

# Coding Policy

## Laboratory Services, Professional Charges

CODING POLICY NUMBER: 35

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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. 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.

- II. Company does not pay for duplicate laboratory services.

## PROCEDURE

### GENERAL

#### 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 Coding Policy 95.0 (Modifiers -TC and -26: Technical and Professional Components for Services).

- Professional charges for manual and automated laboratory services submitted with a CMS facility place of service (POS) 19, 21, 22, 23, 24, 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)

## **CROSS REFERENCES**

- Coding Policy 08.0 (Duplicate Diagnostic Test Interpretations)
- Coding Policy 11.0 (Place of Service for Diagnostic Tests)
- Coding Policy 29.0 (Date of Service for Professional Claims)
- Coding Policy 33.0 (Modifiers for Distinct Procedural Services)
- Coding Policy 95.0 (Modifiers -TC and -26: Technical and Professional Components for Services)

## **REFERENCES**

1. Centers for Medicare & Medicaid Services (cms.gov)
2. Medicare Physician Fee Schedule (cms.gov)
3. American Medical Association. Current Procedural Terminology (CPT)
4. Providence Health Plan Coding Edits

## **POLICY REVISION HISTORY**

<b>Date</b>	<b>Revision Summary</b>
1/2022	Original policy effective date.

1/2023	Annual review. Converted to new template 5/2023.
1/2024	Annual review. No changes to policy.
7/2024	Added location code 24 to policy to correspond with existing edit configuration.
1/2025	Annual review. No changes to policy.
5/2025	Annual review. Added reference to CMS website. No changes to policy.
5/2026	Annual review. Added Cross Reference section. Minor formatting changes.