BlueCross BlueShield of Texas

Reimbursement Policy

Policy Number: RP050	**Policy Title:** Concert Laboratory Testing Services
Approval Date: Oct. 30, 2026	**Effective Date:** Feb. 1, 2027

Policy Disclaimer

If a conflict arises between a Reimbursement Policy and any Plan document under which a member is entitled to covered services, the Plan document will govern. If a conflict arises between a reimbursement policy and any provider contract pursuant to which a provider participates in and/or provides covered services to eligible member(s) and/or plans, the provider's contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, Benefit Booklets, Summary Plan Descriptions and other coverage documents. Blue Cross and Blue Shield of Texas may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable Plan documents.

Providers are responsible for submitting accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology (CPT®) Assistant, Healthcare Common Procedure Coding System, ICD-10-CM and ICD-10-PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare & Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services and procedures billed. Claim submissions are subject to claim review, including but not limited to, any terms of benefit coverage, provider contract language, medical policies and reimbursement policies, as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Description

The Plan has implemented a claim(s) edit review process applicable to certain laboratory testing, which may include but is not limited to the following:

- Pathology and Laboratory Procedures (80000 Series CPT Codes)
- Multianalyte Assays with Algorithmic Analyses (MAAA) (M codes)
- Proprietary Lab Analysis (PLA) (U codes)
- Level II Healthcare Common Procedure Coding System (HCPCS)

Reimbursement Information

Billing and Coding

- Procedure codes are determined based on the attributes of the testing performed, not based on the member's diagnosis or clinical indication.
- If the laboratory has obtained an approved Proprietary Laboratory Analyses (PLA) code or the test has a Multianalyte Assays with Algorithmic Analyses (MAAA) code, the PLA/MAAA code must be used to bill for the service.
- If a test qualifies for panel code(s), the panel code(s) must be used.
    - The panel code would be billed when all individual tests in the panel have been performed and would not be billed separately.
    - If multiple genes are evaluated by a single procedure, the laboratory shall report only one unit of service for that code.
    - If a test evaluates multiple analytes (e.g. drugs, pathogens, metabolites, genes) using a procedure that consolidates at least one part of the testing process (e.g., tandem mass spectrometry), and an appropriate panel code exists, the laboratory shall report only one unit of service of one appropriate HCPCS, CPT, or PLA code.
    - If a code descriptor, as defined in the American Medical Associations CPT® Codebook, addresses multiple analytes, it is inappropriate to bill separately for the subcomponents of that panel code without the use of an appropriate modifier.
- If a group of tests overlaps two or more panels, providers must use the panel that incorporates the greatest number of tests and report the remaining individual tests separately.
- Only one unit of the miscellaneous, non-specific codes 81479 and 81599 may be billed per test.

- If a code(s) falls under a National Correct Coding Initiative (NCCI) Procedure-to-Procedure Code (PTP) edit, the code must be billed in alignment with the edit. PTP edits prohibit certain codes from being billed in the presence of other codes as they are "mutually exclusive procedures".
- If a code(s) falls under a NCCI PTP edit, modifiers must ONLY be used when appropriate and Modifier 59 may be used only if no other appropriate modifier describes the service.
- If a code(s) falls under a Medically Unlikely Edit (MUE), the units billed must not exceed the maximum units of service (UOS) defined.
    - Per the NCCI Manual, the MUE defines the maximum UOS reported for a HCPCS/CPT code.

Modifiers

Modifier codes should be used when billing multiple service units of a code as appropriate. This includes but is not limited to:

- Repeat testing
- Testing performed on multiple specimens
- Testing for multiple species

References

Medicare NCCI FAQ Library.

Centers for Medicare & Medicaid Services, "Medicare NCCI Procedure to Procedure (PTP) Edits"

Centers for Medicare & Medicaid Services, "Medically Unlikely Edits"

Centers for Medicare & Medicaid Services. Medicare National Correct Coding Initiative Policy Manual for Medicare Services. U.S. Department of Health & Human Services; 2026. Accessed October 21, 2026.

Centers for Medicare & Medicaid Services (2026) ICD-10-CM. Centers for Medicare & Medicaid Services. Accessed Oct. 22, 2026.

Centers for Medicare & Medicaid Services (2026). Healthcare Common Procedure Coding System (HCPCS). Accessed Oct. 21, 2026.

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Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual, Chapter 16: Laboratory Services. Pub 100-04, Revised April 17, 2026. Accessed Oct. 26, 2026.

Policy History

Approval Date	Description
10/30/2026	New Policy