JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.015
		Effective Date	09/24/2024
		Approval Date	04/20/2023
	Subject **Routine Venipuncture and/or Collection of Specimens**	*Supersedes Date*	07/19/2023
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This document applies to the following Participating Organizations:

EHP	Johns Hopkins Advantage MD	Priority Partners	US Family Health Plan

Keywords: Laboratory, Reimbursement, Specimen Collection, Venipuncture

I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/ billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

To provide basic reimbursement guidance on venipuncture and or the collection of specimens, services for both participating and nonparticipating providers who submit claims to JHHP. Providers must bill for the reimbursement of services that are within the provider's scope of practice under state and federal law. Each line of business possesses its own unique contract and

guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

III. POLICY STATEMENT

JHHP has identified CPT/HCPCS codes that are not payable, not covered, or bundled (not separately reimbursed) which are applicable to this policy. Claims submitted for venipuncture or specimen collection services are reimbursed in accordance with CMS, State, and American Medical Association (AMA) Current Procedural Terminology (CPT) guidelines. Each line of business possesses its own unique guidelines for benefit and payment purposes. As such, JHHP will align with regulatory, state and federal guidance to identify physician and non-physician services that are eligible as reimbursable or non-reimbursable, as applicable to the member's plan.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. GENERAL BILLING GUIDELINES FOR VENIPUNCTURE and SPECIMEN COLLECTION SERVICES

1. Consistent with CMS, regardless of the number of blood specimens drawn, only one venipuncture collection fee will be allowed, per day.
2. JHHP follows the "first in, first out" logic and will only reimburse one venipuncture service per day, regardless of the number of draws performed by the same provider/group.
3. A venipuncture procedure may be paid for when an Evaluation and Management (E/M) service is billed during the same encounter, under limited circumstances.
4. Providers who bill for clinical laboratory services are required to report their valid federal Clinical Laboratory Improvement Amendments (CLIA) certificate identification number, on the claim form, in order to be eligible for reimbursement.
5. In accordance with CMS, for services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.
   - Refer to the JHHP National Provider Identifier (NPI) policy for additional information.
6. The diagnosis code(s) must be included on the corresponding claim line(s) that best describes the patient's condition for which the venipuncture service was performed.
7. NCCI and Medically Unlikely Edits (MUEs) are applicable to this policy and will be utilized to prevent payment for a potentially inappropriate number/quantity of the same service on a single day.
   - Refer to the JHHP reimbursement policy on NCCI and MUE Edits policy for coding guidance and additional information.
8. CPT 36415 is only eligible for reimbursement when it is billed once, even when multiple specimens are drawn or when multiple sites are accessed to obtain an adequate specimen size for the desired test(s).
9. JHHP may allow separate reimbursement for CPT 36415 when other lab services provided and billed for that same date of service, by the same provider, are for specimens not obtained by venipuncture (e.g. urinalysis, sputum culture).
   - Example: *A provider performs venipuncture during an office visit and sends the specimen to an outside laboratory for testing. Since no testing of that sample was performed in the office, the venipuncture will be reimbursed to the provider who collected the specimen, and not the laboratory.*
10. Venipuncture and other central venous access for the collection of specimens are considered incidental to the blood or serum laboratory service.

11. When CPT 36591 is billed with CPT 36592, CPT code 36592 will be the only venipuncture code eligible for reimbursement.
12. HCPCS code G0471 is for the collection of venous blood by venipuncture or urine sample by catheterization from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA) and only reimbursed in certain situations.
    - Refer to Medicare Claims Processing Manual Chapter 16 - Laboratory Services guidance regarding specimen collection for individuals in a SNF or HHA.

V. INAPPROPRIATE BILLING of SERVICES

1. In accordance with CPT guidance, codes 36400-36410 describe venipuncture procedures necessitating the skill of a physician or other qualified healthcare professional, not to be used for routine venipuncture. As such, it is not appropriate for a physician, or other qualified healthcare professional, to perform the venipuncture and bill for one of these services because a clinical staff member is unavailable to perform the service for them.
2. CPT 36416 is never eligible for payment or separate reimbursement, and no modifier will exempt CPT 36416 from bundling into CPT code 36415.
3. When submitting a claim for a venipuncture performed during the same encounter as a blood/serum lab test, it is inappropriate to append Modifiers XS, XP, XE, XU, 59, 90 or 91 to the claim line, as the venipuncture is not considered a separate procedure in this situation.
    - Example: *Provider performs a venipuncture service in the office and tests the specimen they collected, in this scenario, the venipuncture is not considered a separate and significant procedure. Therefore, CPT 36415 will not be reimbursed as the venipuncture is considered an integral to the lab test that was performed in the office.*
4. It is inappropriate to bill CPT 36591 and 36592 with a modifier, to bypass claim edits.
5. 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.
6. It is inappropriate to append Modifier 25 to an E/M service, when only a venipuncture is performed, as the venipuncture is not considered a significant and separately identifiable service.
7. JHHP will not reimburse providers for a venipuncture service when the provider also performs a blood laboratory service during the same encounter.
    - The collection of the blood sample is considered an integral part of the lab service and may be bundled into other blood lab services performed by the same provider.
8. JHHP will deny CPT 99000 or 99001 as incidental, and no separate payment can be made, as these codes are designated as status B codes (bundled and never separately reimbursed).
9. A collection fee will not be reimbursed to any provider who did not perform the specimen extraction.
10. Consistent with CMS, JHHC considers S9529 to be a non-reimbursable service code, and is ***not eligible*** for reimbursement. HCPCS code S9529 represents a routine venipuncture for collection of specimen(s) for a single homebound, nursing home, or skilled nursing facility patient. The code description focuses more on the place of service rather than the venipuncture service itself.
    - HCPCS code S9529 is more accurately represented by CPT® code 36415, which must be reported with the appropriate place of service code.
        - The Medicare Physician Fee Schedule (MPFS) defines S9529 as a Status “I” code (invalid; use another code for reporting of, and payment for, these services).

VI. EXCEPTIONS and EXCLUSIONS

PPMCO: Priority Partners will process and reimburse for venipuncture and/or specimen collection services in accordance to the Code of Maryland Regulations (COMAR) and Maryland Department of Health (MDH). Please consult the authoritative guidance found in these manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.

- Per MDH guidelines, HCPCS G0471 is not a covered service and is not eligible for payment.
- In alignment with MDH, JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
- Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.
    a. Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.

USFHP: JHHP will process and reimburse for venipuncture and/or specimen collection services in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional, specific information on policy, benefits, and coverage not outlined in the policy.

VII. TERMS and DEFINITIONS

Definition of Terms

Term	Definition
Evaluation and Management (E/M)	Per the CPT manual, E/M service guidelines have sections that are common to all E/M categories and sections that are category specific. These guidelines are to be used by the reporting physician or other qualified healthcare professional to select the appropriate level of service. The E/M section of the CPT® manual is divided into broad categories and further divided into sub-categories of E/M services.
Incidental Procedure	Service performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.
Physician or Other Qualified Health Care Professional (OQHCP)	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
Same Group Physician or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group who report with the same Federal Tax Identification Number (TIN).

Clinical Staff Member	A person (e.g., nurse, phlebotomist, or other health professional) 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 specific professional service, but does not individually report that professional service.
Venipuncture	The collection of blood from a vein; most often used for laboratory testing.

VIII. MODIFIERS

Modifier	**Definition**
25	Significant, separately identifiable Evaluation and Management (E/M) by the same physician or other qualified health care professional on the same day of the procedure or other service. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.
59	Distinct Procedural Service
90	Reference (Outside) Laboratory
91	Repeat clinical diagnostic laboratory test is used to report the same lab test when performed on the same patient, on the same day, to obtain subsequent test results.
XE	Separate Encounter, a service that is distinct because it occurred during a separate encounter.
XS	Separate Structure, a service that is distinct because it was performed on a separate organ/structure.
XP	Separate Practitioner, a service that is distinct because it was performed by a different practitioner.
XU	Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service.

IX. CODES

Procedure Codes (CPT® & HCPCS)

Code	Definition
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.
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 (e.g., finger, heel, ear stick).
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.
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).
G0471	Collection of venous blood by venipuncture or urine sample by catheterization from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA).
S9529	Routine venipuncture for collection of specimen(s), single home bound, nursing home, or skilled nursing facility patient.

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X. REFERENCES

This policy has been developed through consideration of the following:

- Clinical Laboratory Improvement Amendments (CLIA) | CMS
- CMS Regulations & Guidance
- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT® Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Medicare Claims Processing Manual Chapter 16 - Laboratory Services
- NCCI for Medicaid | CMS
- NCCI for Medicare | CMS
- TRICARE Policy Manual- Administration Chapter 1 Section 12.1, Healthcare Common Procedure Coding System (HCPCS) “C” And “S” Codes

XI. REVISION HISTORY

Date	Review or Revision	Reason for Modification	Approved By
9/24/2024	Review/Revision	Updated policy verbiage	Reimbursement Policy Committee (RPC)
7/19/2023	Revision	Updated policy verbiage	Reimbursement Policy Committee (RPC)
04/20/2023	New	Initial Release	Reimbursement Authorizations and Coding Committee (RAC)