



Covered Benefit: Laboratory Services

CMP Published: Yes ¹ No

CMP Link: [Genetic Testing](#)

CPG Published: Yes No

Definitions: Laboratory services include basic lab panels, screening for therapeutic drug panels, screening for sexually transmitted diseases (STD), urine testing and more advanced laboratory tests.

Genetic testing involves tests done for clinical genetic purposes including the diagnosis of genetic disease in children and adults; the identification of future disease risks; the prediction of drug responses; and the detection of risks of disease to future children.

Benefit Packages: RItE Care, Children with Special Health Care Needs, Substitute Care, Rhody Health Plan, and Extended Family Planning (EFP).

Coverage Limitations:

Genetic testing is covered as a clinical option when determined medically necessary by Neighborhood's Medical Management Department. Prior authorization is required in accordance with the Clinical Medical Policy (CMP).

Per CMS Local Coverage Determination (L29813) the laboratory test for CPT code 88342 Immunohistochemistry (including tissue immunoperoxidase), each antibody, is limited to 10 analyses per tissue sample.

Exclusions:

Genetic testing is not considered a clinical option for any of the following indications:
Genetic testing to provide information for future generations of member's family
Genetic testing conducted to benefit care and treatment of member of the patient's family who is not covered by Neighborhood
Genetic testing that is experimental.

For EFP covered laboratory services see the EFP Benefit Coverage Summary. Please note that no genetic testing is covered.

Please refer to Table below for non-covered laboratory services.

Coverage Includes:

- Laboratory tests
- Genetic testing
- Amniocentesis lab
- Blood Draw
- Pathology Consultations

¹ Genetic Testing CMP www.nhpri.org



Episodes of care can occur across multiple settings:

- Office (POS 11)
- Urgent Care (POS 20)
- Inpatient (POS 21)
- Outpatient (POS 22)
- Emergency Room (POS 23)
- Federally Qualified Health Center (POS 50)
- Independent Laboratory (POS 81)

Laboratory Services - Non-Covered

Description Laboratory Non-Covered	Codes	Description
CPT Codes	“80414”	Chorionic Gonadotropin stimulation panel; testosterone response
	“80415”	Chorionic Gonadotropin stimulation panel; estradiol response
	“80426”	Gonadotropin releasing hormone stimulation panel
	“81099”	Unlisted urinalysis procedure
	“82075”	Alcohol, breath
	“82757”	Fructose, semen
	“83727”	Luteinizing releasing factor (LRH)
	“84830”	Ovulation tests, by visual color comparison methods for human luteinizing hormone
	“84999”	Unlisted chemistry procedure
	“86077”	Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report
	“86910”	Blood typing, for paternity testing, per individual; ABO Rh and MN
	“86911”	Blood typing, for paternity testing, per individual; ABO Rh and MN, each additional antigen system
	“87001”	Animal inoculation, small animal; with observation
	“87003”	e
	“88000” to “88099”	Codes for anatomic pathology, postmortem Examination
	“89250” to “89300”, “89325” to “8998 ”	Codes for reproductive medicine procedures
HCPCS Codes	“S3890”	DNA analysis, fecal, for colorectal cancer screening
	“P2028” to “P2038”	Chemistry and Toxicology Tests “considered obsolete”
	“P9603”	Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient; prorated miles actually travelled.
	“P9604”	Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient; prorated trip charge.

Notes:

Venipuncture is a covered billable service when the following conditions are met:

1. For providers billing on a CMS 1500 with Place of Service 11 (Office), 12 (Home), 20 (Urgent Care Center) or 81 (Independent Lab)
2. When laboratory services are not billed on the same date of service by the same provider
3. CPT code 36416, collection of capillary blood specimen, is not a payable service



For further information on amniocentesis procedures see Maternity Services benefit coverage summary.

Publication Date:

9/1/2010

Revision Date:

10/8/2010; 9/1/2011