

Reimbursement Policy

Venipuncture

REIMBURSEMENT POLICY NUMBER: 21

Effective Date: 10/1/2026

Last Review Date: 9/2026

Next Annual Review: 9/2027

SCOPE AND APPLICATION.....	1
POLICY STATEMENT.....	1
POLICY GUIDELINES.....	2
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)	2
BILLING AND CODING GUIDELINES	3
CROSS REFERENCES.....	3
REFERENCES.....	3
POLICY REVISION HISTORY.....	3

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits, reimbursement methodologies, and acceptable billing practices, intended to help health care providers submit claims accurately in order to reduce delays and ensure more accurate claim adjudication. Reimbursement policies do not constitute a guarantee of coverage. They allow for the consistent application of our member contracts, provider contracts, clinical edits, and medical policies. In the event of a conflict between one of these documents and a reimbursement policy, these documents will take precedent over the reimbursement policy. If contracts and policies are silent, the Company may defer to guidance from the Centers for Medicare & Medicaid Services (CMS) when available and applicable. In addition to correct billing practices, in order to qualify for reimbursement, all services, items, and procedures must be covered member benefits and must also meet applicable authorization and medical necessity guidelines. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time.

SCOPE AND APPLICATION

Provider Type:

- ☒ Providence Health Plan Participating Providers
- ☒ Non-Participating Providers

Plan Product:

- ☒ Commercial
- ☒ Medicare
- ☒ Medicaid/Oregon Health Plan (OHP)

POLICY STATEMENT

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

NOTES:

- Provider contract language applies and may vary.
 - This policy applies to **CPT 36415** and **HCPCS G0471** only. It does **not** apply to **CPT 36416** (*Collection of capillary blood specimen (eg, finger, heel, ear stick)*), which is addressed in a Coding Policy for bundled services (see Cross References).
 - Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits also apply.
- I. A flat rate of \$3.00 will be paid for CPT code 36415 unless a different rate is specified in the provider's contract. This includes claims billed by providers who are paid for laboratory services based on Medicare's fee schedule for laboratory services, even if all other services for that provider are paid at a percent of billed charges.
 - II. A flat rate of \$3.00 will be paid for CPT code 36415 billed by non-participating providers for Medicare and OHP/Medicaid members.
 - III. HCPCS code G0471 will be paid using the lab fee schedule reimbursement specified in provider contracts.

POLICY GUIDELINES

BACKGROUND

Specific codes are available to describe specimen collection. The code selected is based on method of collection, as well as who has performed the collection. Medicare requires a “trained technician” to personally draw the specimen. The term “trained technician” refers to staff providing specimen collection services, and can include a phlebotomist.^{1,2}

CPT code 36415 is defined as:

Collection of venous blood by venipuncture

This code is intended to describe the process of inserting a needle into a vein for collection of a blood sample.

HCPCS code G0471 is defined as:

Collection of venous blood by venipuncture or urine sample by catheterization from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA)

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

As of 7/8/2026, the following Centers for Medicare & Medicaid (CMS) guidance was identified which addresses appropriate use of CPT code 36415:

- Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 16 - Laboratory Services, § 60.1.2 - Coding Requirements for Specimen Collection
- Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 16 - Laboratory Services, §60.1.4 - Coding Requirements for Specimen Collection

The above policy statements are consistent with the CMS guidance regarding 36415 and G0471.

BILLING AND CODING GUIDELINES

In accordance with CPT code descriptions, CPT codes 36400-36410 are used when the skill of a physician or other qualified healthcare professional **is** required, while CPT code 36415 should be used for all **routine** venipuncture specimen collections, when the skill of a physician or other qualified healthcare professional is **not** required.

Regardless of CPT billed and specimens drawn, only one collection fee is allowed for each patient encounter.³

CROSS REFERENCES

- [Bundled or Adjunct Services](#), CP13

The full Company portfolio of current Reimbursement Policies is available online and can be [accessed here](#).

REFERENCES

1. Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 16 - Laboratory Services, §60.1.2 - Coding Requirements for Specimen Collection. 23 Jan 2023. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf>. Accessed 7/8/2026.
- Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 16 - Laboratory Services, §60.1.4 - Coding Requirements for Specimen Collection. 1 Dec 2014. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf>. Accessed 7/8/2026.

POLICY REVISION HISTORY

Date	Revision Summary
8/2025	New Reimbursement Policy
10/2026	Annual review, no changes