Washington State Department of
Labor & Industries

Chapter 13: Laboratory and Pathology Services

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

Updates and corrections

An annual update of the entire payment policies and fee schedules (MARFS) is published routinely to coincide with the beginning of each state fiscal year (July 1).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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General information: Laboratory and pathology services

The insurer covers certain pathology and laboratory services when needed to treat an accepted condition or establish causal relationship for a condition. Authorization of treatment in cases of probable exposure (not injury) doesn't bind the insurer to allowing a claim later. An accident report (Report of Accident, Self-Insurer Accident Report, or Provider's Initial report for self-insured workers) is required before the insurer can pay for testing and treatment. Laboratories cannot file a Report of Accident, Self-Insurer Accident Report, or Provider's Initial report. See Chapter 3 for who can file these forms.

Note: Labs provided for inpatient services are paid through the hospital or ambulatory surgery center. See Chapter 26: Hospitals and Ambulatory Surgery Centers (ASCs) for details.

Prior authorization

Prior authorization is required for certain pathology and laboratory services. See fee schedule and relevant policies for details.

Who must perform these services to qualify for payment

All laboratories must have an L&I provider account number prior to rendering services. Providers drawing specimens in nursing homes, skilled nursing facilities, or homebound patients must have a provider account number. See the Payment Policy: Specimen Collection and Handling for additional details.

All labs must have CLIA accreditation.

Documentation requirements

All laboratories must submit a copy of the lab report to the insurer. The lab report must contain information needed to support services billed, and include:

- What tests were performed,
- What the results were,
- Dates of collection, date specimen was received by the lab, and report date,
- Rendering provider name,
- L&I claim number, *and*
- Referring provider name and contact information.

Services that aren’t covered

The insurer won’t reimburse pharmacies who provide lab-grown cells to facilities for surgical implant.

Payment policy: Bloodborne pathogens

Prior authorization

The insurer may pay for post exposure testing and treatment whenever an injury or probable exposure occurs and there is a potential exposure to an infectious disease.

Authorization of testing and treatment in cases of probable exposure (not injury) doesn't bind the insurer to allowing a claim later.

The exposed worker must submit an accident report form before the insurer can pay for testing and treatment.

Services that can be billed

For information on which diagnostic tests and procedures are covered, refer to the Professional Services Fee Schedule.

Link: See L&I's coverage decision about post exposure prophylaxis and testing (PEP)..

Treating a reaction to testing or treatment of an exposure

The insurer will allow a claim and applicable accident fund benefits when a worker has a reaction to covered treatment for a probable exposure.

Covered test protocols

Testing schedule

Testing for hepatitis B, hepatitis C, and HIV should be done:

- At the time of exposure, *and*
- At 3, 6, and 12 months post exposure.

Hepatitis B

For hepatitis B (HBV), the following test protocols are covered:

- HbsAg (hepatitis B surface antigen),
- Anti-HBc or HBc-Ab (antibody to hepatitis B core antigen),
- Anti-HBs or HBs-Ab (antibody to hepatitis B surface antigen).

Hepatitis C

For hepatitis C (HCV), the following test protocols are covered:

- Enzyme Immunoassay (EIA),
- Recombinant Immunoblot Assay (RIBA),
- Strip Immunoblot Assay (SIA).

The qualitative reverse transcriptase polymerase chain reaction (RT-PCR) test is the only way to determine whether or not one has active HCV.

The following tests are covered services only if HCV is an accepted condition on the claim:

- Quantitative reverse transcriptase polymerase chain reaction (RT-PCR),
- Branched chain DNA (bDNA),
- Genotyping,
- Liver biopsy.

HIV

For HIV, 2 blood tests are needed to verify the presence of HIV in blood:

- Rapid HIV or EIA test, *and*
- Western Blot test to confirm seropositive status.

The following tests are used to determine the presence of HIV in blood:

- Rapid HIV test,
- EIA test,
- Western Blot test,
- Immunofluorescent antibody.

The following tests are covered services only if HIV is an accepted condition on the claim:

- HIV antiretroviral drug resistance testing,
- Blood count, kidney, and liver function tests,
- CD4 count,
- Viral load testing.

Covered bloodborne pathogen treatment regimens

When a possible exposure to bloodborne pathogens occur, the insurer will pay for post-exposure prophylaxis (PEP) treatment in accordance with the most recent U.S. Public Health Service Guidelines.

Hepatitis B

Treatment with hepatitis B immune globulin (HBIG) and the hepatitis B vaccine may be appropriate for PEP.

Chronic hepatitis B

For chronic hepatitis B (HBV):

- Interferon alfa-2b,
- Lamivudine.

Hepatitis C

For hepatitis C (HCV) – acute:

- Mono therapy,
- Combination therapy.

HIV/AIDS

For HIV/AIDS, covered services are limited to those within the most recent guidelines issued by the US Department of Health and Human Services AIDSinfo. Prior authorization isn't required for HIV PEP.

When PEP is administered, the insurer will pay at baseline and periodically during drug treatment for drug toxicity monitoring including:

- Complete blood count,
- Renal and hepatic chemical function tests.

Link: The US Department of Health and Human Services AIDSinfo guidelines are available online. For PEP HIV drugs dispensed by a Washington State hospital emergency department, see Chapter 26: Hospitals and Ambulatory Surgery Centers (ASCs). For PEP HIV drugs dispensed through a pharmacy, see Chapter 19: Pharmacy.

Payment policy: COVID-19 testing

Prior authorization

Prior authorization is required for COVID-19 tests.

Requirements for billing

U0002 is only payable to laboratories as outlined by Centers for Medicare and Medicaid Services (CMS).

High-throughput testing may only be performed and billed by pathologists.

Services that can be billed

Lab testing is covered when:

- The worker is receiving treatment or preparing for an invasive procedure that has been approved under the claim, *and*
- The provider requires the test, *and*
- The insurer authorizes the test.

Examples of procedures that may require testing in advance include:

- Approved surgeries, *or*
- Approved dental treatments.

Workers who reside in a nursing home, group home, skilled nursing facility, or are receiving home health at home may have lab testing for COVID-19 provided prior authorization is obtained.

Link: For updates on COVID-19 coverage and code changes, see the MARFS updates and corrections online.

Services that aren’t covered

Lab testing isn’t covered when:

- The provider doesn’t require the test, *or*
- The treatment or procedure hasn’t been approved under the claim, *or*
- The claim manager hasn’t authorized the test, *or*
- The employer has requested testing as a requirement for returning to work.

At-home testing kits aren’t covered for any reason and are not reimbursable to any claim party.

Payment policy: Drug screens

Prior authorization

Definitive testing HCPCs codes **G0480**, **G0481**, **G0482**, and **G0483** require prior authorization.

Services that can be billed

The insurer may pay for drug screening using the following billing codes:

- For presumptive testing billing codes **80305**, **80306**, or **80307**, *or*
- For definitive testing HCPCS codes **G0480**, **G0481**, **G0482**, or **G0483**.

Billing codes **80305**, **80306**, and **80307** are payable to laboratories with a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver.

Payment limits

HCPCS billing codes **G0480**, **G0481**, **G0482** and **G0483** are limited to 1 unit per day per patient encounter regardless of the CLIA status of the laboratory.

Who must perform these services to qualify for payment

The insurer will pay for:

- Drug screening conducted in the office setting by a laboratory with a (CLIA) certificate of waiver, *and*
- Confirmation testing performed at a laboratory not requiring a CLIA certificate of waiver.

Payment policy: Non-CLIA Waived Testing

Requirements for billing

Complex or moderately complex clinical pathology procedures that aren't waived under the Clinical Laboratory Improvement Act (CLIA) must be performed in laboratories that are accredited or have a categorized status under the State Department of Health or equivalent accrediting body.

Payment limits

Payment for complex and moderately complex clinical pathology procedures won't be paid to any provider that only has a CLIA certificate of waiver or the Provider Performed Microscopic Procedure certificate.

Payment policy: Panel tests

Services that can be billed

Automated multichannel tests

When billing for panels containing automated multichannel tests, performing providers may bill either the panel code or individual test codes, but not both. Please refer to our fee schedule for code coverage and fees.

Refer to CPT® for a list of automated multichannel tests or panels comprised solely of automated multichannel tests.

Additional information: How to calculate payments

Automated tests

The automated individual and panel tests above are paid based on the total number of unduplicated automated multichannel tests performed per day per patient.

Calculate the payment using the following steps:

- When a panel is performed, the CPT® codes for each test within the panel are determined, *then*
- The CPT® codes for each test in the panel are compared to any individual tests billed separately for that day, *then*
- Any duplicated tests are denied, *then*
- The total number of remaining unduplicated automated tests is counted.

To determine the payable fee based on the total number of unduplicated automated tests performed, see the following table:

If the number of unduplicated automated tests performed is…	Then the fee is:
1 test	Lesser of the single test or **$11.44**
2 tests	**$11.44**
3-12 tests	**$14.00**
13-16 tests	**$18.71**
17-18 tests	**$20.96**

If the number of unduplicated automated tests performed is…	Then the fee is:
19 tests	**$24.27**
20 tests	**$25.04**
21 tests	**$25.85**
22-23 tests	**$26.61**

Panels with automated and non-automated tests

When panels are comprised of both automated multichannel tests and individual non-automated tests, they are priced based on the:

- Automated multichannel test fee based on the number of tests, added to
- Sum of the fee(s) for the individual non-automated test(s).

For example, CPT® code **80061** is comprised of 2 automated multichannel tests and 1 non-automated test. As shown in the table below, the fee for **80061** is **$25.55**.

If the CPT® 80061 component tests is:	And the number of automated tests is…	Then the maximum fee is:
Automated: CPT® **82465** and CPT® **84478**	2	Automated: **$14.00**
Non-automated: CPT® **83718**	n/a	Non-automated: **$11.55**
Maximum payment for CPT® code **80061**:		**$25.55**

Multiple panels

When multiple panels are billed or when a panel and individual tests are billed for the same date of service for the same patient, payment will be **limited to the total fee allowed for the unduplicated component tests.**

The table below shows how to calculate the maximum payment when:

- **Panel codes 80050**, **80061**, and **80076** are billed with
- **Individual test codes 82977**, **83615**, **84439**, and **85025**.

Test type	CPT® panel codes				Individual tests	Test count	Max fee
	80050	**80061**	**80076**				
Automated tests	**82040**, **82247**, **82310**, **82374**, **82435**, **82565**, **82947**, **84075**, **84132**, **84155**, **84295**, **84450**, **84460**, and **84520**	**82465** and **84478**	**82248** + these duplicated tests: **82040**, **82247**, **84075**, **84155**, **84450**, and **84460**		**82977** **83615**	= 19 unduplicated automated tests (Note the fee in previous table on fees for automated tests)	**$24.27**
	84443		—	—	—	—	**$26.69**
	85025 or **85027** and **85004** or **85027** and **85007** or **85027** and **85009**		—	—	—	—	**$10.96**
	83718		—	—	—	—	**$11.55**
	—		—	—	**84439**	—	**$12.72**

Test type	CPT® panel codes				Individual tests	Test count	Max fee
	80050	**80061**	**80076**				
Non-automated tests	—		—	—	**85025** or **85027** and **85004** or **85027** and **85007** or **85027** and duplicated test **85009**	—	**$10.96**
						Maximum payment:	**$97.15**

Payment policy: Repeat tests

Requirements for billing

Additional payment is allowed for repeat test(s) performed for the same patient on the same day. However, a specimen(s) **must be taken** from separate encounters. Also, the medical necessity for repeating the test(s) **must be documented** in the patient's record.

When billing, modifier **–91** must be used to identify the repeated test(s).

Payment for repeat panel tests or individual components tests will be made based on the methodology described in the Panel Tests payment policy section of this chapter (above).

Payment limits

Tests normally performed in a series (for example, glucose tolerance tests or repeat testing of abnormal results) don't qualify as separate encounters.

Payment policy: Specimen collection and handling

Requirements for billing

Specimen collection

Use HCPCS billing codes:

- **P9612**, which is for “Catheterization for collection of specimen, single patient, all places of service,” *and*
- **P9615**, which is for “Catheterization for collection of specimen(s) multiple patient(s).”

For venipuncture, use CPT® billing code **36415**.

Travel

To bill for actual mileage, use HCPCS code **P9603** (1 unit equals 1 mile).

Services that can be billed

Specimen collection

Complex vascular injection procedures, such as arterial punctures and venisections, aren’t subject to this policy and will be paid with the appropriate CPT® or HCPCS billing codes.

Travel

Travel will be paid in addition to the specimen collection fee when all of the following conditions are met:

- It is medically necessary for a provider to draw a specimen from a nursing home, skilled nursing facility, or homebound patient, *and*
- The provider personally draws the specimen, *and*
- The trip is solely for collecting the specimen.

Services that aren’t covered

Specimen collection

Specimen collection performed by patients in their homes isn’t paid (such as stool sample collection).

Travel

HCPCS code **P9604** (Travel allowance, 1 way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient, prorated trip charge) isn't covered.

Who must perform these services to qualify for payment

The fee for billed specimen collection services is payable only to the provider who actually draws the specimen.

Payment for the specimen may be made to nursing homes or skilled nursing facilities when an employee qualified to do specimen collection performs the draw.

Payment limits

Specimen collection

Costs for media, labor, and supplies (for example, gloves, slides, antiseptics, etc.) are included in the specimen collection. Payment for performing the test is separate from the specimen collection fee.

A collection fee isn't allowed when the cost of collecting the specimen(s) is minimal, such as:

- A throat culture, *or*
- Pap smear, *or*
- A routine capillary puncture for clotting or bleeding time.

Handling

Handling and conveyance won't be paid (for example, shipping, messenger, or courier service of specimen(s). This includes preparation and handling of specimen(s) for shipping to a reference laboratory. These are integral to the process and are **bundled** into the total fee for testing service.

Travel

Travel won't be paid to nursing home or skilled nursing facility staff that performs specimen collection.

If the specimen draw is incidental to other services, no travel is payable.

Payment policy: STAT lab fees

Requirements for billing

Tests ordered STAT should be limited only to those needed to manage the patient in a true emergency situation. Also:

- The medical record must reflect the medical necessity and urgency of the service, *and*
- The laboratory report should contain the name of the provider who ordered the STAT test(s).

Payment is limited to 1 STAT charge per episode (not once per test).

Services that can be billed

Usual laboratory services are covered under the Professional Services Fee Schedule.

When lab tests are appropriately performed on a STAT basis, the provider may bill HCPCS codes **S3600** or **S3601**.

Payment limits

The STAT charge will only be paid with these tests:

- HCPCS code **G0306** (Complete CBC, auto w/diff), *or*
- HCPCS code **G0307** (Complete CBC, auto), *or*
- For presumptive testing CPT® codes **80305**, **80306**, or **80307**, *or*
- For definitive testing HCPCS codes **G0480**, **G0481**, **G0482**, or **G0483**.

…with these CPT® billing codes:								
80047	**80184**	**81003**	**82435**	**83874**	**84520**	**85049**	**86880**	**87210**
80048	**80185**	**81005**	**82550**	**83880**	**84550**	**85378**	**86900**	**87281**
80051	**80188**	**82009**	**82565**	**84100**	**84702**	**85380**	**86901**	**87327**
80069	**80192**	**82040**	**82803**	**84132**	**84704**	**85384**	**86902**	**87400**
80076	**80194**	**82150**	**82945**	**84155**	**85004**	**85396**	**86920**	**89051**
80156	**80197**	**82247**	**82947**	**84157**	**85007**	**85610**	**86921**	
80162	**80198**	**82248**	**83615**	**84295**	**85025**	**85730**	**86922**	
80164	**81000**	**82310**	**83663**	**84450**	**85027**	**86308**	**86923**	
80170	**81001**	**82330**	**83664**	**84484**	**85032**	**86367**	**86971**	
80178	**81002**	**82374**	**83735**	**84512**	**85046**	**86403**	**87205**	

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125
US Department of Health and Human Services AIDS info guidelines	National Institute of Health (NIH) website
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare services (including pathology and laboratory services)	Fee schedules on L&I's website

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

