Select Health

CODING/REIMBURSEMENT POLICY

DIAGNOSTIC LABORATORY AND GENETIC TEST

Policy # CR-100

Implementation Date: 11/1/25
Review Dates:
Revision Dates:

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Scope

This scope includes codes billed from the following sections in the 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)

Inclusion within the scope of this policy does not imply all codes are covered and/or reimbursable.

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Billing Requirements

All providers billing for laboratory services must include standard, complete information on the claim, or claim 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 part of an inpatient hospital stay.

Coding Requirements

Coding must be consistent with AMA coding guidelines and the National Correct Coding Initiative (NCCI) manual:

- 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 a Multianalyte Algorithmic Assay (MAAA) code, the PLA/MAAA code must be used to bill for the service.
- Proprietary codes may be used to bill 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.
    - Per the NCCI Manual, Chapter 10, Section F-8, if one laboratory procedure evaluates multiple genes using a next generation sequencing procedure, the laboratory shall report only one unit of service of one genomic sequencing procedure code.
    - 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.
- Only one unit of the miscellaneous, non-specific codes 81479 and 81599 may be billed per test.
- Codes may be used when the date of service falls after the listed effective date and prior to the date of retirement.
- Modifiers 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

- All providers billing for laboratory services must bill according to the recommendations of the National Correct Coding Initiative (NCCI) manual, or claims may be denied:
- If a code(s) falls under a NCCI PTP edit, the code must be billed in alignment with the edit. PTP edits prohibit certain codes from being billed in presence of other codes as they are "mutually exclusive procedures."
- If a code(s) falls under an NCCI PTP 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 MUE, the units billed must not exceed the maximum units of service (UOS) defined. Per the NCCI Manual, the MUE defines the maximum 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 MUEs.

Genetic Testing Requirements

- For genetic and molecular testing (tests coded with 81105−81479, 81490−81599, select PLA codes), all providers must follow these additional requirements when submitting claims or prior authorization requests:
    - ● Register on the Concert website (https://app.concertgenetics.com) to:
        - Verify accuracy of the lab’s genetic test catalog
        - Access Concert GTUs
        - Complete a brief quality profile
- Bill for services according to the Concert coding engine standards.
- To support accurate and timely payment of your claim:
    - For non-specific codes (e.g. 81479), a procedure description is required, with use of the Concert GTU being strongly recommended (e.g. “GTU-6V98G” or “6V98G”).
    - For all other codes impacted by this policy, including the Concert GTU in the procedure description is recommended.
- All providers requesting prior authorization for genetic and molecular testing services are required to add the appropriate Concert GTU descriptor to all prior authorization requests.

SELECT HEALTH MEDICARE (CMS)

Select Health Medicare will follow the commercial plan policy.

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care will follow the commercial plan policy.

Sources

1. American Medical Association. CPT® Code Book. Last updated: April 2024.
2. Centers for Medicare and Medicaid Services, “NCCI Policy Manual, Chapter 10.” https://www.cms.gov/ncci-medicare/medicare-ncci-policy-manual
3. 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
4. Centers for Medicare and Medicaid Services, “Medically Unlikely Edits.” https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html
5. 2023 Medicare NCCI FAQ Library. https://www.cms.gov/ncci-medicare/medicare-ncci-faq-library

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member’s individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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Members may contact Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Select Health Provider Relations at **801-442-3692**.