REIMBURSEMENT POLICY

Genetic/Molecular Test Coding

Active

Policy Number: Laboratory/Pathology – 008
Policy Title: Genetic/Molecular Test Coding
Section: Lab-Path Services
Effective Date: 10/01/20

Description

The following policy addresses Blue Cross and Blue Shield of Minnesota's (Blue Cross) general guide for coding genetic and molecular testing services billed to Blue Cross.

Definitions

A medical or clinical laboratory is a facility equipped to perform tests on specimens obtained from a patient in order to diagnose, treat or prevent an illness. Specimens include, but are not limited to blood, other body fluids, tissue specimens and organs. A variety of tests are available that pertain to chemistries, microbiology, hematology and genetics as well as anatomic pathology that includes macroscopic or gross pathology of specimens and organs as well as microscopic pathology that encompasses cytology, histology and electron microscopy of tissue samples.

This policy applies to codes billed from the following sections in the CPT/HCPCS Manual:

- Molecular Pathology
- Genomic Sequencing Procedures and Other Molecular Multianalyte Assays
- Multianalyte Assays with Algorithmic Analyses

Policy Statement

Blue Cross requires that all providers billing for genetic and molecular testing services bill according to the coding recommendation in the Concert Genetics portal. The portal can be accessed at the following url: join.concertgenetics.com/bcbsmn

Noncompliance with this policy may result in a written notification from Blue Cross reminding provider of the requirement of this policy and any continued noncompliance may result in a denied payment or could result in termination of the provider's contract per the terms of the Provider Services Agreement.

Ordering Provider

Providers may only bill for laboratory services that are ordered by a physician or other qualified practitioner. The name of the ordering provider must be included on all claim transactions or the services may deny. Tests must be medically necessary in order to be billed and eligible for coverage.

Clinical Laboratory Improvement Amendments (CLIA) number requirements

The CLIA number must be submitted on all 837P transactions for laboratory services billed by any provider performing tests covered by CLIA. Claims submitted by providers for clinical laboratory services covered under CLIA without a valid and current CLIA certificate will be denied.

Lab Billed through the BlueCard Program

Blue Cross may contract with providers outside of their exclusive service area for services provided to local and BlueCard members within their own service area for independent clinical lab services. Providers who perform lab services should file the claim to the Blue plan where the referring physician is located. The claim will be adjudicated based on the provider's participation status with that Blue plan.

Documentation Submission

Documentation must clearly identify, and support procedures performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, Blue Cross fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement are subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event any new codes are developed over the course of the Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier: N/A

ICD Diagnosis: N/A

ICD Procedure: N/A

HCPCS: See above

Revenue Codes: N/A

Deleted Codes: N/A

Policy History

Initial Committee Approval Date: June 10, 2020
Code Update: N/A
Policy Review Date: N/A
Cross Reference: N/A