

 HAWAII HEALTH SYSTEMS C O R P O R A T I O N <i>"Touching Lives Everyday"</i> Policies and Procedures	<i>Quality Through Compliance</i>	Policy No.: FIN 0504
		Revision No.: N/A
Subject: <i>Laboratory Anatomical and Surgical Pathology Services</i>	Issued by: Corporate Compliance Committee	Effective Date: September 15, 2000
	Approved by: Thomas M. Driskill, Jr. President & CEO	Supersedes Policy: N/A
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I. PURPOSE: To ensure pathology services are billed in accordance with Medicare, Medicaid, and other federally funded payor requirements.

II. POLICY: Billing for Anatomical & Surgical Pathology services (both technical & professional components) must comply with the contractual arrangements between the facility and the pathologist and with Medicare, Medicaid, and other federally funded payor requirements.

III. PROCEDURE:

A. Billing Options:

Hospitals or other healthcare facilities have the following three options for billing of pathology services depending upon the physician's contractual relationship:

- Bill the technical component only.
- Do not bill at all.
- Bill globally - both the technical and professional components.

Only those services as defined in the CPT-4 coding manual may be billed as separate components.

The guidelines for each of these options are listed below:

Option 1 - Bill Technical Component Only

Hospitals and other healthcare facilities billing the technical component of Anatomical, Surgical, Cytology, and Interpretative Pathology services must either:

- Perform the technical services;
- Be responsible for providing the services;
- Refer the technical services under arrangement; or
- Refer the technical services and meet the guidelines as outlined in HHSC Policy No. FIN 0501, Referred Laboratory Testing.

If the facility bills on the UB-92 form, use the applicable CPT code(s) to indicate the technical service. If the technical component is being billed on an HCFA-1500 form, use the applicable CPT code(s) and the TC modifier. The pathologist bills for the professional component on an HCFA-1500 form utilizing the applicable CPT code(s) and modifier 26. Only those tests identified in the Medicare Physician Fee Schedule may be billed as a professional component.

Option 2 - Do Not Bill Either Component

Facilities may choose not to bill either the technical or the professional component if the pathologist(s) is not employed by the facility, and a contractual agreement exists permitting the pathologist(s) to bill both components.

Option 3 - Bill Globally (Technical & Professional Component)

The facility must bill globally (technical and professional component) when the pathologist is employed by and/or a contractual agreement exists permitting the facility to bill globally. Both components are billed on an HCFA-1500 with the applicable CPT code(s) and no modifiers. However, for inpatient (DRG) services the technical component is included in the DRG reimbursement and therefore may not be billed separately from the inpatient services.

If a facility bills the technical component of anatomical, surgical, and cytological services, it must:

- Own or lease equipment for sample/tissue processing; and
- Employ personnel associated with sample/tissue processing; and
- Provide supplies for sample/tissue processing.

If the facility refers the technical services to another laboratory, it may bill the technical component as long as it meets the criteria defined in HHSC Policy No. FIN 0501, Referred Laboratory Testing.

B. Implementation and Annual Review:

1. Laboratory personnel must review the contractual relationship with the pathologist to determine if the pathologist is employed by the facility, working under a contractual arrangement, or independent. If the pathologist is independent, split billing must be performed. If the pathologist is under contract to bill both technical and professional fees, the facility must not bill for these same services. If the pathologist is employed by the facility or working under arrangement which specifies the facility must bill, the facility must perform global billing for both technical and professional services.
2. Laboratory personnel must review and ensure applicable revisions are made to the chargemaster and related Laboratory and Order Entry masterfiles/dictionaries to ensure component(s) are being billed for Anatomical & Surgical Pathology services as outlined in the guidelines above.

3. Laboratory and business office personnel must educate all staff associates responsible for ordering, charging, or billing laboratory services on the contents of this policy.
4. Business office personnel must identify intermediary interpretations which vary from the interpretations in this policy. Specific intermediary documentation related to the variance(s) must be obtained and faxed to the Corporate Compliance Officer or Director of Reimbursement.

C. Definitions:

1. Technical Component: Specimen handling, accessioning, processing, transcription/reporting, and record keeping of all levels of Surgical/Anatomic and Cytopathology services rendered.
2. Professional Component: The examination, interpretation, and consultative services of all levels of Surgical Pathology services, and Cytopathology procedures, as defined by the American Medical Association in conjunction with CPT and adopted by HCFA.
3. Global Billing: Billing for both the professional and technical component.
4. Split Billing: Billing for either the professional or the technical component.