If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a Clinical Payment and Coding Policy 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. Blue Cross and Blue Shield of IL may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. Blue Cross and Blue Shield of IL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act 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, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative 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

Policy Number: CPCP021

Version 1.0

Clinical Payment and Coding Policy Committee Approval Date: June 28, 2024

Plan Effective Date: June 28, 2024

Description

This policy provides guidance on the appropriate billing for laboratory tests that are included in an organ or disease-oriented panel when they are billed on the same date of service for a member.

Reimbursement Information

Laboratory panels outlined below were developed for coding purposes only, they are defined and published by AMA in the CPT® codebook under the *Pathology and Laboratory* chapter, *Organ, or Disease-Oriented Panels* subchapter. Orders for laboratory tests must be member-specific, 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 coded panels. The codes for the individual tests in the custom panel must be reported accurately and appropriately.

The plan reserves the right to bundle 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 bundle the procedure codes for appropriate reimbursement. Likewise, when medical documentation is submitted with a claim and shows that a panel was ordered and performed, but the claim submitted shows the individual components of the panel were billed, claim reviewers may bundle the codes into the appropriate panel code for reimbursement.

In the absence of supporting evidence, Proprietary Laboratory Analyses/PLA or Multianalyte Assays with Algorithmic Analyses/MAAA codes are not reimbursable services unless necessary, appropriate, and specifically noted **as a covered benefit.**

Billing & Coding

1. **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, and other individual tests are rendered such as 82947 (Assay Glucose Blood Quant), 84520 (Assay of Urea Nitrogen), 82565 (Assay of Creatinine) and 82550 (Assay of CK (CPK)), the individual tests should be billed separately from the electrolyte panel code.

2. **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.

3. **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. Both panels include these tests, but only the Electrolyte panel should be billed. Any remaining tests that are not inclusive of a panel should be billed separately.

4. **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	Basic Metabolic Panel (Calcium, Ionized)
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	Basic Metabolic Panel Total (Calcium, Total)
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[1]**
80053	Comprehensive Metabolic Panel
84443	Assay Thyroid Stim Hormone
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 Diff WBC Count, B-Coat

80051	**Electrolyte Panel**
82374	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 Transferase (ALT) (SGPT)
84450	Aspartate Amino Transferase (AST) (SGOT)
84520	Assay of Urea Nitrogen

80055	**Obstetric Panel[1]**
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

Note, Obstetric Panel CPT code 80055 should not be billed when a syphilis screening is conducted using a treponemal antibody approach (86780). If this approach is used, providers should assign the individual codes for the tests performed in the OB panel in conjunction with CPT code 86780.

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
84295	Assay of Serum Sodium
84520	Assay of Urea Nitrogen

80074	Acute Hepatitis Panel
86709	Hepatitis A IGgM Antibody
86705	HEP B Core Antibody IGgM
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 Transferase (ALT) (SGPT)
84450	Aspartate Amino Transferase (AST) (SGOT)

80081	Obstetric Panel (+HIV Testing)[1]
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 Diff WBC Count, B-Coat

Note, Obstetric Panel (+HIV Testing) CPT code 80081 should not be billed when a syphilis screening is conducted using a treponemal antibody approach (86780). If this approach is used, providers should assign the individual codes for the tests performed in the OB panel in conjunction with CPT code 86780.

[1]When CPT code 85025 (Complete CBC Automated) is reported with CPT code 85004 (Automated Diff WBC Count), the Plan will deny 85004.

Repeat Testing

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. **Modifier 91** should not be submitted when a test is rerun to confirm the initial results due to an issue with the specimen, equipment or for any other reason when the one-time reportable result was all that was required. 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

All laboratory testing on a member for a health assessment, to determine a diagnosis, prevention, or treatment of a disease is regulated under the Clinical Laboratory Improvement Amendments /CLIA that was passed in 1988. For additional information refer to the plan's provider website. [2]In the event a test is CLIA waived, providers should append **modifier QW.**

Additional Resources

Clinical Payment and Coding Policy
CPCP023 Modifier Reference Policy

Medical Policy
ADM1001.028 Inside the U.S. Food and Drug Administration (FDA)

References

[2]Centers for Medicare and Medicaid Services. Medicare Learning Network Matters MM13455. New Waived Tests. Accessed 04.17.2024
https://www.cms.gov/files/document/mm13455-new-waived-tests.pdf

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
06/04/2021	Annual Review
07/30/2021	Updated verbiage
03/30/2022	Annual Review
04/06/2022	Annual Review with additional revisions
06/21/2023	Annual Review
06/28/2024	Annual Review