Physician Related and Professional Healthcare Services Payment Policy

The effective date for this publication is: 9/1/12

The procedure codes and fee schedule amounts in this document do not necessarily indicate coverage or payment. All coverage and payments are subject to Offender Health Plan Coverage, exclusions, limitations, and pre-authorization requirements. For detailed coverage information, refer to the Department of Corrections (DOC) *Offender Health Plan, Billing Instructions and Payment Policies.* For directions on submitting claims to ProviderOne, see the ProviderOne Billing and Resource Guide.

Fees in this publication are subject to change without notice. Although we make every effort to ensure the accuracy of the fees in our publications, changes or corrections may occur throughout the year.

Visit the DOC web site at www.doc.wa.gov/business/healthcareproviders to download the latest versions of this fee schedule, and all other DOC publications mentioned in this document.

(Rev. 7/31/12)

Physician Related and Professional Healthcare Services

Payment Policy

Table of Contents

I. General Information

The Department of Corrections (DOC) *Professional Provider Fee Schedule* contains the maximum allowances for professional services. The maximum allowances in this document do not reflect the payment differentials that apply to certain provider types.

DOC's primary fee schedule updates will occur annually in July. The July fee schedule will include updates to the Resource Based Relative Value Scale (RBRVS) relative value units (RVUs), and statewide Geographic Practice Cost Indices (GPCIs). It will also include fee updates for codes not priced by the RBRVS method. A second update in January will incorporate added codes and remove deleted codes. Added codes will be priced using the RBRVS RVU's and Statewide GPCI's for the new year.

The DOC RVU schedule uses Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes. Code descriptions are not included in the DOC RVU schedule due to the AMA copyright on the CPT® code descriptions. For billing purposes, use the most current CPT®and HCPCS level II coding references, which include complete code descriptions.

II. RBRVS Pricing

The majority of the DOC fee schedule is based on the RBRVS reimbursement methodology. The RBRVS maximum allowances are calculated by multiplying DOC's conversion factor for Fiscal Year 2013 by geographically adjusted relative value units (RVUs).

For dates of service September 1, 2012 through June 30, 2013 the DOC Conversion factor is $60.

The RVUs for most services are based on the Centers for Medicare & Medicaid Services (CMS) 2012 relative value units (RVUs). The CMS 2012 RVUs are available on the CMS Web site at www.cms.hhs.gov.

The RVUs are geographically adjusted using the 2012 statewide Geographic Practice Cost Indices (GPCIs). The statewide GPCIs are a blend of the 2012 CMS Seattle/King County GPCIs and the 2012 CMS Rest of Washington GPCIs.

RVU Component	Statewide GPCI
Work	1.006
Practice Expense	1.022
Malpractice	0.774

The GPCI'd RVU totals are calculated by the following formula:

GPCI'd RVU =

(work RVU x work GPCI)
+ (practice expense RVU x practice expense GPCI)
+ (malpractice RVU x malpractice GPCI)

**Note that the result is rounded to 2 decimal places.

The RBRVS maximum allowances are determined by the following formula:

***DOC Maximum Allowable Fee** = DOC RBRVS conversion factor x GPCI'd RVUs*

III. Services not paid by RBRVS

Professional services not reimbursed using the RBRVS methodology include, but are not limited to:

- Laboratory Services
- Anesthesia Services
- Drug's and Biological
- Durable Medical Equipment
- Prosthetics and Orthotics

A. By Report

Codes without payment methodology's explained in this document are subject to review to determine payment. When billing with "By Report" codes you must submit with the claim, supporting documentation to include chart notes, the manufactures invoice and/or any other pertinent information supporting the submitted charges.

B. Bundled Supplies and Services

DOC does not pay separately for supplies and services that are considered "bundled"—included as an integral part of another service.

The DOC Fee Schedules show which supplies and services are considered bundled.

DOC does not pay separately for surgical dressings when applied by a provider during the course of a procedure or an office visit.

DOC does not pay for CPT® code 99070 (miscellaneous supplies provided by the physician). Providers must bill specific HCPCS level II codes for supplies, prosthetics, and durable medical equipment.

C. Code Accepted for Tracking Purposes Only

CPT® Category II Codes (codes ending with the letter "F") are tracking codes intended for performance measurement. Use of these codes is optional and is not required for correct coding although the Category II codes will be accepted and processed, these codes are not eligible for payment by DOC.

Visit www.ama-assn.org for the most current list of CPT® Category II codes

IV. Site of Service Payment Differential

For many procedure codes, DOC professional provider reimbursement differs based on where the procedure is performed. This site of service payment differential for professional claims is based on the CMS dual practice expense RVUs and accompanying policy.

Higher reimbursement is made for services provided in "non-facility" sites of service, such as a physician office. Services provided in "facility" sites of service, such as hospital or ambulatory surgery center, receive a lower professional reimbursement because additional separate reimbursement is made to the facility.

The applicable CMS 2-digit place of service code must be included on all professional claims submitted to DOC for payment consideration. These codes are specified in the table below.

Code	Facility or Non-Facility	Place of Service Description
01	Non-Facility	Pharmacy
03	Non-Facility	School
04	Non-Facility	Homeless Shelter
05	Facility	Indian Health Service Free-Standing Facility
06	Facility	Indian Health Service Provider-Based Facility
07	Facility	Tribal 638 Free-Standing Facility
08	Facility	Tribal 638 Provider-Based Facility
09	Facility	Prison Correctional Facility
11	Non-Facility	Office
12	Non-Facility	Home
13	Non-Facility	Assisted Living Facility
14	Non-Facility	Group Home
15	Non-Facility	Mobile Unit
20	Non-Facility	Urgent Care Facility
21	Facility	Inpatient Hospital
22	Facility	Outpatient Hospital
23	Facility	Emergency Room—Hospital
24	Facility	**Ambulatory Surgical Center (ASC)** An ASC facility must be licensed by the state(s) in which it operates, unless that state does not require licensure. In addition, the facility must be Medicare-certified or be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or have accreditation as an ASC by another national accrediting organization recognized by DOC.
Code	**Facility or Non-Facility**	**Place of Service Description**

25	Non-Facility	Birthing Center
26	Facility	Military Treatment Facility
31	Facility	Skilled Nursing Facility
32	Non-Facility	Nursing Facility
33	Non-Facility	Custodial Care Facility
34	Facility	Hospice
41	Facility	Ambulance (Land)
42	Facility	Ambulance (Air or Water)
49	Non-Facility	Independent Clinic
50	Non-Facility	Federally Qualified Health Center
51	Facility	Inpatient Psychiatric Facility
52	Facility	Psychiatric Facility Partial Hospitalization
53	Facility	Community Mental Health Center
54	Non-Facility	Intermediate Care Facility/Mentally Retarded
55	Non-Facility	Residential Substance Abuse Treatment Facility
56	Facility	Psychiatric Residential Treatment Center
57	Non-Facility	Non-Residential Substance Abuse Treatment Facility
60	Non-Facility	Mass Immunization Center
61	Facility	Comprehensive Inpatient Rehabilitation Facility
62	Non-Facility	Comprehensive Outpatient Rehabilitation Facility
65	Non-Facility	End Stage Renal Disease Treatment Facility
71	Non-Facility	State or Local Public Health Clinic
72	Non-Facility	Rural Health Clinic
81	Non-Facility	Independent Laboratory
99	Non-Facility	Other Place of Service

A. Facility Setting Relative Value Units (RVU)

When professional services are performed in a facility setting, DOC payment is based on

"facility setting RVU." These payments do not include reimbursement for facility overhead and resource costs. The facility bills DOC separately for associated facility charges.

B. Non-Facility Setting Relative Value Units (RVU)

When professional services are performed in a non-facility setting, DOC payment is based on "non-facility setting RVU." These payments apply when the professional provider who performs the service is responsible for overhead expenses and resource costs such as labor, medical supplies and equipment. When the non-facility RVU applies, DOC does not pay facility charges separately.

C. Services Provided in a Prison Correctional Facility

When professional services are performed at a Washington State prison, DOC payment is based on "facility setting RVU." Please bill the department using place of service code "09" and designate the NPI number for the prison as found in the table below:

Facility	NPI
Airway Heights Correction Center	1902197882
Cedar Creek Correction Center	1750672572
Clallam Bay Correction Center	1902197387
Coyote Ridge Correction Center	1629369095
Larch Correction Center	1538450911
Mission Creek Correction Center for Women	1689965063
Monroe Correctional Complex	1588955306
Olympic Correction Center	1194016576
Stafford Creek Correction Center	1427349802
Washington Correction Center	1447541834
Washington Correction Center for Women	1114218591
Washington State Penitentiary	1164713558

V. Global Day Periods

DOC follows Medicare's global surgery rules. Under these rules, DOC pays a single fee for all services provided by the surgeon before, during, and after a surgical procedure. All care by the surgeon during the postoperative period is included in the global surgery payment.

A. Services Included in the Global Surgical Package

The global surgery definition includes:

- The operation
- Preoperative visits, in or out of the hospital, beginning on the day before surgery
- Services by the primary surgeon, in or out of the hospital, during a standard postoperative period as described above
- Dressing changes; local incisional care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral IV lines, and nasogastric and rectal tubes; and change and removal of tracheostomy tubes
- All additional medical or surgical services required because of complications that do not require additional trips to the operating room

B. Global Day Periods

The global day periods associated with the global surgery rules payment policy addressed in the billing manual are included on the fee schedule. The global day periods include:

- 90-day postoperative periods for major procedures
- 10-day postoperative periods for minor surgeries and endoscopies
- MMM for maternity procedures with a 45-day postoperative periods
- XXX for procedures where the global concept does not apply
- ZZZ for procedures where the global period is included in the global period of another procedure

VI. Therapies Provided in Hospitals or Skilled Nursing Facilities

DOC does not pay the performing provider of the following therapies separately when services are provided in a hospital or skilled nursing facility:

- Physical therapy
- Massage therapy
- Occupational therapy
- Speech therapy

The facility must submit a consolidated bill for all therapies provided, consistent with Medicare's consolidated billing requirements.

VII. Surgical Assistants

DOC covers services provided by a surgeon, assistant surgeon*, licensed physician assistant*, certified registered nurse first assistant*, and anesthesia provider in performing medically necessary surgery for a covered condition.

*DOC follows Medicare's rules about assistants at surgery

VIII. Documentation Requirements for Unlisted Procedures

When billing with unlisted CPT® and/or HCPCS level II codes, you must submit supporting documentation with the claim. Unlisted codes do not refer to a specific procedure and generally end with "99" or "9" in the last digits of the CPT® code. Supporting documentation is defined as follows in the chart below.

Type of Unlisted Service	Unlisted CPT® Codes Within This Range	Type of Supporting Documentation
Surgical procedures	15999 to 69979	Operative report
Radiology	76496 to 79999	Clinic or office notes, X-ray report, and/or written description on or attached to the claim
Laboratory	80299 to 89240	Laboratory or pathology report and/or written description on or attached to the claim
Medicine	90399 to 99199 and 99600	Written description on or attached to the claim
Evaluation and man-agement	99429 and 99499	Daily office notes and/or written description on or attached to the claim
Drugs and biologicals (administered by the professional provider)	J3490 – J9999 Note: Codes J8499 and J8999 for oral drugs are generally not covered.	Name, manufacturer, strength, dosage, and quantity of the drug. If there is a specific drug code available, it must be used instead of an unclassified or unspecified drug code.

You can identify unlisted HCPCS level II codes by the terms used to describe them:

- Unlisted
- Not otherwise classified (NOC)
- Unspecified
- Unclassified
- Other
- Miscellaneous

Use the appropriate unlisted procedure code, and include a written description of the item or service with the claim.

IX. Modifiers That May Affect Payment

You must use a valid CPT® or HCPCS level II modifier when a modifier is needed to clarify a service. The modifiers in the following table may affect how DOC pays a claim. While other valid CPT® and HCPCS level II modifiers may be used for informational purposes, they do not affect payment.

Modifier	Description
24	Unrelated evaluation and management (E&M) services by the same physician during a postoperative period
25	Significant, separately identifiable E&M service by the same physician on the same day of a procedure or other service
26	Professional component
50	Bilateral procedure
51	Multiple procedures
54	Surgical care only
55	Postoperative management only
56	Preoperative management only
57	Decision for surgery
58	Staged or related procedure or service by same physician during the postoperative period
59	Distinct procedural service
62	Two surgeons
66	Surgical team
78	Return to O.R. for related procedure during postoperative period
80	Assistant surgeon
81	Minimum assistant surgeon
82	Assistant surgeon (when qualified resident surgeon not available)
99	Multiple modifiers which may affect payment
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
TC	Technical component

These modifiers are explained in more detail under the appropriate service headings on the following pages.

A. Requirements for Submission of Supporting Documentation for Modifiers

DOC reviews claims with modifiers 51, 62, and 66 before paying the claim.

- When using modifier 51 and reporting more than five procedures, you must submit supporting documentation with the claim. If reporting fewer than five procedures, you do not need to submit supporting documentation with the claim, but we may request it during our review.
- When using modifiers 62 and 66, you do not need to submit an operative report or supporting documentation with the claim, but we may request it during our review.
- When using other modifiers, you need to submit supporting documentation only if requested to do so by DOC.

B. Modifiers for Evaluation and Management (E&M) Services

DOC does not pay separately for most E&M services provided during the global surgery period indicated on the DOC fee schedule. DOC follows the same global surgery rules as the Centers for Medicare and Medicaid Services (CMS), with a few exceptions.

Description of Modifier	
24	Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service
57	Decision for Surgery

Some E&M services during the global surgery period will be paid separately when the appropriate modifier is used (see the table). You may be asked to send supporting documentation when these modifiers are used

C. Modifiers for Surgical Procedures

DOC follows Medicare's pricing rules for the CPT® surgical modifiers listed below.

Surgical Modifiers	
50	**Bilateral Procedure** The bilateral modifier identifies cases where a procedure typically performed on one side of the body is, in fact, performed on both sides of the body. For surgical procedures typically performed on one side of the body that are, in a specific case, performed bilaterally, the maximum allowance is 150% of the global surgery fee schedule amount for the procedure. Providers must bill using the single procedure code with modifier 50. When multiple bilateral procedures are performed, the bilateral surgery adjustment is applied to each bilateral procedure, and then the multiple procedure adjustment is applied. For example, if two procedures are performed bilaterally, the maximum allowance for the highest valued procedure would be 150% of the global surgery fee schedule amount for the procedure and the maximum allowance for the second bilateral procedure would be 75% of the global surgery fee schedule amount for the procedure (50% of 150%).
51	**Multiple Procedures** ***Multiple Surgeries:*** If multiple procedures are performed on the same offender at the same operative session or on the same day, the total maximum allowance is equal to the sum of the following: 100% of the global fee schedule amount for the highest fee-schedule-valued procedure and 50% of the global fee schedule amount for the second through fifth procedures. Surgical procedures in excess of five require submission of supporting documentation and individual review to determine payment amount. ***Multiple Endoscopies:*** Related endoscopic procedures performed on the same day are subject to the multiple endoscopy rules. The maximum allowance for the procedure with the highest fee schedule value is the full fee schedule amount. The maximum allowance for the second procedure is the full fee schedule amount minus the fee schedule amount for its base diagnostic endoscopy procedure. Unrelated endoscopic procedures performed on the same day are subject to the regular multiple surgery rules instead of the multiple endoscopy rule, since the codes are not in the same procedure family. The maximum allowance for the procedure with the highest fee schedule value is the full fee schedule amount, and the second procedure is allowed at 50% of the fee schedule amount. If multiple related endoscopies (for example, upper and lower gastrointestinal endoscopies) are performed on the same day, the special multiple endoscopy rules are applied separately within each group, and the multiple surgery rules are applied between groups. Please note: Providers should not discount their billed charges for multiple procedures. The appropriate discount as indicated above is applied to the maximum allowances by DOC.

Surgical Modifiers	
54, 55 & 56 Providers Furnishing Less than the Global Surgical Package	
These modifiers are designed to ensure that the sum of all maximum allowances for all practitioners who furnished parts of the services included in a global surgery fee schedule allowance do not exceed the total amount that would have been allowed to a single practitioner. The payment policy pays each provider directly for the portion of the global surgery services furnished to the enrollee. DOC follows Medicare's pre-, post-, and intraoperative percentages as published in the Medicare Physician Fee Schedule Data Base. For split-care, there must be an agreement for the transfer of care between the surgeon and provider who will provide pre- and/or postoperative care. Postoperative care is paid according to the number of days each provider is responsible for the offender's care and must be agreed upon by each provider so each provider bills the correct number of days. The three modifiers used are:	
54	**Surgical Care Only** This modifier is used when the surgeon performs only the preoperative and intraoperative care. Payment is limited to the amount allotted to the preoperative and intraoperative services
55	**Postoperative Management Only** This modifier must be used when a provider other than the operating surgeon assumes responsibility for the postoperative care of the offender. When submitting charges, the same CPT® code that the surgeon used must be billed with modifier 55. The postoperative care is paid at a percentage of the physician's fee schedule. The receiving provider cannot bill for any part of the service included in the global period until he/she provides at least one service. The receiving provider must bill postoperative care as one DOC sum
56	**Preoperative Management Only** This modifier is used by a provider who performs the preoperative care and evaluation and who is not the operating surgeon. Payment is limited to the amount allotted to the preoperative services.
58	**Staged or Related Procedure or Service by Same Physician During the Postoperative Period** This modifier is used when a surgical procedure is performed during the postoperative period of another surgical procedure because the subsequent procedure: a) was planned at the time of the original procedure; b) was more extensive than the original procedure; or c) was for therapy following a diagnostic surgical procedure
59	**Distinct Procedural Service**

	This modifier represents procedure(s) or service(s) not ordinarily performed or encountered on the same day by the same provider, but that are appropriate under certain circumstances (for example, different site or organ system, or separate excision or lesion). Supporting documentation may be requested for review.
62	**Co-Surgeons** This modifier is used when surgical procedures requiring the skills of two surgeons (each with a different specialty) are performed. The maximum allowance for each surgeon is 62.5% of the global surgical fee schedule amount. No payment is made for an assistant-at-surgery in these cases
Surgical Modifiers	
66	**Team Surgery** This modifier is used when highly complex procedures are carried out by a surgical team, which may include the concomitant services of several physicians, often of different specialties; other highly skilled, specially trained personnel; and various types of complex equipment. Procedures with this modifier are reviewed and priced on an individual basis. Supporting documentation may be requested for review
76	**Repeat Procedure by Same Physician** This modifier is used to indicate that a procedure or service was repeated subsequent to the original procedure or service.
77	**Repeat Procedure by Another Physician** This modifier is used to indicate that a procedure or service performed by another physician had to be repeated.
78	**Return to O.R. for Related Surgery During Postoperative Period** Use of this modifier allows separate payment for procedures associated with complications from surgery. The maximum allowance is limited to the amount allotted for intraoperative services only.
80, 81, 82, & AS Assistant-at-Surgery	
	Four modifiers may be used to identify procedures where a second provider assists another in the procedure. They are: 80 – Assistant Surgeon 81 – Minimum Assistant Surgeon 82 – Assistant Surgeon (when qualified resident surgeon is not available)

	AS – Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery. Note: “AS” is the appropriate modifier for Certified Registered Nurse First Assistant claims. The maximum allowance for procedures with these modifiers is the lesser of the following: • Actual charge. • Twenty (20) percent of the global surgery fee schedule amount for the procedure. Multiple surgery rules apply to subsequent multiple procedures. Provider payment differentials described in Section VII of this manual apply to maximum allowances for services reported with modifier AS
Other Related Modifiers	
22	**Unusual Services** This modifier is used when the services were significantly greater than what is usually described by the given procedure code. Claims with this modifier are individually reviewed prior to payment. An operative report and/or other supporting documentation must be submitted with the claim for review
24	**Unrelated Evaluation and Management (E&M) Services by the Same Physician During a Postoperative Period** This modifier is used when an evaluation and management service unrelated to the surgical procedure (and thus separately payable) was performed during the postoperative period. Supporting documentation may be requested for review
Other Related Modifiers	
25	**Significant, Separately Identifiable Evaluation and Management (E&M) Service by the Same Physician on the Same Day of a Procedure or Other Service** This modifier is used to indicate that, on the day of a procedure or other service, a significant, separately identifiable, related or unrelated E&M service was required due to the offender’s condition. Supporting documentation may be requested for review
99	**Multiple Modifiers** Under certain circumstances, two or more modifiers may be necessary to completely delineate a service. For procedures where more than two modifiers which affect payment apply, modifier “99” must be added to the base procedure and other applicable modifiers listed as part of the service description. Claims with this modifier are individually reviewed prior to payment. Supporting documentation may be requested for review

X. Radiology Services

Services covered by DOC under this benefit include X-rays and other imaging tests, studies, and examinations intended to establish a diagnosis or monitor the progress and outcome of therapy.

Diagnostic testing must be appropriate to the diagnosis or symptoms reported by the ordering provider and must be medically necessary. The ordering provider must be an authorized provider.

A. Modifiers Required for Professional and Technical Components

DOC will pay for professional and technical components of radiology procedures according to Medicare payment rules. Providers must use the following modifiers, as appropriate, when billing radiology services.

Description of Modifier	
26	**Professional Component** This modifier is used to bill for the professional component of a procedure which can be split into professional and technical components.
TC	**Technical Component** This modifier is used to bill for the technical component of a procedure which can be split into professional and technical components

Some providers may use modifiers 26 and/or TC to separately report the professional and/or technical components of a service when the global service was provided. In these instances, DOC's combined payment for the separate components will not exceed the fee schedule amount for the global procedure.

If another provider (for example, a facility) performs the technical component of a service, the provider performing only the professional component must report his/her service using the 26 modifier to signify that he/she performed only the professional component of the service.

The reverse is true in instances where another provider performs the professional component; in this case, the provider performing only the technical component must report the service using the TC modifier to signify that only the technical component of the service was performed.

XI. Laboratory Services

Services covered by DOC under this benefit include diagnostic laboratory tests, studies, and examinations intended to establish a diagnosis or monitor the progress and outcome of therapy.

Diagnostic testing must be appropriate to the diagnosis or symptoms reported by the ordering physician and must be medically necessary. The ordering physician must be an authorized provider. If the clinician refers lab tests to an authorized outside vendor for processing, the diagnosis/es must accompany the referral.

A. Payment for Laboratory Services

The following laboratory services are reimbursed based on the relative value units established in the Medicare Physician Fee Schedule Data Base (MPFSDB):

- Clinical pathology consultations
- Bone marrow services
- Physician blood bank services
- Cytopathology services
- Surgical pathology services

Codes not contained on the MPFSDB are reimbursed at 100% of the Medicare Clinical Lab Fee schedule amount

B. Clinical Laboratory Pricing

Codes not contained on the MPFSDB are reimbursed at 100% of the Medicare Clinical Lab Fee schedule amount and can be found on the DOC Professional Provider Fee Schedule in the allowed amount column.

C. Organ-and Disease-Oriented Lab Panels

Please refer to a current CPT® reference for complete descriptions of the component tests within each laboratory panel code.

The DOC allowed amount will be the same whether the service is billed using the individual test codes or the lab panel code. When component tests of a lab panel are billed separately, DOC bundles the individual codes to the appropriate lab panel code for payment, and the reimbursement is distributed among the separately billed codes.

Automated Multichannel Lab Test Codes		
82040	82565	84295
82247	82947	84450
82248	82977	84460
82310	83615	84478
82330	84075	84520
82374	84100	84550
82435	84132	
82465	84155	
82550	82565	

D. Automated Multichannel Chemistries

Providers will bill the organ and disease oriented panel CPT® code(s) if all component tests within the panel code are performed.

Payment for automated multichannel laboratory tests is determined as follows:

- When all automated multichannel laboratory component tests of an organ and disease panel CPT® code are billed separately, DOC bundles the individual codes to the appropriate organ and disease oriented panel CPT® code for payment.

- All other automated multichannel laboratory tests billed are paid according to the total number of automated multichannel laboratory tests performed. The DOC fee for the total number of tests performed will be distributed among the individual codes billed so that the total allowed charge does not exceed the DOC maximum allowable fee.

Number of Automated Multichannel Lab Tests	2010 Max Fee
1-2 tests	ATP02
3 tests	ATP03
4 tests	ATP04
5 tests	ATP05
6 tests	ATP06
7 tests	ATP07
8 tests	ATP08
9 tests	ATP09
10 tests	ATP10
11 tests	ATP11
12 tests	ATP12
13-16 tests	ATP16
17-18 tests	ATP18
19 tests	ATP19
20 tests	ATP20
21 tests	ATP21
22 tests	ATP22
23+ tests	ATP23

E. Modifiers Required for Professional and Technical Components

DOC will pay for professional and technical components of laboratory services according to Medicare payment rules. Providers must use the following modifiers, as appropriate, when billing laboratory services:

Modifier	Description
26	Professional Component This modifier is used to bill for the professional component of a procedure which can be split into professional and technical components.
TC	Technical ComponentThis modifier is used to bill for the technical component of a procedure which can be split into professional and technical components

Some providers may use modifiers 26 and/or TC to separately report the professional and/or technical components of a service when the global service was provided. In these instances, DOC's combined payment for the separate components will not exceed the

fee schedule amount for the global procedure.

If another provider (for example, a facility) performs the technical component of a service, the provider performing the professional component must report his/her service using the 26 modifier to signify that he/she performed only the professional component of the service.

The reverse is true in instances where another provider performs the professional component; in this case, the provider performing the technical component must report the service using the TC modifier to signify that only the technical component of the service was performed.