Manual:	Reimbursement Policy		
Policy Title:	**Routine Venipuncture and/or Collection of Specimens**		
Section:	Laboratory & Pathology		
Subsection:	None		
Date of Origin:	1/1/2000	Policy Number:	RPM012
Last Updated:	2/3/2021	Last Reviewed:	2/10/2021

Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

Reimbursement Guidelines

A. **For Professional and Clinical Laboratory Services** (including Dialysis Centers and Home Health):

Venipuncture is the most common method used to obtain blood samples for blood or serum lab procedures. The work of obtaining the specimen sample is an essential part of performing the test. Reimbursement for the venipuncture is included in the reimbursement for the lab test procedure code.

1. CPT Code 36415

    a. For Moda Health Advantage:

    36415 is eligible for separate reimbursement, consistent with Original Medicare payment policy.

    b. For all other lines of business, the following policies apply:

        i. CPT 36415 is only eligible to be billed once, even when multiple specimens are drawn or when multiple sites are accessed to obtain an adequate specimen size for the desired test(s). (CMS[4])

        ii. Moda Health does not allow separate reimbursement for CPT 36415 (venipuncture) when billed in conjunction with a blood or serum lab procedure performed on the same day and billed by the same provider (procedure codes in the 80048 - 89399 range). 36415 will be denied as a subset to the lab test procedure.

        iii. If some of the blood and/or serum lab procedures are performed by the provider and others are sent to an outside lab, CPT 36415 is not eligible for separate reimbursement.

iv. Modifier 90 (reference laboratory) will not bypass the subset edit. The outside laboratory that is actually performing the test will need to bill Moda Health directly for the lab tests in order for 36415 to be separately reimbursable to the provider performing the venipuncture to obtain the specimen for the outside laboratory.

v. The use of modifiers XS, XP, XE, XU, or 59 with 36415 when blood/serum lab tests are also billed is not a valid use of the modifier. The venipuncture is not a separate procedure in this situation.

vi. Moda Health does allow separate reimbursement for CPT 36415 when the only other lab services billed for that date by that provider are for specimens not obtained by venipuncture (e.g. urinalysis).

2. CPT code 36416

a. CPT 36416 is designated as a status B code (bundled and never separately reimbursed) on the Physician Fee Schedule RBRVU file. Moda Health clinical edits will deny CPT code 36416 to provider responsibility. This applies whether 36416 is billed with another code or as the sole service for that date. This edit is not eligible for a modifier bypass.

b. Denial explanation codes include:

i. WGO *(Service/supply is considered incidental and no separate payment can be made. Payment is always bundled into a related service)*

ii. z39 (This claim line is being disallowed because the procedure code has no Medicare relative value unit and may be considered incidental.)

c. 835 CARC/RARC denial combination:

CARC 97	(*The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.*)
RARC M15	(*Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.*)

3. CPT codes 36591 and 36592

a. CPT codes 36591 and 36592 are eligible for separate reimbursement only under very limited and specific circumstances.

i. The CPT book includes parenthetical guidelines below these codes which state: "(Do not report 36591 [or 36592] in conjunction with other services except a laboratory service.)" (AMA[8, 9])

ii. Under CMS guidelines, CPT 36591 and 36592 are designated as status T codes on the Physician Fee Schedule RBRVU file. Status T is defined as "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."

b. CPT codes 36591 or 36592 will be denied when reported in conjunction with other non-laboratory services. This may be identified by Moda Health clinical edits or by coding-to-records review. The denial is not eligible for a modifier bypass.

    i. For example:

        CPT codes 36591 and 36592 may not be submitted in combination with chemotherapy services. The collection of the blood sample is included in the reimbursement for the chemotherapy administration service, and may not be separately reported on the claim. This limitation applies to both the professional services and facility claims.

    ii. Denial explanation codes include:

        1) WGT *(Bundled or incidental service/supply. Not eligible for separate payment, per CPT and/or CMS guidelines.)*

        2) 771 (*Claim review results. Item(s)/services identified as not eligible to be separately reported or never eligible for separate reimbursement.*)

        3) u10 (*Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.*)

    iii. 835 CARC/RARC denial combinations:

CARC 97	(*The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.*)
RARC N390	(*This service/report cannot be billed separately.*)

CARC 97	(*The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.*)
RARC M15	(*Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.*)

4. Point of Care Testing & Obtaining Samples

a. Point of care (POC) testing and obtaining specimen samples for POC testing is not separately reimbursable.

b. Point of care testing includes but is not limited to:

    i. Urine dip stick

    ii. Glucometry testing

    iii. Mobile computer devices such as, but not limited to, those used for the analysis of blood gases, electrolytes, metabolites and urinary retention

    iv. Obtaining samples from existing lines or insertion of peripheral IV lines

5. Handling fees, CPT codes 99000 and 99001

   a. CPT codes 99000 and 99001 are designated as status B codes (bundled and never separately reimbursed) on the Physician Fee Schedule RBRVU file.

   b. Moda Health clinical edits will deny CPT 99000 or 99001, whether 99000 or 99001 is billed with another code or as the sole service for that date. This edit is not eligible for a modifier bypass.

   c. Denial explanation codes:

      i. WGO *(Service/supply is considered incidental and no separate payment can be made. Payment is always bundled into a related service)*

      ii. z39 *(This procedure code or service is a status B or otherwise considered Bundled, and is not eligible for separate reimbursement.)*

   d. 835 CARC/RARC denial combination:

CARC 97	*(The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.)*
RARC M15	*(Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.)*

B. For Ambulatory Surgery Centers (ASC):

Per CMS policy, routine venipuncture or other routine collection of specimens, if needed, is not separately reimbursable to ASCs. These services are included in the packaged reimbursement for the primary procedure or service.

C. For Outpatient Hospital (OPPS) Services:

The CMS OPPS Medically Unlikely Edit (MUE) limits apply for routine venipuncture procedure codes or other routine collection of specimens.

D. For Inpatient Hospital Services:

A maximum of one collection fee (any procedure code) is allowed per specimen type (venous blood, arterial blood) per date of service, per CMS policy. (CMS[4, 5, 6, 7]) Specimen collections out of an existing line (e.g. arterial line, CVP line, port, etc.) are not separately reimbursable.

Codes and Definitions

Code	Code Definition
36415	Collection of venous blood by venipuncture
36416	Collection of capillary blood specimen (eg, finger, heel, ear stick)
36500	Venous catheterization for selective organ blood sampling

36591	Collection of blood specimen from a completely implantable venous access device
36592	Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified
75893	Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation
99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory
99001	Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory (distance may be indicated)

Coding Guidelines

- When existing vascular access lines or selectively placed catheters are utilized to procure arterial or venous samples, reporting the sample collection separately is inappropriate. (CMS[3])

- CPT codes 36500 or 75893 may occasionally be appropriate if more extensive work beyond routine venipuncture is required. For instance, if a physician needs to place a catheter to obtain a blood specimen from a specific organ or location. CPT codes 36500 (venous catheterization for selective organ blood sampling) or 75893 (venous sampling through catheter with or without angiography...) may be reported for venous blood sampling through a catheter placed for the sole purpose of venous blood sampling. CPT code 75893 includes concomitant venography if performed. (CMS[3])

- If a catheter is placed for a purpose other than venous blood sampling with or without venography (CPT code 75893), it is a misuse of CPT codes 36500 or 75893 to report them in addition to CPT codes for the other venous procedure(s). CPT codes 36500 or 75893 should not be reported for blood sampling during an arterial procedure. (CMS[3])

- Only one collection fee is allowed for each type of specimen for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter. (CMS[4])

- "(Do not report 36591 in conjunction with other services except a laboratory service.)" (AMA[8])

- "(Do not report 36592 in conjunction with other services except a laboratory service.)" (AMA[9])

Cross References

None.

References & Resources

1. Moda Health system-supplied Clinical Editing Resource Guide.

2. CMS. Medicare Physician Fee Schedule Database.

3. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 5 Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems, § D, 13, p V-13.

4. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 16 – Laboratory Services, §60.1.

5. Noridian Administrative Services (NAS). Ask the Contractor Teleconference, February 12, 2009. Q & A, question 10.

6. Noridian Administrative Services (NAS). Ask the Contractor Teleconference, November 12, 2009. Q & A, question 17.

7. Noridian Administrative Services (NAS). Ask the Contractor Teleconference, August 13, 2009. Q & A, question 10.

8. AMA. *Current Procedural Terminology (CPT)*. Chicago: AMA Press. Guidelines in parenthesis directly under CPT code 36591.

9. AMA. *Current Procedural Terminology (CPT)*. Chicago: AMA Press. Guidelines in parenthesis directly under CPT code 36592.

Background Information

Venipuncture or phlebotomy is the puncture of a vein with a needle or an IV catheter to withdraw blood. Venipuncture is the most common method used to obtain blood samples for blood or serum lab procedures, and is sometimes referred to as a "blood draw."

Collection of a capillary blood specimen (36416) or of venous blood from an existing access line or by venipuncture that does not require a physician's skill or a cutdown is considered "routine venipuncture."

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document Moda Health's payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Moda Health Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Providers are expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between the Moda Health Reimbursement Policy and the member's medical benefit plan, the

member's medical benefit plan will prevail. Fee determinations will be based on the applicable **provider** fee schedule, whether out of network or participating provider's agreement, and Moda Health Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; Moda Health strives to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****