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):
This policy position applies to all commercial and/or Medicare Advantage lines of business as indicated above. Reimbursement policies are intended only to establish general guidelines for reimbursement under Highmark plans. Highmark retains the right to review and update its reimbursement policy guidelines at its sole discretion.

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 *64999 85060
* 85390 85576 86077 86078 86079 86255 86256 86320 86325
* 86327 86334 86335 87164 87207 86375 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:

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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:

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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.

This policy position applies to all commercial and/or Medicare Advantage lines of business as indicated above. Reimbursement policies are intended only to establish general guidelines for reimbursement under Highmark plans. Highmark retains the right to review and update its reimbursement policy guidelines at its sole discretion.
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.
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.

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

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