

## Routine Venipuncture and/or Collection of Specimens

**Last Updated:** 1/8/2026

**Last Reviewed:** 1/14/2026

**Originally Effective:** 1/1/2000

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a

**Policy #:** RPM012

### Scope

**Companies:** Moda Partners, Inc. and its subsidiaries & affiliates (All)

**Provider Contract Status:** Any

**Claim Forms:** CMS1500 & CMS1450 (paper and electronic versions)

**Claim Dates:** All

### Reimbursement Guidelines

#### A. General Policies for All Settings

CPT codes 36400 - 36410 are for venipuncture but the code descriptions state they are “not to be used for routine venipuncture.”

1. The code descriptions specify the work of the venipuncture is performed by, and requires the skill of, a [physician](#) or [other qualified health care professional](#).<sup>8, 10, 11</sup> This is a key factor in distinguishing routine venipuncture from a more extensive, non-routine venipuncture.
  - a. “Requires the skill” means that routine venipuncture by clinical staff was attempted and not successful.
  - b. It is not appropriate to report codes 36400 - 36410 if the physician performs the venipuncture merely because the nurse, phlebotomist, or other [clinical staff](#) is unavailable to perform the service.<sup>8, 10, 11</sup>
2. Do not report these procedure codes if [clinical staff](#) such as a phlebotomist, the IV team, specially trained nurses, etc. collected the blood.

#### B. For Professional and Clinical Laboratory Services (including Dialysis Centers and Home Health):

Blood samples for blood or serum lab procedures are commonly obtained by venipuncture or collecting capillary blood. The work of obtaining the specimen sample is an essential part of performing the test.

In most cases, reimbursement for routine venipuncture or a capillary blood specimen is included in the reimbursement for the lab test procedure code; see below for more details.

1. CPT Code 36415
  - a. For Medicare Advantage:  
36415 is eligible for separate reimbursement, consistent with Original Medicare payment policy.
  - b. For all other lines of business, the following policies apply:
    - i. CPT 36415 is only eligible to be billed once per patient encounter<sup>4</sup>, even when multiple specimens are drawn or when multiple sites are accessed to obtain an adequate specimen size for the desired test(s).

A note about MUE limits:

The CMS MUE limit for 36415 is 2 units per date of service. This does not mean that more than one unit may be billed per patient encounter, or that a second venipuncture may be reported when a redraw is needed for an inadequate specimen. Rather, it allows for the possibility of two distinct patient encounters on a single date (e.g., morning and afternoon) that are separate, unplanned, and medically necessary.

- ii. Separate reimbursement for CPT 36415 is not allowed when it is billed on the same date as blood or serum laboratory tests (ranges 80048 – 89399, 0001U – 0599U, some G-codes). In these cases, 36415 is denied as a subset of the lab test.
  - iii. If any blood or serum lab tests are referred to an outside lab while others are performed by the provider, CPT 36415 remains ineligible for separate reimbursement.
  - iv. Use of modifier 90 (Reference Laboratory) does not override this subset edit. For 36415 to be separately reimbursable, the outside laboratory must bill directly for the lab tests, while the provider bills only for the venipuncture to obtain the specimen.
  - v. Modifiers XS, XP, XE, XU, or 59 are not valid with 36415 when blood or serum lab tests are billed, as venipuncture is not considered a separate procedure in this scenario.
  - vi. Separate reimbursement for CPT 36415 is allowed only when the provider bills lab services that do not require venipuncture (for example, urinalysis) on the same date.
2. CPT code 36416
- a. CPT 36416 is a status B code on the Physician Fee Schedule RBRVU file, meaning it is never separately reimbursed. Claims for CPT 36416 will deny to provider responsibility, whether billed alone or with other services. This edit does not allow modifier bypass.
  - b. Denial explanation codes include:
    - i. WGO (*Service/supply is considered incidental and no separate payment can be made. Payment is always bundled into a related service*)
    - ii. z39 (*This claim line is being disallowed because the procedure code has no Medicare relative value unit and may be considered incidental.*)
  - c. 835 CARC/RARC denial combination:

CARC 97	<i>(The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.)</i>
RARC M15	<i>(Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.)</i>

3. CPT codes 36591 and 36592
- a. CPT codes 36591 and 36592 are eligible for separate reimbursement only in very limited circumstances.
    - i. According to the CPT book parenthetical notes, these codes may not be reported with any other services except laboratory services.<sup>8,9</sup>
    - ii. Under CMS guidelines, CPT 36591 and 36592 are assigned status T on the Physician Fee Schedule RBRVU file. Status T indicates that although RVUs and payment amounts exist, these services are payable only when no payable physician fee schedule services are billed by the same provider on the same date. If another payable service is billed on the same date, these services are bundled into the primary service and are not separately reimbursed.<sup>12, 13</sup>
  - b. As a result, CPT codes 36591 or 36592 are denied when billed with other non-laboratory services. Such denials may be triggered through clinical edits, or pre- or post-payment review and are not eligible for modifier bypass.
    - i. Example:
 

CPT codes 36591 and 36592 may not be billed with chemotherapy services. Blood collection is included in the reimbursement for the chemotherapy administration and cannot be reported separately. This policy applies to both the professional and facility claims.
    - ii. Denial explanation codes include:

- 1) WGT (*Bundled or incidental service/supply. Not eligible for separate payment, per CPT and/or CMS guidelines.*)
  - 2) 771 (*Claim review results. Item(s)/services identified as not eligible to be separately reported or never eligible for separate reimbursement.*)
  - 3) u10 (*Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.*)
- iii. 835 CARC/RARC denial combinations:

CARC 97	<i>(The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.)</i>
RARC N390	<i>(This service/report cannot be billed separately.)</i>

CARC 97	<i>(The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.)</i>
RARC M15	<i>(Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.)</i>

4. Point of Care Testing & Obtaining Samples
- a. Point of care (POC) testing and collection of specimens for POC testing is not separately reimbursable.
  - b. POC testing includes but is not limited to:
    - i. Urine dip stick
    - ii. Glucometry testing
    - iii. Mobile computer devices such as, but not limited to, those used for the analysis of blood gases, electrolytes, metabolites and urinary retention
    - iv. Obtaining samples from existing lines or insertion of peripheral IV lines
5. Handling fees, CPT codes 99000 and 99001
- a. CPT codes 99000 and 99001 are designated as status B (bundled) on the Physician Fee Schedule RBRVU file and ARE never separately reimbursed.
  - b. Claims billed with CPT 99000 or 99001 will be denied, whether these codes are billed alone or in combination with other services on the same date of service. Modifier bypass is not allowed for these denials.
  - c. Denial explanation codes:
    - i. WGO (*Service/supply is considered incidental and no separate payment can be made. Payment is always bundled into a related service*)
    - ii. z39 (*This procedure code or service is a status B or otherwise considered Bundled, and is not eligible for separate reimbursement.*)
  - d. 835 CARC/RARC denial combination:

CARC 97	<i>(The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.)</i>
RARC M15	<i>(Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.)</i>

**C. For Ambulatory Surgery Centers (ASC):**

Per CMS policy, routine venipuncture or other routine collection of specimens are not separately reimbursable for ASCs. These services are bundled into the reimbursement for the primary procedure.

#### D. For Outpatient Hospital Services:

The CMS Outpatient Prospective Payment System (OPPS) Medically Unlikely Edit (MUE) limits apply to routine venipuncture procedure codes and other routine specimen collection codes.

#### E. For Inpatient Hospital Services:

Per CMS policy, one collection fee maximum (any procedure code) is allowed per specimen type (e.g., venous blood, arterial blood) per date of service.<sup>4, 5, 6, 7</sup> Specimen collections from an existing line (e.g., arterial line, CVP line, port, etc.) is not separately reimbursable.

## Definitions

### Acronyms/Abbreviations

Acronym	Definition
AMA	American Medical Association
ASC	Ambulatory Surgery Center
CARC	Claim Adjustment Reason Code
CCI	Correct Coding Initiative (see "NCCI")
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CVP	Central Venous Pressure
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
IV	Intravenous
MUE	Medically Unlikely Edits (a type of CCI edit)
NCCI	National Correct Coding Initiative (aka "CCI")
PFS	Physician Fee Schedule
POC	Point of care
POCT	Point of care testing
RARC	Remittance Advice Remark Code
RBRVS	Resource-Based Relative Value Scale
RBRVU	Resource-Based Relative Value Unit (aka "RVU")
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	Relative Value Unit (aka "RBRVU")
UB	Uniform Bill

### Definition of Terms

Term	Definition
Clinical Staff	A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a professional service, but who does not individually report that professional service. Other policies may also affect who may report specific services. <sup>8, 10, 11</sup>
Other Qualified Health Care Professional	An "other qualified health care professional" is an individual who not a physician but is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." <sup>8, 10, 11</sup>

Term	Definition
Physician	A “physician or other qualified health care professional” is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from “clinical staff.” <sup>8, 11</sup>
Point Of Care Testing	Point-of-Care Testing (POCT) is defined as laboratory testing conducted close to the site of patient care, typically by clinical personnel whose primary training is not in the clinical laboratory sciences, or by patients (self-testing). POCT refers to any testing conducted outside a main, central, or core laboratory setting.  Other common terms for POCT are ancillary, bedside, decentralized, near-patient, patient-focused, peripheral, portable, and satellite testing. <sup>7</sup>
Resource-Based Relative Value Scale	The physician payment system used by the Centers for Medicare & Medicaid Services (CMS) and most other payers. It consists of three components: physician work, practice expense and professional liability insurance, and is documented on the CMS Physician Fee Schedule (PFS) file.
Relative Value Unit	The score or value assigned to an individual procedure code under the CMS RRVRS system. (aka “Resource-Based Relative Value Unit”)
Resource-Based Relative Value Unit	The score or value assigned to an individual procedure code under the CMS RRVRS system. (aka “Relative Value Unit”)

### Procedure codes (CPT & HCPCS)

Code	Code Description
36400	Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein
36405	Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; scalp vein
36406	Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; other vein
36410	Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)
36415	Collection of venous blood by venipuncture
36416	Collection of capillary blood specimen (eg, finger, heel, ear stick)
36500	Venous catheterization for selective organ blood sampling
36591	Collection of blood specimen from a completely implantable venous access device
36592	Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified
75893	Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation
99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory
99001	Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory (distance may be indicated)

## Modifier Definitions

Modifier	Modifier Description & Definition	Comments
59	<p><b>Distinct Procedural Service:</b> Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.</p> <p><b>Note:</b> Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same day, see modifier 25.</p>	<a href="#">Not valid for venipuncture with blood/serum lab tests.</a>
90	<p><b>Reference (Outside) Laboratory:</b> When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.</p>	<a href="#">Will not bypass the denial of venipuncture for blood or serum tests.</a>
XE	Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter	<a href="#">Not valid for venipuncture with blood/serum lab tests.</a>
XS	Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure	<a href="#">Not valid for venipuncture with blood/serum lab tests.</a>
XP	Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner	<a href="#">Not valid for venipuncture with blood/serum lab tests.</a>
XU	Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service	<a href="#">Not valid for venipuncture with blood/serum lab tests.</a>

## Related Policies

- A. [“Moda Health Reimbursement Policy Overview.”](#) Moda Health Reimbursement Policy Manual, RPM001.
- B. [“Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service.”](#) Moda Health Reimbursement Policy Manual, RPM027.
- C. [“Reference \(Outside\) Laboratory -- Modifier 90.”](#) Moda Health Reimbursement Policy Manual, RPM045.

## Resources

1. Facets system-supplied Clinical Editing Resource Guide, 2013.
2. CMS. Medicare Physician Fee Schedule Database.

3. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 5 Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems, § D, 13, p V-13.
4. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 16 – Laboratory Services, §60.1.
5. AMA. *Current Procedural Terminology (CPT)*. Chicago: AMA Press. Guidelines in parenthesis directly under CPT code 36591.
6. AMA. *Current Procedural Terminology (CPT)*. Chicago: AMA Press. Guidelines in parenthesis directly under CPT code 36592.
7. Wild, David G., Editor *The Immunoassay Handbook (Fourth Edition)*. Chapter 6.3 - Point-of-Care Testing. Elsevier, 2013. p. 455. ISBN 9780080970370.  
<https://www.sciencedirect.com/science/article/pii/B9780080970370000312> .
8. AMA. "Instructions for Use of the CPT Codebook." *Current Procedural Terminology (CPT)*. Chicago: AMA Press. Introduction. Page xiv (new or revised text in 2023 edition).
9. AMA. "**Coding Consultation: Venipuncture.**", CPT Assistant, May 2001, page 11.
10. AMA. "Frequently Asked Questions, Introduction." CPT Assistant, May 2015, pp. 10-11.
11. AMA. "Reporting CPT Codes for Oncology Navigation Services: The Cancer Moonshot<sup>SM</sup>." CPT Assistant, Special Edition, November Update 2023. pp. 1-11.
12. CMS. "MPFSDB Status Indicators." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 23 - Fee Schedule Administration and Coding Requirements, § 30.2.2.
13. CMS. "Status Indicators." Last updated May 30, 2024. Last accessed January 7, 2025.  
<https://www.cms.gov/status-indicators> .

## Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: [https://www.modahealth.com/medical/policies\\_reimburse.shtml](https://www.modahealth.com/medical/policies_reimburse.shtml)

Date	Summary of Update
1/14/2026	Acronyms & Definition of Terms updated. Added details to 10/18/2022 history entry. Minor rewording. Formatting updates. No policy changes. Retired sections: Background Information, Coding Guidelines & Sources, and Important Statement (info found in Related Policy RPM001).
1/8/2025	Updated Cross References and References & Resources. Formatting updates. No policy changes.
2/14/2024	Minor clarification of "Other Qualified Health Care Professional" definition. Updated References & Resources. Formatting updates. No policy changes.
6/14/2023	Clarified limits for 36415 per encounter and per date of service. Formatting updates. No policy changes.
10/18/2022	Added information for 36400 – 36410. Idaho added to Scope. Definition of Terms, Modifier table, Coding Guidelines & Sources, Cross References, References & Resources updated. Formatting updates. No policy changes.
7/22/2011	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
Prior to 1/1/2000	Original Effective Date (with or without formal documentation). Policy based on clinical editing bundling rationale in claims processing system & administrative decision by Claims Management.