LifeWise Health Plan of Washington

Payment Policy

cmi_051699

Title	**Blood Draw/Venipuncture - 36415**		
Number	**CP.PP.089.v2.7**		
Last Approval Date	08/12/24	**Original Effective Date**	11/11/1999
Cross Reference	• *Contract Exclusions/Disallowed Charges – Inpatient and Outpatient Facility Services* • *Laboratory and Pathology Billing Guidelines*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define the Plan limitations for a blood draw that are submitted on a CMS 1500 paper claim or 837P electronic claim form or UB-04/CMS-1450 paper claim form or an 837I electronic claim form
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company, and Premera Blue Cross HMO lines of business and products.
Policy	Current Procedural Terminology (CPT) procedure code 36415 is billed for the collection of a blood specimen for lab testing. **One** routine venipuncture per date of service, per provider, per member for all of the tests performed from the specimen is allowed and reimbursed. The date of service on a laboratory test is the date the specimen was collected. If the specimen is collected **over two or more days**, the date of service is the date the collection of the specimen ended. The Plan will reimburse one unit of routine venipuncture/venous blood draw (36415), per provider, per patient, per date of service regardless of the number of specimens drawn.
Codes/Coding Guidelines	**36415** – Collection of venous blood by venipuncture
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined in Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	None
Laws, Regulations & Standards	None

References	• American Medical Association's Current Procedural Terminology (CPT) Professional Edition codebook • Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative Policy Manual, 2023 • Centers for Medicare and Medicaid Services (CMS) Practitioner and Facility Outpatient Hospital Services MUE tables

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department	
Annual Review Dates	08/12/24; 11/09/23; 12/07/22; 01/07/22; 01/27/21; 02/10/20; 02/18/19; 02/27/18; 04/10/17; 05/23/16; 05/30/15; 06/08/14; 06/09/13; 06/10/12; 07/05/11; 07/30/10; 10/09/09; 12/19/08; 12/20/07; 11/24/06; 08/29/05; 03/01/05; 10/08/04; 02/17/04; 06/30/03; 11/09/99	
Version History	02/27/18	Added Codes/Coding Guideline section
	02/18/19	Annual review; no changes
	02/10/20	Annual review; no changes
	01/27/21	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P electronic claim forms
	01/07/22	Annual review; no changes
	12/07/22	Added cross reference to policy "Contract Exclusions/Disallowed Charges – Inpatient and Outpatient Facility Services" where limit is also one unit/per provider/per day
	11/09/23	Added a Cross Reference to the Laboratory and Pathology Billing Guidelines Payment Policy. Revised the Policy statement to be more explanatory on coding for venipuncture. Added References.
	08/12/24	Annual review; no changes

This policy was published on August 15, 2024