Current Issues in Cytology: Coding Questions, Quagmires, and Quandaries
Please turn off or silence your cell phones
Panelists

Diane Davis Davey, MD: University of Central Florida, Orlando (Moderator)
Susan E. Spires, MD: University of Kentucky
W. Stephen Black-Schaffer, MD: Massachusetts General Hospital
Dennis Padget, MBA, CPA, FHFMA: DLPadget Enterprises, Inc., Florida
Carol Ann Filomena, MD: Duke University, Durham
Schedule

- Dr. Spires: CPT and RUC process
- Dr. Black-Schaffer: Regulatory background
- Break
- Mr. Padget: Practical applications including new cytology codes
- Dr. Filomena: Role as CPT Advisor for ASC
- Panel and audience questions
Panel Objectives

- Describe the genesis of CPT codes and how they are valued for payment
- Correctly document and code cytology immediate evaluation procedures
- List new cytology CPT codes and describe how they are used
- Identify and correct frequent coding errors in the cytology laboratory
CODING QUESTIONS, QUAGMIRES AND QUANDARIES

SUSAN E. SPIRES MD
University of Kentucky College of Medicine
• No conflicts of interest

• CAP Delegate RUC 2008 to present

• ASC RUC Advisor, 1999 to 2008
• Fee for Service based on CPT codes and Negotiated Amounts for the service...
• Third parties—negotiated individually
• Governmental—negotiated nationally with code and fee development through a rule making process
The Players and the Process

• AMA Specialty Society CPT Committee
• The AMA/ Specialty Society RBRVS Update Committee (RUC)
• CMS and Development of the Final Rule

Important because 3rd party payers closely follow Government payment rules
Overview of the “language” of medical billing: CPT codes.

CPT is the universal “language” used today in the United States to describe, bill, and pay medical, surgical, and related physician services and procedures. (DME or goods excluded).

CPT taxonomy offers HCPs, hospitals, laboratories, third-party payers, managed care companies, and private medical insurers a way to communicate consistently and concisely regarding the medical and surgical services they provide.

CPT is a registered trademark of the American Medical Association (AMA), and the text is owned and maintained exclusively by the AMA.
• The current coding system is based on 5-digits/characters.

• Category I
  – 00000-01999 Anesthesiology
  – 10000-69999 Surgery
  – 70000-79999 Radiology
  – 80000-89999 Laboratory and Pathology
  – 90000-99999 Medicine
    (99201-99445 Evaluation & Management)

• Category II (Performance measures--PQRI)
  – 0001F-6999F

• Category III (New technology)
  0001T-XXXT
Procedures listed in CPT are classified by category

- **Category I** services are those that reflect the contemporary, widespread practice of medicine by physicians in this country.
- 99% of all procedural entries in CPT fall under this category.
- Category I is updated effective each January 1 through the CPT-RUC cycle.
Use CPT for All Payers and Insurers.

- In 2000, DHHS selected CPT as the national standard for reporting medical services under the Health Insurance Portability and Accountability Act.
- According to HIPAA, the CPT data set must be used by all providers, government payers, and private medical insurers.
CPT CODE PROCESS

• **CPT Editorial Panel**
  - 16 members-including Internal Medicine, Family Practice, Surgery, Pathology, CMS, Managed Care, Insurance Industry.

• **CPT Advisory Committee**
  - >90 members from all specialty societies represented in AMA Federation + several other physician/non-physician societies (including USCAP, ASC, ASCP, ACMG, AACC).
  - Responsible for code language, development and presentation of codes at CPT
The CPT advisor for ASC:

Carol Filomena, MD
carol.filomena@duke.edu
**CPT Codes—the Basis of Payment**

- **Category I CPT Code changes:** Any professional or organization has the ability to request a code addition, deletion, or modification.

- Code proposals as submitted by individuals, industry or SS are screened through the CPT advisors (and PCC), then presented to the Editorial Panel for decision.

- It is a political process!

- It is a slow process!

- It is an arcane process!
• **Pathology Coding Caucus** - Created 2003 by the AMA Editorial Panel, partially in response to HIPAA and the concerns of the non-physician laboratory community for a voice in laboratory CPT coding

• **Role:** Through a consensus process, communicate a unified opinion on Lab and Pathology codes to CPT

• **Chaired and staffed by the College of American Pathologists**
A CPT code request may be:

• Accepted as submitted

• Accepted with modification
  – which may occur up to the date of release of the level of interest forms to the RUC advisors

• Rejected to be modified and resubmitted
AMA-\textit{CPT} maintains the codes and does NOT set the prices.

The Resource Based Relative Value System Update Committee or

\textit{RUC} allocates payment in RVUs
RUC PROCESS: Which codes are RUC valued?

- “Physician” performed testing → Resource Based Relative Value System (RB-RVS)

- Clinical laboratory analyses performed by non physicians → Clinical Laboratory Fee Schedule (CLFS) with statutorily determined payment. Includes Pap screening.
CPT/RUC Cycle for developing codes and Payment

- CPT meets 3 times a year to determine code changes for the next year
- RUC meets 3 times a year to consider and to provide recommendations for $
- CMS publishes the annual update to the Medicare RVS in the *Federal Register*
- Codes and values go into effect annually January 1
- *Strictly confidential with prohibition of discussion of codes until PFS published in the Final Rule*
CPT- RUC Cycle

1. Code
2. CPT Editorial Panel
3. Level of Interest
   - Survey
   - Specialty Society RVS Committee
4. CMS
5. The RUC
Medicare RBRVS

• Standardized physician payment schedule where payments for services are determined by the survey-derived relative work and costs to provide them
• Most public and private payors utilize some form of Medicare RBRVS scale
• While third party payers are bound by HIPAA to use CPT they are not required to use the MC PFS amount
Anesthesiology
Cardiology
Dermatology
Emergency Medicine
Family Medicine
Gastroenterology*
General Surgery
Pulmonary Medicine*

Internal Medicine
Neurology
Neurosurgery
Obstetrics/Gynecology
Ophthalmology
Orthopaedic Surgery
Otolaryngology
Pathology

Colorectal Surgery*
Pediatrics
Plastic Surgery
Psychiatry
Radiology
Thoracic Surgery
Urology

* indicates rotating seat
RUC Advisory Committee

• One physician representative appointed from each of the 109 specialty societies seated in the AMA House of Delegates

• Advisory Committee members assist in the development of Valuation and present their specialties’ recommendations to the RUC

• Each member is allowed comment on recommendations made by other specialties
RUC Advisory Committee

The ASC RUC advisor:

Margaret Havens Neal MD

amhneal@yahoo.com
• Pathology at the table with 25 other specialties
• Set new/revised code values *relative* to other services
• Public (government) - private (physicians) *partnership* instead of government dictated payment amounts
One view of Reimbursement

by John Chase

How relative value units are determined.
RUC Survey Process
Selection of Reference Codes

- Allows for comparison physician work of new or revised code to the work of an established code
- Survey participants are given a specific reference list and must choose a code they are familiar with which is similar to the new or revised code
Physician Work Survey

- Relative value units ("RVUs")
- Determined by:
  - Time to perform the service
  - Technical skill and physical effort
  - Mental effort and judgment
  - Stress due to potential risk to the patient
Physician Work = Time x Intensity
• Initially, allocated as % MD work ("Harvard Studies was 40%)
• In 1999, CMS transitioned to a resource-based practice expense relative value for each CPT code
• Direct expenses: eg scalpel blades, reagents, slides
• Indirect: eg secretarial, computer, rent
Components of 88305-26

- Practice Expense RVU’s 32%
- Professional Liability Insurance RVU’s 2%
- Work RVU’s 67%
Calculating Payment

The general formula for calculating Medicare payment amounts for Jan 1 – December 31, 2010, is derived by multiplying each component as adjusted by geographic practice cost index:

Total RVU = 

\[ ((wRVU \times wGPCI) + (peRVU \times peGPCI) + (pliRVU \times pliGPCI)) \]

Total RVU x Conversion Factor* = Medicare Payment

*The Conversion Factor for CY 2010 = $36.87  (For 2009 was $36.0666)
• CMS/Carrier Medical Director review
• Proposed Rule in June with a 60-day Comment period
• Final Rule in November
• CMS’s acceptance rate of RUC proposals was traditionally more than 90% annually until now.
• Payment determination doesn’t stop at the Final Rule Stage
• There is an suprastructure of caveats and limitations to payment
  – NCCI
  – MUEs
• Many apply to some 3rd party payers
Medicare does not pay for services that are not reasonable and medically necessary

- Title 18 SSA, Sec 1862: No payment may be made under Part A or B for any expenses incurred...which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed member.

- Exception: Statutorily defined screening tests

Documentation of services provided is Mandatory- Legible, maintained in Medical record and signed by physician or HCP, eg. IE on FNA
• Medicare does not pay for Quality Assurance!!!
  e.g. Paps to Pathologist where no suspected abnormality is present

• Unbundling is prohibited...

  “CMS does not pay twice ... for the same test result even if performed by two methods unless... medically reasonable and necessary.” e.g. BAL w/ cytospins and thinprep, may bill either 88108 or 88112

• Therefore...
• With multiple services on one beneficiary, same provider, same day [e.g. urine cytospins (88108), sputum smears (88161)], add -59 Modifier (bypassing edits)

• **Reflex testing is allowable** (somewhat):
  Some tests require additional testing e.g. abnormal Pap requires MD interpretation with standing order
  Otherwise physician order is required, e.g. HPV testing on ASCUS Pap
• CPT determines payment amount

• ICD-9 required to document necessity*

* PM 6-10-03, ..reminder that physicians/ practitioners “must provide a diagnosis on all orders and referrals” not merely lab tests or screening cytology. Must be provided by the practitioner, not derived from archives.
• ICD-9 Codes (Diagnosis Codes)
  – Mandatory for all, CPT code specific for lab and screening benefit payment
  – Updated semi-annually in April & October with no grace period
• Made up of 3, 4 or 5 digits
• Coded to highest level of specificity
Acceptable Screening Pap Diagnoses

- V72.31 – routine Physical exam
- V72.32 – Physical exam, high risk
- V76.2  – routine Pelvic exam
- V76.47 – post hysterectomy for non-malignant condition
- V76.49 – patients without cervix
- V15.89 – routine pelvic, high risk
- Signs and symptoms
- Covers Pap payment at 11 or 23 month intervals
Diagnostic ICD-9’s (not “V” codes) for medical necessity

- 795.0 series: excludes CIN, SIL, CIS on biopsy

  795.00: AGUS
  795.01: ASCUS
  795.02: ASC-H
  795.03: LGSIL
  795.04: HGSIL
  795.05: HR-DNA +
  795.07: Sat Pap lacking TZ
  795.08: Unsat Pap
  795.09: Other abnl smear/HPV
  795.10-.19: Vaginal Pap abnormalities
• Be a tireless advocate for the practice of Cytology, not just in DC but in everyday practice
• Present a unified voice through the ASC and CAP (among others)
• Stay vigilant and inform your leadership and advisors of payment issues requiring address
Keep it up!

When you think you’re finished, you are finished!

--- Benjamin Franklin
Current Issues in Cytology: Coding Questions, Quandaries and Quagmires

Stephen Black-Schaffer, M.D.
Massachusetts General Hospital
November 15, 2010
None
The bolts and nuts of payment policy...

• I know this is backwards.
• Backwards is a good way to think about this!
• Why?
• The Golden Rule (à la Mark Synovec):
  • "They have the gold; they make the rules."
• So ask yourself, "What Would Payers Do?"
• You'll have a better chance of understanding how (and why) this all works the way it does.
Edits and audits

- Payers have two ways to apply their rules:
  - Prepayment edits
  - Postpayment audits
- CMS has the most comprehensive publicly available set of payment policies
- So that's what compliance programs target
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<tr>
<th>Prepayment Claim Review Programs</th>
<th>Postpayment Claim Review Programs</th>
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<td>National Correct Coding Initiatives (NCCI) Edits</td>
<td>Comprehensive Error Rate Testing (CERT) Program</td>
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<td>Medically Unlikely Edits (MUE)</td>
<td>Recovery Audit Contractor (RAC)</td>
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<td>Carrier/FI/MAC Medical Review (MR)</td>
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<th>Providers Impacted</th>
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Reasonable and Necessary Services

Medically Unlikely Services
Unit coding – what is it?

- It's how we code for our services in anatomic pathology
  - (exception = flow cytometry)
- Each and every separate item (specimen) gets a code
- A pathology bills looks like a laundry list!

Is this good or bad?
Unit coding – pros and cons

• **Pros - pathology is distinctive:**
  • Accurate work representation
  • Addition new technologies
  • Adoption new practices

• **Cons - pathology is distinctive:**
  • Multiple different codes to report episode of care
    - National Correct Coding Initiative (NCCI)
  • Multiples of same code to report episode of care
    - Medically Unlikely Edits (MUEs)
What are MUEs?

• The MUE for a CPT code is the maximum units of service under most circumstances that a provider would report for that code for a single beneficiary on a single date of service.

• Medicare contractors adjudicate each line of a claim separately against the MUE value for the code on that line.

• The appropriate use of some modifiers (e.g., -59) may bypass an MUE value because the modifier causes the CPT code to appear on separate lines of the claim.
What is the "modifier" option?

• **Modifier -59: Distinct Procedural Service:** indicate a procedure or service was distinct or independent from other services performed on the same day.

• This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, or separate lesion.

2. Be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs.
6. The **unit of service** for CPT code 88172 is the separately identifiable lesion (tumor).

- Per the code descriptor all specimens from a single lesion are included in a single unit of service.
- Multiple "passes" into the same lesion to obtain multiple specimens for immediate cytohistologic study, are included in the single unit of service.
• The same concept applies to the unit of service for CPT code 88173 (cytopathology, evaluation of fine needle aspirate; interpretation and report).

• A separate unit of service may be reported for each distinct, separate lesion, but only one unit of service may be reported for all specimens from a single lesion.
How to find the MUEs

• The **majority** of MUEs are posted on the CMS website accessed through the MUE webpage at
  [http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage](http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage)

• Published MUE consist of most codes with MUE values of 1-3. CMS does not publish all MUE values of 4 or higher because of concerns about fraud and abuse.

• CMS updates MUE values and NCCI edits quarterly.
Published anatomic pathology
MUEs

11 88331

4 88104, 88160, 88161, 88311, 88329, 88333, 88347

3 88106, 88162, [88172, 88173], 88233, 88239, 88240, 88241, 88273, 88309, 88318

2 88182, 88230, 88261, 88262, 88264, 88267, 88269, 88283, 88300, 88302, 88358

1 88125, 88130, 88140, [88141, 88142], 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88155, 88164, 88165, 88166, 88167, 88174, 88175, 88184, 88187, 88188, 88189, 88245, 88248, 88249, 88263, 88289, 88291, 88321, 88323, 88325, 88348, 88349, 88355, 88356, 88362, 88371, 88372, 88380, 88381, 88384, 88385, 88386
Reasonable and Necessary Services

National Correct Coding Initiative
Pros and cons of unit coding

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  • Multiples of same code to report episode of care

- [National Correct Coding Initiative (NCCCI)]
- [Medically Unlikely Edits (MUEs)]
National Correct Coding Initiative (NCCI)

- NCCI => "edit pairs" of CPT codes => not considered (by CMS) separately payable when => services billed:
  - => by same provider
  - => for same patient
  - => on same day.
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The ... edits have column 1 code of [flow cytometry]. The column 2 codes are cytopathology codes that are often misused with [flow cytometry].

Some providers report one of these [cytopathology] codes when they ... perform... flow cytometry and interpret... other cytopathology ... material.

In this category, the column 2 coded procedures are both part of the flow cytometry procedure and duplicative of the other diagnostic material.

These edits permit use of NCCI associated modifiers if the column 2 coded cytopathology procedures are performed for diagnostic purposes unrelated to the flow cytometry testing process and are not duplicative of the other diagnostic cytological ... material.
### NCCCI edits with flow cytometry (selected)

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<td>20081001</td>
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<td>88187</td>
<td>88342</td>
<td></td>
<td>20050101</td>
<td>*</td>
<td>1</td>
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<tr>
<td>88188</td>
<td>88342</td>
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<td>20050101</td>
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<td>1</td>
</tr>
<tr>
<td>88189</td>
<td>88342</td>
<td></td>
<td>20050101</td>
<td>*</td>
<td>1</td>
</tr>
</tbody>
</table>
3. Medicare does not pay for duplicate testing.

- immunocytochemistry and flow cytometry should not in general be reported for the same or similar specimens.

- The diagnosis should be established using one of these methods.

- report both CPT codes if both methods are required because the initial method does not explain all the light microscopic findings.

- report both methods utilizing modifier -59 and document the need for both methods in the medical record.
Reasonable and Necessary Services
Local Coverage Determinations
Local Coverage Determinations (LCDs)

- Local coverage determinations (LCDs) => more than 90% of all Medicare coverage decisions.
- The Social Security Act authorizes CMS to pay for reasonable and medically necessary services.
- "Reasonable and necessary" is language that allows CMS and its Medicare Administrative Contractors (MACs) to deny claims for services they do not consider medically necessary.
- An LCD limits payment for a CPT-service your MAC considers to be subject to medically inappropriate utilization.
MAC Jurisdictions in 2016
DHHS OIG Risk Areas

- Risk Area: A. Local Coverage Determination
- Physicians must bill Federal health care programs
- => only for reasonable and necessary items and services.
- Physician must apply appropriate LCD
- => whether item or service is reasonable and necessary under Medicare guidelines.
• 42 CFR, Section 410.32, indicates that diagnostic tests may only be ordered by the treating physician.

• A pathologist may perform additional tests under the following circumstances:
  • These services are medically necessary so that a complete and accurate diagnosis can be reported to the treating physician;
  • The results of the tests are communicated to and are used by the treating physician in the treatment of the beneficiary; and
  • The pathologist documents in his/her report why additional testing was done.
• **Documentation Requirements**

• The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD.

• This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.
• **Indications:**
  Immunohistochemistry is useful in the **evaluation of various malignancies, for diagnosis, staging, and the estimation of prognosis.** It is also useful for the identification of a number of infectious organisms.

• **Utilization Guidelines:**
  It is unusual to require more than 10 immunohistochemical analyses in order to adequately evaluate a sample of tissue. **Utilization beyond this threshold should be supported in the medical record, and may be subject to review.**
Local Coverage Determinations (LCDs)

- The most important section of an LCD is the list of covered diagnoses.
- ICD codes are used to list covered diagnoses, signs or symptoms => any diagnosis, sign or symptom not on this list is typically not covered.
• Limitations of Coverage:
• ICD Codes that Support Medical Necessity
• The correct use of an ICD code does not assure coverage of a service.
• The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.
### Listed ICDs for immunohistochemistry (L29813)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>041.86</td>
<td>HELICOBACTER PYLORI</td>
</tr>
<tr>
<td>070 - 070.9</td>
<td>VIRAL HEPATITIS</td>
</tr>
<tr>
<td>078.1</td>
<td>VIRAL WARTS UNSPECIFIED</td>
</tr>
<tr>
<td>078.11</td>
<td>CONDYLOMA ACUMINATUM</td>
</tr>
<tr>
<td>078.19</td>
<td>OTHER SPECIFIED VIRAL WARTS</td>
</tr>
<tr>
<td>079.4</td>
<td>HUMAN PAPILLOMAVIRUS</td>
</tr>
<tr>
<td>079.83</td>
<td>PARVOVIRUSB19</td>
</tr>
<tr>
<td>079.89</td>
<td>OTHER SPECIFIED VIRAL INFECTION</td>
</tr>
<tr>
<td>079.98</td>
<td>UNSPECIFIED CHLAMYDIAL INFECTION</td>
</tr>
<tr>
<td>079.99</td>
<td>UNSPECIFIED VIRAL INFECTION</td>
</tr>
<tr>
<td>140 - 208.92</td>
<td>MALIGNANT NEOPLASM</td>
</tr>
<tr>
<td>210 - 229.9</td>
<td>BENIGN NEOPLASM</td>
</tr>
<tr>
<td>230 - 234.9</td>
<td>CARCINOMA IN SITU</td>
</tr>
<tr>
<td>235 - 239.9</td>
<td>NEOPLASM OF UNCERTAIN BEHAVIOR</td>
</tr>
<tr>
<td>273.1</td>
<td>MONOCLONAL PARAPROTEINEMIA</td>
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<tr>
<td>289.1</td>
<td>CHRONIC LYMPHADENITIS</td>
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<tr>
<td>289.2</td>
<td>NONSPECIFIC MESENTERIC LYMPHADENITIS</td>
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<td>289.3</td>
<td>LYMPHADENITIS UNSPECIFIED EXCEPT MESENTERIC</td>
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<tr>
<td>348.89</td>
<td>OTHER CONDITIONS OF BRAIN</td>
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<tr>
<td>359 - 359.9</td>
<td>MYOPATHY</td>
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<tr>
<td>511.9</td>
<td>UNSPECIFIED PLEURAL EFFUSION</td>
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<td>530.0 - 578.9</td>
<td>HEMORRHAGE OF GASTROINTESTINAL TRACT</td>
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<tr>
<td>579</td>
<td>CELIAC DISEASE</td>
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<tr>
<td>ICD Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>596.8</td>
<td>OTHER SPECIFIED DISORDERS OF BLADDER</td>
</tr>
<tr>
<td>596.9</td>
<td>UNSPECIFIED DISORDER OF BLADDER</td>
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<tr>
<td>600 - 602.9</td>
<td>DISORDERS OF PROSTATE</td>
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<td>610.0 - 610.9</td>
<td>SOLITARY CYST OF BREAST - BENIGN MAMMARY DYSPLASIA UNSPECIFIED</td>
</tr>
<tr>
<td>611.0 - 611.9</td>
<td>INFLAMMATORY DISEASE OF BREAST - UNSPECIFIED BREAST DISORDER</td>
</tr>
<tr>
<td>728.2</td>
<td>MUSCULAR WASTING AND DISUSE ATROPHY NOT ELSEWHERE CLASSIFIED</td>
</tr>
<tr>
<td>728.87</td>
<td>MUSCLE WEAKNESS (GENERALIZED)</td>
</tr>
<tr>
<td>733.13</td>
<td>PATHOLOGICAL FRACTURE OF VERTEBRAE</td>
</tr>
<tr>
<td>733.99</td>
<td>OTHER DISORDERS OF BONE AND CARTILAGE</td>
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<tr>
<td>782.2</td>
<td>LOCALIZED SUPERFICIAL SWELLING MASS OR LUMP</td>
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<td>782.4</td>
<td>JAUNDICE UNSPECIFIED NOT OF NEWBORN</td>
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<tr>
<td>782.8</td>
<td>CHANGES IN SKIN TEXTURE</td>
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<tr>
<td>784.2</td>
<td>SWELLING MASS OR LUMP IN HEAD AND NECK</td>
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<tr>
<td>785.6</td>
<td>ENLARGEMENT OF LYMPH NODES</td>
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<tr>
<td>786.6</td>
<td>SWELLING MASS OR LUMP IN CHEST</td>
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<tr>
<td>787.20 - 787.7</td>
<td>DYSPHAGIA, UNSPECIFIED - ABNORMAL FECES</td>
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<tr>
<td>789.00 - 789.9</td>
<td>SYMPTOMS INVOLVING ABDOMEN AND PELVIS</td>
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<tr>
<td>790.93</td>
<td>ELEVATED PROSTATE SPECIFIC ANTIGEN [PSA]</td>
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<tr>
<td>791.9</td>
<td>OTHER NONSPECIFIC FINDINGS ON EXAMINATION OF URINE</td>
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<tr>
<td>795.05</td>
<td>CERVICAL HIGH RISK HUMAN PAPILLOMAVIRUS (HPV) DNA TEST POSITIVE</td>
</tr>
<tr>
<td>795.09</td>
<td>OTHER ABNORMAL PAPANICOLAOU SMEAR OF CERVIX AND CERVICAL HPV</td>
</tr>
<tr>
<td>795.4</td>
<td>OTHER NONSPECIFIC ABNORMAL HISTOLOGICAL FINDINGS</td>
</tr>
<tr>
<td>996.80 - 996.89</td>
<td>COMPLICATIONS OF TRANSPLANTED ORGAN</td>
</tr>
</tbody>
</table>
What's missing here?

This is such a long list ... what could it be missing?

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-9 Code Description</th>
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<tr>
<td>622.10</td>
<td>DYSPLASIA OF CERVIX, UNSPECIFIED</td>
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<td>622.11</td>
<td>MILD DYSPLASIA OF CERVIX</td>
</tr>
<tr>
<td>622.12</td>
<td>MODERATE DYSPLASIA OF CERVIX</td>
</tr>
</tbody>
</table>

Sounds like a job for ... the CAC rep! Who's that?
Local Coverage Determinations (LCDs)

• Congress created the Contractor Advisory Committee (CAC) as the advisory body for Medicare contractors.

• The CAC is composed of physicians from listed specialties (pathology included) as well as from medical societies and other relevant entities.

• The CAC representative is a liaison representing opinions of his or her specialty and providing advice to Medicare contractors in the development of LCDs.

• When diagnosis code set is established, the ICD codes are incorporated into the Medicare contractor's claims-processing software.
Local Coverage Determinations (LCDs)

• Claims for a service covered by an LCD submitted without a listed ICD code will be denied.
• Medicare rules allow Contractor Medical Directors (CMDs) to add ICD diagnoses to the diagnosis code set without requiring comment.
• Bringing forward omitted ICD codes for an LCD is a typical responsibility for a CAC member.
• So, to deal with an LCD problem, you need to know your MAC, your CAC ... and also your ICDs!
ICD coding concepts

• What is the basic concept of ICD coding for diagnostic services?
• Pathologists – code your own diagnosis
• Cytotechnologists – code the indication
• Screening services – code for screening
A. Diagnostic Tests Ordered for Signs and/or Symptoms

1. If a diagnosis is made by the pathologist on a test:
   • code the pathologist's diagnosis;
   • clinical signs and symptoms may also be coded
     \[=>\] unless fully explained by pathologist's diagnosis
     - Example: Surgical specimen sent to pathologist with clinical diagnosis of "mole." Pathologist personally reviews slides made from specimen and makes diagnosis of "malignant melanoma." Pathologist should code "malignant melanoma" as primary diagnosis.
2. If no diagnosis is made on the test:
   - code the reason (signs and symptoms) for the test
     - **Example 1**: Patient referred to radiologist for spine x-ray with complaint of "back pain." Radiologist performs x-ray and results are normal. Radiologist should code diagnosis of "back pain" since this was reason for performing spine x-ray.
     - **Example 2**: Patient seen in ER for chest pain. EKG normal, and final diagnosis chest pain due to suspected gastroesophageal reflux disease (GERD). Patient told to follow-up with primary care physician for further evaluation of suspected GERD. Primary diagnosis code for EKG should be chest pain. (Though EKG normal, definitive cause for chest pain not determined.)
3. If no diagnosis made on the test, and

• The referring physician's reason for the test is a diagnosis that indicates uncertainty (e.g., probable, suspected, questionable, rule out, or working):
  => do not code the referring physician's (uncertain) diagnostic reason for the test;
  => code the patient's signs and symptoms

• Example: Patient referred to radiologist for chest x-ray, with clinical diagnosis "rule out pneumonia." Radiologist performs chest x-ray, and results are normal. Radiologist should code sign(s) or symptom(s) that prompted test (e.g., cough).
B. Determining the Reason for the Test

- All tests must be ordered by the treating physician. The treating physician must provide diagnostic information (reason) when the test is ordered.
- If no diagnosis is made based on the test, and the referring physician is unavailable, obtain information from the medical record, or directly from the patient (but attempt to confirm patient information).
E. Diagnostic Tests Ordered in Absence of Signs and/or Symptoms (e.g., screening tests)

- Diagnostic tests ordered in the absence of signs, symptoms, or other evidence of illness or injury, => code screening as the primary diagnosis
- Test result may be coded as additional diagnosis
F. Use of ICD To Greatest Degree of Accuracy and Completeness

- Code the diagnosis from test or the signs and symptoms to the highest degree of accuracy and completeness
- "Highest degree of accuracy and completeness" means the precise code that most fully explains the narrative description of sign, symptom, or diagnosis
Summary

- To understand payment policy, try to see it from the payer's perspective, because they've got the gold, so they make the rules!
- MUEs are about multiple CPTs, and NCCI edits are about CPT combinations => if you know the rules, you will know when you can override them
- LCDs are about medical necessity, so these involve both services (CPTs) and diagnoses/signs/symptoms (ICDs) => if you know the rules, you will know how to comply with them, and what to do to change them, when they don't work for you
Thank you!

• Questions?
BREAK
Part II

For the Last time we are NOT there yet!
Cytopathology CPT Coding Issues & Solutions

Dennis L. Padget, MBA, CPA, FHFMA
DLPadget Enterprises, Inc. (The Villages, FL)
No conflicts of interest
New 88120 – Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual

New 88121 – …; using computer-assisted technology

New (For morphometric in situ hybridization on cytologic specimens other than urinary tract, see 88367, 88368)

New (For more than 5 probes, use 88399)
Change  88172 – Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site

New  (The evaluation episode represents a complete set of cytologic material submitted for evaluation and is independent of the number of needle passes or slides prepared. A separate evaluation episode occurs if the proceduralist provider obtains additional material from the same site, based on the prior immediate adequacy assessment, or a separate lesion is aspirated)
New  (Report one unit of 88173 for the interpretation and report from each anatomic site, regardless of the number of passes or evaluation episodes performed during the aspiration procedure)

Padget Note: The preceding new parenthetical instruction appears immediately under listed code 88173 [Cytopathology, evaluation of fine needle aspirate;] interpretation and report
New + 88177 – …; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)

New (When repeat immediate evaluation episode(s) is required on subsequent cytologic material from the same site, eg, following determination the prior sampling that was not adequate for diagnosis, use 1 unit of 88177 for each additional evaluation episode)

New (Use 88177 in conjunction with 88172)
Cytology CPT Solutions

- 88104 - *Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation*
  - A “direct” smear is a swab or swipe-type application of cellular material to a glass slide. The smear is made without concentrating or otherwise processing the sample before it’s transferred to slides. The smear may be fixed or air-dried.
  - The number of direct smear slides prepared for a specimen doesn’t affect the charge code: 88104 applies whether the number is one, six, twelve, etc.
• 88106 - *Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation*

• 88107 - *...; smears and simple filter preparation with interpretation*

• Convention and logic direct that “simple filter method” refers to a millipore or nuclear membrane process

• The millipore and nuclear membrane filter methods are seldom used in cytology labs today, so there’s a very good chance you don’t need to concern yourself with [these] code[s].
• 88108 - Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)

• Report this code when a fluid, washing, brushing (including an endocervical brushing), anal-rectal cytology, or sputum sample is prepared by concentration method not involving selective cellular enrichment or enhancement.

• The most commonly encountered concentration methods... are cytospin, Saccomanno, and general cytocentrifugation.

• The number of concentrated smears prepared for a specimen doesn’t affect the charge code.
• 88112 - *Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid-based slide preparation method), except cervical or vaginal*

• Report 88112 when a fluid, washing, endocervical or other brushing, or anal-rectal cytology specimen is prepared by selective cellular enrichment or enhancement process, recognizing that concentration is invariably an integral part of that process. [e.g., ThinPrep® or SurePath®]

• The number of enriched/concentrated smears prepared for a specimen doesn’t affect the billing code.
Cytology CPT Solutions

• 88160 - Cytopathology, smears, any other source; screening and interpretation
• 88161 - ...; preparation, screening and interpretation
• 88162 - ...; extended study involving over 5 slides and/or multiple stains

• For example: sputum, Tzanck smear, anal-rectal smear, nipple discharge, ascites fluid, seminal fluid cytology.
• BUT ... report only for direct smear (see 88108, 88112 for concentrated or cellular enhanced smear).
Never report 88104-88112 or 88160-88162 for a true fine needle aspirate specimen (see 88173).

Always separately charge special stains, IHC, cell block and intraoperative work.

Never report 88108 and 88112 together for same specimen.

Never report an 88104-88112 code and an 88160-88162 code together for same specimen.

Government payers: only one preparation method (most complex) allowed per specimen. (Okay to bill 88104 & 88108 or 88104 & 88112 for other payers if permitted by contract.)

Never report 88162 instead of or in addition to 88173 for same specimen.
• I’m sometimes called to the OR to do an immediate evaluation of bronchial brushings. Can I report 88172 for the rapid read even though it’s not an FNA?
• Don’t report immediate study code 88172 for this service because that code only applies to fine needle aspirations.
• [This] intraoperative work...is reportable with code 88333, provided the service is adequately documented in the cytopathology report, ideally in a separate and distinct section.
• [If all smears] are...diagnosed intraoperatively...you’d report code 88333 alone for the specimen [that is, no primary code like 88104 or 88108 would be billed as well].
• We sometimes do touch or squash preps on brain biopsies, lymph nodes, and lumpectomies in addition to frozen sections for intraoperative diagnosis. Can we charge both 88331 and 88333 or 88334?
• Government payers: only the frozen section (88331) may be charged, unless the specimen supports multiple site exam via the different preparations (e.g., breast margins)—proper codes are 88331 + 88334 in the latter instance.
• Non-government payers: conventional wisdom says ‘yes’ (88331 plus 88334) even for specimen without distinct margins, but CAP appears to advocate Medicare rule.
• Can 88108 or 88112 be billed separately when a morphologic evaluation of a specimen is performed in conjunction with a flow cytometry test?

• Conventional wisdom says it’s appropriate to post code 88108 [or 88112] (both [PC] and [TC]) for the cytospin [or thin prep] preparation and [non-QC] interpretation, in addition to the codes for the flow test itself. Not surprisingly, CMS disagrees: It says the smear is built into the payment for the flow test, so code 88108 [or 88112] can’t be reported as an add-on to the study.
• Medicare is denying multiple 88321 consult charges on the same day for patients. Is there a modifier I can use to get paid more than one unit?

• [It is] CMS policy to pay only one consultation fee—one unit of 88321, 88323 or 88325—per Medicare beneficiary per date of service. [This coverage policy was effective 10/01/2007.]

• The NCCI manual clearly states that this frequency limit cannot be bypassed with a procedure code modifier (e.g., 51, 59, GD).

• Coverage policy, not MUE limit. ABN rule applies in theory, but not viable from practical standpoint.
• Medicare is denying multiple 88142, 88342 and other charges on the same day for patients. Is there a modifier I can use to get paid more units?
• Published MUE (medically unlikely edit) limits for many lab codes. Some still “black box” (e.g., 88305, 88307, 88342).
• Add modifier 59 (or maybe 91) to regular CPT code to bypass edit when medically justified.
• Line 1 – 8834226 x 10 Line 2 – 883422659 x 6
We had been billing an E/M consult (eg, 99242) for FNA cases in addition to 10021 for the physical exam by our pathologist. Are the E/M consult codes still covered by Medicare?

The formal E/M consultation codes in the series 99241-99255 cannot be reported [for] Medicare beneficiaries; CMS outlawed payment for these codes effective Jan. 1, 2010. (The change applies to both physician and hospital billing.) Instead, Medicare instructs physicians and hospitals to report the applicable “office” or “inpatient” CPT code.
• Can I bill pathologist Pap test interpretation code 88141 for evaluating a smear with endometrial cells (post-menopausal, age 40+)?

• According to [the AMA’s] CPT Information Services, “the presence of endometrial cells in a post-menopausal patient is abnormal and could be due to a variety of factors, including endometrial cancer”; therefore, code 88141 (or HCPCS equivalent for a Medicare beneficiary) is properly reported in this instance when a cytotechnologist refers the smear to a pathologist for interpretation and report.
• If a pathologist reviews a negative Pap smear for QC but signs it out with an abnormality, can 88141 be reported for the pathologist’s interpretation?

• [Pap smears] reviewed by a pathologist solely for quality control/assurance purposes don’t warrant reporting interpretation code 88141, regardless of when the review is conducted (i.e., concurrently or retrospectively). {CAP Today, Feb. 1999} An exception to this is the situation where the pathologist discovers and reports an abnormality missed at the screening level, provided the discrepancy is detected and the report is corrected prior to its initial release.
Cytology CPT Dilemmas

• Intraoperative codes can present a dilemma
  – 88172 FNA immediate study, first evaluation episode
  – 88177 FNA immediate study, each add’l evaluation episode same site
  – 88333 Consult during surgery, cytology prep, first site
  – 88334 Consult during surgery, cytology prep, each add’l site

• Principal dilemmas (defer to general Q&A session)
  – Can 88172TC be billed for cytotechnologist FNA adequacy evaluation if a pathologist isn’t involved in the immediate study?
  – How do I properly document (in my report) FNA material and tissue core biopsies from same surgical session, and how are these cases appropriately coded?
Thank you!

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Author: Pathology Service Coding Handbook
Carol A. Filomena, MD
CPT Advisor for ASC
Duke Raleigh Hospital
Carol.Filomena@duke.edu
Conflict of interest – None
CPT Advisor for ASC

- Prepare CPT codes application submitted by ASC or assist a related specialty society with its application
- Comment on other applicants’ proposals in advance of Panel meetings
- Assist society RUC Advisor in preparing submissions to the RUC
Panel Discussion And Questions
References

• Pathology Service Coding Handbook, Dennis Padget, MBA, CPA, FHFMA
• Pathology/Lab Coding Alert (newsletter)
• CAP Today has frequent articles. Examples:
  – Moriarty AT. When and how to use CPT code 88172. Sept 2006.
References


• Federal Register Vol. 63, No. 163, August 24, 1998. Publication of OIG Compliance Program Guidance for Clinical Laboratories
Sample Image Guided Fine Needle Aspirate and Needle Core Tissue Biopsy Case

Date Collected: January 5, 2010

Case No.: C10-0005

Final Microscopic Diagnosis
Thyroid, image guided fine needle aspirate and core biopsy (aspirate smear, core biopsy, cell block, cytospin smear): Follicular lesion, consistent with nontoxic multi-nodular goiter.

Comment: Abundant colloid is seen within the small sheets of thyroid follicular epithelium.

Immediate Evaluation
Fine needle aspirate, thyroid (lesion at one site):
   Pass #1: no epithelial cells identified
   Pass #2: diagnostic material obtained
Image guided core biopsy (lesion at one site):
   Core biopsies (2): follicular lesion (touch prep exam x 2)
   Comment: Two cores on one Telfa pad without distinction.

The adequacy evaluation results were reported to Dr. Radiologist during the procedure at 1430 hrs. on 01/05/10. Immediate study performed by Mary Jane Pathologist, MD.

Gross Description
Received are 10 aspirate smears, two stained with Papanicolaou and eight with DiffQuik. Also received are two touch prep slides, which were used to report the immediate evaluation of the core biopsies. Also received is a container labeled with the patient’s name and “right thyroid.” In the container are two small, tan threads of tissue from the biopsy procedure, which measure less than 0.1 x 0.2 cm in the aggregate. The tissue fragments are submitted for embedding in a single cassette. Also in the container is 7.5 ml of bloody fluid, with tissue particles floating on top. The fluid is strained to remove the particles, and the remainder is submitted for cytospin processing (2 slides). The tissue particles are submitted for embedding in a single cell block.

Report electronically signed:
Mary Jane Pathologist, MD
January 6, 2010

ICD9: 241.1
CPT: 88172x2; 88333; 88334; 88305x2; 88173; 88108

[Coder’s Notes (not part of medical report): Not a government insured patient. Patient’s insurer prescribes following AMA coding rules, not NCCI. Two tissue biopsy cores without distinction in one vial is one specimen—one 88305—but two “sites”—initial and additional—for ORC touch prep reporting. Second 88305 is cell block. FNA direct smears and separate cytospin slides. DiffQuik is routine stain with rapid smears.]

[Alternate procedure coding: If this were a Medicare patient, the procedure coding would be 88172x1 (one lesion), 8833559, 8833459, 88305x2 and 88173 (88108 bundled into 88173). See Appendix 6 and chapter 8 for details.]