COMMERCIAL REIMBURSEMENT POLICY

Professional Component for Pathology Test

Active

Policy Number: Lab Path Services – 002
Policy Title: Professional Component for Pathology Test
Section: Lab Path Services
Effective Date: 11/1/2023

Description

Professional billing components for clinical pathology tests are generally not allowed. However, the professional component of anatomic pathology services may be allowed.

Definitions

Clinical pathology: The subspecialty in pathology concerned with the theoretical and technical aspects (the methods or procedures) of chemistry, immunohematology, microbiology, parasitology, immunology, hematology, and other fields as they pertain to the diagnosis of disease and the care of patients, as well as to the prevention of disease and the services related to such.

Anatomic pathology: The subspecialty of pathology that pertains to the gross and microscopic study of organs and tissues removed for biopsy or during postmortem examination, and also the interpretation of the results of such study and the services related to such.

Policy Statement

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.

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	84999*	85060	85390	85576	86077
86078	86079	86153	86255	86256	86320	86325	86327	86334	86335
87164	87207	88375	89060	G0452					

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

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 reimbursement):

81349	81523	81560	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	88371	88372	88373	88374	88377	88380	88381
88387	88388	88399	89250	89251	89253	89254	89255	89257	89260
89261	89268	89272	89280	89281	89300	89310	89320	89321	89322
89325	89335	89337	89342	89343	89344	89346	89352	89353	89354
89356	G0123	G0124	G0141	G0143	G0144	G0145	G0147	G0416	P3000
P3001									

Effective 1/1/2022, in accordance with the National Correct Coding Initiatives (NCCI) Policy Manual guidance, Blue Cross and Blue Shield of Minnesota (Blue Cross) expects the use of the most specific code when reporting services. It may, upon audit, require additional supporting documentation when a less specific code is reported. When a prostate needle biopsy pathology is reported, Blue Cross will reimburse providers the amount equivalent to code G0416 if code 88305 is billed, regardless of units billed.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier: 26
ICD-10 Diagnosis: N/A
ICD-10 Procedure: N/A
CPT/HCPCS: Refer to Appendix
Revenue Codes: N/A

Policy History

10/21/2015	Initial Committee Approval Date
01/09/2018	Annual Policy Review
04/20/2020	Annual Policy Review
10/26/2021	Annual Policy Review: Policy Section: Updated to add NCCI Manual guidance re: prostate needle biopsy effective 1/1/2022 Codes deleted: 0058T
1/25/2022	Code update: Q1 – added 80220, 80503, 80504, 80505, 80506, 81349,81523,81560,82653,83521,83529, 86015,86036,86037,86051,86052,86053,86231,86258,86362,86363,86364, 86381,86596,87154
10/24/2023	Annual Policy Review

BlueCross BlueShield Minnesota

Appendix

81349	81523	81560	83020	84165	84166	84181	84182	84999*	85060
85097	85390	85396	85576	86077	86078	86079	86153	86255	86256
86320	86325	86327	86334	86335	87164	87207	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
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88348	88350	88355	88356	88358	88360	88361	88362	88363	88364
88365	88366	88367	88368	88369	88371	88372	88373	88374	88375
88377	88380	88381	88387	88388	88399	89060	89250	89251	89253
89254	89255	89257	89260	89261	89268	89272	89280	89281	89300
89310	89320	89321	89322	89325	89335	89337	89342	89343	89344
89346	89352	89353	89354	89356					
G0123	G0124	G0141	G0143	G0144	G0145	G0147	G0416	G0452	
P3000	P3001								