Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:
Laboratory and Pathology

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products
☒ Tufts Health Plan Commercial products

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan
☒ Tufts Health One Care – A dual-eligible product

Senior Products

☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
☒ Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

Policy

Point32Health reimburses laboratory and pathology services performed at contracted laboratories. Testing must be based on a specific written request from an authorized ordering, referring and/or prescribing provider for the purpose of diagnosis, treatment, or otherwise specified medically necessary reason. Point32Health follows any relevant government policies when applicable.

Prerequisites

Applicable Point32Health referral, notification, and authorization policies may apply. Refer to the appropriate sections within the Provider Manuals for more information.

General Benefit Information

Services are pursuant to the member's benefit plan documents and are subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible). Member eligibility and benefit specifics should be verified prior to initiating services.

Use of non-contracted labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Point32Health may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Point32Health Reimburses

- Clinical laboratory tests, when performed by a technician under physician supervision
- Individual codes, when all components in a panel have not been performed
- Laboratory and pathology consultant opinions, when the test results are outside the normal expected range and the ordering physician requests additional outside testing
- Panel codes, when all individual tests in the panel have been performed
- Pre-admission testing when applicable
- Presumptive and definitive urine drug screening
- Routine screening labs
- Testing for medication levels, when part of an active treatment plan ordered and managed by a contracted provider
- The administration of blood and blood products, including typing , cross matching, processing/storage
- Traveling allowance when medically necessary laboratory specimen collection is drawn from members that are homebound or who are residents or custodial status at a skilled nursing facility or rehabilitation facility/LTAC hospital

Point32Health Does *Not* Reimburse

- Amylase when billed with lipase
- Definitive drug testing where there has been no underlying presumptive test or where the presumptive test is negative
- Employment drug screening
- Handling charges
- HLA tissue typing for bone marrow registries beyond testing for A, B or DR antigens
- Laboratory and pathology services provided at no charge by state agencies, including but not limited to pertussis and rubella
- Laboratory and pathology services that are rendered in conjunction with an inpatient stay, observation stay, or during the course of Facility-Based Behavioral Health Program or authorized skilled nursing, rehabilitation facility/LTAC hospital admission. Laboratory services should be billed to the facility as they are included in the respective global payment (i.e., DRG, per diem, etc.)
- Laboratory and Pathology tests that are experimental, unproven, or investigational and not supported by evidence-based medicine and established peer reviewed scientific data
- Lipoprotein subclass testing in the evaluation of cardiovascular disease
- Mandated drug testing (e.g., court ordered, residential monitoring, non-medically necessary testing)
- NAB (neutralizing antibody testing) in multiple sclerosis patients
- Paternity testing
- Payment to blood/blood product donors in exchange for their donation or the cost of transportation of blood and/or blood products
- Specimen collection
- Transfer factor for the treatment of multiple sclerosis
- Venipuncture charges made in conjunction with blood or related laboratory services or evaluation and management services when reported on the same day by any provider reporting the same Federal Tax ID Number (TIN)

Provider Billing Guidelines and Documentation

Providers are reimbursed according to the applicable contracted rates and fee schedules.

Required Documentation

Requests for laboratory services must be in writing to the lab and include the following information:

- Date of the request
- The name or other means of identifying the member to be tested
- The legible name and address of the authorized ordering, referring, and/or prescribing provider
- The name of the specific laboratory test(s) to be performed
- The frequency for performing each laboratory test (applicable to standing orders only)
- The duration and maximum number of times each laboratory test(s) are to be performed (applicable to standing orders only)
- A statement by the authorized ordering, referring, and/or prescribing provider that such testing is required as part of the member's medical or drug treatment plan
- The identification number of the specimen
- If the specimen is referred by another laboratory, the name of the referring laboratory
- The date the specimen was collected, the name of the person who collected the specimen and the location of the collection
- The date on which the specimen was received by the laboratory
- The specific tests performed
- The date(s) on which each test was performed
- The results of each test, the name and address of all persons to whom the test is reported and the date of the reporting
- The name and address of the laboratory to which the specimen was referred, if applicable

If a laboratory refers a specimen to a testing laboratory, the referring laboratory must also forward the original request to perform the service. Both laboratories must keep a record of each request for laboratory services, each specimen and each test result for at least six years from the date on which the results were reported to the authorized ordering, referring, and/or prescribing provider.

Modifiers

- Use the 26 modifier when the professional component is reported separately from the technical component.
- Use the TC modifier when the technical component is reported separately from the professional component
- It is not appropriate to use the 26 or TC modifier if the CPT code represents a procedure to which the technical or professional component does not apply
- Always report the 26 or TC modifier in the first modifier field when reporting with other modifiers

Point32Health uses the Center for Medicare and Medicaid Services (CMS) Professional component/Technical Component (PC/TC) indicators in the National Physician Fee Schedule (NPFS) Relative Value File to determine whether a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code is eligible for separate reimbursement for professional and technical services.

Other Information

- Use appropriate CPT and/or HCPCS codes for laboratory and pathology services performed in a non-institutional setting
- Submit unlisted CPT codes on a paper claim with supporting documentation
- Use panel codes only when all individual tests included in the panel have been performed; if other tests are performed together with those specified in the panel, bill separately in addition to the panel code
- Bill multiple same-day services on one line/ claim with a count representing the number of services rendered
- If a code is eligible to be reimbursed once per year, this refers to a rolling year (every 365 days) rather than a calendar year.

Harvard Pilgrim
Bill one unit of HCPCS G0416 for all prostate biopsies. CPT 88305 will not be reimbursed for pathology of prostate biopsies

Tufts Health Direct, Tufts Health Together and Tufts Health One Care
An invoice must be submitted for all codes that MassHealth designates as individual consideration.

Related Policies and Resources

Payment Policies

- CPT and HCPCS Level II Modifiers
- Emergency Department Services
- Evaluation and Management
- General Coding and Claims Editing
- Inpatient Hospital Admissions
- Non-covered Services
- Obstetrics/Gynecology
- Rehabilitation Facilities/Long-Term Acute Care Hospitals
- Skilled Nursing Facility
- Unlisted/Unspecified Procedure Codes
- Urine Drug Testing

Clinical Policies

- Cardiovascular Disease Risk Tests
- Genetic and Molecular Diagnostic Testing
- Noncovered Investigational Services
- Urine Drug Testing
- Vitamin B12 Screening and Testing
- Vitamin D Screening and Testing

Additional Resources

- Patient Protection and Affordable Care Act (Federal Health Care Reform)

Publication History

09/01/2026: Annual policy review; administrative edits for clarity
09/01/2025: Policy moved to new template, includes all lines of business

Background and Disclaimer Information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management requirements (when applicable), adherence to Plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.