

Coding Policy

Date of Service for Professional Claims

CODING POLICY NUMBER: 29

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SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”). **The full Company portfolio of current coding policies is available online and can be [accessed here](#).**

POLICY APPLICATION

- Providence Health Plan Participating Providers Non-Participating Practitioners
 Commercial Medicaid/Oregon Health Plan Medicare

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Coding policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

POLICY STATEMENT

- I. Company follows the Center for Medicare and Medicaid Services (CMS) guidelines for dates of service for radiology, surgical and anatomical pathology, clinical laboratory services, transitional care management, cardiovascular monitoring, services spanning two calendar dates, and neuropsychological testing and evaluations.

- II. Providers are referred to PHP Coding Policy 07.0 (Global Payment for Obstetrical Care) for information about dates of service for global obstetrical codes.

PROCEDURE

GENERAL

Radiology Services

Radiology services typically have two separate components, a professional and a technical component. These codes have a PC/TC indicator of “1” on the Medicare Physician Fee Schedule (MPFS).

- The date of service for the technical component is the date the test was performed.
- The date of service for the professional component is the date the interpretation was completed.
- When billing a global service (i.e., both technical and professional components performed by the same provider), the provider may submit the test using the date the interpretation (professional component) was completed OR the date the test was performed (technical component).

Surgical and Anatomical Pathology

These services have two separate components, a professional component and a technical component. These codes have a PC/TC indicator of “1” on the MPFS.

- The date of service for the technical component is the date the specimen was collected.
- When the collection spans multiple dates, the date of service for the technical component is the date the collection ended.
- The date of service for the professional component is the date the interpretation was completed.
- When billing a global service (i.e., both technical and professional components performed by the same provider), the provider may submit the test using the date the interpretation (professional component) was completed OR the date the specimen was collected (technical component).

Clinical Laboratory Services

- The date of service for clinical laboratory services is the date the specimen was collected.
- If the specimen is collected over a period that spans two multiple dates, the date of service is the date the collection ended.

Transitional Care Management

CPT codes 99495-99496 are used to report transitional care management (TCM) services provided to patients whose conditions require moderate or high-complexity medical decision making (MDM) during transitions from a facility setting to their community setting.

TCM requires a face-to-face visit, initial patient contact, and medication reconciliation within specified time frames. All services required to support the TCM codes must be documented in the patient's record.

Only one individual may report TCM services and only once per patient within 30 days of discharge. TCM commences upon the date of discharge and continues for the next 29 days. **The date of service reported is the date the practitioner completes the initial required face-to-face visit.**

Both the level of MDM and the length of time before the first face-to-face visit occurs after discharge determine the appropriate CPT code reported for these services; time alone or MDM alone do not support code selection. Code 99495 is reported for TCM with MDM of at least moderate complexity and the first face-to-face post-discharge visit within 8-14 days. Code 99496 is reported for TCM with MDM of high complexity and the first face-to-face post-discharge visit within 7 days.

Cardiovascular Monitoring Services

Cardiovascular monitoring services have separate codes to identify professional and technical components, as well as codes representing a combination of both professional and technical components. The date of service is based on the code description and the time listed.

- For services that include the physician review and/or interpretation and report, the date of service is the date the physician completes that activity.
- For technical services, the date of service is the date the monitoring concludes based on the description of the service. For example, for procedures that include 30 days of monitoring with physician interpretation and report, the date of service is no earlier than the 30th day of monitoring and is the date the physician completes the professional component of the service.

Services Spanning Two Calendar Dates

There are multiple types of service that begin on one day and conclude on the following day. The service may not be billed to PHP until completed, but the date of service may be either the date the service began or the date the service was concluded.

Neuropsychological Testing and Evaluations

Psychological and neuropsychological testing and evaluations (codes 96116, 96121, 96130-96133, 96136-96139) are sometimes completed in multiple sessions that occur on different days. In these situations, **the date of service is the date on which the service is concluded**. Documentation should

show that the service began on one day and was concluded on another day (i.e., the date of service reported on the claim). If documentation is requested, medical records for both days should be submitted.

Psychiatric testing provided over multiple days is billed based on the time involved as described by the CPT code, and **the date of service is the last date of the test**. As with all time-based codes, the time spent on each day must be documented in the patient's record.

Date of Service (DOS) Exceptions

- For specimens stored **less than or equal to 30 calendar days** from the date specimen was collected, the DOS of the test/service must be the date the test/service was performed only if:
 - The test/service is ordered by the patient's physician at least 14 days following the date of the patient's discharge from the hospital;
 - The specimen was collected while the patient was undergoing a hospital surgical procedure;
 - It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;
 - The results of the test/service do not guide treatment provided during the hospital stay; and
 - The test/service was reasonable and medically necessary for treatment of an illness.
- For specimens stored **more than 30 calendar days** before testing, the specimen is considered archived and the DOS of the test/service must be the date the specimen was obtained from storage.
- For chemotherapy sensitivity tests/services performed on live tissue, the DOS must be the date the test/service was performed only if:
 - The decision regarding the specific chemotherapeutic agents to test is made at least 14 days after discharge;
 - The specimen was collected while the patient was undergoing a hospital surgical procedure;
 - It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;
 - The results of the test/service do not guide treatment provided during the hospital stay; and
 - The test/service was reasonable and medically necessary for treatment of an illness.

NOTE: For purposes of applying the above exception, a "chemotherapy sensitivity test" is defined as a test that requires a fresh tissue sample to test the sensitivity of tumor cells to various chemotherapeutic agents. CMS identifies such tests through program instructions issued to the Medicare Administrative Contractors (MACs).
- For molecular pathology tests performed by a laboratory other than a blood bank or center, or a test designated by CMS as an ADLT under paragraph (1) of the definition of advanced diagnostic laboratory test in 42 CFR 414.502, the DOS must be the date the test was performed only if:
 - The test was performed following a hospital outpatient's discharge from the hospital outpatient department;

- The specimen was collected from a hospital outpatient during an encounter;
- It was medically appropriate to have collected the sample from the hospital outpatient during the hospital outpatient encounter;
- The results of the test do not guide treatment provided during the hospital outpatient encounter; and
- The test was reasonable and medically necessary for the treatment of an illness.

NOTE: For the purpose of this section, a “blood bank or center” means an entity whose primary function is the performance or responsibility for the performance of, the collection, processing, testing, storage and/or distribution of blood or blood components intended for transfusion and transplantation.

CROSS REFERENCES

- Coding Policy 07.0 (Global Payment for Obstetrical Care)

REFERENCES

1. Center for Medicare & Medicaid Services (CMS) (cms.gov)
2. Providence Health Plan Clinical Edits

POLICY REVISION HISTORY

Date	Revision Summary
3/2019	Original policy effective date.
1/2023	Annual review. Converted to new template 5/2023.
1/2024	Annual review. No changes to policy.
1/2025	Annual review. No changes to policy.
5/2025	Annual review. Augmented TCM information with coding guidelines.
5/2026	Annual review. Added Cross References section. Added OHP disclaimer under Policy Application. Updated References formatting.