



REIMBURSEMENT POLICY STATEMENT

Wisconsin Marketplace

Policy Name & Number	Date Effective
Venipuncture and Laboratory Testing-WI MP-PY-1614	02/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates 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.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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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

- A. 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

- A. 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 for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon 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	New policy. 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. National Cancer Institute Dictionary of Cancer Terms. Accessed September 8, 2025. www.cancer.gov