moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM012
Policy Title:	Routine Venipuncture and/or Collection of Specimens		
Section:	Laboratory & Pathology	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	1/1/2000	Initially Published:	7/22/2011
Last Updated:	2/14/2024	Last Reviewed:	2/14/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:	2/14/2024		

Reimbursement Guidelines

A. General Policies for All Settings

CPT codes 36400 - 36410 are for venipuncture but are "not to be used for routine venipuncture."

1. The code descriptions specify the work of the venipuncture is performed by and requires the skill of a physician or other qualified health care professional. (AMA[8, 10, 11]) This is a key factor in distinguishing routine venipuncture from a more extensive, non-routine venipuncture.
   a. "Requires the skill" means that routine venipuncture by clinical staff was attempted and not successful.
   b. It is not appropriate to report codes 36400 - 36410 if the physician performs the venipuncture merely because the nurse, phlebotomist, or other clinical staff is unavailable to perform the service. (AMA[8, 10, 11])
2. These procedure codes may not be reported if the blood collection is performed by clinical staff such as a phlebotomist, the IV team, specially trained nurses, etc.

B. For Professional and Clinical Laboratory Services (including Dialysis Centers and Home Health):

Venipuncture or collecting a capillary blood specimen are the most common methods used to obtain blood samples for blood or serum lab procedures. The work of obtaining the specimen sample is an essential part of performing the test.

In most cases, reimbursement for routine venipuncture or a capillary blood specimen is included in the reimbursement for the lab test procedure code; see below for more details.

1. CPT Code 36415
    a. For Medicare Advantage:

        36415 is eligible for separate reimbursement, consistent with Original Medicare payment policy.

    b. For all other lines of business, the following policies apply:

        i. CPT 36415 is only eligible to be billed once per patient encounter (CMS[4]), even when multiple specimens are drawn or when multiple sites are accessed to obtain an adequate specimen size for the desired test(s).

            A note about MUE limits:
            The CMS MUE limit for 36415 is 2 units per date of service. This does not mean that more than one unit may be billed per patient encounter, or that a second venipuncture may be reported when a redraw is needed for an inadequate specimen. Rather, it allows for the possibility of two distinct patient encounters in a single date (e.g., morning and afternoon) that are separate, unplanned, and medically necessary.

        ii. We do not allow separate reimbursement for CPT 36415 (venipuncture) when billed in conjunction with a blood or serum lab procedure performed on the same day and billed by the same provider (procedure codes in the 80048 - 89399 range). 36415 will be denied as a subset to the lab test procedure.

        iii. If some of the blood and/or serum lab procedures are performed by the provider and others are sent to an outside lab, CPT 36415 is not eligible for separate reimbursement.

        iv. Modifier 90 (reference laboratory) will not bypass the subset edit. The outside laboratory that is actually performing the test will need to bill us directly for the lab tests in order for 36415 to be separately reimbursable to the provider performing the venipuncture to obtain the specimen for the outside laboratory.

        v. The use of modifiers XS, XP, XE, XU, or 59 with 36415 when blood/serum lab tests are also billed is not a valid use of the modifier. The venipuncture is not a separate procedure in this situation.

        vi. Separate reimbursement is allowed for CPT 36415 when the only other lab services billed for that date by that provider are for specimens not obtained by venipuncture (e.g., urinalysis).

2. CPT code 36416
    a. CPT 36416 is designated as a status B code (bundled and never separately reimbursed) on the Physician Fee Schedule RBRVU file. Clinical edits will deny CPT code 36416 to provider responsibility. This applies whether 36416 is billed with another code or as the sole service for that date. This edit is not eligible for a modifier bypass.

b. Denial explanation codes include:

   i. WGO *(Service/supply is considered incidental and no separate payment can be made. Payment is always bundled into a related service)*

   ii. z39 (This claim line is being disallowed because the procedure code has no Medicare relative value unit and may be considered incidental.)

c. 835 CARC/RARC denial combination:

CARC 97	(*The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.*)
RARC M15	(*Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.*)

3. CPT codes 36591 and 36592

   a. CPT codes 36591 and 36592 are eligible for separate reimbursement only under very limited and specific circumstances.

      i. The CPT book includes parenthetical guidelines below these codes which state: "(Do not report 36591 [or 36592] in conjunction with other services except a laboratory service.)" (AMA[8, 9])

      ii. Under CMS guidelines, CPT 36591 and 36592 are designated as status T codes on the Physician Fee Schedule RBRVU file. Status T is defined as "There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made."

   b. CPT codes 36591 or 36592 will be denied when reported in conjunction with other non-laboratory services. This may be identified by clinical edits or by coding-to-records review. The denial is not eligible for a modifier bypass.

      i. For example:

         CPT codes 36591 and 36592 may not be submitted in combination with chemotherapy services. The collection of the blood sample is included in the reimbursement for the chemotherapy administration service and may not be separately reported on the claim. This limitation applies to both the professional services and facility claims.

      ii. Denial explanation codes include:

         1) WGT *(Bundled or incidental service/supply. Not eligible for separate payment, per CPT and/or CMS guidelines.)*

         2) 771 (*Claim review results. Item(s)/services identified as not eligible to be separately reported or never eligible for separate reimbursement.*)

         3) u10 (*Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.*)

iii. 835 CARC/RARC denial combinations:

CARC 97	(*The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.*)
RARC N390	(*This service/report cannot be billed separately.*)

CARC 97	(*The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.*)
RARC M15	(*Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.*)

4. Point of Care Testing & Obtaining Samples
   a. Point of care (POC) testing and obtaining specimen samples for POC testing is not separately reimbursable.
   b. Point of care testing includes but is not limited to:
      i. Urine dip stick
      ii. Glucometry testing
      iii. Mobile computer devices such as, but not limited to, those used for the analysis of blood gases, electrolytes, metabolites and urinary retention
      iv. Obtaining samples from existing lines or insertion of peripheral IV lines

5. Handling fees, CPT codes 99000 and 99001
   a. CPT codes 99000 and 99001 are designated as status B codes (bundled and never separately reimbursed) on the Physician Fee Schedule RBRVU file.
   b. Clinical edits will deny CPT 99000 or 99001, whether 99000 or 99001 is billed with another code or as the sole service for that date. This edit is not eligible for a modifier bypass.
   c. Denial explanation codes:
      i. WGO *(Service/supply is considered incidental and no separate payment can be made. Payment is always bundled into a related service)*
      ii. z39 *(This procedure code or service is a status B or otherwise considered Bundled, and is not eligible for separate reimbursement.)*
   d. 835 CARC/RARC denial combination:

CARC 97	(*The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.*)
RARC M15	(*Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.*)

C. For Ambulatory Surgery Centers (ASC):

Per CMS policy, routine venipuncture or other routine collection of specimens, if needed, is not separately reimbursable to ASCs. These services are included in the packaged reimbursement for the primary procedure or service.

D. For Outpatient Hospital Services:

The CMS OPPS Medically Unlikely Edit (MUE) limits apply for routine venipuncture procedure codes or other routine collection of specimens.

E. For Inpatient Hospital Services:

A maximum of one collection fee (any procedure code) is allowed per specimen type (venous blood, arterial blood) per date of service, per CMS policy. (CMS[4, 5, 6, 7]) Specimen collections out of an existing line (e.g., arterial line, CVP line, port, etc.) are not separately reimbursable.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
ASC	=	Ambulatory Surgery Center
CARC	=	Claim Adjustment Reason Code
CCI	=	Correct Coding Initiative (see “NCCI”)
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
CVP	=	Central Venous Pressure
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
IV	=	Intravenous
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
MUE	=	Medically Unlikely Edit (a type of NCCI edit)
NCCI	=	National Correct Coding Initiative (aka “CCI”)
OPPS	=	Outpatient Prospective Payment System
POC	=	Point of care
POCT	=	Point of care testing

Acronym or Abbreviation		Definition
RARC	=	Remittance Advice Remark Code
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	=	Relative Value Unit
UB	=	Uniform Bill

Definition of Terms

Term	Definition
Clinical Staff	A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a professional service, but who does not individually report that professional service. Other policies may also affect who may report specific services. (AMA[8, 10, 11])
Other Qualified Health Care Professional	An "other qualified health care professional" is an individual who not a physician but is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." (AMA[8, 10, 11])
Physician	A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." (AMA[8, 11])
Point Of Care Testing	Point-of-Care Testing (POCT) is defined as laboratory testing conducted close to the site of patient care, typically by clinical personnel whose primary training is not in the clinical laboratory sciences, or by patients (self-testing). POCT refers to any testing conducted outside a main, central, or core laboratory setting. Other common terms for POCT are ancillary, bedside, decentralized, near-patient, patient-focused, peripheral, portable, and satellite testing. (Wild[7])

Procedure codes (CPT & HCPCS):

Code	Code Description
36400	Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein
36405	Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; scalp vein

Code	Code Description
36406	Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; other vein
36410	Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)
36415	Collection of venous blood by venipuncture
36416	Collection of capillary blood specimen (eg, finger, heel, ear stick)
36500	Venous catheterization for selective organ blood sampling
36591	Collection of blood specimen from a completely implantable venous access device
36592	Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified
75893	Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation
99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory
99001	Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory (distance may be indicated)

Modifier Definitions:

Modifier	Modifier Description & Definition	Comments
59	**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same day, see modifier 25.	Not valid for venipuncture with blood/serum lab tests.

Modifier	Modifier Description & Definition	Comments
90	**Reference (Outside) Laboratory:** When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.	Will not bypass the denial of venipuncture for blood or serum tests.
XE	Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter	Not valid for venipuncture with blood/serum lab tests.
XS	Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure	Not valid for venipuncture with blood/serum lab tests.
XP	Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner	Not valid for venipuncture with blood/serum lab tests.
XU	Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service	Not valid for venipuncture with blood/serum lab tests.

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

When existing vascular access lines or selectively placed catheters are utilized to procure arterial or venous samples, reporting the sample collection separately is inappropriate. (CMS[3])

CPT codes 36500 or 75893 may occasionally be appropriate if more extensive work beyond routine venipuncture is required. For instance, if a physician needs to place a catheter to obtain a blood specimen from a specific organ or location. CPT codes 36500 (venous catheterization for selective organ blood sampling) or 75893 (venous sampling through catheter with or without angiography...) may be reported for venous blood sampling through a catheter placed for the sole purpose of venous blood sampling. CPT code 75893 includes concomitant venography if performed. (CMS[3])

If a catheter is placed for a purpose other than venous blood sampling with or without venography (CPT code 75893), it is a misuse of CPT codes 36500 or 75893 to report them in addition to CPT codes for the other venous procedure(s). CPT codes 36500 or 75893 should not be reported for blood sampling during an arterial procedure. (CMS[3])

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. (CMS[4])

"(Do not report 36591 in conjunction with other services except a laboratory service.)" (AMA[5])

"(Do not report 36592 in conjunction with other services except a laboratory service.)" (AMA[6])

"***Question***

My physician performs a venipuncture for a patient after a previous attempt by an RN to access the vessel was unsuccessful. Should code 36410, Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture., be used to identify this service?

AMA Comment

Code 36410 would be reported if a routine venipuncture, usually performed, for example, by a nurse or phlebotomist, is unsuccessful and the skill of the physician is required to perform the procedure. In this case, it is no longer a routine venipuncture. It would not be appropriate to report code 36410 if the physician performs the venipuncture merely because the nurse, phlebotomist, or other health professional is unavailable to perform the service." (AMA[9])

Cross References

A. "Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service." Moda Health Reimbursement Policy Manual, RPM027.

B. "Reference (Outside) Laboratory -- Modifier 90." Moda Health Reimbursement Policy Manual, RPM045.

References & Resources

1. Facets system-supplied Clinical Editing Resource Guide, 2013.
2. CMS. Medicare Physician Fee Schedule Database.
3. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 5 Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems, § D, 13, p V-13.
4. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 16 – Laboratory Services, §60.1.
5. AMA. *Current Procedural Terminology (CPT)*. Chicago: AMA Press. Guidelines in parenthesis directly under CPT code 36591.
6. AMA. *Current Procedural Terminology (CPT)*. Chicago: AMA Press. Guidelines in parenthesis directly under CPT code 36592.
7. Wild, David G., Editor *The Immunoassay Handbook (Fourth Edition)*. Chapter 6.3 - Point-of-Care Testing. Elsevier, 2013. p. 455. ISBN 9780080970370. https://www.sciencedirect.com/science/article/pii/B9780080970370000312 .
8. AMA. "Instructions for Use of the CPT Codebook." *Current Procedural Terminology (CPT)*. Chicago: AMA Press. Introduction. Page xiv (new or revised text in 2023 edition).
9. AMA. **"**Coding Consultation: Venipuncture.", CPT Assistant, May 2001, page 11.
10. AMA. "Frequently Asked Questions, Introduction." CPT Assistant, May 2015, pp. 10-11.

11. AMA. "Reporting CPT Codes for Oncology Navigation Services: The Cancer Moonshot℠." CPT Assistant, Special Edition, November Update 2023. pp. 1-11.

Background Information

Venipuncture or phlebotomy is the puncture of a vein with a needle or an IV catheter to withdraw blood. Venipuncture is the most common method used to obtain blood samples for blood or serum lab procedures and is sometimes referred to as a "blood draw."

Collection of a capillary blood specimen (36416) or of venous blood from an existing access line or by venipuncture that does not require a physician's skill or a cutdown is considered "routine venipuncture."

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
2/14/2024	Clarification/Update: Corrected footnote numbering (#11 was cited but not listed in References & Resources). Definition of Terms: Slight clarification of "Other Qualified Health Care Professional" definition. References & Resources: Added 2 entries. Minor rewording without meaning or content changes.

Date	Summary of Update
6/14/2023	Clarification/Update: Clarified limits for 36415 per encounter and per date of service. Cross References: Links added.
10/18/2022	Clarification/Update: Change to new header. Idaho added. Section A: Added information for 36400 – 36410. Definition of Terms table added. Modifier table: Added. Coding Guidelines & Sources: 1 quote added. Cross References: 2 entries added. References & Resources: 3 entries removed (Noridian Ask the Contractor Teleconference February 12, 2009 Q#10, November 12, 2009 Q#17, & August 13, 2009 Q#10). These are no longer available on the Noridian website, and there is no record of the content of the questions and answers related to routine venipuncture which they contained. Entries # 8 & 9 are renumbered to now become # 5 & 6. 3 entries added. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
7/22/2011	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
Prior to 1/1/2000	Original Effective Date (with or without formal documentation). Policy based on clinical editing bundling rationale in claims processing system & administrative decision by Claims Management.