Coding Policy **Policy and Procedure**		
SUBJECT: Coding Policy 29.0 Date of Service for Professional Claims	DEPARTMENT: **Health Care Services**	
ORIGINAL EFFECTIVE DATE: 03/19	DATE(S) REVIEWED/REVISED: 07/21, 01/22, 01/23	
APPROVED BY: Coding Policy Review Committee	NUMBER: **MC 29.0**	PAGE: **1 of 4**

SCOPE:
Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:
Health Plan Providers
All Lines of Business

POLICY:
Company follows the Center for Medicare and Medicaid Services (CMS) guidelines for dates of service for radiology, surgical and anatomical pathology, clinical laboratory services, transitional care management, cardiovascular monitoring, services spanning two calendar dates, and neuropsychological testing and evaluations.

Providers are referred to PHP Coding Policy 07.0 (Global Payment for Obstetrical Care) for information about dates of service for global obstetrical codes.

PROCEDURE:
Radiology Services: Radiology services typically have two separate components, a professional and a technical component. These codes have a PC/TC indicator of "1" on the Medicare Physician Fee Schedule (MPFS).

- The technical component is always billed on the date the patient had the test performed.
- When billing a global service, the provider may submit the professional component with the date the review and interpretation is completed OR with the same date as the technical component.
- If the provider performed only one component of the service, the date of service for the technical component is the date the patient received the service, and the date of service for the professional component is the date the review and interpretation is completed.

Surgical and Anatomical Pathology: These services have two separate components, a professional component and a technical component. These codes have a PC/TC indicator of "1" on the MPFS.

- The technical component is always billed on the date the specimen was collected.
- When billing a global service, the provider may submit the professional component with the date the review and interpretation is completed OR with the same date as the technical component.
- If the provider performed only one component of the service, the date of service for the technical component is the date the patient received the service, and the date of service for the professional component is the date the review and interpretation is completed.

- When the collection spans two calendar dates, the date of service is the date the collection ended.

Clinical Laboratory Services:

- The date of service for clinical laboratory services is the date the specimen was collected.
- If the specimen is collected over a period that spans two calendar dates, the date of service is the date the collection ended.

Transitional Care Management:

Transitional care management (TCM) services are 30-day services provided when a patient is discharged from an appropriate facility and requires moderate or high-complexity medical decision making. The date of service is the date the practitioner completes the required face-to-face visit. Providers are reminded that all services required to support the TCM codes must be documented in the patient's record.

Cardiovascular Monitoring Services:

Cardiovascular monitoring services have separate codes to identify professional and technical components, as well as codes representing a combination of both professional and technical components. The date of service is based on the code description and the time listed.

- For services that include the physician review and/or interpretation and report, the date of service is the date the physician completes that activity.
- For technical services, the date of service is the date the monitoring concludes based on the description of the service. For example, for procedures that include 30 days of monitoring with physician interpretation and report, the date of service is no earlier than the 30th day of monitoring and is the date the physician completes the professional component of the service.

Services Spanning Two Calendar Dates:

There are multiple types of service that begin on one day and conclude on the following day. The service may not be billed to PHP until completed, but the date of service may be either the date the service began or the date the service was concluded.

Neuropsychological Testing and Evaluations:

Psychological and neuropsychological testing and evaluations (codes 96116, 96121, 96130-96133, 96136-96139) are sometimes completed in multiple sessions that occur on different days. In these situations, the date of service is the date on which the service is concluded. Documentation should show that the service began on one day and was concluded on another day, i.e., the date of service reported on the claim. If documentation is requested, medical records for both days should be submitted.

Psychiatric testing provided over multiple days is billed based on the time involved as described by the CPT code, and the date of service is the last date of the test. As with all time-based codes, the time spent on each day must be documented in the patient's record.

Exceptions:

- For specimens stored <u>for less than or equal to 30 calendar days</u> from the date specimen was collected, the DOS of the test/service must be the date the test/service was performed only if:
    - The test/service is ordered by the patient's physician at least 14 days following the date of the patient's discharge from the hospital;
    - The specimen was collected while the patient was undergoing a hospital surgical procedure;
    - It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;
    - The results of the test/service do not guide treatment provided during the hospital stay; and
    - The test/service was reasonable and medically necessary for treatment of an illness.
- For specimens stored <u>more than 30 calendar days</u> before testing, the specimen is considered to have been archived and the DOS of the test/service must be the date the specimen was obtained from storage.
- For chemotherapy sensitivity tests/services performed on live tissue, the DOS must be the date the test/service was performed only if:
    - The decision regarding the specific chemotherapeutic agents to test is made at least 14 days after discharge;
    - The specimen was collected while the patient was undergoing a hospital surgical procedure;
    - It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;
    - The results of the test/service do not guide treatment provided during the hospital stay; and
    - The test/service was reasonable and medically necessary for treatment of an illness.

  NOTE: For purposes of applying the above exception, a "chemotherapy sensitivity test" is defined as a test that requires a fresh tissue sample to test the sensitivity of tumor cells to various chemotherapeutic agents. CMS identifies such tests through program instructions issued to the Medicare Administrative Contractors (MACs).
- For molecular pathology tests performed by a laboratory other than a blood bank or center, or a test designated by CMS as an ADLT under paragraph (1) of the definition of advanced diagnostic laboratory test in 42 CFR 414.502, the DOS must be the date the test was performed only if:

- The test was performed following a hospital outpatient's discharge from the hospital outpatient department;
- The specimen was collected from a hospital outpatient during an encounter;
- It was medically appropriate to have collected the sample from the hospital outpatient during the hospital outpatient encounter;
- The results of the test do not guide treatment provided during the hospital outpatient encounter; and
- The test was reasonable and medically necessary for the treatment of an illness.

NOTE: For the purpose of this section, a "blood bank or center" means an entity whose primary function is the performance or responsibility for the performance of, the collection, processing, testing, storage and/or distribution of blood or blood components intended for transfusion and transplantation.

REFERENCE:

CMS / Medicare Rules and Regulations
Providence Health Plan Clinical Coding Edits