

Coding Communication: Professional Component for Clinical Laboratory Services (CPT codes 80048-89356)

Although the use of modifier 26, *Professional Component*, and clinical laboratory services has been previously addressed in the *CPT Assistant* (May 1999), the discussion continues to surface as an area of great interest among our members and subscribers. Building upon the May 1999 foundation, this coding update further expands upon the role of the pathologist with respect to their capacity in the clinical laboratory setting.

The use of modifier 26, *Professional component*, is required for CPT codes 80048-89356 in those instances when the physician is only billing for the professional component of the laboratory tests (eg, medical direction, supervision or interpretation). This method of reporting is appropriate when the technical and professional components are performed by different providers. A written report for an individual patient is not a requirement for having performed a professional component service.

Pathologists often report the professional component of clinical laboratory tests because they oversee the clinical laboratory and are responsible for the results. As stated in the College of American Pathologists *Professional Relations Manual* (pages 151-152 under the section Pathologist Professional Component Billing for Clinical Pathology Services):

Professional component billing is one valid method of billing for the professional services of pathologists in the clinical laboratory. In many communities, the standard practice is for the pathologist to direct bill patients for the professional component of clinical laboratory services. When the pathologist bills a professional component to a non-Medicare patient, no payment is made by the hospital to the pathologist for this

service. The hospital's bill for the technical component covers hospital costs for laboratory equipment, supplies and non-physician personnel—it does not include the professional services of the pathologist.

Pathologists in their capacity as medical directors of hospital clinical laboratories provide valuable, necessary medical services for patients. These services and responsibilities, often called *clinical pathology professional component services*, include:

- Ensuring that tests, examinations, and procedures are properly performed, recorded and reported
- Interacting with members of the medical staff regarding issues of laboratory operations, quality, and test availability
- Designing protocols and establishing parameters for performance of clinical testing
- Recommending appropriate follow-up diagnostic tests, when appropriate
- Supervising laboratory technicians and advising technicians regarding aberrant results
- Selecting, evaluating, and validating test methodologies
- Directing, performing, and evaluating quality assurance and control procedures
- Evaluating clinical laboratory data and establishing a process for review of test results prior to issuance of patient reports
- Ensuring the hospital laboratory's compliance with state licensure laws, Medicare conditions, Joint Commission on Accreditation of Healthcare Organizations standards, the College of American Pathologists Laboratory Accreditation Program, and federal certification standards

continued on bottom of page 10

Neurostimulator, continued from page 8

increments may vary. In addition, history, physical examination, and medical decision making are provided concerning the patient's medication regimen to address concurrent medical problems and to counsel the patient and family about psychosocial difficulties encountered in coping with moderately advanced Parkinson's disease.

When separately identifiable evaluation and management (E/M) services are provided, they are coded separately. The time included in the E/M service is exclusive of any time used to determine the coding of 95978 and 95979. The services provided on the same day can include both E/M services as well as reprogramming. The reprogramming time is inclusive of the several stages of that service, including the initial system analysis, initial reprogramming time, initial time waiting for stabilization, subsequent cycles of reprogramming and waiting for stabilization, and final counseling and instructions.

Professional, continued from page 9

In closing, when reporting the professional or technical component of a procedure or service, it is important to familiarize yourself with the various reporting requirements of individual insurance companies in your area. These reporting and reimbursement policies may vary from one insurance company to another.

The book *Medicare RBRVS: The Physicians' Guide* can be ordered by contacting the American Medical Association's Customer Service department at (800) 621-8335.

Glossary

anode: The positive pole of a galvanic battery or the electrode connected with it.

cathode: The negative pole of a galvanic battery or the electrode connected with it.

dystonia: A state of abnormal (either hypo or hyper) tonicity in any of the tissues.

neurostimulator: A device for electrical excitation of the central or peripheral nervous system.

Parkinson's disease: A progressive degenerative disease of unknown etiology characterized by rhythmic tremor of the limbs, stooped posture, slowness of voluntary movements, and mask-like facial expression.

parkinsonian: Relating to or the suffering from parkinsonism. ■

For information regarding the College of American Pathologist (CAP) manual, contact the CAP at (800) 323-4040.

References:

American Medical Association. *Medicare RBRVS: The Physicians' Guide 2005*. Chicago, Ill: AMA; 2005.

College of American Pathologists. *Professional Relations Manual*. 12th ed. Northfield, Ill: CAP; 2003: 151-152. ■