropriate billing or medical necessity may be assessed upon claim submission (post-service) prior to payment as follows:

All procedure codes managed under this program may be subject to post-service medical necessity review.

Any and all available claims data (e.g., ICD code, age, gender, historical or co-existing procedures, modifiers, etc.) may be used to determine medical necessity or identify cases requiring further review.

Claims data may be sufficient to determine medical necessity without additional clinical information. When medical necessity is determined based on claims data alone, the claims information that will either support or refute medical necessity is defined in the clinical policy (e.g., submitted ICD codes do not support medical necessity for a procedure).

When a case is identified for additional post-service medical necessity review, communication is sent to at least the rendering provider requesting additional information with the following possible outcomes:

If the required clinical information is provided and fulfills criteria, the procedure is approved and the claim is released for further adjudication.

If the required clinical information is provided and does not fulfill criteria, the procedure is denied for lack of medical necessity.

If the required clinical information is not provided within the specified time frame, the procedure is denied for failure to comply with the post-service review process.

The factors that may prompt post-service medical necessity review include, but are not limited to:

ICD codes that support clinical criteria are not reported on the claim.

A billed amount threshold is exceeded.

A particular procedure code is billed with other procedure codes (e.g., bundled testing whether defined by the laboratory as a panel or not).

The claim is submitted by a provider (participating and non-participating) selected for focused review.

Billing portrait demonstrates billing patterns selected for focused review.

ABN (Advanced Beneficiary Notice) Modifiers GX, GY, GA, or GZ are present on the claim indicating that the test is expected to be non-covered.

There are multiple sources of the rules established by this policy including CMS documents, published code definitions, specialty guidelines, peer reviewed literature, expert opinion, and claims experience with codes or providers.

### Automated Clinical Policy Edits

Any and all information submitted on a claim may be used to determine medical necessity and/or appropriate coding and billing. Where automated clinical policy edits apply, the medical necessity and billing requirements will be addressed in the clinical policy for that laboratory procedure. These requirements may include, but are not limited to:

Clinical information, such as diagnosis coding that supports or does not support the billed service

Demographics, including age and reported gender (see the Gender Nondiscrimination portion of this policy for additional information)

Maximum frequency limits per day and other timeframes

Provider data including the type of provider or specific providers that have been identified for focused management

Other procedure codes billed with a service that either cannot be billed together or provide context for the type of testing being performed

Procedure code modifiers used to provide supplemental details about a service

Exceptions to these automated clinical policy edits will be handled on a case-by-case basis.

### Lifetime Maximums

In general, the same or similar tests performed on heritable DNA should not need to be performed more than once on the same person in that person's lifetime (e.g., gene sequencing or a similar mutation panel on a gene should not need to be repeated). Rarely, a procedure code may be billed twice for the same female

member when subsequent instances represent testing on the female member's fetus. It is the provider's responsibility to determine if any contemplated genetic testing has already been performed for the member and to avoid unnecessary repeat testing.

Lifetime maximum rules will be applied for procedure codes that involve genetic testing of heritable DNA in the following manner:

Only a single date of service will be reimbursed for any procedure code with a lifetime maximum for a single individual.

While most procedure codes have a lifetime maximum of one unit, some have a limit of 2 (e.g. known familial mutations for recessive conditions).

Procedure codes representing tests that may reasonably be performed on a fetus through prenatal diagnosis are covered services more than once per lifetime. When applicable, claims should include the following ICD code to indicate prenatal diagnosis: O35.2X.

All claims submitted for procedure codes subject to lifetime maximums will be checked for previous payment in historical claims data.

Testing more than once per lifetime is not medically necessary and such claims will be denied for reimbursement if:

The same procedure code, or a procedure code representing a significantly repetitive service, is known to have already been paid for that member, and

The member is a male, or

The member is a female, and

The code does not allow a prenatal diagnosis override, or

No ICD code suggesting prenatal diagnosis is submitted for a code that does allow a prenatal diagnosis override

A list of procedure codes subject to lifetime maximum rules is available on request.

### Gender Nondiscrimination

Gender reported on a claim is one element used to determine medical necessity. In situations where the reported gender may not be consistent with the medical needs based on biological sex (e.g., transgender, transsexual, intersex individuals), the KX modifier should be appended to each billed procedure code that may have gender-related policy. The KX modifier will allow automated gender-specific edits to be bypassed.

## **Industry Standard Edits**

### **Maximum Units per Date of Service**

**Most procedure codes have a reasonable maximum number of expected units that should be billed on a single date of service. Maximum expected units are coded into claims systems to prevent billing, data entry, and payment errors.**

**The CMS National Correct Coding Initiative provides guidance on maximum units for many procedure codes through their Medically Unlikely Edits. The files are available at:**

**<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE>.**

**Maximum units per date of service rules are administered as follows:**

**Total billed units are calculated based on the combined number of times a procedure code is billed on a single date of service. This applies to codes billed with multiple units on a single claim line, units reported on separate claims lines on the same claim, or multiple units reported on separate claims for that date of service. All maximum unit rules are applied per date of service and do not allow additional units simply because they are billed on separate claim lines.**

**When multiple units are billed, only the number of units up to the allowable daily maximum will be reimbursed.**

**Some unusual circumstances justify exceeding the established maximum units per date of service.**

**When such exceptions are recognized in eviCore clinical policy, instructions for submitting claims with additional units are provided.**

**When exceptions are not specifically addressed in policy, reimbursement of additional units will be considered if supporting documentation is provided.**

### **NCCI PTP Coding Edits**

**When two or more procedure codes are billed for the same member, on the same date of service, by the same provider, those codes must be compared to ensure the procedures are distinct from each other, should commonly be billed together, and are not mutually exclusive. The CMS National Correct Coding Initiative provides guidance through their Procedure to Procedure (PTP) coding edits.**

**NCCI PTP coding edits are administered as follows:**

**Providers should bill only the most comprehensive procedure code(s) that represent the performed procedures with the fewest number of codes possible.**

**All billed codes from a provider are compared to the NCCI PTP Edits file applicable for the date of service. The files are available at:**

**<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/PTP-Coding-Edits>. When two codes are billed together that appear in columns 1 and 2 of this**



table, the code in column 1 is paid, while the code in column 2 is denied as inclusive.

Some unusual circumstances justify billing both codes in a pair for separate, reasonable indications. When allowable, an appropriate modifier may be used to override the NCCI edit. NCCI provides a modifier override indicator in the referenced files. However, eviCore claims processing may not allow an automated override and additional supporting documentation may be required to explain the necessity of both procedures.

#### Professional and Technical Component Modifiers

Modifiers may be used to convey when only the professional or technical components of a test have been performed separately by the billing provider:

Modifier 26 represents the professional component, such as the clinical interpretation of a test.

Modifier TC represents the technical component, such as the equipment, supplies, and technical work.

The CMS Professional Component/Technical Component (PC/TC) indicators in the National Physician Fee Schedule Relative Value File are used to determine whether a procedure code is eligible for separate reimbursement for professional and technical components. The file is available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html>. In some instances, professional services are billed separately from technical services even when the billing code does not have a modifier 26 or TC designation. This policy applies to all instances of services where there are separate professional and technical charges.

Professional and technical modifiers are administered as follows:

If a procedure code is eligible for separate PC/TC reimbursement (PC/TC indicator 1), that code may be billed with no modifier to represent a global service (both PC and TC components) or the modifiers 26 or TC, but not both.

If a procedure code specifically describes only a professional or technical service (e.g., PC/TC indicator 2, 3, 6), a modifier is not necessary. A modifier cannot be billed that is inconsistent with the procedure code (e.g., a professional component only code billed with a TC modifier).

Procedure codes that are designated as only global without being eligible for separate PC/TC component reimbursement (including PC/TC indicator 9) will not be reimbursable when billed with modifier 26 or TC.

#### Add-on Codes

Some procedure codes are defined as “add-on” codes that should always be supplemental to a separate primary code. The CMS National Correct Coding Initiative provides guidance through their Add-on Code Edits. The file is available at:

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits>. Language in the code description or knowledge of testing practices may also be used to supplement these edits.

Add-on code edits are administered as follows:

Any procedure code designated as an add-on code will not be reimbursed when not billed with the appropriate primary code(s) on the same date of service by the same provider.

## **References**

Centers for Medicare & Medicaid Services. National Correct Coding Initiative Edits: Medically Unlikely Edits. Available at:

<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html>.

Centers for Medicare & Medicaid Services. National Correct Coding Initiative Edits: PTP Coding Edits. Available at:

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/PTP-Coding-Edits>

Centers for Medicare & Medicaid Services. Physician Fee Schedule: PFS Relative Value Files. Available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files>

Centers for Medicare & Medicaid Services. National Correct Coding Initiative Edits: Add-on Code Edits. Available at:

<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html>.

Centers for Medicare & Medicaid Services. Clinical Laboratory Improvement Amendments (CLIA). Available at: <http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html>.

Centers for Medicare & Medicaid Services. Accreditation Organizations/Exempt States. Available at: [http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Accreditation Organizations and Exempt States.html](http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Accreditation%20Organizations%20and%20Exempt%20States.html)

US Food and Drug Administration. CLIA Clinical Laboratory Improvement Amendments- Currently Waived Analytes. Available at:

<https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm>

Washington State Department of Health. Medical Test Site Licensing. Available at: <https://doh.wa.gov/licenses-permits-and-certificates/facilities-z/laboratory-quality-assurance/medical-test-site-licensing>

U.S. Food and Drug Administration. IVD Regulatory Assistance: Clinical Laboratory Improvement Amendments (CLIA). Available at:

<http://www.fda.gov/medicaldevices/deviceregulationandguidance/ivdregulatoryassistance/ucm124105.htm>.

CPT 2019 Professional Edition. American Medical Association, 2019.

**164(4):866-870.**