Coding Policy **Policy and Procedure**		
SUBJECT: Coding Policy 35.0 Laboratory Services, Professional Charges	DEPARTMENT: **Health Care Services**	
ORIGINAL EFFECTIVE DATE: 01/2022	DATE(S) REVIEWED/REVISED: 01/22, 01/23	
APPROVED BY: Coding Policy Review Committee	NUMBER: **MC 35.0**	PAGE: **1 of 2**

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").

APPLIES TO:
Health Plan Providers
All Lines of Business

POLICY:
Providers are responsible for submitting accurate claims. This policy gives coding and billing guidelines for professional charges for laboratory services. Company uses coding and billing guidelines outlined by the American Medical Association (AMA) in the Current Procedural Terminology (CPT) book and by Centers for Medicare and Medicaid Services (CMS), as well specialty societies and other national coding guidelines. Company does not pay for duplicate laboratory services.

PROCEDURE:
Professional Charges for Laboratory Services Performed in a Facility Setting
Hospitals must provide directly or under arrangement all services furnished to patients admitted to the hospital as inpatient or outpatient status. If a code has only a technical component and no professional component, and the service is performed for a patient admitted to a facility, professional charges are denied as provider responsibility. Payment for this service is the responsibility of the facility, as it is included in the facility payment. See also **Coding Policy 95.0** (Codes with Technical and Professional Components for Services Performed in Facilities).

- Professional charges for manual and automated laboratory services submitted with a CMS facility place of service (POS) 19, 21, 22, 23, 26, 34, 51, 52, 55, 56, 57 or 61 are not reimbursable. These services are included in the facility payment. When facilities obtain manual or automated laboratory tests for patients under arrangement with an independent laboratory, reference laboratory, or pathology group, only the facility may be reimbursed for the services.
- Company uses the CMS National Medicare Physician Fee Schedule (MPFS) Professional Component/Technical Component (PC/TC) indicators "3" and "9" to identify laboratory services that are not reimbursable to an independent laboratory, reference laboratory, or non-reference laboratory provider for patients in a facility setting.
    - PC/TC indicator 3: Technical Component Only Codes
    - PC/TC indicator 9: PC/TC Concept Not Applicable

Duplicate Laboratory Services, Same Provider
Only one laboratory service is reimbursed when duplicate laboratory services are submitted from the same physician or other health care professional.

- Separate consideration will be given to repeat procedures (i.e., two laboratory procedures performed the same day) by the same provider when reported with modifier 91. Modifier 91 may be used when it is necessary to repeat the same laboratory test for the same patient on the same day to obtain subsequent test results, such as when repeated blood tests are required at different intervals during the same day.
- Modifier 59, XE, XP, XS, or XU may be used when the same laboratory services are performed for the same patient on the same day for different species or strains, as well as specimens from distinctly separate anatomic sites. See **Coding Policy 33.0** (Modifiers for Distinct Procedural Services).
- Modifier 59, XE, XP, XS, XU, or 91 should be used to indicate repeat or distinct laboratory services when reported by the same provider. Separate consideration for reimbursement will NOT be given to laboratory codes reported with modifier 76 or 77.

Duplicate Laboratory Services, Different Providers

Only one laboratory provider is reimbursed when multiple individuals report duplicate laboratory services. Multiple individuals may include, but are not limited to, any physician or other health care professional, independent laboratory, reference laboratory, referring laboratory, or pathologist reporting duplicate services. See **Coding Policy 08.0** (Duplicate Diagnostic Test Interpretations) for additional information.

Date of Service for Laboratory Services

- See **Coding Policy 29.0** (Date of Service for Professional Claims).

Place of Service for Laboratory Services

- See **Coding Policy 11.0** (Place of Service for Diagnostic Tests).

REFERENCE:

CMS/Medicare Rules and Regulations
Medicare Physician Fee Schedule
Current Procedural Terminology (CPT)
Providence Health Plan Coding Edits