Title: Physician Laboratory and Pathology Services

Policy Number: RP-016

Version Number: 2026.08.31

Medicare Advantage:	PA, WV, DE, NY	Version Effective:	August 31, 2026
Commercial:	PA, WV, DE, NY	Originally Effective:	October 1, 2017
Claim Type:	CMS 1500	History Versions:	Click Here → History

Description:

This policy describes the reimbursement for surgical pathology, clinical pathology, and clinical pathology consultation services. The policy also addresses place of service and date of service relating to laboratory services. This policy does not address reimbursement for all laboratory codes.

Reimbursement Guidelines:

Commercial

The total charge for a diagnostic study includes both a professional and a technical component. The technical component (modifier TC) is the performance of the test and is generally performed by non-physician personnel and/or automated equipment. The professional component (modifier 26) is the physician's involvement, including interpretation of the test results.

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.

Conversely, 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):

85097	88029	88125	88160	88182	88240	88272	88304	88325	88350	88367	89250	89281	89346
85396	88036	88130	88161	88184	88241	88273	88305	88329	88355	88368	89251	89300	89352
88000	88037	88140	88162	88185	88245	88274	88307	88331	88356	88369	89253	89310	89353
88005	88040	88141	88164	88187	88248	88275	88309	88332	88358	88373	89254	89320	89354
88007	88045	88142	88165	88188	88249	88280	88311	88333	88360	88374	89255	89321	89356
88012	88099	88143	88166	88189	88261	88283	88312	88334	88361	88377	89257	89322	G0416
88014	88104	88147	88167	88199	88262	88285	88313	88341	88362	88380	89260	89325	
88016	88106	88148	88172	88230	88263	88289	88314	88342	88363	88381	89261	89335	
88020	88108	88150	88173	88233	88264	88291	88319	88344	88364	88387	89268	89342	
88025	88112	88152	88174	88235	88267	88299	88321	88346	88365	88399	89272	89343	
88027	88120	88153	88175	88237	88269	88300	88323	88348	88366	89220	89280	89344	
88028	88121	88155	88177	88239	88271	88302							

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	84166	84182	85390	86153	86256	86325	86335	87207	88372	89060	*86078	*86079	G0452
84165	84181	85060	85576	86255	86320	86334	87164	88371	88375	*86077			

*Note: Blood banking services of hematologists and pathologists are paid under the physician fee schedule when analyses are performed on donor and/or patient blood to determine compatible donor units for transfusion where cross matching is difficult or where contamination with transmissible disease of donor is suspected.

Claims for clinical pathology studies performed out-of-state are reimbursable regardless of place of service or whether or not it is the practice of the Blue Shield Plan of that state.

Medicare Advantage

Reimbursement for physician laboratory and pathology services are limited to:

1. Specific cytopathology, hematology and blood banking services that are identified to require performance by a physician and are listed below;
2. Surgical pathology services; and
3. Clinical laboratory interpretation services that meet the requirements and which are specifically listed under Clinical Laboratory Interpretation Services in this policy.

Surgical Pathology

Surgical pathology services include the gross and microscopic examination of organ tissue performed by a physician. Surgical pathology services performed for autopsies are not covered. Either the professional component, the technical component, or both components may be paid for the following surgical pathology services:

88300	88305	88311	88314	88331	88334	88344	88355	88360	88364	88367	88373	88377	88381
88302	88307	88312	88319	88332	88341	88346	88356	88361	88365	88368	88374	88380	88387
88304	88309	88313	88323	88333	88342	88348	88358	88362	88366	88369			

Code 88341 is for each additional single antibody stain procedure. Code 88341 can only be reported in conjunction with code 88342. Code 88344 is for each multiplex antibody stain procedure. Only one unit of each of these three codes, 88341, 88342, and 88344 can be reported for each separately identifiable antibody per specimen. Codes 88321, 88325 and 88329 represent physician services.

Cytopathology

Cytopathology services include the examination of cells from fluids, washings, brushings or smears, but generally exclude hematology. Examining cervical and vaginal smears are the most common service in cytopathology. Cervical and vaginal smears do not require interpretation by a physician unless the results are or appear to be abnormal. In such cases, a physician personally conducts a separate microscopic evaluation to determine the nature of an abnormality. This microscopic evaluation ordinarily does require performance by a physician.

When medically necessary and when furnished by a physician, the professional component of the following services is eligible:

88104	88106	88108	88112	88120	88121	88125	88160	88161	88162	88172	88173	88177	88182

Codes 88141, 88187, 88188, and 88189 represent the professional service only.

Physician hematology services include microscopic evaluation of bone marrow aspirations and biopsies. It also includes those limited number of peripheral blood smears which need referred to a physician to evaluate the nature of an apparent abnormality identified by the technologist. These services include codes 85060 and 85097 which represent professional-only component services and have no technical component values.

The professional component for the interpretation of an abnormal blood smear (85060) furnished to a hospital inpatient by a hospital physician or an independent laboratory is eligible for reimbursement. For hematology codes 85390 and 85576, reimbursement may be made for the professional component if the service is furnished to a patient by a hospital physician or independent laboratory.

Blood banking services of hematologists and pathologists are paid when analyses are performed on donor and/or patient blood to determine compatible donor units for transfusion where cross matching is difficult or where contamination with transmissible disease of donor is suspected.

The blood banking codes 86077, 86078, and 86079 represent physician-only services.

Reasons for Noncoverage

Codes 80503, 80504, 80505, 80506 represent consultation services, therefore, the technical component and professional component concepts do not apply. Codes 85060, 85097, 86077, 86078, 86079, 88414, 88321, 88325, and 88329 represent only professional services, therefore, the technical component and total component concepts do not apply to these codes. Claims reporting only the professional component for laboratory and pathology services not addressed on this policy are not covered. A provider cannot bill the member for the denied service.

Documentation Requirements

Medical record documentation should support the service that was reported and also indicate that the requirements for a Clinical Consultation have been met. Medical record documentation should support the medical necessity for interpretation by a physician for services listed under Specific Hematology, Cytopathology and Blood Banking Services. Medical record documentation should support the medical necessity for separate review and interpretation of cytopathology studies.

Denial Statements

Services denied as not reasonable and medically necessary, under section 1862(a) (1) of the Social Security Act, are subject to the Limitation of Liability provision. A contracted provider must inform the enrollee to request an organization determination from The Plan or the provider can request the organization determination on the enrollee's behalf. Failure to provide a compliant denial to the enrollee means that the enrollee is not liable for services provided by a contracted provider or upon referral from a contracted provider.

Clinical consultation services

Consultation services should be reported using codes 80503, 80504, 80505, and 80606 based on the criteria listed below.

Clinical consultation services are paid under the physician fee schedule based on the following:

1. Clinical consultation services are requested by the patient's attending physician;
2. The services are related to a test result that lies outside the clinically significant normal or expected range in view of the condition of the patient;
3. Clinical consultation services are documented in a written narrative report beyond the original diagnostic procedural assessment, included in the patient's permanent medical record; and requires the documented exercise of medical judgement by the consulting physician.

Routine conversations held between a laboratory director and an attending physician regarding test orders and results do not qualify as consultation services unless all the above requirements above are met.

Coding:

Providers will report on the claim, the date of service in which the service was provided. For instance, if a professional service is being reported, the date of service reported on the claim should be the date in which that professional component (modifier 26) was provided, not the date in which the technical component (modifier TC) was administered.

Definitions:

Modifier	Definition
26	Professional component
TC	Technical component
Term	**Definition**
Total Component	Frequently referred to as a global service or complete procedure billed with no modifiers attached. It indicates that a single provider or entity furnished both the equipment/staff and the physician interpretation for the service.

References:

- Title XVIII of the Social Security Act, Section 1862(a)(7), and (a)(1)(A)
- Title XVIII of the Social Security Act, Section 1833(e)
- Centers for Medicare and Medicaid Services (CMS) online Manual, Pub. 100-04. Chapter 12, Section 60, 60.3
- CMS Online Manual, Pub. 100-04 Claims Processing, Transmittal 382, CR 3467. Effective November, 2004
- CMS Manual Online Pub. 100-04. Transmittal 2857, CR 8567. Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits. Effective January, 2014
- MLN Matters, Screening Pap Tests and Pelvic Examinations. Effective December, 2015

Related Plan Policies:

Refer to the following Reimbursement Policies for additional information:

- RP-015: Technical and Professional Components for Applicable Services
- RP-041: Services Not Separately Reimbursed
- RP-035: Correct Coding Guidelines

Policy Update History:

7 / 2023	Removed PHE exception note for codes 99000 and 99001
1 / 2025	Removed code 88388 and 86327
8 / 2026	Moved direction onto new policy template and merged MRP-002 into this policy's Medicare Advantage section

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-016		
Subject:	Physician Laboratory and Pathology Services		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	January 1, 2025	**Revised Date:**	January 2025
Date Reviewed:	December 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

COMMERCIAL REIMBURSEMENT GUIDELINES:

The total charge for a diagnostic study includes both a professional and a technical component. The technical component (modifier TC) is considered to be the performance of the test and is generally performed by non-physician personnel and/or automated equipment. The professional component (modifier 26) is the physician's involvement, including interpretation of the test results.

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.

Conversely, 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 payment):

85097	88104	88160	88199	88272	88313	88356	88399	89322
85396	88106	88161	88230	88273	88314	88358	89220	89325
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88014	88125	88167	88240	88285	88329	88364	89255	89346
88016	88130	88172	88241	88289	88331	88365	89257	89352
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88099	88155	88189	88271	88312	88355	88387	89321	

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:

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84165	84182	85576	86256	86334	87207	88375	*86078	
84166	85060	86153	86320	86335	88371	89060	*86079	

***Note**: Blood banking services of hematologists and pathologists are paid under the physician fee schedule when analyses are performed on donor and/or patient blood to determine compatible donor units for transfusion where cross matching is difficult or where contamination with transmissible disease of donor is suspected.

Claims for clinical pathology studies performed out-of-state are reimbursable regardless of place of service or whether or not it is the practice of the Blue Shield Plan of that state.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

Payments for physician laboratory and pathology services are limited to:

- Surgical pathology services;
- Specific cytopathology, hematology and blood banking services that have been identified to require performance by a physician and are listed below;
- Clinical pathology consultation services that meet the requirements discussed in Medicare Advantage Medical Policy Bulletin N-161; **and**,
- Clinical laboratory interpretation services that meet the requirements and which are specifically listed under Clinical Laboratory Interpretation Services in this policy.

Surgical Pathology

Surgical pathology services include the gross and microscopic examination of organ tissue performed by a physician, except for autopsies, which are not covered.

Either, the professional component, the technical component or both components may be paid for the following surgical pathology services:

88300	88309	88319	88334	88348	88361	88367	88377
88302	88311	88323	88341	88355	88362	88368	88380
88304	88312	88331	88342	88356	88364	88369	88381
88305	88313	88332	88344	88358	88365	88373	88387
88307	88314	88333	88346	88360	88366	88374	

Code 88341 is for each additional single antibody stain procedure. Code 88341 is out of sequence and can *only be reported* in conjunction with code 88342.

Code 88344 is for each multiplex antibody stain procedure.

Only one unit of each of these 3 codes, 88341, 88342, and 88344 can be reported for each separately identifiable antibody per specimen.

Codes 88321, 88325 and 88329 represent physician services.

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Cytopathology services include the examination of cells from fluids, washings, brushings or smears, but generally exclude hematology. Examining cervical and vaginal smears are the most common service in cytopathology. Cervical and vaginal smears do not require interpretation by a physician unless the results are or appear to be abnormal. In such cases, a physician personally conducts a separate microscopic evaluation to determine the nature of an abnormality. This microscopic evaluation ordinarily does require performance by a physician.

When medically necessary and when furnished by a physician, the professional component of the following services is eligible:

88104	88108	88120	88125	88161	88172	88177
88106	88112	88121	88160	88162	88173	88182

Codes 88141, 88187, 88188, and 88189 represent only the professional service.

Physician hematology services include microscopic evaluation of bone marrow aspirations and biopsies. It also includes those limited number of peripheral blood smears which need to be referred to a physician to evaluate the nature of an apparent abnormality identified by the technologist. These codes include 85060 and 85097.

The professional component for the interpretation of an abnormal blood smear (code 85060) furnished to a hospital inpatient by a hospital physician or an independent laboratory is eligible for reimbursement.

For the other listed hematology codes (85390 and 85576), payment may be made for the professional component if the service is furnished to a patient by a hospital physician or independent laboratory.

Codes 85060 and 85097 represent professional-only component services and have no technical component values.

Blood banking services of hematologists and pathologists are paid when analyses are performed on donor and/or patient blood to determine compatible donor units for transfusion where cross matching is difficult or where contamination with transmissible disease of donor is suspected.

The blood banking codes are 86077, 86078, and 86079 and represent physician-only services.

Reasons for Noncoverage

Codes 80503, 80504, 80505, 80506 represent consultation services. Therefore, the technical components (modifier TC) and professional component (PC) concept does not apply.

The following services represent only professional services. Therefore, the technical component (modifier TC) and total component concepts do not apply:

85060 85097 86077 86078 86079 88141 88321 88325 88329

Claims reporting only the professional component for laboratory and pathology services not addressed on this policy are not covered. A provider cannot bill the member for the denied service.

Services are denied non-covered and therefore, not medically necessary.

Documentation Requirements

Medical record documentation should support the service that was reported and also indicate that the requirements for a Clinical Consultation have been met.

Medical record documentation should support the medical necessity for interpretation by a physician for services listed under Specific Hematology, Cytopathology and Blood Banking Services.

Medical record documentation should support the medical necessity for separate review and interpretation of cytopathology studies.

Denial Statements

Services denied as not reasonable and medically necessary, under section 1862(a) (1) of the Social Security Act, are subject to the Limitation of Liability provision. A contracted provider must inform the enrollee to request an organization determination from The Plan or the provider can request the organization determination on the enrollee's behalf. Failure to provide a compliant denial to the enrollee means that the enrollee is not liable for services provided by a contracted provider or upon referral from a contracted provider.

DEFINITIONS:

Modifier	Definition
26	Professional component
TC	Technical component

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed
- RP-035: Correct Coding Guidelines
- MRP-002: Reporting Clinical Pathology Consultation Services

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

Providers will report on the claim, the date of service in which the service was provided. For instance, if a professional service (26 modifier) is being reported, the date of service reported on the claim should be the date in which that professional component was provided, not the date in which the technical component was administered.

REFERENCES:

- Title XVIII of the Social Security Act, Section 1862(a)(7), and (a)(1)(A)
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- MLN Matters, Screening Pap Tests and Pelvic Examinations. Effective December, 2015.

POLICY UPDATE HISTORY INFORMATION:

10 / 2017	Implementation
4 / 2020	Removed codes 82131, 82542, 84999 and added 86153, 88371, 88372
10 / 2020	Added notification exception for codes 99000 and 99001 regarding PHE
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy
2 / 2022	Removed G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001
6 / 2022	Removed 0058T and replaced codes 80500, 80502 with 80503, 80504, 80505, 80506
7 / 2023	Removed PHE exception note for codes 99000 and 99001
1 / 2025	Removed code 88388 and 86327

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-016		
Subject:	Physician Laboratory and Pathology Services		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	July 10, 2023	**Revised Date:**	July 2023
Date Reviewed:	July 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
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Medical record documentation should support the medical necessity for separate review and interpretation of cytopathology studies.

Denial Statements

Services denied as not reasonable and medically necessary, under section 1862(a) (1) of the Social Security Act, are subject to the Limitation of Liability provision. A contracted provider must inform the enrollee to request an organization determination from The Plan or the provider can request the organization determination on the enrollee's behalf. Failure to provide a compliant denial to the enrollee means that the enrollee is not liable for services provided by a contracted provider or upon referral from a contracted provider.

DEFINITIONS:

Modifier	Definition
26	Professional component
TC	Technical component

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed
- RP-035: Correct Coding Guidelines
- MRP-002: Reporting Clinical Pathology Consultation Services

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

Providers will report on the claim, the date of service in which the service was provided. For instance, if a professional service (26 modifier) is being reported, the date of service reported on the claim should be the date in which that professional component was provided, not the date in which the technical component was administered.

REFERENCES:

- Title XVIII of the Social Security Act, Section 1862(a)(7), and (a)(1)(A)
- Title XVIII of the Social Security Act, Section 1833(e)
- CMS online Manual, Pub. 100-04. Chapter 12, Section 60.
- CMS Online Manual, Pub. 100-04 Claims Processing, Transmittal 382, CR 3467. Effective November, 2004.
- CMS Manual Online Pub. 100-04. Transmittal 2857, CR 8567. Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits. Effective January, 2014.
- MLN Matters, Screening Pap Tests and Pelvic Examinations. Effective December, 2015.

POLICY UPDATE HISTORY INFORMATION:

10 / 2017	Implementation
4 / 2020	Removed codes 82131, 82542, 84999 and added 86153, 88371, 88372
10 / 2020	Added notification exception for codes 99000 and 99001 regarding PHE
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy
2 / 2022	Removed G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001
6 / 2022	Removed 0058T and replaced codes 80500, 80502 with 80503, 80504, 80505, 80506
7 / 2023	Removed PHE exception note for codes 99000 and 99001