Payment Policy: Concert Laboratory Payment Policy

Reference Number: CG.CC.PP.01
Product Types: ALL
Date of Last Revision: 02/28/2025

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Application
This policy addresses laboratory services (excluding genetic and molecular testing, which are addressed in CG.PP.551 Genetic and Molecular Testing) and applies to codes billed in an outpatient setting from the following sections in the AMA CPT/HCPCS Manual:

- Pathology and Laboratory Procedures (80000 Codes)
- Category III Multianalyte Assays with Algorithmic Analyses (MAAA) (M codes)
- Proprietary Lab Analysis (PLA) (U codes)
- Level II Healthcare Common Procedure Coding System (HCPCS)

Reimbursement
All providers billing for laboratory services must include standard information on the claim, or payment for services may be denied:

- Bill for the test performed as indicated on the test requisition form and delivered on the test result.
- Include ordering and rendering provider information on all claim transactions.
- Include appropriate and accurate diagnosis codes, related to the procedure performed, per the International Classification of Diseases (ICD) coding system created by the World Health Organization (WHO). Header codes (3 digit ICDs) may lack specificity to determine coverage in some instances and may be denied for insufficient specificity.
- Include the date and place of service on all claim transactions. Place of Service codes will be used to distinguish outpatient testing from testing provided within the Emergency Department or as a part of an inpatient hospital stay.

All providers billing for laboratory services must bill according to coding standards set by the American Medical Association (AMA) and National Correct Coding Initiative (NCCI) manual, or payment for services may be denied:

- Procedure codes are determined based on the attributes of the testing performed, not based on the member's diagnosis or clinical indication.
- If the laboratory has obtained an approved Proprietary Laboratory Analyses (PLA) code or the test has an MAAA code, the PLA/MAAA code must be used to bill for the service.
- Proprietary codes may be used only for the specific test to which the code is assigned.

- If a test qualifies for panel code(s), the panel code(s) must be used.
    - If a test evaluates multiple analytes (e.g. drugs, pathogens, metabolites, genes) using a procedure that consolidates at least one part of the testing process (e.g., tandem mass spectrometry), the laboratory shall report only one unit of service of one appropriate level II HCPCS, CPT, or PLA code.
- If a panel code is not appropriate, a limited number of individual components from multi-gene tests may be billed.
- Codes may be used when the Date of Service falls after the listed effective date and prior to the date of retirement.
- Modifier codes should be used when billing multiple service units of a code is appropriate. This includes but is not limited to repeat testing, testing performed on multiple specimens, and testing for multiple species.
- When interpretation of existing data resulting from a separate test is conducted, the provider may bill at an adjusted rate using Modifier 52 to indicate that the wet lab procedures were not performed.
- Procedure-to-Procedure (PTP) and Medically Unlikely Edit (MUE) Requirements
    - If a code(s) falls under a NCCI procedure-to-procedure edit, the code must be billed in alignment with the edit. PTP edits prohibit certain codes billed in presence of other codes as they are "mutually exclusive procedures."
    - If a code(s) falls under an NCCI procedure-to-procedure edit, modifiers must ONLY be used when appropriate and Modifier 59 may be used only if no other appropriate modifier describes the service.
    - If a code(s) falls under a Medically Unlikely Edit (MUE), which defines the maximum units of service (UOS), the units billed must not exceed the maximum UOS. Per the NCCI Manual, the MUE is the maximum units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier for the same beneficiary on the same date of service. Not all HCPCS/CPT codes have an MUEs.

References

1. American Medical Association. CPT® Code Book. Last updated April, 2024
2. World Health Organization. (2019). International statistical classification of diseases and related health problems (11th ed.). https://icd.who.int/
3. Centers for Medicare and Medicaid Services, "NCCI Policy Manual", Chapter 10 https://www.cms.gov/ncci-medicare/medicare-ncci-policy-manual
4. Medicare NCCI FAQ Library. https://www.cms.gov/ncci-medicare/medicare-ncci-faq-library
5. Centers for Medicare and Medicaid Services,"Medicare NCCI Procedure to Procedure (PTP) Edits"https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ptp-edits
6. Centers for Medicare and Medicaid Services, "Medically Unlikely Edits" https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

Revision History	
11/8/2023	Policy developed.
02/28/2025	Annual review. Renamed to "Outpatient Laboratory Services." Minor rewording for clarity. Added "Application" and "Reimbursement" section headers, with other restructuring. In applicable code ranges at the beginning of the policy, replaced "HCPCS level I codes for lab tests (G codes and S codes)" with Level II HCPCS and specified that in-scope codes are those unrelated to genetic and molecular tests, which are addressed by CG.PP.551. Combined AMA and NCCI coding requirements into one section, and added additional detail regarding NCCI manual instructions for billing panel codes. In reimbursement section: removed requirements for next generation sequencing as it is out of the policy's scope; added requirement for billed units for tests analyzing multiple analytes; removed requirements for 81479 as it is specific to genetic and molecular testing; added requirement "modifier code should be used…", added requirement "when interpretation of existing data…" References updated.

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This payment policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.