Internal Medicine Coding Alert

Reader Question: Get to Know Medicare's New CBC Codes

Question: An office staff member draws a Medicare patient's blood and performs a complete blood count (CBC). Should I submit G0001 or a CPT lab code? Also, if I report a lab code, should I use a modifier?

Texas Subscriber

Answer: Because your personnel performed the laboratory test in the office, you should report the test in addition to the blood draw (G0001, Routine venipuncture for collection of specimen[s]).

When you bill a CBC for a Medicare patient, you may need to submit a HCPCS Level II laboratory code, if the CBC doesn't include a platelet count. If the CBC without a platelet count doesn't include an automated white blood count (WBC) differential count, report G0307 (Complete CBC, automated [HgB, Hct, RBC, WBC; without platelet count]). If it does, assign G0306 (Complete CBC, automated [HgB, Hct, RBC, WBC, without platelet count] and automated WBC differential count).

This year, Medicare added G0306 and G0307, which correspond to CPT lab codes 85025 (Blood count; complete [CBC], automated [Hgb, Hct, RBC, WBC and platelet count] and automated differential WBC count) and 85027 (... complete [CBC], automated [Hgb, Hct, RBC, WBC and platelet count]). The corresponding CPT codes include a platelet count, so check with your carrier before you submit these new codes. Because the Clinical Laboratory Improvement Amendments (CLIA) classify a CBC as a moderate-complexity test, you shouldn't append modifier -QW (CLIA waived test) to the lab code. Modifier -QW only applies to CLIA-waived laboratory tests. Your office must maintain a moderate- or high-complexity certificate to perform CBCs. When you submit the claim, make sure to enter your practice's CLIA certification number on line 23 of the CMS-1500 form.