Clover

Clover Health Laboratory Services Reimbursement Policy

Policy #RP-052

Policy Title	Laboratory Services Reimbursement Policy
Policy Department	Payment Strategy and Operations
Effective Date	4/1/2022
Revision Date(s)	
Next Review Date	

Disclaimer:

Clover Health applies The Center for Medicare and Medicaid Services (CMS) criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

Description: Clinical diagnostic laboratory tests are done when a doctor or provider orders them. Laboratory tests include certain blood tests, urinalysis, tests on tissue specimens, and some screening tests.

Definitions:

- Component Codes - Identify individual tests that when performed together may comprise a panel
- Duplicate Laboratory Service - Identical or equivalent bundled laboratory Component Codes, submitted for the same patient on the same date of service on separate claim lines or on different claims regardless of the assigned Maximum Frequency per Day (MFD) value.
- Independent Laboratory - An Independent Laboratory is one that is independent both of an attending or consulting physician's office and of a hospital that meets at least the requirements to qualify as an emergency hospital. An Independent Laboratory must meet Federal and State requirements for certification and proficiency testing under the Clinical Laboratories Improvement Act (CLIA).

Policy:

This policy describes the reimbursement methodology for medical necessary laboratory panels and individual Component Codes, as well as reimbursement for venipuncture services, laboratory services performed in a facility setting, and laboratory handling.

The date of service for either a clinical laboratory test or the technical component of physician pathology service is as follows:

- General Rule: The date of service of the test/service must be the date the specimen was collected.
- Variation: If a specimen is collected over a period that spans two calendar days, then the date of service must be the date the collection ended.

Duplicate laboratory code submissions by the same or multiple Physicians or Other Qualified Health Care Professionals, as well as certain laboratory services provided in a facility place of service, are also addressed in this policy.

A specimen collection fee is allowed when drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization. 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.

Physicians:
Clover Health allows a specimen collection fee for physicians only when:

- When it is the accepted and prevailing practice among physicians in the locality to make separate charges for drawing or collecting a specimen,
- and it is the customary practice of the physician performing such services to bill separate charges for drawing or collecting the specimen.

Independent Labs:
Clover Health allows separate charges made by laboratories for drawing or collecting specimens whether or not the specimens are referred to hospitals or independent laboratories. The laboratory does not bill for routine handling charges where a specimen is referred by one laboratory to another.
Clover Health follows CMS requirements related to Organ or Disease Oriented Panels.
Clover Health requires laboratories to bill the HCPCS panel test code and not unbundle the

individual components if all components of the HCPCS panel are performed.

Providers and suppliers are required to submit all AMCC laboratory test HCPCS for the same beneficiary, performed on the same date of service on the same claim. This billing policy applies when:

- Submitting a complete organ disease panel;
- or submitting individual component tests of an organ disease panel when all components of the panel were not performed.

Documentation requirements for diagnostic laboratories:
Diagnostic test order's documentation requirements are met if the record includes:

- A signed order or requisition listing the specific test
- An authenticated medical record supporting the medical necessity of the specific test.

Clover Health requires documentation in the patient's medical record to support the medical necessity for ordering the service(s). The medical necessity for the services rendered must be individualized to the patient and not 'standing orders'. Clover Health cautions referring providers and laboratories from standing orders.

- Providers should be aware of the various meanings of the term standing orders. Some understand this to mean recurring orders specific to the care of an individual patient. Others interpret this as routine orders for services delivered to a population of patients. Only medically necessary services ordered and rendered, including those based on treatment protocols, are considered for reimbursement when documentation supports the orders and/or protocols are individualized to each patient.

Clover Health specifically places the responsibility for ensuring medical necessity onto diagnostic laboratories as they are the party submitting a bill for reimbursement.

Claim Codes (if applicable)	**Specimen Collection Codes:** ● **36415** - Collection of venous blood by venipuncture. ● **G0471** - Collection of venous blood by venipuncture or urine sample by catheterization from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA) ● **P96I5** - Catheterization for collection of specimen(s). **Modifiers:**

	• 90 - Reference (Outside) Laboratory • 91 - Modifier is used for laboratory tests paid under the clinical laboratory fee schedule. • 26 - Professional Component • AY - Item or service furnished to an ESRD patient that is not for the treatment of ESRD • TC - Technical Component • QP - Documentation is on file showing that the laboratory test(s) was ordered individually or ordered as a CPT-recognized panel other than automated profile codes 80002-80019, G0058, G0059, and G0060 • QW - A CLIA waiver test

References
CMS Chapter 16 - Laboratory Services