CareSource

REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Venipuncture and Laboratory Testing-MP-PY-1618	02/01/2026 IN, OH, WV inactive as of 01/01/2027
Policy Type	
REIMBURSEMENT	

Reimbursement Policies are intended to provide a general reference regarding billing, coding, and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design, and other factors are considered in developing Reimbursement Policies. Reimbursement Policies do not guarantee authorization or payment for services. Coverage and payment determinations are subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines.

Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document used to make the determination. Reasonable discretion may be used in interpreting and applying this policy to services provided in a particular case and the policy may be modified at any time. Reimbursement policies may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

This policy applies to the following Marketplace(s):			
☒ **Georgia**	☒ **Indiana**	☒ **Ohio**	☒ **West Virginia**

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A. Subject
Venipuncture and Laboratory Testing

B. Background
N/A

C. Definitions
- **Venipuncture** – A needle is used to collect blood from a vein, usually for laboratory testing.

D. Policy
I. Laboratory Services
A. Venipuncture is considered an incidental service when billed on a claim containing laboratory testing with the same place of service for the same member on the same date. Therefore, venipuncture is included in the reimbursement for the laboratory test performed and is not separately reimbursable.
B. The following CPT codes are considered venipuncture: 36400, 36405, 36406, 36410, 36415, 36591, and 36592.
C. CareSource may reimburse CPT code(s) 36400, 36405, 36406, and 36410 when billed with modifier 59, and appropriate documentation and the medical record reflect a distinct service requiring the skill of a qualified health care professional.

II. Professional Services
Routine venipuncture (36415) is not eligible for reimbursement when reported with office or other outpatient E/M codes (ie, 99202-99205, 99211-99215). Routine venipuncture is included in the reimbursement for office visit E/M services and not reimbursed separately.

III. Outpatient Facility Services
Venipuncture codes (ie, 36400, 36405, 36406, 36410, 36415, 36416) are not eligible for reimbursement when reported by an outpatient facility. These codes will be included in the facility payment and not allowed for separate reimbursement.

IV. CareSource may conduct a post-payment review on claims with venipuncture and no other laboratory testing to ensure compliance.

E. Conditions of Coverage
Reimbursement policies are designed to assist providers when submitting claims to CareSource and are routinely updated to promote accurate coding and provide policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement of claims may be subject to limitations and/or qualifications. Reimbursement will be established based on a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify a member's eligibility.

Reimbursement is dependent upon, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

Providers must follow proper billing, industry standards, and state compliant codes on all claim submissions. The use of modifiers must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, CareSource policies apply to both participating and nonparticipating providers and facilities.

F. Related Policies/Rules

Modifier 59
Overpayment Recovery

G. Review/Revision History

	DATE	ACTION
Date Issued	05/21/2025	Approved at Committee.
Date Revised	10/22/2025	Periodic review. Updated definition. Removed modifier 22 from D.I.C. Added II. and III. Added reference. Approved at Committee.
Date Effective	02/01/2026	
Date Archived		

H. References

1. NCI dictionary of cancer terms. National Cancer Institute. Accessed September 8, 2025. www.cancer.gov

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.