Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-016		
Subject:	Physician Laboratory and Pathology Services		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	July 10, 2023	**Revised Date:**	July 2023
Date Reviewed:	July 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

COMMERCIAL REIMBURSEMENT GUIDELINES:

The total charge for a diagnostic study includes both a professional and a technical component. The technical component (modifier TC) is considered to be the performance of the test and is generally performed by non-physician personnel and/or automated equipment. The professional component (modifier 26) is the physician's involvement, including interpretation of the test results.

Generally, there is no identifiable personal physician involvement in a clinical pathology test. Claims reporting only the professional component of clinical pathology studies should be denied in all places of service. Further, claims reporting clinical pathology studies (total charge) rendered in a hospital setting (in-hospital or outpatient hospital) or skilled nursing facility should be denied.

Conversely, anatomic pathology studies require physician interpretation. Claims for these tests performed in the physician's office or an independent laboratory should be reimbursed as a total service unless otherwise reported. Anatomic pathology performed in a hospital setting (in-hospital, outpatient hospital or skilled nursing facility) should be paid as a professional component.

The following procedure codes designate anatomic pathology studies (although some of the services listed may not be eligible for payment):

85097	88104	88160	88199	88272	88313	88356	88388	89321
85396	88106	88161	88230	88273	88314	88358	88399	89322
88000	88108	88162	88233	88274	88319	88360	89220	89325
88005	88112	88164	88235	88275	88321	88361	89250	89335
88007	88120	88165	88237	88280	88323	88362	89251	89342

88012	88121	88166	88239	88283	88325	88363	89253	89343
88014	88125	88167	88240	88285	88329	88364	89254	89344
88016	88130	88172	88241	88289	88331	88365	89255	89346
88020	88140	88173	88245	88291	88332	88366	89257	89352
88025	88141	88174	88248	88299	88333	88367	89260	89353
88027	88142	88175	88249	88300	88334	88368	89261	89354
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88029	88147	88182	88262	88304	88342	88373	89272	G0416
88036	88148	88184	88263	88305	88344	88374	89280	
88037	88150	88185	88264	88307	88346	88377	89281	
88040	88152	88187	88267	88309	88348	88380	89300	
88045	88153	88188	88269	88311	88350	88381	89310	
88099	88155	88189	88271	88312	88355	88387	89320	

Although, the following pathology tests are classified as clinical pathology services, they require personal physician involvement in providing an appropriate analysis of the results. Therefore, when billed, the professional component for these services should be paid:

83020	84181	85390	86255	86325	86335	88371	89060	*86079
84165	84182	85576	86256	86327	87164	88372	*86077	G0452
84166	85060	86153	86320	86334	87207	88375	*86078	

***Note**: Blood banking services of hematologists and pathologists are paid under the physician fee schedule when analyses are performed on donor and/or patient blood to determine compatible donor units for transfusion where cross matching is difficult or where contamination with transmissible disease of donor is suspected.

Claims for clinical pathology studies performed out-of-state are reimbursable regardless of place of service or whether or not it is the practice of the Blue Shield Plan of that state.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

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- Surgical pathology services;
- Specific cytopathology, hematology and blood banking services that have been identified to require performance by a physician and are listed below;
- Clinical pathology consultation services that meet the requirements discussed in Medicare Advantage Medical Policy Bulletin N-161; **and**,
- Clinical laboratory interpretation services that meet the requirements and which are specifically listed under Clinical Laboratory Interpretation Services in this policy.

Surgical Pathology

Surgical pathology services include the gross and microscopic examination of organ tissue performed by a physician, except for autopsies, which are not covered.

Either, the professional component, the technical component or both components may be paid for the following surgical pathology services:

88300	88309	88319	88334	88348	88361	88367	88377
88302	88311	88323	88341	88355	88362	88368	88380
88304	88312	88331	88342	88356	88364	88369	88381
88305	88313	88332	88344	88358	88365	88373	88387
88307	88314	88333	88346	88360	88366	88374	88388

Code 88341 is for each additional single antibody stain procedure. Code 88341 is out of sequence and can *only be reported* in conjunction with code 88342.

Code 88344 is for each multiplex antibody stain procedure.

Only one unit of each of these 3 codes, 88341, 88342, and 88344 can be reported for each separately identifiable antibody per specimen.

Codes 88321, 88325 and 88329 represent physician services.

Cytopathology

Cytopathology services include the examination of cells from fluids, washings, brushings or smears, but generally exclude hematology. Examining cervical and vaginal smears are the most common service in cytopathology. Cervical and vaginal smears do not require interpretation by a physician unless the results are or appear to be abnormal. In such cases, a physician personally conducts a separate microscopic evaluation to determine the nature of an abnormality. This microscopic evaluation ordinarily does require performance by a physician.

When medically necessary and when furnished by a physician, the professional component of the following services is eligible:

88104	88108	88120	88125	88161	88172	88177
88106	88112	88121	88160	88162	88173	88182

Codes 88141, 88187, 88188, and 88189 represent only the professional service.

Physician hematology services include microscopic evaluation of bone marrow aspirations and biopsies. It also includes those limited number of peripheral blood smears which need to be referred to a physician to evaluate the nature of an apparent abnormality identified by the technologist. These codes include 85060 and 85097.

The professional component for the interpretation of an abnormal blood smear (code 85060) furnished to a hospital inpatient by a hospital physician or an independent laboratory is eligible for reimbursement.

For the other listed hematology codes (85390 and 85576), payment may be made for the professional component if the service is furnished to a patient by a hospital physician or independent laboratory.

Codes 85060 and 85097 represent professional-only component services and have no technical component values.

Blood banking services of hematologists and pathologists are paid when analyses are performed on donor and/or patient blood to determine compatible donor units for transfusion where cross matching is difficult or where contamination with transmissible disease of donor is suspected.

The blood banking codes are 86077, 86078, and 86079 and represent physician-only services.

Reasons for Noncoverage

Codes 80503, 80504, 80505, 80506 represent consultation services. Therefore, the technical components (modifier TC) and professional component (PC) concept does not apply.

The following services represent only professional services. Therefore, the technical component (modifier TC) and total component concepts do not apply:

85060 85097 86077 86078 86079 88141 88321 88325 88329

Claims reporting only the professional component for laboratory and pathology services not addressed on this policy are not covered. A provider cannot bill the member for the denied service.

Services are denied non-covered and therefore, not medically necessary.

Documentation Requirements

Medical record documentation should support the service that was reported and also indicate that the requirements for a Clinical Consultation have been met.

Medical record documentation should support the medical necessity for interpretation by a physician for services listed under Specific Hematology, Cytopathology and Blood Banking Services.

Medical record documentation should support the medical necessity for separate review and interpretation of cytopathology studies.

Denial Statements

Services denied as not reasonable and medically necessary, under section 1862(a) (1) of the Social Security Act, are subject to the Limitation of Liability provision. A contracted provider must inform the enrollee to request an organization determination from The Plan or the provider can request the organization determination on the enrollee's behalf. Failure to provide a compliant denial to the enrollee means that the enrollee is not liable for services provided by a contracted provider or upon referral from a contracted provider.

DEFINITIONS:

Modifier	Definition
26	Professional component
TC	Technical component

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed
- RP-035: Correct Coding Guidelines
- MRP-002: Reporting Clinical Pathology Consultation Services

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

Providers will report on the claim, the date of service in which the service was provided. For instance, if a professional service (26 modifier) is being reported, the date of service reported on the claim should be the date in which that professional component was provided, not the date in which the technical component was administered.

REFERENCES:

- Title XVIII of the Social Security Act, Section 1862(a)(7), and (a)(1)(A)
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- CMS online Manual, Pub. 100-04. Chapter 12, Section 60.
- CMS Online Manual, Pub. 100-04 Claims Processing, Transmittal 382, CR 3467. Effective November, 2004.
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POLICY UPDATE HISTORY INFORMATION:

10 / 2017	Implementation
4 / 2020	Removed codes 82131, 82542, 84999 and added 86153, 88371, 88372
10 / 2020	Added notification exception for codes 99000 and 99001 regarding PHE
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy
2 / 2022	Removed G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001
6 / 2022	Removed 0058T and replaced codes 80500, 80502 with 80503, 80504, 80505, 80506
7 / 2023	Removed PHE exception note for codes 99000 and 99001

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Bulletin Number:	RP-016		
Subject:	Physician Laboratory and Pathology Services		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	June 27, 2022	**Revised Date:**	June 2022
Date Reviewed:	June 2022		
Source:	Reimbursement Policy		

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Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
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Claims for clinical pathology studies performed out-of-state are reimbursable regardless of place of service or whether or not it is the practice of the Blue Shield Plan of that state.

Note: As 99000 and 99001 are not clinical pathology test, the terms of this policy will not apply to those codes in order to assist with the Public Health Emergency declared by the Department of Health and Human Services (HHS). This exception payment will remain in place until the PHE expires.

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6 / 2022	Removed 0058T, Replaced 80500, 80502 with 80503, 80504, 80505, 80506, Replaced N-116 with MRP-002 in reference section. Added RP-035

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-016		
Subject:	Physician Laboratory and Pathology Services		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	January 3, 2022	**Revised Date:**	January 2022
Date Reviewed:	October 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
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Separate payment for a physician's interpretation of a pap smear to any patient (i.e., hospital or non-hospital) is eligible as long as:

1. The laboratory's screening personnel suspect an abnormality; **and,**
2. the physician reviews and interprets the pap smear.

This policy also applies to screening pap smears requiring a physician interpretation. These services are reported under codes G0124, G0141, or P3001.

Physician hematology services include microscopic evaluation of bone marrow aspirations and biopsies. It also includes those limited number of peripheral blood smears which need to be referred to a physician to evaluate the nature of an apparent abnormality identified by the technologist. These codes include 85060 and 85097.

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For the other listed hematology codes (85390 and 85576), payment may be made for the professional component if the service is furnished to a patient by a hospital physician or independent laboratory.

Codes 85060 and 85097 represent professional-only component services and have no technical component values.

Blood banking services of hematologists and pathologists are paid when analyses are performed on donor and/or patient blood to determine compatible donor units for transfusion where cross matching is difficult or where contamination with transmissible disease of donor is suspected.

The blood banking codes are 86077, 86078, and 86079 and represent physician-only services.

Reasons for Noncoverage

Codes 80500 and 80502 represent consultation services. Therefore, the technical components (modifier TC) and professional component (PC) concept does not apply.

The following services represent only professional services. Therefore, the technical component (modifier TC) and total component concepts do not apply:

85060 85097 86077 86078 86079 88141 88321 88325 88329

Claims reporting only the professional component for laboratory and pathology services not addressed on this policy are not covered. A provider cannot bill the member for the denied service.

Services are denied non-covered and therefore, not medically necessary.

Documentation Requirements

Medical record documentation should support the service that was reported and also indicate that the requirements for a Clinical Consultation have been met.

Medical record documentation should support the medical necessity for interpretation by a physician for services listed under Specific Hematology, Cytopathology and Blood Banking Services.

Medical record documentation should support the medical necessity for separate review and interpretation of cytopathology studies.

Denial Statements

Services denied as not reasonable and medically necessary, under section 1862(a) (1) of the Social Security Act, are subject to the Limitation of Liability provision. A contracted provider must inform the enrollee to request an organization determination from The Plan or the provider can request the organization determination on the enrollee's behalf. Failure to provide a compliant denial to the enrollee means that the enrollee is not liable for services provided by a contracted provider or upon referral from a contracted provider.

RELATED MEDICAL POLICIES:

Refer to the following Medicare Advantage Medical Policies for additional information:

- N-161: Clinical Pathology Consultation Services

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

Providers will report on the claim, the date of service in which the service was provided. For instance, if a professional service (26 modifier) is being reported, the date of service reported on the claim should be the date in which that professional component was provided, not the date in which the technical component was administered.

REFERENCES:

- Title XVIII of the Social Security Act, Section 1862(a)(7), and (a)(1)(A)
- Title XVIII of the Social Security Act, Section 1833(e)
- CMS online Manual, Pub. 100-04. Chapter 12, Section 60.
- CMS Online Manual, Pub. 100-04 Claims Processing, Transmittal 382, CR 3467. Effective November, 2004.
- CMS Manual Online Pub. 100-04. Transmittal 2857, CR 8567. Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits. Effective January, 2014.
- MLN Matters, Screening Pap Tests and Pelvic Examinations. Effective December, 2015.

POLICY UPDATE HISTORY INFORMATION:

10 / 2017	Implementation
4 / 2020	Removed codes 82131, 82542, 84999. Added 86153, 88371, 88372.
10 / 2020	Added notification exception for codes 99000 and 99001 regarding PHE
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP- 016		
Subject:	Physician Laboratory and Pathology Services		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☐	**NY** ☒
Applicable Claim Type	**UB**	☐	**1500**	☒			

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

COMMERCIAL REIMBURSEMENT GUIDELINES:

The total charge for a diagnostic study includes both a professional and a technical component. The technical component (modifier TC) is considered to be the performance of the test and is generally performed by non-physician personnel and/or automated equipment. The professional component (modifier 26) is the physician's involvement, including interpretation of the test results.

Generally, there is no identifiable personal physician involvement in a clinical pathology test. Claims reporting only the professional component of clinical pathology studies should be denied in all places of service. Further, claims reporting clinical pathology studies (total charge) rendered in a hospital setting (in-hospital or outpatient hospital) or skilled nursing facility should be denied.

Conversely, anatomic pathology studies require physician interpretation. Claims for these tests performed in the physician's office or an independent laboratory should be reimbursed as a total service unless otherwise reported. Anatomic pathology performed in a hospital setting (in-hospital, outpatient hospital or skilled nursing facility) should be paid as a professional component.

The following procedure codes designate anatomic pathology studies (although some of the services listed may not be eligible for payment):

85097	85396	88000	88005	88007	88012	88014	88016	88020
88025	88027	88028	88029	88036	88037	88040	88045	88099
88104	88106	88108	88112	88120	88121	88125	88130	88140
88141	88142	88143	88147	88148	88150	88152	88153	

88155	88160	88161	88162	88164	88165	88166	88167	88172
88173	88174	88175	88177	88182	88184	88185	88187	88188
88189	88199	88230	88233	88235	88237	88239	88240	88241
88245	88248	88249	88261	88262	88263	88264	88267	88269
88271	88272	88273	88274	88275	88280	88283	88285	88289
88291	88299	88300	88302	88304	88305	88307	88309	88311
88312	88313	88314	88319	88321	88323	88325	88329	88331
88332	88333	88334	88341	88342	88344	88346	88348	88350
88355	88356	88358	88360	88361	88362	88363	88364	88365
88366	88367	88368	88369			88373	88374	88377
88380	88381	88387	88388	88399	89220	89250	89251	89253
89254	89255	89257	89260	89261	89268	89272	89280	89281
89300	89310	89320	89321	89322	89325	89335	89342	89343
89344	89346	89352	89353	89354	89356	G0123	G0124	G0141
G0143	G0144	G0145	G0147	G0148	G0416	P3000	P30001	0058T

Although, the following pathology tests are classified as clinical pathology services, they require personal physician involvement in providing an appropriate analysis of the results. Therefore, when billed, the professional component for these services should be paid:

83020	84165	84166	84181	84182	85060	85390	85576	*86077
*86078	*86079	86153	86255	86256	86320	86325	86327	86334
86335	87164	87207	88371	88372	88375	89060	G0452	

***Note**: Blood banking services of hematologists and pathologists are paid under the physician fee schedule when analyses are performed on donor and/or patient blood to determine compatible donor units for transfusion where cross matching is difficult or where contamination with transmissible disease of donor is suspected.

Claims for clinical pathology studies performed out-of-state are reimbursable regardless of place of service or whether or not it is the practice of the Blue Shield Plan of that state.

Note: As 99000 and 99001 are not clinical pathology test, the terms of this policy will not apply to those codes in order to assist with the Public Health Emergency declared by the Department of Health and Human Services (HHS). This exception payment will remain in place until the PHE expires.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

Payments for physician laboratory and pathology services are limited to:

- Surgical pathology services;
- Specific cytopathology, hematology and blood banking services that have been identified to require performance by a physician and are listed below;
- Clinical pathology consultation services that meet the requirements discussed in Medicare Advantage Medical Policy Bulletin N-161; **and**,

- Clinical laboratory interpretation services that meet the requirements and which are specifically listed under Clinical Laboratory Interpretation Services in this policy.

Surgical Pathology

Surgical pathology services include the gross and microscopic examination of organ tissue performed by a physician, except for autopsies, which are not covered.

Either, the professional component, the technical component or both components may be paid for the following surgical pathology services:

88300	88302	88304	88305	88307	88309	88311	88312	88313
88314	88319	88323	88331	88332	88333	88334	88341	88342
88344	88346	88348	88355	88356	88358	88360	88361	88362
88364	88365	88366	88367	88368	88369	88373	88374	88377
88380	88381	88387	88388					

Code 88341 is for each additional single antibody stain procedure. Code 88341 is out of sequence and can *only be reported* in conjunction with code 88342.

Code 88344 is for each multiplex antibody stain procedure.

Only one unit of each of these 3 codes, 88341, 88342, and 88344 can be reported for each separately identifiable antibody per specimen.

Codes 88321, 88325 and 88329 represent physician services.

Cytopathology

Cytopathology services include the examination of cells from fluids, washings, brushings or smears, but generally exclude hematology. Examining cervical and vaginal smears are the most common service in cytopathology. Cervical and vaginal smears do not require interpretation by a physician unless the results are or appear to be abnormal. In such cases, a physician personally conducts a separate microscopic evaluation to determine the nature of an abnormality. This microscopic evaluation ordinarily does require performance by a physician.

When medically necessary and when furnished by a physician, the professional component of the following services is eligible:

88104	88106	88108	88112	88120	88121	88125	88160	88161
88162	88172	88173	88177	88182				

Codes 88141, 88187, 88188, and 88189 represent only the professional service.

Separate payment for a physician's interpretation of a pap smear to any patient (i.e., hospital or non-hospital) is eligible as long as:

1. The laboratory's screening personnel suspect an abnormality; **and,**
2. the physician reviews and interprets the pap smear.

This policy also applies to screening pap smears requiring a physician interpretation. These services are reported under codes G0124, G0141, or P3001.

Physician hematology services include microscopic evaluation of bone marrow aspirations and biopsies. It also includes those limited number of peripheral blood smears which need to be referred to a physician to evaluate the nature of an apparent abnormality identified by the technologist. These codes include 85060 and 85097.

The professional component for the interpretation of an abnormal blood smear (code 85060) furnished to a hospital inpatient by a hospital physician or an independent laboratory is eligible for reimbursement.

For the other listed hematology codes (85390 and 85576), payment may be made for the professional component if the service is furnished to a patient by a hospital physician or independent laboratory.

Codes 85060 and 85097 represent professional-only component services and have no technical component values.

Blood banking services of hematologists and pathologists are paid when analyses are performed on donor and/or patient blood to determine compatible donor units for transfusion where cross matching is difficult or where contamination with transmissible disease of donor is suspected.

The blood banking codes are 86077, 86078, and 86079 and represent physician-only services.

Reasons for Noncoverage

Codes 80500 and 80502 represent consultation services. Therefore, the technical components (modifier TC) and professional component (PC) concept does not apply.

The following services represent only professional services. Therefore, the technical component (modifier TC) and total component concepts do not apply:

85060 85097 86077 86078 86079 88141 88321 88325 88329

Claims reporting only the professional component for laboratory and pathology services not addressed on this policy are not covered. A provider cannot bill the member for the denied service.

Services are denied non-covered and therefore, not medically necessary.

Documentation Requirements

Medical record documentation should support the service that was reported and also indicate that the requirements for a Clinical Consultation have been met.

Medical record documentation should support the medical necessity for interpretation by a physician for services listed under Specific Hematology, Cytopathology and Blood Banking Services.

Medical record documentation should support the medical necessity for separate review and interpretation of cytopathology studies.

Denial Statements

Services denied as not reasonable and medically necessary, under section 1862(a) (1) of the Social Security Act, are subject to the Limitation of Liability provision. A contracted provider must inform the enrollee to request an organization determination from The Plan or the provider can request the

organization determination on the enrollee's behalf. Failure to provide a compliant denial to the enrollee means that the enrollee is not liable for services provided by a contracted provider or upon referral from a contracted provider.

RELATED MEDICAL POLICIES:

Refer to the following Medicare Advantage Medical Policies for additional information:

- N-161: Clinical Pathology Consultation Services

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

Providers will report on the claim, the date of service in which the service was provided. For instance, if a professional service (26 modifier) is being reported, the date of service reported on the claim should be the date in which that professional component was provided, not the date in which the technical component was administered.

REFERENCES:

- Title XVIII of the Social Security Act, Section 1862(a)(7), and (a)(1)(A)
- Title XVIII of the Social Security Act, Section 1833(e)
- CMS online Manual, Pub. 100-04. Chapter 12, Section 60.
- CMS Online Manual, Pub. 100-04 Claims Processing, Transmittal 382, CR 3467. Effective November, 2004.
- CMS Manual Online Pub. 100-04. Transmittal 2857, CR 8567. Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits. Effective January, 2014.
- MLN Matters, Screening Pap Tests and Pelvic Examinations. Effective December, 2015.

POLICY UPDATE HISTORY INFORMATION:

10 / 2017	Implementation
4 / 2020	Removed codes 82131, 82542, 84999. Added 86153, 88371, 88372.
10 / 2020	Added notification exception for codes 99000 and 99001 regarding PHE
11 / 2021	Added NY region applicable to the policy

Highmark Reimbursement Policy Bulletin

HISTORY VERSIONS

Bulletin Number:	RP-016		
Subject:	Physician Laboratory and Pathology Services		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	October 26, 2020	**Revised Date:**	October 2020
Date Reviewed:	October 2020		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV** ☒		
Applicable Claim Type	**UB**	☐	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

The total charge for a diagnostic study includes both a professional and a technical component. The technical component (modifier TC) is considered to be the performance of the test and is generally performed by non-physician personnel and/or automated equipment. The professional component (modifier 26) is the physician's involvement, including interpretation of the test results.

REIMBURSEMENT GUIDELINES:

Generally, there is no identifiable personal physician involvement in a clinical pathology test. Claims reporting only the professional component of clinical pathology studies should be denied in all places of service. Further, claims reporting clinical pathology studies (total charge) rendered in a hospital setting (in-hospital or outpatient hospital) or skilled nursing facility should be denied.

Conversely, anatomic pathology studies require physician interpretation. Claims for these tests performed in the physician's office or an independent laboratory should be reimbursed as a total service unless otherwise reported. Anatomic pathology performed in a hospital setting (in-hospital, outpatient hospital or skilled nursing facility) should be paid as a professional component.

The following procedure codes designate anatomic pathology studies (although some of the services listed may not be eligible for payment):

85097	85396	88000	88005	88007	88012	88014	88016	88020
88025	88027	88028	88029	88036	88037	88040	88045	88099
88104	88106	88108	88112	88120	88121	88125	88130	88140
88141	88142	88143	88147	88148	88150	88152	88153	
88155	88160	88161	88162	88164	88165	88166	88167	88172
88173	88174	88175	88177	88182	88184	88185	88187	88188
88189	88199	88230	88233	88235	88237	88239	88240	88241
88245	88248	88249	88261	88262	88263	88264	88267	88269
88271	88272	88273	88274	88275	88280	88283	88285	88289
88291	88299	88300	88302	88304	88305	88307	88309	88311
88312	88313	88314	88319	88321	88323	88325	88329	88331
88332	88333	88334	88341	88342	88344	88346	88348	88350
88355	88356	88358	88360	88361	88362	88363	88364	88365
88366	88367	88368	88369			88373	88374	88377
88380	88381	88387	88388	88399	89220	89250	89251	89253
89254	89255	89257	89260	89261	89268	89272	89280	89281
89300	89310	89320	89321	89322	89325	89335	89342	89343
89344	89346	89352	89353	89354	89356	G0123	G0124	G0141
G0143	G0144	G0145	G0147	G0148	G0416	P3000	P30001	0058T

Although, the following pathology tests are classified as clinical pathology services, they require personal physician involvement in providing an appropriate analysis of the results. Therefore, when billed, the professional component for these services should be paid:

83020	84165	84166	84181	84182	85060	85390	85576	*86077
*86078	*86079	86153	86255	86256	86320	86325	86327	86334
86335	87164	87207	88371	88372	88375	89060	G0452	

***Note**: Blood banking services of hematologists and pathologists are paid under the physician fee schedule when analyses are performed on donor and/or patient blood to determine compatible donor units for transfusion where cross matching is difficult or where contamination with transmissible disease of donor is suspected.

Claims for clinical pathology studies performed out-of-state are reimbursable regardless of place of service or whether or not it is the practice of the Blue Shield Plan of that state.

Note: As 99000 and 99001 are not clinical pathology test, the terms of this policy will not apply to those codes in order to assist with the Public Health Emergency declared by the Department of Health and Human Services (HHS). This exception payment will remain in place until the PHE expires.

Medicare Advantage

Payments for physician laboratory and pathology services are limited to:

- Surgical pathology services;
- Specific cytopathology, hematology and blood banking services that have been identified to require performance by a physician and are listed below;
- Clinical pathology consultation services that meet the requirements discussed in Medicare Advantage Medical Policy Bulletin N-161; **and**,
- Clinical laboratory interpretation services that meet the requirements and which are specifically listed under Clinical Laboratory Interpretation Services in this policy.

Surgical Pathology

Surgical pathology services include the gross and microscopic examination of organ tissue performed by a physician, except for autopsies, which are not covered.

Either, the professional component, the technical component or both components may be paid for the following surgical pathology services:

88300	88302	88304	88305	88307	88309	88311	88312	88313
88314	88319	88323	88331	88332	88333	88334	88341	88342
88344	88346	88348	88355	88356	88358	88360	88361	88362
88364	88365	88366	88367	88368	88369	88373	88374	88377
88380	88381	88387	88388					

Code 88341 is for each additional single antibody stain procedure. Code 88341 is out of sequence and can *only be reported* in conjunction with code 88342.

Code 88344 is for each multiplex antibody stain procedure.

Only one unit of each of these 3 codes, 88341, 88342, and 88344 can be reported for each separately identifiable antibody per specimen.

Codes 88321, 88325 and 88329 represent physician services.

Cytopathology

Cytopathology services include the examination of cells from fluids, washings, brushings or smears, but generally exclude hematology. Examining cervical and vaginal smears are the most common service in cytopathology. Cervical and vaginal smears do not require interpretation by a physician unless the results are or appear to be abnormal. In such cases, a physician personally conducts a separate microscopic evaluation to determine the nature of an abnormality. This microscopic evaluation ordinarily does require performance by a physician.

When medically necessary and when furnished by a physician, the professional component of the following services is eligible:

88104	88106	88108	88112	88120	88121	88125	88160	88161
88162	88172	88173	88177	88182				

Codes 88141, 88187, 88188, and 88189 represent only the professional service.

Separate payment for a physician's interpretation of a pap smear to any patient (i.e., hospital or non-hospital) is eligible as long as:

1. The laboratory's screening personnel suspect an abnormality; **and,**
2. the physician reviews and interprets the pap smear.

This policy also applies to screening pap smears requiring a physician interpretation. These services are reported under codes G0124, G0141, or P3001.

Physician hematology services include microscopic evaluation of bone marrow aspirations and biopsies. It also includes those limited number of peripheral blood smears which need to be referred to a physician to evaluate the nature of an apparent abnormality identified by the technologist. These codes include 85060 and 85097.

The professional component for the interpretation of an abnormal blood smear (code 85060) furnished to a hospital inpatient by a hospital physician or an independent laboratory is eligible for reimbursement.

For the other listed hematology codes (85390 and 85576), payment may be made for the professional component if the service is furnished to a patient by a hospital physician or independent laboratory.

Codes 85060 and 85097 represent professional-only component services and have no technical component values.

Blood banking services of hematologists and pathologists are paid when analyses are performed on donor and/or patient blood to determine compatible donor units for transfusion where cross matching is difficult or where contamination with transmissible disease of donor is suspected.

The blood banking codes are 86077, 86078, and 86079 and represent physician-only services.

Reasons for Noncoverage

Codes 80500 and 80502 represent consultation services. Therefore, the technical components (modifier TC) and professional component (PC) concept does not apply.

The following services represent only professional services. Therefore, the technical component (modifier TC) and total component concepts do not apply:

85060 85097 86077 86078 86079 88141 88321 88325 88329

Claims reporting only the professional component for laboratory and pathology services not addressed on this policy are not covered. A provider cannot bill the member for the denied service.

Services are denied non-covered and therefore, not medically necessary.

Documentation Requirements

Medical record documentation should support the service that was reported and also indicate that the requirements for a Clinical Consultation have been met.

Medical record documentation should support the medical necessity for interpretation by a physician for services listed under Specific Hematology, Cytopathology and Blood Banking Services.

Medical record documentation should support the medical necessity for separate review and interpretation of cytopathology studies.

Denial Statements

Services denied as not reasonable and medically necessary, under section 1862(a) (1) of the Social Security Act, are subject to the Limitation of Liability provision. A contracted provider must inform the enrollee to request an organization determination from The Plan or the provider can request the organization determination on the enrollee's behalf. Failure to provide a compliant denial to the enrollee means that the enrollee is not liable for services provided by a contracted provider or upon referral from a contracted provider.

RELATED MEDICAL POLICIES:

Refer to the following Medical Policies for additional information:

- Medicare Advantage N-161: Clinical Pathology Consultation Services

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

Providers will report on the claim, the date of service in which the service was provided. For instance, if a professional service (26 modifier) is being reported, the date of service reported on the claim should be the date in which that professional component was provided, not the date in which the technical component was administered.

REFERENCES:

- Title XVIII of the Social Security Act, Section 1862(a)(7), and (a)(1)(A)
- Title XVIII of the Social Security Act, Section 1833(e)
- CMS online Manual, Pub. 100-04. Chapter 12, Section 60.
- CMS Online Manual, Pub. 100-04 Claims Processing, Transmittal 382, CR 3467. Effective November, 2004.
- CMS Manual Online Pub. 100-04. Transmittal 2857, CR 8567. Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits. Effective January, 2014.
- MLN Matters, Screening Pap Tests and Pelvic Examinations. Effective December, 2015.

POLICY UPDATE HISTORY INFORMATION:

10 / 2017	Implementation

4 / 2020	Removed codes 82131, 82542, 84999. Added 86153, 88371, 88372.
10 / 2020	Added notification exception for codes 99000 and 99001 regarding PHE

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-016		
Subject:	Physician Laboratory and Pathology Services		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	October 2, 2017		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒		
Applicable Claim Type	**UB**	☐	**1500**	☒		

Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreements supersede Reimbursement Policy direction and regional applicability.

PURPOSE:

The total charge for a diagnostic study includes both a professional and a technical component. The technical component (modifier TC) is considered to be the performance of the test and is generally performed by non-physician personnel and/or automated equipment. The professional component (modifier 26) is the physician's involvement, including interpretation of the test results.

REIMBURSEMENT GUIDELINES:

Generally, there is no identifiable personal physician involvement in a clinical pathology test. Claims reporting only the professional component of clinical pathology studies should be denied in all places of service. Further, claims reporting clinical pathology studies (total charge) rendered in a hospital setting (in-hospital or outpatient hospital) or skilled nursing facility should be denied.

Conversely, anatomic pathology studies require physician interpretation. Claims for these tests performed in the physician's office or an independent laboratory should be reimbursed as a total service unless otherwise reported. Anatomic pathology performed in a hospital setting (in-hospital, outpatient hospital or skilled nursing facility) should be paid as a professional component.

The following procedure codes designate anatomic pathology studies (although some of the services listed may not be eligible for payment):

85097	85396	88000	88005	88007	88012	88014	88016	88020
88025	88027	88028	88029	88036	88037	88040	88045	88099
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88173	88174	88175	88177	88182	88184	88185	88187	88188
88189	88199	88230	88233	88235	88237	88239	88240	88241
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88312	88313	88314	88319	88321	88323	88325	88329	88331
88332	88333	88334	88341	88342	88344	88346	88348	88350
88355	88356	88358	88360	88361	88362	88363	88364	88365
88366	88367	88368	88369	88371	88372	88373	88374	88377
88380	88381	88387	88388	88399	89220	89250	89251	89253
89254	89255	89257	89260	89261	89268	89272	89280	89281
89300	89310	89320	89321	89322	89325	89335	89342	89343
89344	89346	89352	89353	89354	89356	G0123	G0124	G0141
G0143	G0144	G0145	G0147	G0148	G0416	P3000	P30001	0058T

Although, the following pathology tests are classified as clinical pathology services, they require personal physician involvement in providing an appropriate analysis of the results. Therefore, when billed, the professional component for these services should be paid:

82131	82542	83020	84165	84166	84181	84182	*84999	85060
85390	85576	86077	86078	86079	86255	86256	86320	86325
86327	86334	86335	87164	87207	88375	89060	G0452	

* When reported for mass spectral analysis of organic compound with mass spectrometer.

Claims for clinical pathology studies performed out-of-state are reimbursable regardless of place of service or whether or not it is the practice of the Blue Shield Plan of that state.

Medicare Advantage Provision

Payments for physician laboratory and pathology services are limited to:

- Surgical pathology services;
- Specific cytopathology, hematology and blood banking services that have been identified to require performance by a physician and are listed below;
- Clinical pathology consultation services that meet the requirements discussed in Medicare Advantage Medical Policy Bulletin N-161; **and**,
- Clinical laboratory interpretation services that meet the requirements and which are specifically listed under Clinical Laboratory Interpretation Services in this policy.

Surgical Pathology

Surgical pathology services include the gross and microscopic examination of organ tissue performed by a physician, except for autopsies, which are not covered.

Either, the professional component, the technical component or both components may be paid for the following surgical pathology services:

88300	88302	88304	88305	88307	88309	88311	88312	88313
88314	88319	88323	88331	88332	88333	88334	88341	88342
88344	88346	88348	88355	88356	88358	88360	88361	88362
88364	88365	88366	88367	88368	88369	88373	88374	88377
88380	88381	88387	88388					

Code 88341 is for each additional single antibody stain procedure. Code 88341 is out of sequence and can *only be reported* in conjunction with code 88342.

Code 88344 is for each multiplex antibody stain procedure.

Only one unit of each of these 3 codes, 88341, 88342, and 88344 can be reported for each separately identifiable antibody per specimen.

Codes 88321, 88325 and 88329 represent physician services.

Cytopathology

Cytopathology services include the examination of cells from fluids, washings, brushings or smears, but generally exclude hematology. Examining cervical and vaginal smears are the most common service in cytopathology. Cervical and vaginal smears do not require interpretation by a physician unless the results are or appear to be abnormal. In such cases, a physician personally conducts a separate microscopic evaluation to determine the nature of an abnormality. This microscopic evaluation ordinarily does require performance by a physician.

When medically necessary and when furnished by a physician, the professional component of the following services is eligible:

88104	88106	88108	88112	88120	88121	88125	88160	88161
88162	88172	88173	88177	88182				

Codes 88141, 88187, 88188, and 88189 represent only the professional service.

Separate payment for a physician's interpretation of a pap smear to any patient (i.e., hospital or non-hospital) is eligible as long as:

1. The laboratory's screening personnel suspect an abnormality; **and,**
2. the physician reviews and interprets the pap smear.

This policy also applies to screening pap smears requiring a physician interpretation. These services are reported under codes G0124, G0141, or P3001.

Physician hematology services include microscopic evaluation of bone marrow aspirations and biopsies. It also includes those limited number of peripheral blood smears which need to be referred to a physician to evaluate the nature of an apparent abnormality identified by the technologist. These codes include 85060 and 85097.

The professional component for the interpretation of an abnormal blood smear (code 85060) furnished to a hospital inpatient by a hospital physician or an independent laboratory is eligible for reimbursement.

For the other listed hematology codes (85390 and 85576), payment may be made for the professional component if the service is furnished to a patient by a hospital physician or independent laboratory.

Codes 85060 and 85097 represent professional-only component services and have no technical component values.

Blood banking services of hematologists and pathologists are paid when analyses are performed on donor and/or patient blood to determine compatible donor units for transfusion where cross matching is difficult or where contamination with transmissible disease of donor is suspected.

The blood banking codes are 86077, 86078, and 86079 and represent physician-only services.

Reasons for Noncoverage

Codes 80500 and 80502 represent consultation services. Therefore, the technical components (modifier TC) and professional component (PC) concept does not apply.

The following services represent only professional services. Therefore, the technical component (modifier TC) and total component concepts do not apply:

85060	85097	86077	86078	86079	88141	88321	88325	88329

Claims reporting only the professional component for laboratory and pathology services not addressed on this policy are not covered. A provider cannot bill the member for the denied service.

Services are denied non-covered and therefore, not medically necessary.

Documentation Requirements

Medical record documentation should support the service that was reported and also indicate that the requirements for a Clinical Consultation have been met.

Medical record documentation should support the medical necessity for interpretation by a physician for services listed under Specific Hematology, Cytopathology and Blood Banking Services.

Medical record documentation should support the medical necessity for separate review and interpretation of cytopathology studies.

Denial Statements

Services denied as not reasonable and medically necessary, under section 1862(a) (1) of the Social Security Act, are subject to the Limitation of Liability provision. A contracted provider must inform the enrollee to request an organization determination from The Plan or the provider can request the organization determination on the enrollee's behalf. Failure to provide a compliant denial to the enrollee means that the enrollee is not liable for services provided by a contracted provider or upon referral from a contracted provider.

RELATED MEDICAL POLICIES:

Refer to the following Medical Policies for additional information:

- Medicare Advantage Medical Policy N-161: Clinical Pathology Consultation Services

ADDITIONAL BILLING INFORMATION, REFERENCES AND GUIDELINES:

- Title XVIII of the Social Security Act, Section 1862(a)(7), and (a)(1)(A)
- Title XVIII of the Social Security Act, Section 1833(e)
- CMS online Manual, Pub. 100-04. Chapter 12, Section 60.
- CMS Online Manual, Pub. 100-04 Claims Processing, Transmittal 382, CR 3467. Effective November, 2004.
- CMS Manual Online Pub. 100-04. Transmittal 2857, CR 8567. Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits. Effective January, 2014.
- MLN Matters, Screening Pap Tests and Pelvic Examinations. Effective December, 2015.