HEALTH PLAN POLICY	
Policy Title: Reimbursement Policy - Routine Venipuncture and/or Collection of Specimens	**Number:** OPC42 **Revision:** D
Department: Operations	**Sub-Department:** Claims
Applicable Lines of Business: ☐ Children's Health Insurance Plan ☒ Medicare ☐ Commercial Insured ☐ Non Insured Business ☒ Health Insurance Exchange ☐ USFHP ☐ Medicaid	
Effective Date: 03/11/2020	
Revision Date(s): 04/01/2021, 03/21/2022, 03/30/2023, 03/26/2024	

PURPOSE:

To outline routine venipuncture and/or collection of specimens policy for professional and clinical laboratory services, including home health and dialysis centers.

DEFINITIONS AND ACRONYMS:

- **Centers for Medicare & Medicaid Services (CMS)** – The federal agency responsible for administering the Medicare and Medicaid programs, as well as the federally-facilitated Marketplace.
- **Current Procedural Terminology (CPT®)** – A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT codes mentioned in this policy:
    - **CPT 36415** – Routine Venipuncture (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 (CPT 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."
    - **CPT 36416** – Collection of capillary blood specimen (e.g., finger, heel, ear stick). 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 to be "routine venipuncture."
    - **CPT 36591** – Draw blood off venous device.
    - **CPT 36592** – Collect blood from picc.
    - **CPT 99000** – Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory.
    - **CPT 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).
- **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.

POLICY:

CPT code 36415 – Routine Venipuncture

CMS lists procedure code 36415 on the Medicare Physician Fee Schedule with a procedure code status 'X'

indicating statutory exclusion. These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes and no payment may be made under the physician fee schedule.

CPT 36415 is used to report the insertion of a needle into a vein or into the skin for the purpose of withdrawing a sample of blood for analysis or testing. This procedure is a necessary step in obtaining a sample of blood for analysis and, in most cases, is performed by a technician or a nurse. CPT code 36415 is only eligible to be billed once, even when multiple specimens are drawn or when multiple sites are accessed in order to obtain an adequate specimen size for the desired test(s).

CHRISTUS Health Plan does 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. CPT code 36415 is considered to be an incidental procedure.

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.

The use of modifiers XS, XP, XE, XU, 90, 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.

CHRISTUS Health Plan does allow separate reimbursement 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).

CPT code 36416 – Collection of capillary blood specimen (e.g., finger, heel, ear stick).

CPT 36416 is designated as cpt code that is bundled and never separately reimbursed. CHRISTUS Health Plan 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.

Other code designations:

The following codes are eligible for separate reimbursement only under very limited and specific circumstances.

- CPT 36591 and 36592 are designated as status T codes on the CMS 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."
- CPT codes 36591 or 36592 will be denied when reported in conjunction with other non-laboratory services. This may be identified by CHRISTUS Health Plan clinical edits or by coding-to-records review. The denial is not eligible for a modifier bypass.
    - 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.

The following codes are not eligible for separate reimbursement.

- CPT codes 99000 and 99001 are designated as status B codes (bundled and never separately reimbursed) on the Physician Fee Schedule RBRVU file. CHRISTUS Health Plan clinical edits will deny CPT 99000 or 99001 as incidental and no separate payment can be made. Payment is always

bundled into a related service), whether 99000 or 99001 is billed with another code or as the sole service for that date.

- Routine venipuncture or other routine collection of specimens performed in an Ambulatory Surgical Center. These services are included in the packaged reimbursement for the primary procedure or service.
- Specimen collections out of an existing line (e.g. arterial line, CVP line, port, etc.).

Important Notes

Providers are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that providers are reimbursed based on the code or codes that correctly describe the health care services provided. CHRISTUS Health Plan reimbursement policies may use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for purposes of definition only and do not imply any right to reimbursement. This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms.

This policy applies to all products and all network and non-network physicians, and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals. This policy also applies to laboratories, including, but not limited to, independent, reference and referring laboratories. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy. This information is intended to serve only as a general reference resource regarding CHRISTUS Health Plan reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, CHRISTUS Health Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case.

Further, the policy does not address all issues related to reimbursement for health care services provided to CHRISTUS Health Plan enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies.

CHRISTUS Health Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

REFERENCES:

- Medicare Physician Fee Schedule
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

RELATED DOCUMENTS:

None

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REVISION HISTORY:

Revision	Date	Description of Change	Approval Committee
New	03/11/2020	Initial release.	Executive Leadership
A	04/01/2021	Annual review. No change to policy content.	Executive Leadership
B	03/21/2022	Annual review. No change to policy content.	Executive Leadership
C	03/30/2023	Annual review. No change to policy content.	Executive Leadership
D	03/26/2024	Annual review. Updated formatting and definitions.	Executive Leadership