Claims and Payment Policy: E&M Visits Bundled with Dipstick, Venipuncture, & Catheter Services (KY Medicaid Only)(CE019)

Policy Number: CPP-158

BACKGROUND

This policy addresses the Department for Medicaid Services (DMS) reimbursement policies pertaining to dipstick, venipuncture, and catheter laboratory services for professional provider claims submitted on a Form CMS-1500, whether performed in a provider's office, a hospital laboratory, or an independent laboratory.

Kentucky Legislative Research Commission, Section 6. Laboratory, Venipuncture, and Catheter policy: 907 KAR 3:010 states the following:

Section 6. Laboratory, Venipuncture, and Catheter

(1) Except for a service specified in paragraph (a) or (b) of this subsection, a physician laboratory service shall be reimbursed in accordance with 907 KAR 1:028.

(a) Charges for a laboratory test performed by dipstick or reagent strip or tablet in a physician's office shall be included in the office visit charge.

(b) A routine venipuncture procedure shall not be separately reimbursed if submitted with a charge for an office, hospital, or emergency room visit or in addition to a laboratory test.

(2) Reimbursement for placement of a central venous, arterial, or subclavian catheter shall be:

(a) Included in the fee for the anesthesia if performed by the anesthesiologist;

(b) Included in the fee for the surgery if performed by the surgeon; or

(c) Included in the fee for an office, hospital, or emergency room visit if performed by the same provider.

POSITION STATEMENT

In accordance with Kentucky state regulations, WellCare may deny payment of a claim if the following criteria are not met:

Criteria

Description
CPT codes 81002 and 81003 (Urinalysis by dip stick or tablet reagent) should not be paid on same claim or same vendor, member, date of service as an office visit charge. Per DMS regulation 907 KAR 3:010, "charges for a laboratory test performed by dipstick or reagent strip or tablet in a physician's office shall be included in the office visit charge."

CPT code 36415 and S9529 (routine Venipuncture/Capillary Blood Collection) should not be paid if submitted with a charge for an office visit, hospital visit, or ER visit. Per DMS regulation 907 KAR 3:010, "a routine venipuncture procedure shall not be separately reimbursed if submitted with a charge for an office, hospital, or emergency room visit or in addition to a laboratory test."
CPT code 36415 and S9529 (routine Venipuncture/Capillary Blood Collection) should not be paid if performed in addition to a lab test. Per DMS regulation 907 KAR 3:010, "a routine venipuncture procedure shall not be separately reimbursed if sub mitted with a charge for an office, hospital, or emergency room visit or in addition to a laboratory test."
CPT codes 36620, 36625, 36640, 36555-36558, 36568, 36569, 36572, 36573, 36578, 36580, 36581, and 36584 (placement of a central venous, arterial, or subclavian catheter) should not be paid separately and shall be included in the anesthesia fee if performed by the anesthesiologist. Per DMS regulation 907 KAR 3:010, "reimbursement for placement of a central venous, arterial, or subclavian catheter shall be included in the fee for anesthesia if performed by the anesthesiologist".
CPT codes 36620, 36625, 36640, 36555-36558, 36568, 36569, 36572, 36573, 36578, 36580, 36581, and 36584 (placement of a central venous, arterial, or subclavian catheter) should not be paid separately and shall be included in the surgery fee if performed by the surgeon. Per DMS regulation 907 KAR 3:010, "reimbursement for placement of a central venous, arterial, or subclavian catheter shall be included in the fee for the surgery if performed by the surgeon".
CPT codes 36620, 36625, 36640, 36555-36558, 36568, 36569, 36572, 36573, 36578, 36580, 36581, and 36584 (placement of a central venous, arterial, or subclavian catheter) should not be paid separately and shall be included in the fee for an office visit, hospital visit, or ER visit, if performed by the same provider. Per DMS regulation 907 KAR 3:010, "reimbursement for placement of a central venous, arterial, or subclavian catheter shall be included in the fee for an office, hospital, or emergency room visit if performed by the same provider". Office visit, hospital visit, and ER visit CPT codes include 99201-99499

APPEAL PROCESS

If denied, beneficiaries and/or providers may appeal to DMS/MCO per federal and state appeal statutes and regulations.

CODING & BILLING

ICD-10 CM Codes

All applicable ICD-10 CM codes deemed as medically necessary per the American Medical Association (AMA).

CPT Codes

Code	Description
36415	Collection of venous blood by venipuncture
36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older
36557	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; younger than 5 years of age
36558	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older
36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age
36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; age 5 years or older

36572	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age
36573	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older
36578	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site
36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the replacement
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous
36625	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); cutdown
36640	Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy

Define Office Visits	99201,99202,99203,99204,99205,99213,99214,99215,99381,99382,99383,99384,99385,99386,99387,99391,99392,99393,99394,99395,99396,99397

Define Hospital Visits	99217,99218,99219,99220,99221,99222,99223,99224,99225,99226,99231,99232,99233,99234,99235,99236, 99238,99239

Define ER Visits	99281,99282,99283,99284,99285

Define Critical Care Visits	99291,99292

Define Anesthesia Services	01000 - 01999

Define Surgery Services	10004-10021, 20100-29999, 30000-32999, 33016-39599, 40490-49999, 50010-53899, 56405-60699, 61000-649999, 65091-68899

Define Labs, excluding labs without venipuncture	[80000 – 89999] except the following subsets: 81000-81099.

HCPCS Codes:

Code	Description
S9529	Routine venipuncture for collection of specimen(s), single homebound, nursing home, or skilled nursing facility patient

Note: Modifier 25 is exempt for use in accordance with Kentucky Legislative Research Commission, Section 6. Laboratory, Venipuncture, and Catheter policy: 907 KAR 3:010.

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

DEFINITIONS

Catheter	A **catheter** is a thin tube made from medical grade materials serving a broad range of functions. Catheters are medical devices that can be inserted in the body to treat diseases or perform a surgical procedure. By modifying the material or adjusting the way catheters are manufactured, it is possible to tailor catheters for cardiovascular, urological, gastrointestinal, neurovascular, and ophthalmic applications. Catheters can be inserted into a body cavity, duct, or vessel. Functionally, they allow drainage, administration of fluids or gases, access by surgical instruments, and also perform a wide variety of other tasks depending on the type of catheter. The process of inserting a catheter is "catheterization". In most uses, a catheter is a thin, flexible tube ("soft" catheter) though catheters are available in varying levels of stiffness depending on the application. A catheter left inside the body, either temporarily or permanently, may be referred to as an "indwelling catheter" (for example, a peripherally inserted central catheter). A permanently inserted catheter may be referred to as a "permcath".
Dipstick	U**rine test strip** or **dipstick** is a basic diagnostic tool used to determine pathological changes in a patient's urine in standard. A standard urine test strip may comprise up to 10 different chemical pads or reagents which react (change color) when immersed in, and then removed from a urine sample. The test can often be read in as little as 60 to 120 seconds after dipping, although certain tests require longer. Routine testing of the urine with multiparameter strips is the first step in the diagnosis of a wide range of diseases. The analysis includes testing for the presence of proteins, glucose, ketones, hemoglobin, bilirubin, urobilinogen, acetone, nitrite and leucocytes as well as testing of pH and specific gravity or to test for infection by different pathogens.

Venipuncture	**Venipuncture** is the process of obtaining intravenous access for the purpose of venous blood sampling (also called *phlebotomy*) or intravenous therapy. In healthcare, this procedure is performed by medical laboratory scientists, medical practitioners, some EMTs, paramedics, phlebotomists, dialysis technicians, and other nursing staff. Venipuncture is one of the most routinely performed invasive procedures and is carried out to obtain blood for diagnostic purposes, to monitor levels of blood components, to administer therapeutic treatments including medications, nutrition, or chemotherapy, to remove blood due to excess levels of iron or erythrocytes (red blood cells), or to collect blood for later uses, mainly transfusion either in the donor or in another person.

REFERENCES

1. Kentucky Legislative Research Commission, Section 6. Laboratory, Venipuncture, and Catheter: 907 KAR 3:010. Retrieved on September 9, 2020 from https://apps.legislature.ky.gov/law/kar/907/003/010.pdf

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.

The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.

References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com.

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
N/A	• Approved by RGC