Laboratory and Pathology Payment Policy

Applies to the following CarePartners of Connecticut products:

- ☒ CareAdvantage Preferred
- ☒ CarePartners Access

The following payment policy applies to providers who render laboratory and pathology services to members of the CarePartners of Connecticut plans selected above.

Note: Audit and disclaimer information is located at the end of this document.

Policy

CarePartners of Connecticut covers medically necessary laboratory and pathology services, in accordance with the member's benefits.

General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

Third Party Testing

CarePartners of Connecticut does not cover specimen collection and lab processing costs ordered by third parties, such as schools, courts, or employers, or requested by a provider for the sole purpose of meeting the requirements of a third party.

Referral/Prior Authorization/Notification Requirements

No referrals, prior authorizations or inpatient notifications are required for in-network services. Referrals are required for out-of-network services rendered for HMO members.

A medical requisition form/prescription is required from the requesting provider to direct the member to the appropriate lab, as well as to perform medically necessary services.

Billing Instructions

Unless otherwise stated, CarePartners of Connecticut follows industry-standard coding guidelines. Refer to current industry-standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

Use of labs not participating in the member's applicable network(s) may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, CarePartners of Connecticut may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Append modifier 26 to indicate professional components and/or modifier TC to indicate technical components that require the use of a modifier whether in an office, inpatient or outpatient setting.

Note: Procedures defined as professional or technical component only in nature do not require a modifier and therefore should not be billed with modifier 26 or TC. Refer to the CMS's National Physician Relative Value File for additional information.

Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules, regardless of the address where the service is rendered.

CarePartners of Connecticut participating provider groups may have a specific prepaid contract agreement for lab services to be performed by a specific lab provider. For additional information, contact Provider Relations at 888-341-1508.

Benign Paroxysmal Positional Vertigo (BPPV)

CarePartners of Connecticut does not routinely compensate 80047-89398 (lab tests) if the only diagnosis on the claim line is benign paroxysmal positional vertigo.

Colorectal Cancer Screening Tests (DNA-based)

CarePartners of Connecticut does not routinely compensate 81528 (oncology colorectal screening) if billed under the following circumstances:

- Without a colorectal cancer screening diagnosis or if the member's age is greater than 85 years on the date of service
- If the member's age is less than 50 years of age on the date of service

Diagnosis Limitations

CarePartners of Connecticut does not routinely compensate for the following:

- EGFR gene analysis, common variants if billed without a diagnosis of malignant neoplasm of the trachea, bronchus or lung, malignant neoplasm of the pleura, or malignant neoplasm of the brain
- PCA3 testing, BCR/ABL fusion gene, or JAK2 gene analysis if billed without an appropriate diagnosis

Drug Testing

CarePartners of Connecticut does not routinely compensate urine drug screenings in conjunction with a service which includes clinical diagnostic laboratory testing as an integral component (i.e.; inpatient hospital stays, skilled nursing facilities or behavioral health facility-based treatment program).

CarePartners of Connecticut does not routinely compensate for more than the following within a 365-day period per member, as they exceed clinical guidelines:

- 80305-80307, 80375-80377 (qualitative drug screen) if billed with any combination of more than 20 units
- G0480-G0483 (drug confirmation) if billed more than 10 units

CarePartners of Connecticut does not routinely compensate for urinalysis (81000-81003, 81005, 81099), creatinine (82570), pH; body fluid (83986) or spectrophotometry (84311) when billed with the following toxicology procedure codes:

- Presumptive drug screen (80305-80307)
- Definitive drug testing (80320-80377, 83992, G0480-G0483)

CarePartners of Connecticut does not routinely compensate presumptive (80305-80307) or definitive (G0480-G0483, G0659) drug testing when billed more than one combined unit per day.

Duplicate Services

CarePartners of Connecticut does not routinely compensate under the following circumstances:

- Duplicate claim lines reported by an independent laboratory when billed by a different tax ID, any provider ID or any specialty
- Duplicate drug codes if the same code with the same units has been billed on a different claim by any provider for the same date of service
- CarePartners of Connecticut does not routinely compensate for 80000-89999 (Pathology and Laboratory services) when billed by an outpatient hospital in place of service 22 and the same submitted code has been billed by any provider in place of service 81.

Fecal Occult Blood Tests

82270 or 82274 (fecal occult blood tests) are compensated once in a three-day period.

Genetic Testing

Coverage of genetic testing procedures for inherited conditions is limited to once in a member's lifetime.

CarePartners of Connecticut does not routinely compensate for the following:

- Genetic testing procedures if billed with a Tier 1 molecular pathology procedure will be denied
- BRCA 1, BRCA 2, gene or full sequence analyses, common duplication/deletion variants or BRCA 2 gene or full sequence analyses will be denied if any of these codes have been previously paid for the same date of service.

Genital Herpes Screening

CarePartners of Connecticut does not routinely compensate 86696 (antibody; herpes simplex, type 2) if billed for a member 13 years of age or older on the date of service if the only diagnosis is a screening diagnosis code.

Germline Mutation Testing

The following genetic biomarker procedures are considered noncovered services and are not compensated: 81161, 81200, 81205, 81228-81229, 81243-81244, 81260, 81291, 81302-81304, 81330-81331, 81410-81417, 81420, 81425-81427, 81430-81431, 81434, 81439, 81440, 81442, 81460, 81465 or 81470-81471.

Helicobacter pylori (H. pylori)

CarePartners of Connecticut does not routinely compensate for 78267, 78268, 83009, 83013, 83014, 86677, 87338, or 87339 if billed more than once every eight weeks (56 days).

Human Immunodeficiency Virus (HIV) Testing

CarePartners of Connecticut does not compensate for human immunodeficiency virus testing if billed without a covered diagnosis.

Human Papilloma Virus (HPV) Testing

CarePartners of Connecticut does not routinely compensate for the following:

- 87623 (infectious agent detection by nucleic acid [DNA or RNA]; HPV low-risk types)
- 87624-87625, G0476 (HPV testing) under the following circumstances:
- If billed more than once in a five-year period by any provider for a female member between 30 and 65 years of age on the date of service if the only diagnosis is a screening diagnosis code
- G0476 (HPV screening) under the following circumstances:
- If the member's age is greater than 65 years on the date of service
- If billed by any provider more than once every five years

Natriuretic Peptide

CarePartners of Connecticut will not compensate for natriuretic peptide if billed more than four times per year.

Nuclear Matrix Protein 22 (NMP22)

CarePartners of Connecticut does not routinely compensate for immunoassays for tumor antigen, qualitative or semi-quantitative if billed with nuclear matrix protein 22 (NMP22) for the same diagnosis.

Prostate Cancer Screening Tests

CarePartners of Connecticut will not routinely compensate G0102-G0103 (prostate cancer screening tests) for members under 50 years of age on the date of service.

Reduced and Discontinued Services Modifiers

CarePartners of Connecticut does not separately compensate for any laboratory panel code if billed with modifier 52 or 53.

Serum

CarePartners of Connecticut does not routinely compensate for aluminum (82108) or ferritin (82728) if billed more than once in a 90-day period and a diagnosis of ESRD is on the claim.

Surgical Pathology Diagnosis Limitations

CarePartners of Connecticut does not routinely compensate surgical pathology gross & microscopic exams (88305, 88307 or 88309) if the only diagnosis on the claim line is any of the following:

- Appendix
- Cornea
- Gallbladder
- Ganglion cyst
- Hemorrhoid

- Hydrocele or spermatocele
- Polyp of stomach and duodenum

Thyroid Testing

84436, 84439, 84443, and/or 84479 (thyroid testing) is compensated up to four times per year (any combination of codes).

Venipuncture Services

Venipuncture services are not separately compensated when billed for the same DOS as a lab service under the same provider group/tax identification number, as blood collection is considered an integral component of the lab service.

Similarly, venipuncture services performed in a facility are not separately compensated, as they are considered an integral component of all facility fees, regardless of which other services are billed.

Note: Venipuncture services performed as the sole service (i.e., without an accompanying lab service) will continue to be compensated.

Vitamin D Testing

- 82306 (Vitamin D; 25 dihydroxy) is not compensated if billed without an appropriate diagnosis code.
- 82306 (Vitamin D; 25 dihydroxy) is not compensated if billed more than four times per year for the diagnosis of vitamin D deficiency.

Additional Resources

- CarePartners of Connecticut Provider Manual

Document History

- January 2025: Annual coding updates; removed end-dated CPT codes C9803, 81280-81282, 0500T; removed COVID-19 billing instructions
- August 2024: Annual policy review; no changes
- September 2023: Annual policy review; administrative updates
- July 2022: Added billing requirements for COVID-19 testing and treatment codes, effective for dates of service on or after September 1, 2022
- April 2022: Added compensation information for venipuncture services, effective for dates of service on or after June 1, 2022
- May 2021: Added claim edits for duplicate laboratory services for outpatient hospital and independent laboratory; and thyroid testing effective for dates of service on or after July 1, 2021
- March 2021: Template updates; added compensation information for urine drug screenings in conjunction with a service which includes clinical diagnostic laboratory testing
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after Jan. 1, 2021
- November 2020: Reviewed by committee, no content changes
- August 2020: Added third party testing content
- January 2020: Eliminate referral requirements for in-network providers effective Jan. 1, 2020
- August 2019: Removed reference to Claims Submission Policy (retired)
- May 2019: Added claim edits for benign paroxysmal positional vertigo (BPPV), surgical pathology, and duplicate drug codes, effective for dates of service on or after July 1, 2019
- January 2019: Policy created

Audit and Disclaimer Information

CarePartners of Connecticut reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member

eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.