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Payment Policy

cmi_171661

Title	**Laboratory and Pathology Billing Guidelines**		
Number	**CP.PP.416.v1.4**		
Last Approval Date	04/07/25	**Original Effective Date**	04/28/21
Replaces			
Cross Reference	• *Blood Draw/Venipuncture - 36415* • *Medicare Indicator "Status B, Status P and Status T" Services* • *Modifier 26 – Professional Component* • *Modifier 76-Repeat Procedure by the Same Provider* • *Modifier 77-Repeat Procedure by Another Provider* • *Modifier 90 – Reference (Outside) Laboratory* • *Modifier 91 – Repeat Clinical Diagnostic Laboratory Test* • *Modifier TC – Technical Component* • *Modifiers XE, XS, SP and XU – Separate Encounter, Separate Structure, Separate Practitioner and Unusual Overlapping Service* • *Place of Service Codes*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose/ Application	To define how the Plan recognizes correct billing of laboratory/pathology services that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company, and Premera Blue Cross HMO lines of business and products.
Policy	This policy applies primarily to the following laboratory and pathology procedure codes when covered by a member's benefits or by a medical or payment policy: • Procedure codes in the Pathology and Laboratory section of the Current Procedural Terminology (CPT) codebook, • Appendix O-Multianalyte Assays with Algorithmic Analyses and Proprietary Laboratory Analyses codes in the CPT codebook, and • Pathology and Laboratory Services (P2028-P9615) codes in the Healthcare Common Procedure Coding System (HCPCS) codebook. The code that best describes the laboratory/pathology service performed should be selected. Laboratory/Pathology specimens include blood, other body fluids, tissue specimens, and organs. **<u>Organ and Disease Oriented Panels and Proprietary Lab Panels</u>** Organ and Disease Oriented Panels pertain to CPT codes 80047-80081. Proprietary Lab Panel codes pertain to codes listed in the Appendix O-Multianalyte Assays with Algorithmic Analyses and Proprietary Analyses codes in the CPT Codebook.

Organ or Disease Oriented Panel codes are defined by a single CPT procedure code which is made up of multiple individual lab test procedure codes. ALL tests listed in the organ or disease-oriented panels must be performed if the lab panel code is to be billed.

Other lab tests that are not part of the organ or disease-oriented lab panel CPT procedure codes or do not make up another lab panel can be billed separately. Each lab panel code is submitted as a single claim line with a single unit on a claim form**.**

If a group of lab tests overlap two or more lab panels, the lab panel code that incorporates the greatest number of tests should be reported and all the remaining tests that are not part of the panel should be billed separately.

Proprietary Lab test panels included in Appendix O of the current CPT codebook include:

- Multianalyte assays with algorithmic analysis (MAAA)
- Category I MAAA codes
- Proprietary laboratory analyses (PLA) codes

These codes are a unique proprietary make up of a variety of individual lab tests that are **NOT** part of a CPT code organ or disease-oriented lab panel but are unique to a specific laboratory (e.g., cardiovascular panels, genetic panels, etc.).

ALL the individual lab test procedure codes, whether organ or disease-oriented lab panels or proprietary lab test panels, rendered to the same patient by the same lab on the same date of service, must be billed on the same claim form to be reimbursed correctly. Failure to bill all lab services rendered on the same date of service on the same claim may result in the denial of reimbursement.

Surgical Pathology (88300-88309)

Per CPT Codebook guidelines, surgical pathology codes include accession, examination, and reporting. The unit of service for these codes is the specimen, the tissue(s) that are submitted for individual or separate attention, requiring individual examination and pathologic diagnosis.

Two or more specimens from the same patient are each appropriately assigned an individual code reflective of its proper level of service and may be reported on one line with multiple units. When **duplicate specimens** are reported with the same surgical pathology code, report the second and subsequent codes with one of the following modifiers:

- **XS** – Separate structure, a service that is distinct because it was performed on a separate organ/structure.
- **XU** – Unusual non-overlapping service, the use of a service that is distinct because it does not overlap unusual components of the main service.

Modifier 76-*Repeat procedure by the same provider* and modifier 77-*Repeat procedure by another provider* are **not** appropriate to be appended to a laboratory procedure code to represent a repeat lab service. Repeat lab tests should be appended with modifier 91-*Repeat clinical diagnostic laboratory test* **when subsequent testing meets the criteria**

for modifier 91 use (see Appendix A-Modifiers in the current version of the CPT Codebook.).

Any specimen that is not listed amongst those assigned to the surgical pathology codes should be assigned to the code which most closely reflects the physician's work involved.

Professional and Technical Laboratory Components

Premera uses criteria as established in the current Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (LINK) to identify those laboratory/pathology codes that have a professional or technical component. Specifically, the Plan follows the "PC/TC indicator flag" to determine professional and technical components and whether an appropriate modifier is required to indicate as such.

When billing for a professional lab service or a technical lab service, an appropriate modifier will be required to be appended on applicable laboratory procedure codes as determined by the PC/TC indicator. The correct modifiers to use are:

- **Modifier 26** – professional component of the lab test was performed.
- **Modifier TC** – the technical component of the lab test was performed.

The key "PC/TC indicator flags" that determine whether the lab code is a professional or technical procedure code and therefore **can/cannot** be billed with one of the applicable modifiers include:

- **0 – Physician service codes**
  - modifiers 26 and TC cannot be used with these codes
- **1 – Diagnostic tests for Radiology Services**
  - modifiers 26 and TC can be used with these codes
- **2 – Professional component only code**
  - code is inherently PROFESSIONAL;
  - modifier 26 and TC cannot be used with these codes
- **3 – Technical component only code**
  - code is inherently TECHNICAL;
  - modifier 26 and TC cannot be used with these codes
- **4 – Global Test only codes**
  - code is inherently GLOBAL;
  - modifiers 26 and TC cannot be used with these codes
- **5 – Incident to Codes**
  - modifiers 26 and TC cannot be used with these codes
- **6 – Laboratory physician interpretation codes**
  - modifier 26 can be used with these codes;
  - modifier TC cannot be billed with these codes
- **8 – Physician Interpretation code**
  - code is inherently PROFESSIONAL;
  - modifier 26 and TC cannot be used with these codes
- **9 – Not applicable**
  - concept of professional and technical components does not apply,

- modifiers 26 and TC should not be appended)

Review the applicable Payment Policies for modifier 26 and modifier TC for further details.

Routine Venipuncture (36415)

Only **one** venipuncture charge will be reimbursed per member, per provider per date of service regardless of the number of tests/draws performed. Payment will be made to the provider who extracted/performed the specimen blood drawn.

Dates of Service and billing codes on same claim

The date of service on the clinical lab test/surgical pathology code or service must be **the date the specimen was collected**. If the specimen was taken over 2 calendar days, use the date of service **when the collection ended**.

If a lab test is stored for more than 30 days prior to being evaluated/analyzed, the date of service should represent **the date the lab specimen was retrieved from storage**. If stored in less than 30 days, **the date of collection should be billed**.

When multiple lab services/procedures are analyzed on the same or different dates by the same lab for the same member, whether individual lab tests or lab panels (CPT panel codes or proprietary lab panels), **ALL the procedure codes for the tests performed must be billed on a single claim form, a single line for each lab test performed and the same date.** Failure to bill ALL the lab test procedure codes on a single claim may result in denial of reimbursement.

Lab Handling/Conveyance Fees

Lab handling and/or conveyance of specimen procedure codes 99000 and 99001 are Medicare Status B codes and not separately reimbursed.

Place of Service (POS) Codes

The place of service where the procedure is performed and who owns the equipment is used to determine which provider is able to bill for the components (technical, professional, or global) of the lab service.

Applicable POS codes include but are not limited to:

- **11 - Office**
- **19 – Off-campus Outpatient Hospital Clinic**
- **21 – Inpatient Hospital**
- **22 – On-campus Outpatient Hospital Clinic**
- **24 – Ambulatory Surgical Center**
- **81 - Independent Lab**

	When the patient specimen **originates in the Physician office setting** and ONLY the pathologist performs the Professional component: • Pathologist bills with POS 11 and modifier 26 on the lab test(s) • Technical component is performed and billed by an entity other than the pathology provider When the patient specimen **originates in either the Outpatient Hospital facility or Inpatient Hospital facility setting**: • If the technical component is performed by the hospital owned lab, the Hospital bills the lab service with modifier TC, and • If the professional component is performed by an outside Pathologist, the Pathologist bills with POS 19, 21, or 22 with modifier 26 • If the Hospital performs the "**global**" portion of the lab test(s) (both technical and professional components) in the hospital owned lab and the pathologist is an employee of the hospital, the hospital bills the global code with no modifiers and no separate professional billing is allowed. When the patient specimen is **obtained from a Physician Office or Ambulatory Surgery Center (ASC**) and **BOTH** the technical component and professional components are performed by an outside lab: • All tests are billed with POS 81 **<u>Standing Orders</u>** Standing orders for routine screening tests when a patient has no clinical symptoms are not covered. All lab tests, whether for screening or diagnostic purposes, must be accompanied by either a written physician order, a telephone call documented in the medical records of both the ordering physician and lab or by electronic mail from the requesting physician to the testing lab. Medical records may be requested for validation of physician order.
Codes and Coding Guidelines	
Violations of Policy	Violations of this policy by any party that enters a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined at the Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	
Laws, Regulations & Standards	

References and Resources	• American Medical Association Current Procedural Terminology (CPT) Codebook • Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System (HCPCS) codebook • Centers for Medicare and Medicaid Services National Physician Fee Schedule • Medicare Claims Processing Manual, 100-04, Ch 16-Laboratory Services, Sections 40.1, 60, 90.2 • Medicare Benefits Manual, 100-02, Ch 15-Covered Medical and Other Health Services, Section 80.6.1 • MLN Fact Sheet "Complying with Laboratory Services Documentation Requirements", September 2023, MLN909221

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department	
Annual Review Dates	04/07/25; 10/03/24; 01/16/24; 03/13/23; 04/08/22; 04/28/21	
Version History	04/28/21	Creation of new policy; effective with claims processed on and after July 5, 2021
	04/08/22	• Clarified in the opening paragraphs of the Policy that the policy pertains to codes in the Pathology and Laboratory and Appendix O of the CPT Codebook and the Pathology and Laboratory section of the HCPCS Codebook • Identified the three types of lab panels listed in Appendix O of the CPT Codebook • Added PC/TC Flag 4 to the list of PC/TC Indicator Flags • Added to the Standing Orders section in the Policy the medical records may be requested to validate that a physician order is on file for the lab work
	03/13/23	• In the Cross Reference section, two policies referencing Modifier 76 and 77 are added. • In the Policy section, added the following: o In the first paragraph, created sub-bullets of the types of procedure codes subject to the policy; o In the Surgical Pathology section, added a paragraph which references Modifier 76 and 77 usages; and o In the Place of Service code section, added place of service code 21-Inpatient Hospital which was missing
	01/16/24	• In the Surgical Pathology section, at the end of the third paragraph, added a sentence on how to correctly bill for repeat lab tests with modifier 91 • In the section Professional and Technical Lab Components, added the PC/TC Indicator flag 5 • Added the new section Lab Handling/Conveyance Fees
	10/03/24	Annual review; no changes
	04/07/25	In the Policy section, revised the subsection on Place of Service Codes (POS) and added examples.