Washington State Department of
Labor & Industries
Workers' Compensation Services

Payment Policies for Healthcare Services
Provided to Injured Workers and Crime Victims

Chapter 22: Pathology and Laboratory Services

Effective July 1, 2015

Link: Look for possible **updates and corrections** to these payment policies at:

http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2015/

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Definitions

- **CPT® code modifier mentioned in this chapter:**

  –91 Repeat clinical diagnostic laboratory test

  Performed on the same day to obtain subsequent report test value(s). **Modifier –91** must be used when repeat tests are performed on the same day, by the same provider to obtain reportable test values with separate specimens taken at different times, only when it is necessary to obtain multiple results in the course of treatment. When billing for a repeat test, use **modifier –91** with the appropriate procedure code.

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Payment policy: Bloodborne pathogens

Prior authorization

The insurer may pay for post exposure treatment whenever an injury or probable exposure occurs and there is a potential exposure to an infectious disease.

Authorization of treatment in cases of probable exposure (not injury) doesn't bind the insurer to allowing a claim later.

The exposed worker must submit an accident report form before the insurer can pay for testing and treatment.

Services that can be billed

Diagnostic test or procedure

For diagnostic tests and procedures, the following CPT® codes can be billed:

- **47100**,
- **81370-81383**
- **86689**,
- **86701**,
- **86704**,
- **86706**,
- **86803-86804**,
- **87340**,
- **87390**,
- **87521-87522**,
- **87901**, and
- **87903-87904**.

Testing related procedure

For testing related procedures, the following CPT® codes can be billed:

- **78725**,
- **86360**,
- **87536**,
- **80076,**
- **90371**,
- **90746** (adult),
- **90772-90779**,
- **99201-99215**, *and*
- **99217-99220**.

Treating a reaction to testing or treatment of an exposure

The insurer will allow a claim and applicable accident fund benefits when a worker has a reaction to covered treatment for a probable exposure.

Covered test protocols

Testing schedule

Testing for hepatitis B, hepatitis C, and HIV should be done:

- At the time of exposure, *and*
- At 3, 6, and 12 months post exposure.

Hepatitis B

For hepatitis B (HBV), the following test protocols are covered:

- HbsAg (hepatitis B surface antigen),
- Anti-HBc or HBc-Ab (antibody to hepatitis B core antigen), *and*
- Anti-HBs or HBs-Ab (antibody to hepatitis B surface antigen).

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Note: Treatment with hepatitis B immune globulin (HBIG) and the hepatitis B vaccine may be appropriate for post exposure prophylaxis.

Hepatitis C

For hepatitis C (HCV), the following test protocols are covered:

- Enzyme Immunoassay (EIA),
- Recombinant Immunoblot Assay (RIBA), *and*
- Strip Immunoblot Assay (SIA).

Note: The qualitative reverse transcriptase polymerase chain reaction (RT-PCR) test is the only way to determine whether or not one has active HCV.

The following tests are covered services **only if HCV is an accepted condition** on the claim:

- Quantitative reverse transcriptase polymerase chain reaction (RT-PCR),
- Branched chain DNA (bDNA),
- Genotyping, *and*
- Liver biopsy.

HIV

For HIV, two blood tests are needed to verify the presence of HIV in blood:

- Rapid HIV or EIA test, *and*
- Western Blot test to confirm seropositive status.

The following tests are used to determine the presence of HIV in blood:

- Rapid HIV test,
- EIA test,
- Western Blot test, *and*

- Immunofluorescent antibody.

The following tests are covered services **only if HIV is an accepted condition** on the claim:

- HIV antiretroviral drug resistance testing,
- Blood count, kidney, and liver function tests,
- CD4 count, *and*
- Viral load testing.

Note: When a possible exposure to HIV occurs, the insurer will pay for chemoprophylaxis treatment in accordance with the most recent Public Health Services (PHS) Guidelines. **Prior authorization isn't required**.

When chemoprophylaxis is administered, the insurer will pay at baseline and periodically during drug treatment for drug toxicity monitoring including:

- Complete blood count, *and*
- Renal and hepatic chemical function tests.

Covered bloodborne pathogen treatment regimens

Chronic hepatitis B

For chronic hepatitis B (HBV):

- Interferon alfa-2b, *and*
- Lamivudine.

Hepatitis C

For hepatitis C (HCV) – acute:

- Mono therapy, *and*
- Combination therapy.

HIV/AIDS

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For HIV/AIDS, covered services are limited to those within the most recent guidelines issued by the HIV/AIDS Treatment Information Service (ATIS).

Link: The ATIS guidelines are available on the web at: http://aidsinfo.nih.gov/.

Payment policy: Drug screens

Services that can be billed

The insurer will pay for:

- Drug screening conducted in the office setting by a laboratory with a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver, *and*
- Confirmation testing performed at a laboratory not requiring a CLIA certificate of waiver.

Effective January 1, 2015, the department will pay for drug screening using the following HCPCS codes:

- G6058 (Drug confirmation, each procedure),
- **G0431** (Drug screen, qualitative; single drug class method – for example, immunoassay, enzyme assay – each drug class), *and*
- **G0434** (Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter).

Note: Also see Payment limits on these codes, below.

Payment limits

HCPCS billing codes **G0431 and G6058** are only payable to laboratories that don't require a CLIA certificate of waiver.

HCPCS billing code **G0434** is limited to one unit per day per patient encounter regardless of the CLIA status of the laboratory.

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Payment policy: Non-CLIA Waived Testing

Requirements for billing

Complex or moderately complex clinical pathology procedures that arn't waived under the Clinical Laboratory Improvement Act (CLIA) must be performed in laboratories that are accredited or have a categorized status under the State Department of Health or equivalent accrediting body.

Payment limits

Payment for complex and moderately complex clinical pathology procedures won't be paid to any provider that only has a CLIA certificate of waiver or the Provider Performed Microscopic Procedure certificate.

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Payment policy: Panel tests

Services that can be billed

Automated multichannel tests

When billing for panels containing automated multichannel tests, performing providers may bill either the panel code or individual test codes, but not both.

The following tests (CPT® codes) are automated multichannel tests or panels comprised solely of automated multichannel tests:

- **80048**,
- **80051**,
- **80053**,
- **80069**,
- **80076**,
- **82040**,
- **82247-82248**,
- **82310**,
- **82374**,
- **82435**,
- **82465**,
- **82550**,
- **82565**,
- **82947**,
- **82977**,
- **83615**,
- **84075**,
- **84100**,

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- **84132**,
- **84155**,
- **84295**,
- **84450**,
- **84460**,
- **84478**,
- **84520**, *and*
- **84550**.

Additional information: How to calculate payments

Automated tests

The automated individual and panel tests above are paid based on the total number of unduplicated automated multichannel tests performed per day per patient.

Calculate the payment using the following steps:

- When a panel is performed, the CPT® codes for each test within the panel are determined, *then*
- The CPT® codes for each test in the panel are compared to any individual tests billed separately for that day, *then*
- Any duplicated tests are denied, *then*
- The total number of remaining unduplicated automated tests is counted.

To determine the payable fee based on the total number of unduplicated automated tests performed, see the following table:

If the **number of unduplicated automated tests performed** is…	Then the **fee** is:
1 test	Lesser of the single test or **$9.94**.
2 tests	$9.93
3-12 tests	$12.17
13-16 tests	$16.25

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If the **number of unduplicated automated tests performed** is…	Then the **fee** is:
17-18 tests	$18.21
19 tests	$21.10
20 tests	$21.74
21 tests	$22.46
22-23 tests	$23.11

Panels with automated and nonautomated tests

When panels are comprised of both automated multichannel tests and individual nonautomated tests, they are priced based on the:

- Automated multichannel test fee based on the number of tests, *added to*
- Sum of the fee(s) for the individual nonautomated test(s).

For example, CPT® code **80061 i**s comprised of 2 automated multichannel tests and 1 nonautomated test. As shown in the table below, the fee for **80061** is **$25.53.**

If the **CPT® 80061 component tests** is:	And the **number of automated tests** is…	Then the **maximum fee** is:
Automated: CPT® **82465** and CPT® **84478**	2	Automated: **$9.93**
Non-automated: CPT® **83718**	n/a	Nonautomated: **$15.60**
Maximum payment for CPT® code 80061:		**$25.53**

Multiple panels

When multiple panels are billed or when a panel and individual tests are billed for the same date of service for the same patient, payment will be **limited to the total fee allowed for the unduplicated component tests**.

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The table below shows how to calculate the maximum payment when:

- **Panel codes 80050, 80061**, and **80076** *are billed with*
- **Individual test codes 82977, 83615, 84439**, and **85025**.

Test type	CPT® panel codes			Individual tests	Test count	Max fee
	80050	80061	80076			
Automated tests	82040, 82247, 82310, 82374, 82435, 82565, 82947, 84075, 84132, 84155, 84295, 84450, 84460, *and* 84520	82465 and 84478	82248 + these duplicated tests: 82040, 82247, 84075, 84155, 84450, *and* 84460	82977 83615	= **19** unduplicated automated tests (Note the fee in previous table on fees for automated tests)	**$21.10**
	84443	—	—	—	—	**$31.89**
	85025 *or* 85027 and 85004 *or* 85027 and 85007 *or* 85027 and 85009	—	—	—	—	**$14.81**
	83718	—	—	—	—	**$15.60**
	—	—	—	84439	—	**$16.66**
Non-automated tests	—	—	—	85025 *or* 85027 and 85004 *or* 85027 and 85007 *or* 85027 and duplicated test 85009	—	**$0.00**
					Maximum payment:	**$100.06**

Payment policy: Repeat tests

Requirements for billing

Additional payment is allowed for repeat test(s) performed for the same patient on the same day. However, a specimen(s) **must be taken** from separate encounters. Also, the medical necessity for repeating the test(s) **must be documented** in the patient's record.

When billing, **modifier –91** must be used to identify the repeated test(s).

Note: Payment for repeat panel tests or individual components tests will be made based on the methodology described in the Panel Tests payment policy section of this chapter (above).

Payment limits

Test(s) normally performed in a series (for example, glucose tolerance tests or repeat testing of abnormal results) don't qualify as separate encounters.

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Payment policy: Specimen collection and handling

Who must perform these services to qualify for payment

The fee for billed specimen collection services is payable only to the provider who actually draws the specimen.

Payment for the specimen may be made to nursing homes or skilled nursing facilities when an employee qualified to do specimen collection performs the draw.

Services that can be billed

Specimen collection

Complex vascular injection procedures, such as arterial punctures and venisections, aren't subject to this policy and will be paid with the appropriate CPT® or HCPCS billing codes.

Travel

Travel will be paid in addition to the specimen collection fee when all of the following conditions are met:

- It is medically necessary for a provider to draw a specimen from a nursing home, skilled nursing facility, or homebound patient, *and*
- The provider personally draws the specimen, *and*
- The trip is solely for collecting the specimen.

Note: Also see Services that aren't covered and Payment limits, below.

Services that aren't covered

Specimen collection

Specimen collection performed by patients in their homes isn't paid (such as stool sample collection).

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Travel

HCPCS code **P9604** (Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient, prorated trip charge) isn't covered.

Requirements for billing

Specimen collection

Use HCPCS billing codes:

- **P9612**, which is for "Catheterization for collection of specimen, single patient, all places of service," *and*
- **P9615**, which is for "Catheterization for collection of specimen(s) multiple patient(s)."

For venipuncture, use CPT® billing code **36415**.

Travel

To bill for actual mileage, use HCPCS code **P9603** (1 unit equals 1 mile).

Note: Also see information about travel in Services that can be billed, above, and Payment limits, below.

Payment limits

Specimen collection

Costs for media, labor, and supplies (for example, gloves, slides, antiseptics, etc.) are included in the specimen collection.

Note: Payment for performing the test is separate from the specimen collection fee.

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A collection fee isn't allowed when the cost of collecting the specimen(s) is minimal, such as:

- A throat culture, *or*
- Pap smear, *or*
- A routine capillary puncture for clotting or bleeding time.

Handling

Handling and conveyance won't be paid (for example, shipping, messenger, or courier service of specimen(s). This includes preparation and handling of specimen(s) for shipping to a reference laboratory. These are integral to the process and are bundled into the total fee for testing service.

Travel

Travel won't be paid to nursing home or skilled nursing facility staff that performs specimen collection.

If the specimen draw is incidental to other services, no travel is payable.

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Payment policy: Stat lab fees

Services that can be billed

Usual laboratory services are covered under the Professional Services Fee Schedule.

Link: The fee schedule is available on L&I's website at http://feeschedules.Lni.wa.gov.

When lab tests are appropriately performed on a STAT basis, the provider may bill HCPCS codes **S3600** or **S3601**.

Requirements for billing

Tests ordered STAT should be limited only to those needed to manage the patient in a true emergency situation. Also:

- The medical record must reflect the medical necessity and urgency of the service, *and*
- The laboratory report should contain the name of the provider who ordered the STAT test(s).

Note: Payment is limited to one (1) STAT charge per episode (not once per test).

Payment limits

The STAT charge will **only be paid with these tests**:

- HCPCS code **G0306** (Complete CBC, auto w/diff), *or*
- HCPCS code **G0307** (Complete CBC, auto), *or*
- HCPCS code **G0431** (Drug screen, single class), *or*
- HCPCS code **G0434** (Drug screen, multi drug class), *or*

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… with these CPT® billing codes:								
80047	80184	81003	82435	83874	84520	85049	86880	87210
80048	80185	81005	82550	83880	84550	85378	86900	87281
80051	80188	82009	82565	84100	84702	85380	86901	87327
80069	80192	82040	82803	84132	84704	85384	86902	87400
80076	80194	82150	82945	84155	85004	85396	86920	89051
80156	80197	82247	82947	84157	85007	85610	86921	
80162	80198	82248	83615	84295	85025	85730	86922	
80164	81000	82310	83663	84450	85027	86308	86923	
80170	81001	82330	83664	84484	85032	86367	86971	
80178	81002	82374	83735	84512	85046	86403	87205	

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-125
AIDS Treatment Intervention Service (ATIS) guidelines	National Institute of Health (NIH) website: http://aidsinfo.nih.gov/
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare services (including pathology and laboratory services)	L&I's website: http://feeschedules.Lni.wa.gov

- **Need more help?** Call L&I's Provider Hotline at **1-800-848-0811.**

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