PAYMENT POLICY – Discontinued General Health Panel

Owner	Current Effective Date	Next Review Date
Operations	11/04/2026	11/04/2027

OVERVIEW

The purpose of this policy and procedure is to explain Community Health Choice reimbursement guidelines for CPT code 80050, General Health Panel.

This policy is intended to support accurate claim submission, appropriate documentation, and consistent reimbursement review for participating and non-participating providers.

If a conflict exists, applicable federal or state law, regulatory guidance, the member's benefit plan document, Community Health Choice coverage criteria, or the applicable provider agreement will prevail.

This policy does not determine member eligibility, authorize services, establish medical necessity, guarantee coverage or payment, or supersede applicable federal or state requirements, the member's benefit plan document, Community Health Choice coverage criteria, or the terms of the applicable provider agreement.

Applicable Products

This policy applies to the following Community Health Choice products:

- Health Insurance Marketplace
- Medicare

Policy

Key policy statement: Community Health Choice does not separately reimburse CPT code 80050 under this policy. Providers should bill medically necessary component laboratory services separately using the appropriate individual CPT code, when supported by documentation and permitted under applicable coding, coverage, claim submission, and reimbursement requirements.

CPT code 80050 is considered non-reimbursable when submitted as a bundled General Health Panel code.

Claims submitted with CPT code 80050 are subject to denial as non-reimbursable.

Providers should submit each medically necessary laboratory component service separately using the appropriate CPT code and supporting documentation.

Each component service remains subject to applicable coding, billing, documentation, benefit coverage, medical necessity, prior authorization requirements when applicable, claim submission requirements, provider contract terms, and reimbursement policies.

Component Codes That May Be Reimbursable

The following component services are examples of codes that may be reimbursable when billed separately and supported by required documentation. This list is provided for reference and may not be all-inclusive:

CPT Code	Description
80053	Comprehensive Metabolic Panel
85025	Complete Blood Count with Automated Differential
85027	Complete Blood Count without Automated Differential
84443	Thyroid-Stimulating Hormone

Documentation Requirements

Providers must maintain documentation sufficient to support the services billed, including medical necessity, services rendered, and the CPT code submitted on the claim.

Community Health Choice may request medical records or other supporting documentation, as permitted by applicable law, regulation, or provider agreement, to:

- Validate services billed
- Evaluate medical necessity
- Confirm services were rendered
- Support claim review, audit, or payment activities

Failure to provide requested documentation may result in claim denial, payment adjustment, or recoupment, as permitted by applicable law, regulation, policy, or provider agreement.

Claim Review and Audit

Community Health Choice may review, audit, deny, adjust, or recoup payment when services do not meet applicable coding, billing, documentation, medical necessity, benefit coverage, claim submission, provider contract, payment integrity, or reimbursement requirements.

Claim review may consider applicable federal and state requirements, regulatory guidance, plan-specific coverage determinations, nationally recognized clinical review criteria, Community Health Choice coverage criteria, coding guidance, payment integrity standards, and provider contract terms.

References

Community Health Choice may consider, among other sources, the following references when applying this payment policy:

- Centers for Medicare & Medicaid Services, Clinical Laboratory Fee Schedule
- American Medical Association, *Current Procedural Terminology (CPT®)* and related publications
- Centers for Medicare & Medicaid Services manual publications and applicable guidance

Provider Disclaimer

Codes listed in this policy are provided for reference only and may not be all-inclusive. Deleted codes, inactive codes, or codes that are not valid on the date of service may not be eligible for reimbursement. Inclusion or omission of a code, service, or reference in this policy does not guarantee coverage, authorization, payment, or reimbursement. Payment determinations are based on member eligibility, covered benefits, medical necessity, prior authorization requirements when applicable, correct coding, complete claim submission, provider contract terms, Community Health Choice reimbursement policies and system configuration, payment integrity review, and applicable federal and state requirements.

Community Health Choice follows the Current Procedural Terminology (CPT®) code set. CPT codes and descriptions are copyrighted by the American Medical Association (AMA) and are included for informational purposes only. CPT® is a registered trademark of the AMA. Community Health Choice reserves the right to revise, update, replace, or discontinue this policy at any time based on regulatory requirements, coding guidance, contract terms, benefit coverage, operational requirements, system configuration, payment integrity standards, or industry practice.

RELATED POLICIES

All Payment Policies