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CHAPTER X
PATHOLOGY / LABORATORY SERVICES
CPT CODES 80000 - 89999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter X
Pathology and Laboratory Services
CPT Codes 80000 - 89999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 80000-89999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this Chapter.

Pathology and laboratory CPT coding includes services primarily reported to evaluate specimens obtained from patients (body fluids, cytological specimens, or tissue specimens obtained by invasive/surgical procedures) in order to provide information to the treating physician. This information, coupled with information obtained from history and examination findings and other data, provides the physician with the background upon which medical decision making is established.

Generally, pathology and laboratory specimens are prepared and/or screened by laboratory personnel with a pathologist assuming responsibility for the integrity of the results generated by the laboratory. Certain types of specimens and tests are reviewed personally by the pathologist. CPT coding for this section includes few codes requiring patient contact or evaluation and management services rendered directly by the pathologist. On the occasion that a pathologist provides evaluation and management

services (significant, separately identifiable, patient care services that satisfy the criteria set forth in the E&M guidelines developed by CMS, formerly HCFA, and the AMA), appropriate coding should be rendered from the evaluation and management section of the *CPT Manual*.

If, after a test is ordered and performed, additional related procedures are necessary to provide or verify the result, these would be considered part of the ordered test. For example, if a patient with leukemia has a thrombocytopenia, and a manual platelet count (CPT code 85032) is performed in addition to the performance of an automated hemogram with automated platelet count (CPT code 85027), it would be inappropriate to report CPT codes 85032 and 85027 because the former provides verification for the automated hemogram and platelet count (CPT code 85027). As another example, if a patient has an abnormal test result and repeat performance of the test is done to verify the result, the test is reported as one unit of service rather than two.

If a treating physician orders an automated complete blood count with automated differential WBC count (CPT code 85025) or without automated differential WBC count (CPT code 85027), the laboratory sometimes examines a blood smear in order to complete the ordered test based on laboratory selected criteria flagging the results for additional verification. The laboratory should NOT report CPT code 85007 (microscopic blood smear examination with manual WBC differential count) or CPT code 85008 (microscopic blood smear examination without manual WBC differential count) for the examination of a blood smear to complete the ordered automated hemogram test (CPT codes 85025 or 85027). The same principle applies if the treating physician orders any type of blood count and the laboratory’s practice is to perform an automated complete blood count with or without automated differential WBC count.

If a treating physician orders an automated hemogram (CPT code 85027) and a manual differential WBC count (CPT code 85007), both codes may be reported. However, a provider may not report an automated hemogram with automated differential WBC count (CPT code 85025) with a manual differential WBC count (CPT code 85007) because this combination of codes results in duplicate payment for the differential WBC count. CMS does not pay twice for the same laboratory test result even if performed by two different methods unless the two methods are medically reasonable and necessary.

By contrast some laboratory tests if positive require additional separate follow-up testing which is implicit in the physician's order. For example, if an RBC antibody screen (CPT code 86850) is positive, the laboratory routinely proceeds to identify the RBC antibody. The latter testing is separately reportable. Similarly, if a urine culture is positive, the laboratory proceeds to organism identification testing which is separately reportable. In these cases, the initial positive results have limited clinical value without the additional testing. The additional testing is separately reportable because it is not performed to complete the ordered test. Furthermore, the ordered test if positive requires the additional testing in order to have clinical value. This type of testing is a category of reflex testing that must be distinguished from other reflex testing performed on a positive test result which may have clinical value without additional testing. An example of a latter type of test is a serum protein electrophoresis with a monoclonal protein band. A laboratory should not routinely perform serum immunofixation or serum immunoelectrophoresis to identify the type of monoclonal protein unless ordered by the treating physician. If the patient has a known monoclonal gammopathy, perhaps identified at another laboratory, the serum immunofixation or immunoelectrophoresis would not be appropriate unless ordered by the treating physician.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, or ZZZ. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier. All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure.

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable

on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

Procedures with a global surgery indicator of “XXX” are not covered by these rules. Many of these “XXX” procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other “XXX” procedures are not usually

performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most “XXX” procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day of service which may be reported by appending modifier –25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the “XXX” procedure but cannot include any work inherent in the “XXX” procedure, supervision of others performing the “XXX” procedure, or time for interpreting the result of the “XXX” procedure. Appending modifier –25 to a significant, separately identifiable E&M service when performed on the same date of service as an “XXX” procedure is correct coding.

C. Organ or Disease Oriented Panels

The *CPT Manual* assigns CPT codes to organ or disease oriented panels consisting of a group of specified tests. If all tests of a CPT defined panel are performed, the provider may bill the panel code or the individual component test codes. The panel codes may be used when the tests are ordered as that panel or if the individual component tests of a panel are ordered separately. For example, if the individually ordered tests are cholesterol (CPT code 82465), triglycerides (CPT code 84478), and HDL cholesterol (CPT code 83718), the service could be billed as a lipid panel (CPT code 80061).

NCCI contains edits pairing each panel CPT code (column one code) with each CPT code corresponding to an individual laboratory test that is included in the panel (column two code). These edits allow use of NCCI-associated modifiers to bypass them if one or more of the individual laboratory tests are reported on the same date of service. The repeat testing must be medically reasonable and necessary. Modifier -91 may be utilized to report this repeat testing. Based on the *Internet-Only Manuals(IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 16, Section 100.5.1, the repeat testing cannot be performed to “confirm initial results; due to testing problems with specimens and equipment or for any other reason when a normal, one-time, reportable result is all that is required.”

D. Evocative/Suppression Testing

Evocative/suppression testing involves administration of agents to determine a patient's response to those agents (CPT codes 80400-80440 are to be used for reporting the laboratory components of the testing). When the test requires physician administration of the evocative/suppression agent as described by CPT codes 90760-90775 (therapeutic/ diagnostic injections/infusions), these codes can be separately reported. However, when physician attendance is not required, and the agent is administered by ancillary personnel, these codes are not to be separately reported. In the inpatient setting, these codes are only reported if the physician performs the service personally. In the office setting, the service can be reported when performed by office personnel if the physician is directly supervising the service. While supplies necessary to perform the testing are included in the testing, the appropriate HCPCS J codes for the drugs can be separately reported for the diagnostic agents. Separate evaluation and management services are not to be reported, including prolonged services (in the case of prolonged infusions) unless a significant, separately identifiable service is provided and documented.

Evocative/suppression testing requires the administration of pharmaceutical agents to determine a patient's response to those agents. CPT codes 80400-80440 describe the laboratory components of the testing. Administration of the pharmaceutical agent may be reported with CPT codes 90765-90775. In the facility setting, these codes may be reported by the facility, but not the physician. In the non-facility setting, these codes may be reported by the physician. While supplies necessary to perform the testing are included in the testing CPT codes, the appropriate HCPCS level II J code for the pharmacologic agent may be reported separately. Separate evaluation and management services, including prolonged services (e.g., prolonged infusion) should not be reported separately unless a significant, separately identifiable service is provided and documented.

E. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to

bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. CMS payment policy allows only one unit of service for CPT codes 88321, 88323, and 88325 per beneficiary per provider on a single date of service. Providers should not report these codes on separate lines of a claim utilizing CPT modifiers to bypass the MUEs for these codes.

F. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

3. Multiple CPT codes are descriptive of services performed for bone and bone marrow evaluation. When a biopsy is performed for evaluation of bone matrix structure, the

appropriate code to bill is CPT code 20220 for the biopsy and CPT code 88307 for the surgical pathology evaluation.

When a bone marrow aspiration is performed alone, the appropriate coding is CPT code 38220. Appropriate coding for the interpretation is CPT code 85097 when the only service provided is the interpretation of the bone marrow smear. When both are performed by the same provider, both CPT codes may be reported. The pathological interpretations (CPT code 88300-88309) are not reported in addition to CPT code 85097 unless separate specimens are processed.

When it is medically necessary to evaluate both bone structure and bone marrow, and both services can be provided with one biopsy, only one code (CPT code 38221 or CPT code 20220) can be reported. If two separate biopsies are necessary, then both can be reported using modifier -59 on one of the codes. Pathological interpretation codes 88300-88309 may be separately reported for multiple separately submitted specimens. If only one specimen is submitted, only one code can be reported regardless of whether the report includes evaluation of both bone structure and bone marrow morphology or not.

4. The family of CPT codes 87040-87158 refers to microbial culture studies. The type of culture is coded to the highest level of specificity regarding source, type, etc. When a culture is processed by a commercial kit, report the code that describes the test to its highest level of specificity. A screening culture and culture for definitive identification are not performed on the same day on the same specimen and therefore are not reported together.

5. When cytopathology codes are reported, the appropriate CPT code to bill is that which describes, to the highest level of specificity, what services were rendered. Accordingly, for a given specimen, only one code from a group of related codes describing a group of services that could be performed on a specimen with the same end result (e.g., 88104-88112, 88142-88143, 88150-88154, 88164-88167, etc.) is to be reported. If multiple services (i.e., separate specimens from different anatomic sites) are reported, modifier -59 should be used to indicate that different levels of service were provided for different specimens from different anatomic sites. This should be reflected in the cytopathologic reports. A cytopathology

preparation from a fluid, washing, or brushing is to be reported using one code from the range of CPT codes 88104-88112. It is inappropriate to additionally use CPT codes 88160-88162 because the smears are included in the codes referable to fluids (or washings or brushings) and 88160-88162 references “any other source” which would exclude fluids, washings, or brushings.

6. The CPT codes 80500 and 80502 are used to indicate that a pathologist has reviewed and interpreted, with a subsequent written report, a clinical pathology test. These codes additionally are not to be used with any other pathology service that includes a physician interpretation (e.g., surgical pathology). If an evaluation and management service (face-to-face contact with the patient) takes place by the pathologist, then the appropriate E&M code is reported, rather than the clinical pathology consultation codes, even if, as part of the evaluation and management service, review of the test result is performed. Reporting of these services (CPT codes 80500 and 80502) requires the written order for consultation by a treating physician.

7. The CPT codes 88321-88325 are to be used to review slides, tissues, or other material obtained and prepared at a different location and referred to a pathologist for a second opinion. (These codes should not be reported by pathologists reporting a second opinion on slides, tissue, or material also examined and reported by another pathologist in the same provider group. Medicare generally does not pay twice for an interpretation of a given technical service (e.g., EKGs, radiographs, etc.). CPT codes 88321-88325 are reported with one unit of service regardless of the number of specimens, paraffin blocks, stained slides, etc.

When reporting CPT codes 88321-88325, providers should not report other pathology CPT codes such as 88312, 88313, 88342, 88187, 88188, 88189, etc., for interpretation of stains, slides or material previously interpreted by another pathologist. CPT codes 88312, 88313 and 88342 may be reported with CPT code 88323 if provider performs and interprets these stains de novo.

CPT codes 88321-88325 are not to be used for a face-to-face evaluation of a patient. In the event that a physician provides an evaluation and management service to a patient and, in the course of this service, specimens obtained

elsewhere are reviewed as well, this is part of the evaluation and management service and is not to be reported separately. Only the evaluation and management service would be reported.

8. Multiple tests to identify the same analyte, marker, or infectious agent should not be reported separately. For example, it would not be appropriate to report both direct probe and amplified probe technique tests for the same infectious agent.

9. Medicare does not pay for duplicate testing. CPT codes 88342 (immunocytochemistry, each antibody) and 88184, 88187, 88188, 88189 (flow cytometry) should not in general be reported for the same or similar specimens. The diagnosis should be established using one of these methods. The provider may report both CPT codes if both methods are required because the initial method is nondiagnostic or does not explain all the light microscopic findings. The provider can report both methods utilizing modifier -59 and document the need for both methods in the medical record.

If the abnormal cells in two or more specimens are morphologically similar and testing on one specimen by one method (88342 or 88184, 88187, 88188, 88189) establishes the diagnosis, the same or other method should not be reported on the same or similar specimen. Similar specimens would include, but are not limited to:

(1) blood and bone marrow;
(2) bone marrow aspiration and bone marrow biopsy;
(3) two separate lymph nodes; or
(4) lymph node and other tissue with lymphoid infiltrate.

10. Quantitative or semi-quantitative immunohistochemistry using computer-assisted technology (digital cellular imaging) should not be reported as CPT code 88342 with CPT code 88358. Prior to January 1, 2004, it should have been reported as CPT code 88342. Beginning January 1, 2004, it should be reported as CPT code 88361. CPT code 88361 should not be used to report any service other than quantitative or semi-quantitative immunohistochemistry using computer-assisted technology (digital cellular imaging). Digital cellular imaging includes computer software analysis of stained microscopic slides. Beginning January 1, 2005, quantitative or semi-quantitative immunohistochemistry performed by manual techniques should be

reported as CPT code 88360. Immunohistochemistry reported with qualitative grading such as 1^+ to 4^+ should be reported as 88342.

11. DNA ploidy and S-phase analysis of tumor by digital cellular imaging technique should not be reported as CPT code 88313 with CPT code 88358. Prior to January 1, 2004, it should have been reported as CPT code 88313. Beginning January 1, 2004, it should be reported as CPT code 88358. Prior to January 1, 2004, CPT code 88358 should have been utilized to report DNA ploidy and S-phase analysis of tumor by non-digital cellular imaging techniques. CPT code 88358 should not be used to report any service other than DNA ploidy and S-phase analysis. One unit of service for CPT code 88358 includes both DNA ploidy and S-phase analysis.

12. CPT code 83721 (lipoprotein, direct measurement; direct measurement, LDL cholesterol) is used to report direct measurement of the LDL cholesterol. It should not be used to report a calculated LDL cholesterol. Direct measurement of LDL cholesterol in addition to total cholesterol (CPT code 82465) or lipid panel (CPT code 80061) may be reasonable and necessary if the triglyceride level is too high (greater than or equal to 400 mg/dl) to permit calculation of the LDL cholesterol. In such situations, CPT code 83721 should be reported with modifier -59.

13. Prior to January 1, 2005, qualitative, semi-quantitative, and quantitative (tissue) *in situ* hybridization should have been reported as CPT code 88365 when performed by a physician (limited to M.D./D.O.). Beginning January 1, 2005, quantitative or semi-quantitative *in situ* hybridization (tissue or cellular) performed by computer-assisted technology should be reported as CPT code 88367 when performed by a physician (limited to M.D./D.O.). Beginning January 1, 2005, quantitative or semi-quantitative *in situ* hybridization (tissue or cellular) performed by manual methods should be reported as CPT code 88368 when performed by a physician (limited to M.D./D.O.). Do not report CPT code 88365 with CPT codes 88367 or 88368 for the same probe. Only one unit of service may be reported for CPT code 88365, 88367 or 88368 for each reportable probe. When *in situ* hybridization is performed on tissue or cytology specimens by a non-physician (provider other than M.D./D.O.), it should be reported using appropriate CPT codes in the range 88271-88275. For each reportable probe, a provider should not report CPT codes both from the range 88365-88368 and the range 88271-88275. *In*

situ hybridization reported as CPT codes 88365-88368 includes both physician (limited to M.D./D.O.) and non-physician (non-M.D./D.O.) services to obtain a reportable probe result. The physician (limited to M.D./D.O.) work component of 88365-88368 requires that a physician (limited to M.D./D.O.) rather than laboratory scientist or technician read, quantitate (88367,88368), and interpret the tissues/cells stained with the probe(s). If this work is performed by a laboratory scientist or technician, CPT codes 88271-88275 should be reported.

When a physician (limited to M.D./D.O.) reads/quantitates (CPT codes 88367, 88368) and interprets (CPT codes 88365-88368) the tissues/cells stained with the probe(s), the provider may report the global code or professional component (modifier -26) as appropriate. When the professional component of CPT codes 88365-88368 is reported by the physician (limited to M.D./D.O.), the laboratory may report the technical component (modifier -TC), and a hospital reporting an outpatient laboratory test may report the appropriate CPT code. If a non-physician (provider other than M.D./D.O.) reads and quantitates the tissues/cells stained with the probe(s), the laboratory should not report the technical component (-TC) of CPT codes 88367-88368, and a hospital reporting an outpatient laboratory test should not report CPT codes 88367 or 88368. The laboratory or hospital may report these services with CPT codes 88271-88275.

14. Beginning January 1, 2005, flow cytometry interpretation should be reported using CPT codes 88187-88189. Only one code should be reported for all flow cytometry performed on a specimen. Since Medicare does not pay for duplicate testing, do not report flow cytometry on multiple specimens on the same date of service unless the morphology or other clinical factors suggest differing results on the different specimens. There is no CPT code for interpretation of one marker. The provider should not bill for interpretation of a single marker using another CPT code. Quantitative cell counts performed by flow cytometry (CPT codes 86064, 86359-86361, 86379, and 86587) should not be reported with the flow cytometry interpretation CPT codes 88187-88189 since there is no interpretative service for these quantitative cell counts.

15. Infectious agent molecular diagnostic testing utilizing nucleic acid probes is reported with CPT codes 87470-87801, 87901-87904. These CPT codes include all the molecular

diagnostic processes, and CPT codes 83890-83913 should not be additionally reported with these CPT codes. If the provider performs infectious agent molecular diagnostic testing utilizing nucleic acid probes (87470-87801, 87901-87904) on the same date of service as non-infectious agent molecular diagnostic testing or infectious agent molecular diagnostic testing utilizing methodology that does not incorporate nucleic acid probes, the molecular diagnostic testing CPT codes 83890-83913 may be reported separately with an NCCI-associated modifier.

16. CPT code 83912 describes a medically reasonable and necessary “interpretation and report” associated with molecular diagnostic testing described with CPT codes 83890-83906. CPT code 83912 should not be reported as an “interpretation and report” with CPT codes 87470-87801, 87901-87904 or 88271-88275.

17. Free thyroxine (CPT code 84439) is generally considered to be a better measure of the hypothyroid or hyperthyroid state than total thyroxine (CPT code 84436). If free thyroxine is measured, it is not considered appropriate to measure total thyroxine with or without thyroid hormone binding ratio (CPT code 84479). NCCI does not permit payment of CPT codes 84436 or 84479 with CPT code 84439.

18. CPT codes 88384-88386 describe array-based evaluations of multiple molecular probes. Although CPT code 88384 is Carrier priced, CPT codes 88385 and 88386 are payable from the Medicare Physician Fee Schedule and include significant physician work. If array-based evaluation of multiple molecular probes is performed by a laboratory scientist or technician rather than a physician, it should not be reported with global CPT code 88385 or 88386 since these codes include physician work. Rather, it should be reported as 88385-TC or 88386-TC which includes the non-physician work including interpretation.