

capo'07

The Pathologists' Meeting™



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Education by the Experts



SS102 The Basics of Coding, Compensation, and Compliance

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Disclosure

- I have no financial relationships to disclose.

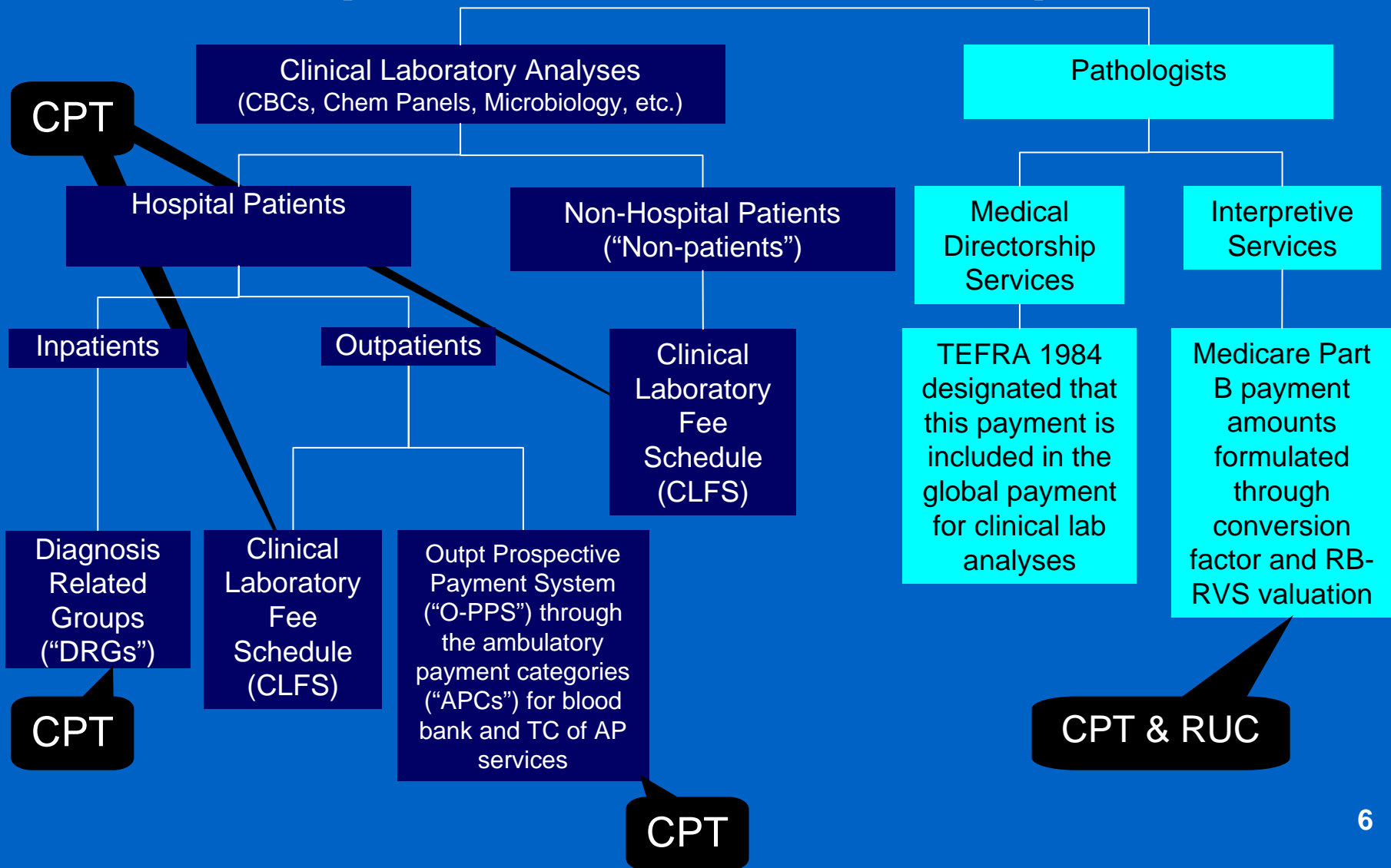
Course Objectives

- Discuss the history, operation, and nuances of CPT
- Describe how CPT codes become valued
- Appropriately use CPT coding within the national compliance requirements of the National Correct Coding Initiative and Medically Unlikely Edits

Goals

- Better understand the AMA-CPT coding system as it pertains to the clinical laboratory and pathology.
- More efficiently use of CPT coding for clinical laboratory and pathology coding.
- Review coding concepts through the use of sample vignettes.

The World of Lab Income (Medicare Version)



The 3 C's of Pathology/Lab Income

1. Coding (CPT)
2. Compensation (CLFS/RUC)
3. Compliance (NCCI)



CPT Codes – The Basis of Payment

The Players!

- *CPT* is owned and “controlled” by the American Medical Association.
- Editorial Panel
 - 16 members-including Internal Medicine, Family Practice, Surgery, CMS, Managed Care, Insurance Industry.
- Advisory Committee
 - >90 members from all specialty societies represented in AMA Federation + several other applicable non-physician societies (including CAP, USCAP, ASC, ASCP, ACMG, AACC).



The Lab Players!

- Pathology Coding Caucus- Created 2003 by the AMA Editorial Panel, partially in response to HIPPA and the concerns of the non-physician laboratory community for a voice in laboratory *CPT* coding
 - Chaired and staffed by the College of American Pathologists

CPT Codes – The Basis of Payment

- Category I *CPT* Code changes are published annually with any party being able to request a code addition, deletion, or modification.
- It is a political process!
- It is a slow process!
- *AMA-CPT* maintains the codes and does NOT set the prices.

2008 CPT (*and 2008 Fee Schedule*) Timeline

Deadline for Submission of CPT Proposals	CPT Meeting Dates
March 2006	June 2006
July 2006	October 2006
November 2006	February 2007

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How are *CPT* Codes Valued?

- Clinical laboratory analyses → Clinical Laboratory Fee Schedule (CLFS)
- “Physician” performed testing → Resource Based Relative Value System (RB-RVS)



Clinical Lab Fee Schedule

- Includes all clinical lab tests. It does not include anatomic pathology analyses, except for the non-professional component of Pap Tests.
- It is based on traditional and customary charges (not cost based).
- The Congress/President's budget set the annual pricing (across the board % increase/decrease).
 - Frozen as a part of the MMA of 2004
- The amount set Federally is known as the NLA (National Limitation Amount). Regional Carriers' Schedules may pay less. In either case they will not pay more than your billed amount.

Clinical Lab Fee Schedule (New Code Assignment)

- As of 2001 new tests (new CPT codes) are published annually in the Federal Register and discussed in a public hearing to assign payment in July
 - Crosswalking- Finding a procedure that is similar to the new code in cost/methodology and using that payment level for the new code.
 - Gap Filling- In the absence of an appropriate crosswalk the code will be temporarily assigned a payment level by the local carrier and then over the next year, data will be collected to arrive at the NLA.

Physician Fee Schedule

- 1965 - 1991

Payment based on percentage of physicians' historical usual and customary charges

- 1992 - Present

Payment based on the resource costs needed to provide services through the the resource-based relative value system (RBRVS)

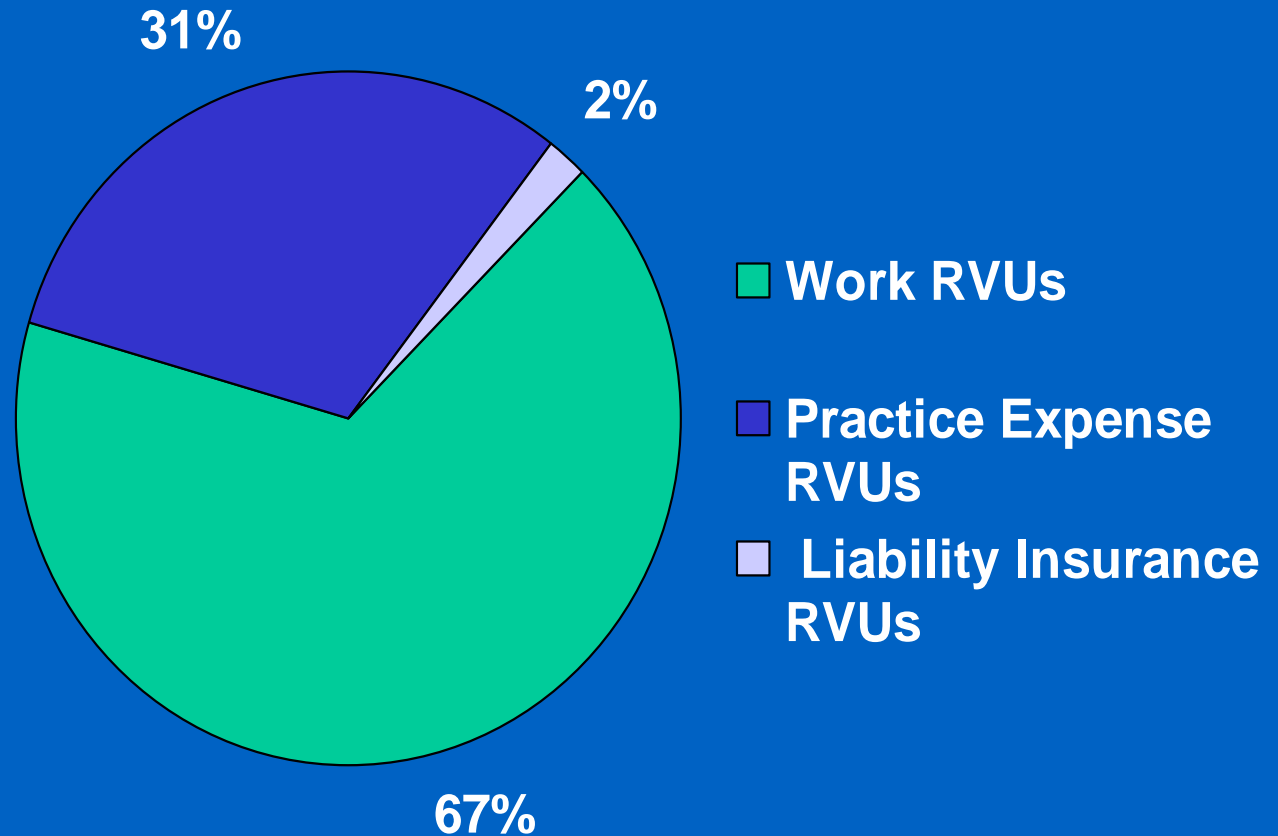
The Physician Payment System (RB-RVS)

Payment for all CPT coded physician services are calculated by the following equation:

$$\text{\$} = \text{CF} \times (\text{RVU}_{\text{work}} \times \text{GPCI}_{\text{work}}) + (\text{RVU}_{\text{PE}} \times \text{GPCI}_{\text{PE}}) + (\text{RVU}_{\text{PLI}} \times \text{GPCI}_{\text{PLI}})$$

CF = Conversion factor, the common single unit that links all physician payments together. Determined by the Sustainable Growth Rate (SGR) computation.

Components of 88305 PC



AMA Relative Value Update Committee (RUC)

- 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 RVUs

RUC Survey Process

- Provides a way to compare 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 and is similar to the new or revised code

RUC Survey Issues

Physician Work = Time x Intensity

RUC Survey Questions

- Intensity of revised codes rated in comparison to the selected reference service in the following areas:
 - Mental Effort and Judgment
 - Technical Skill/Physical Effort
 - Psychological Stress

2008 Fee Schedule Timeline

The CPT Process		The RUC Process		
Deadline for Submission of CPT Proposals	CPT Meeting Dates	LOI Sent to Specialty Societies	Recommendations Due to AMA	RUC Meeting Dates
March-06	June-06	June-06	September-06	October-06
July-06	October-06	October-06	January-07	February-07

Coding Compliance

- National Correct Coding Initiative (NCCI)
- Medically Unlikely (Unbelievable) Edits



Correct Coding Initiative (NCCI)

CMS originally contracted with AdminaStar Federal, Inc, a Medicare carrier in Indiana, to propose and maintain a system of coding edits to be utilized nationally by all Medicare carriers. The first instructions and edits set were published in 1994

These new coding edits are released on a quarterly basis into the system known as the National Correct Coding Initiative (CCI).

Correct Coding Initiative (NCCI)

Two forms of edits:

- “0” CPT Modifiers are not acceptable
- “1” CPT Modifiers are acceptable

Correct Coding Initiative (NCCI)

Modifier -59: Type 1 CCI edits, a CPT modifier may be appropriate and necessary to indicate that distinct or independent services were in fact performed and the inclusion of both codes on the same claim form is not inappropriate coding. The modifier that is most used to attest to distinct services performed on the same date is modifier -59, defined as follows:

-59, Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier '-59' is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances...

Path/Lab NCCI Edits

Consists of three documents (all available at CMS.gov)

- Column 1/Column 2 edits (ccigrp10v122.xls)- 6756 edits to date
- Mutual Exclusive Edits (ccimeg09v122.xls)- 672 edits to date
- NCCI Policy Manual for Medicare Services, v11.3 Chapter X (NCCI_lab_doc_11.3.doc)

Column 1/Column 2 Edits

Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable
88108	88104		19990701	*	1
88108	88106		19990701	*	1
88108	88107		19990701	*	1
88108	88162		19960101	19960101	9
88331	88160		20040101	*	1
88331	88161		20040101	*	1
88331	88162		20040101	*	1
88331	88329		19961001	*	1
88331	88333		20060101	*	1
88331	88334		20060401	*	1

Mutual Exclusive Edits

Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable
88300	88172		19960101	19960101	9
88300	88173		19960101	19960101	9
88302	88172		19960101	19960101	9
88302	88173		19960101	19960101	9
88304	88172		19960101	19960101	9
88304	88173		19960101	19960101	9
88313	88358		20030701	*	1
88361	88360		20050101	*	1
88367	88368		20050101	*	1

NCCI Policy Manual for Medicare Services

“6. 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....”

NCCI Policy Manual for Medicare Services

“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.”

NCCI Policy Manual for Medicare Services

“...that qualitative grading using a system such as 1+ to 4+ should be reported as CPT code 88342. CPT code 88342 represents a qualitative assessment of immunohistochemistry staining while CPT codes 88360 and 88361 are utilized to report the quantitative or semiquantitative morphometric analysis of tumor immunohistochemistry staining.”

Medically Unbelievable Edits (MUEs)

- Preliminary file distributed via the AMA for CMS on December 8, 2005
- Originally contained MUE's for **all** CPT and HCPCS codes. (10,823, 11% in lab section)
- Being dealt with by CMS through the NCCI process.
- Units of service limitations per patient, per provider, per day
- By the nature of pathology (per specimen billing) and voluminous nature of laboratory codes pathologists are disproportionately threatened by this process.

Medically Unbelievable Edits (MUEs) Version I

- Draft examples:

<u>CPT</u>	<u>Description</u>	<u>MUE</u>
82784	Gammaglobulin; IgA, IgD, IgG, IgM, each	1
86920	Compatibility test each unit; immediate spin technique	1
88112	Cytopathology, selective cellular enhancement technique	1
88305	Level IV - Surgical pathology, gross and microscopic examination	2
88321	Consultation and report on referred slides prepared elsewhere	1
88331	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen	1
A0435	Fixed wing air mileage, per statute mile	99

Medically Unbelievable Edits (MUEs) v.I

The saga since that time has been long and sorted however several things have been gleaned:

- Through a concerted effort of multiple Pathology & Laboratory Societies, MUEs had a diminished effect and prolonged implementation
- No one will take credit for the first abysmal UOS set
- "The MUE is one on which prudent people will agree."
- One ill-informed human can cause a great deal of chaos if placed in the right position!
- Originated from fraudulent payment schemes identified Miami and Los Angeles (eg, 5 anorectal manometries per day and 74 in a 30-day period for homeless individuals) identified through the Comprehensive Error Rate Testing (CERT) Program

Medically Unlikely Edits v.II

- Changed name from “Medically Unbelievable” to “Medically Unlikely”
- Units of service limitations per patient, per provider, per day
- Focus has changed from initial release
- Multiple phases released for comment over a two year period

Medically Unlikely Edits

- General Criteria for Edits
 - Anatomic Consideration
 - Code Descriptor
 - CPT Coding Instruction
 - CMS Policies
- Other Criteria
 - Nature of Equipment
 - Nature of Study/Procedure
 - Nature of Analyte
 - Clinical Judgment

Medically Unlikely Edits

- Edit Based on Anatomic Consideration
 - CPT Code 44212 (Laparoscopy, surgical; colectomy, total, abdominal with proctectomy, with ileostomy)
- Edit based on CPT Code Descriptor
 - CPT code 99304 (Initial Nursing Facility Care, per day, for Evaluation and Management)
- Edit based on CPT Coding Instruction
 - CPT Code 12005 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm)
 - CPT Instruction: “When multiple wounds are repaired, add together the lengths of those in the same classification (see above) and from all anatomic sites that are grouped together into the same code descriptor.”

Medically Unlikely Edits

- Edit Based on CMS Policies
 - CPT Code 76516 (Ophthalmic biometry by ultrasound echography, A-Scan)
 - Bilateral Indicator “2”
(RVU’s based on procedure being performed as a bilateral procedure)

Medically Unlikely Edits

- Edit Based on Nature of Analyte
 - Nature of Testing Procedure
 - CPT Code 85557 (Osmotic Fragility, RBC;incubated)
 - Nature of Testing Specimen
 - CPT Code 82575 (Creatinine; clearance)
 - Physiology/Pathophysiology
 - CPT Code 8247 (Folic Acid; RBC)
- Edit Based on
 - Clinical Judgment
 - CPT Code 80053 (Comprehensive Metabolic Panel)

MUE and Modifiers

Pathology and laboratory

- 59 – Distinct Procedural Service
- 91 – Repeat Clinical Diagnostic Laboratory Test

Other modifiers for (non-path/lab) consideration

- 76 – Repeat Procedures by Same Physician
- 77 – Repeat Procedure by Another Physician
- Anatomic Modifiers
 - LT, RT
 - E1, E2
 - F1, F2
 - T1, T2
 - LC, RC, LD

MUE Implementation

Multi-Phased Approach

Phase 1: 1/1/2007 Implementation

Edits Based on anatomic considerations

Phase 2: 4/1/2007 Implementation

Edits Based on Criteria Other Than Clinical Judgment

Includes some laboratory codes

Phase 3: 7/1/2007 Implementation

Edits based on criteria other than clinical judgment

Mostly DMAC codes, some lab, radiology and medicine codes

Phase 4: 10/1/2007 Implementation

Edits based on clinical judgment

MUE Implementation

Phase 5: (Cover letter information)

- 1/1/2008 Implementation
- *“Most edits in Phase V are based on clinical judgment ... although some are based on anatomic considerations, CPT code descriptors/CPT coding instructions, CMS policies, nature of procedure/service, nature of analyte, or nature of equipment.”*
- *“The ideal MUE criterion is one that allows the vast majority of appropriately coded claims utilizing modifiers as described below to pass the MUE criterion.”*

MUE Implementation

To date:

462- 8XXXX MUEs proposed by Correct Coding Solutions, a few have had the UoS modified, none have been reversed.

MUE Implementation

Phase 5: (Cover letter information)

- *“The appropriate use of some modifiers (e.g., -76, -59, -91, anatomic) may bypass an MUE edit because the modifier causes the HCPCS/CPT code to appear on separate lines of the claim.”*
- *“(I)ndividual claim appeals may be filed with the local Medicare carrier if a provider performs medically reasonable and necessary services in excess of the MUE criterion for that service.”*

MUEs: There are still concerns...

- Black-Box Nature of Edits
 - Will not publish final edits for fear of “gaming” of the system
 - But, some edits state that need to use modifier –59 (two cervixes ex)
 - How will someone know when to use modifier if don't know the edit??
- Movement toward Non-Anatomic Edits based on clinical judgment and request for frequency data from contractor

Medically Unlikely Edits (MUEs)

End result

?



DOUBT

**In the battle between you and the world,
bet on the world.**

Key Concepts for CPT Coding for Pathologists (General/Clin Lab)

- The power of the semicolon!

Key Concepts for CPT Coding for Pathologists (General/Clin Lab)

83516 Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; multistep method

83518 single step method (eg, reagent strip)

83519 Immunoassay, analyte, quantitative; by radiopharmaceutical technique (eg, RIA)

83520 not otherwise specified

Key Concepts for CPT Coding for Pathologists (General/Clin Lab)

- The power of the semicolon!
- The introductory paragraphs are worth reading.
- The hierarchy is analyte first, methodology second.

Key Concepts for CPT Coding for Pathologists (General/Clin Lab)

How to code a free T4 performed on a ELISA platform?

83516 Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; multistep method

83519 Immunoassay, analyte, quantitative; by radiopharmaceutical technique (eg, RIA)

84439 Thyroglobulin; Free

Key Concepts for CPT Coding for Pathologists (General/Clin Lab)

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83519 Immunoassay, analyte, quantitative; by radiopharmaceutical technique (eg, RIA)

84439 Thyroglobulin; Free !!!!!

Key Concepts for CPT Coding for Pathologists (Surg. Path.)

Remember units of service definitions:

- 88300-88309: “The separately identifiable specimen” (not always the separate container), e.g.,
 - Skin biopsies
 - Uterus, tubes and ovaries
 - Twin placentas
- Immunohistochemistry: “Per specimen per separately identifiable antibody”, e.g.,
 - Sentinel nodes requiring multiple blocks.
 - Multiple antibodies using different chromagens on same slide.
 - MAK-6 keratin cocktails.

Key Concepts for CPT Coding for Pathologists (Surg. Path.)

Remember units of service definitions:

- Other special stains: “Per stain per specimen”
- In situ hybridization: “Per specimen per separately identifiable probe”;
 - Per different fluorescent marker
- Consultations: “The outside specimen accession” (CAP)
- Frozen sections: “Per frozen section block” (per specimen)

Key Concepts for CPT Coding for Pathologists (Surg. Path.)

CPT codes 88302-9 each have a range of work that may overlap with other codes

- TURP
 - Seborrheic keratoses

If a specimen type grouping in codes CPT 88302-9 were intentionally crafted to optimize the system

- TURP

Key Concepts for CPT Coding for Pathologists (Surg. Path.)

If a specimen type is specifically stated in CPT 88302-9 one MUST use that code:

- Skin excisions for cutaneous tumors are 88305 regardless of specimen size
- Malignant appendices or gallbladders can not be upcoded.

When a specimen type is not specifically stated in CPT 88302-9 one must extrapolate from existing codes with comparable physician work:

- Uvulectomy
- Omentectomy

Key Concepts for CPT Coding for Pathologists (Cytopath)

Be wary of mixing non-GYN CPT for the same specimens

- Direct smears and concentrated preparations on a bronchial brushing
- Also applicable for FNAs
- Not applicable for separate specimens received as a single accession (bronchial brushing and bronchial washing)
- Not applicable for cell blocks.

Remember the unit of service designations for FNAs

- 88172 (FNA rapid interpretation): per separate evaluation
- 88173 Final interpretation: per site

Key Concepts for CPT Coding for Pathologists (Compliance)

Remember who is ultimately responsible for coding:

- ? (You look at them every morning in the mirror when brushing your teeth)

Develop a personal method for coding

- “The bathroom mirror test”
- Assure that your report appropriately justifies your code assignment.

Key Concepts for CPT Coding for Pathologists (Compliance)

Have a plan!

- Develop (and implement) a usable corporate compliance plan
 - See CAP’s “Compliance Guidelines for Pathologists” (1998)
- Within the plan develop strategies to promote Group coding consistency:
 - Have a rational plan for who codes, who checks the codes and who monitors the codes.
 - Discuss within the group problem areas of coding
 - Promote CME activities for coding (i.e., CAP Internet Coding Tutorial)

Key Concepts for CPT Coding for Pathologists (Compliance)

Stay in touch with current issues in CPT coding

- CAP Today (including quarterly Q&A)
- CAP Coding Tutorial
- CPT Assistant
- “Other” sources

When still stumped ask for help!

- CAP Washington Office (Ayanna Wooding)
- CAP Website (CPT Coding Resource Center)
- AMA-CPT Information Services (AMA Members)



Vignettes!

FEAR

Until you have the courage to lose sight of the shore, You will not know the terror of being forever lost at sea.

Case # 1

- A pathologist goes to the radiology suite where the radiologist performs a core needle biopsy from a right lung lesion. The pathologist immediately performs a touch prep evaluation and provides the following diagnosis: “Specimen #1: scar tissue; no malignancy present.”
- A second core needle biopsy is then done separately submitted from a different site of the same lesion. The pathologist immediately performs a touch prep evaluation and diagnosis: “Specimen #2: adenocarcinoma.”
- Both specimens are submitted for routine histopathologic evaluation.

How is this entire exam coded?

Case # 1 (continued)

- A. 88333x1 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site
- 88334x1 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site
- 88305x1
- B. 88333x1
- 88334x1
- 88305x2
- C. 88333x2
- 88305x2

Case # 1 (continued)

The answer is C (88333x2 and 88305x2)

- Two separately received and separately designated specimens are received. Both require immediate cytologic examination by touch prep methodology and routine histologic evaluation.
- 88333 is used for both touch preps as each represent the initial site of each specimen.

Case # 2

- A 45-year-old woman with right mammary carcinoma previously diagnosed by needle biopsy presents for lumpectomy surgery. The surgeon requests an intraoperative evaluation of the margins of the specimen.
- The pathologist evaluates the superior, inferior, lateral, and medial resections margins by 4 touch prep examinations (one slide each) and renders an intraoperative diagnosis of “Superior, inferior, and medial resections margins free of malignancy by cytologic examination. Malignant cells present on lateral resection margin by cytologic examination”.
- The specimen is then submitted for histologic evaluation after margins are marked
- The surgeon re-excises the lateral margin requesting routine histologic examination only.

How is this entire exam coded?

Case # 2 (continued)

- A. 88329 Pathology consultation during surgery
88161x4 Cytopathology, smears, any other source;
preparation, screening and interpretation
88305
88307
- B. 88333x4 Pathology consultation during surgery; cytologic
examination (eg, touch prep, squash prep), initial
site
88305x2
- C. 88333x1 Pathology consultation during surgery; cytologic
examination (eg, touch prep, squash prep), initial
site
88334x3 Pathology consultation during surgery; cytologic
examination (eg, touch prep, squash prep), each
additional site
88307x2

Case # 2 (continued)

The answer is C (88333x1, 88334x3, and 88307x2)

- Two separately received and separately designated specimens are received. Only one requires immediate cytologic examination.
- 88333 is used for the initial touch prep and 88334 is used x3 to account for the three additional sites that were intraoperatively evaluated cytologically.
- As both specimens require histologic evaluation of margins the histopathology is coded using two units of 88307.

Case # 3

- A 45-year-old woman with previously excised breast carcinoma presents for sentinel lymph node biopsy. The lymph node is received and an intraoperative scrape prep is performed.
- The pathologist performs the examination and renders a diagnosis of “rare atypical cells, suspicious but not diagnostic of metastatic carcinoma”.
- The surgeon requests frozen section confirmation and a follow-up cytostat interpretation of small focus of metastatic carcinoma consistent with lobular carcinoma of breast is rendered.
- The specimen is submitted for sentinel lymph node protocol but immunohistochemistry is not deemed necessary by the pathologist.

How is this entire examination coded?

Case # 3 (continued)

- A. 88331 Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen
- 88333 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site
- 88307

- B. 88333 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site
- 88332 Pathology consultation during surgery; each additional tissue block with frozen section(s)
- 88307

- C. 88331
- 88334
- 88307

Case # 3 (continued)

The answer is C (again!) (88331, 88334, 88307)

If the frozen section and touch prep are performed simultaneously, complimentarily aiding in the same diagnosis, the touch preparation shouldn't be separately coded.

If, however, the touch preparation was performed to provide a separate diagnosis (i.e., margin assessment versus tumor classification, or to yield a specific tissue diagnosis when definitive cytologic diagnosis could not be rendered) they may be coded together.

CCI coding edits require that you indicate that the additional examination is distinct (-59 modifier).

Case # 3 (continued)

As a parenthetical exists in the CPT book to define usage of these codes “(For intra-operative consultation on a specimen requiring both frozen section and cytologic evaluation, use 88331 and 88334)”, the temporal relationship between the touch prep and the frozen section do not dictate the code pair (88331/88334 vs. 88332/88333 or 88331/88333).

Case # 4

A 23-year-old man presents with cervical adenopathy and the specimen is received fresh in the laboratory for routine analysis.

Prior to placing the node in a two cassettes, an aliquot is harvested for referral to an outside institution for flow cytometric immunophenotyping and touch preparations are made to be analyzed with the histologic sections.

How would you code this examination?

Case #4 (continued)

- A. 88329 Pathology consultation during surgery
88161 Cytopathology, smears, any other source;
preparation, screening and interpretation
88305

- B. 88305

- C. 88333 Pathology consultation during surgery; cytologic
examination (eg, touch prep, squash prep), initial
site
88305

Case # 4 (continued)

The answer is B (88305)

As the touch prep being performed is not be interpreted intra-procedurally the use of intraoperative consultation codes are inappropriate.

NCCI has determined that touch preparations, used in conjunction with routine histopathology (88302-9) should not be separately coded.

Case # 5

A 42-year-old female with strong family history of breast cancer presents with two left breast masses: one in the upper outer quadrant, cystic by ultrasound; and the other lower inner quadrant, solid by ultrasound with suspicious features (BIRADS 4).

Because you do cyst aspiration, the patient is referred to you for workup. Aspiration of the cyst using a 20 gauge needle yields 2.5 cc of greenish fluid with the cyst collapsing. A monolayer preparation is prepared from the cyst contents. You sample the solid lesion twice with a 23 gauge needle.

Case # 5 (continued)

- Your immediate evaluation number one:
Atypical cells, scanty.
- Your immediate evaluation number two:
Adequate, ductal carcinoma favored.
- Your smears include a Difquik stained smear, a monolayer preparation, and Pap stain.

How is this entire exam coded?

Case # 5 (continued)

- A. 10021 x 2 Fine needle aspiration; without imaging guidance
- 88172 x 2 Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)
- 88173 x 2 Cytopathology, evaluation of fine needle aspirate; interpretation and report

- B. 10021 x 2
- 88112 Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal.

- 88172
- 88173

Case # 5 (continued)

C. 19000 Puncture aspiration of cyst of breast
88112
10021
88172 x 2
88173

D. 19000
88112 x 2
10021
88172 x 2
88173

Case # 5 (continued)

The answer is C (19000, 88112, 10021, 88172x2, 88173)

The cyst aspiration was not performed by FNA technique, but simply as a large bore needle drainage. No immediate evaluation was performed.

The solid mass was sampled with fine needle technique (defined as 22-3 gauge needle or smaller) in two separate passes each separately evaluated with additional sampling indicated after the first.

Case # 5 (continued)

The separate and distinct procedures should be appropriately documented in the report and/or in a procedure note. The 88112 would be billed for the cytologic evaluation of the cyst contents, as this aspiration was not done with FNA technique.

It is not appropriate to bill the 88112 for the mass (answer D) as this monolayer prep is bundled in with the 88173 that encompasses all cellular material reviewed (smears, cytospins and/or monolayer preps) except for the cell block, which, if performed, is separately billable as 88305.

Case # 5 (continued)

It is important to note that while the immediate evaluation, 88172, is separately billable per pass as documented and medically necessary, the 88173 is billable x 1 per specimen site, per patient, per provider, per day.

Case # 6

A bronchial brushing and a bronchial washing are received from a patient with a radiologically identified hilar pulmonary mass. The brush is used to make two direct smears and the washing is used to make a Cytospin™ preparation slide. Both samples are interpreted and a report is issued.

How is this entire exam coded?

- A. 88104, Cytopathology, fluids, washings, or brushings, except cervical or vaginal; smears with interpretation, and 88108, Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)
- B. 88104, Cytopathology, fluids, washings, or brushings, except cervical or vaginal; smears with interpretation, and 88108-59, Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)

Case # 6 (continued)

The answer is B (88104 and 88108-59)

Rationale: The direct smear of the bronchial brushing should be coded with one unit of 88104 as one brushing specimen was received (regardless of the number of slides prepared and reviewed). The Cytospinä preparation of the bronchial washing should be coded using 88108. As the washing specimen was not prepared using a thin layer technique, 88112, the new code that was added in CPT2004, would not be appropriate. Payors that use the NCCI edits (including Medicare) will utilize a payment edit for 88104/88108. For this reason, a –59 modifier will be required allow concurrent recognition of the 88108 service. The use of –59 modifier is defined by CPT as an instance when: “...procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure”

Case # 7

A 19-year-old woman presents for wide re-excision and sentinel lymph node biopsy after be diagnosed with a Clark's IV melanoma of the forearm. The skin excision is totally submitted for histologic evaluation, requiring 15 cassettes. The sentinel lymph node requires two blocks. HMB-45 and S-100 immunostains are performed on both blocks. Intraoperative consultation is not requested.

How is this entire exam coded?

- A. 88305, 88307, 88342x4
- B. 88307x2, 88342x2
- C. 88305, 88307, 88342x2
- D. 88307x2, 88342x2

Case # 7 (cont.)

The answer is C (88305, 88307, 88342x2)

There are three codes that may be used for skin examinations. These are 88302 (plastic repair), 88304 (cyst/tag/debridement), and 88305 (other than cyst/tag/debridement/plastic repair). Of these 88305 is most appropriate.

There are two codes that may be used for lymph node examinations. These are 88305 (lymph node biopsy) and 88307 (lymph node regional dissection and sentinel lymph node). Of these 88307 is most appropriate.

Special stain codes, like the 88300-9 series, are billed per the specimen. In the case of immunostains the definition is further clarified to be “per specimen, per separately designated antibody”. As two antibodies were separately evaluated on a single specimen, two units of 88342 are appropriate.

Case # 8

A 22-year-old woman presents with a history of biopsy proven HSIL and undergoes LEEP excision. Two specimens are received, one designated the “Ectocervical LEEP”, the second labeled “Top-hat LEEP excision”. Both are examined in a conization manner.

How is this entire exam coded?

- A. 88305x2
- B. 88307x2
- C. 88305 & 88307
- D. 88309

Case # 8 (cont.)

The answer is B (88307x2)

LEEP excisions have become the common successor of the cervical conization procedure, that is coded by 88307. Hence, when the LEEP procedure is performed instead, 88307 most closely approximates the pathology work involved in these specimens. This does not however mean that *all* LEEP's are 88307. Small specimens that more closely approximate the work of cervical biopsies should be coded 88305. The same unit of service issues still apply.

Case # 9

A 12-year-old boy presents with tonsillar and adenoidal hypertrophy and undergoes a tonsillectomy and adenoidectomy. A single specimen container designated “bilateral tonsils and adenoids” is received.

How is this entire exam coded?

- A. 88304
- B. 88304x2
- C. 88304x3
- D. 88304x4

Case # 9 cont.

The answer is A (88304)

Although three specimens are received, as the description of 88304 includes “tonsil and/or adenoids”, only one unit of service is warranted.

Case # 10

A 32-year-old immunocompromised man presents with a five lobe pulmonary infiltrate and undergoes pulmonary wedge biopsy. The specimen received is submitted in toto, in 5 cassettes. Each is stained with H&E, GMS, and AFB.

How is this entire exam coded?

- A. 88305 & 88312x10
- B. 88307 & 88313x10
- C. 88305 & 88312x2
- D. 88307 & 88312x2

Case # 10 cont.

The answer is D (88307 & 88312x2)

There are three codes used to code pulmonary specimens. These are 88305 (transbronchial biopsy), 88307 (wedge biopsy) and 88309 (total/lobe/segment resection). Of these 88307 is most appropriate.

Again, special stains are based on the specimen as the unit of service. They are clarified to be “per stain, per specimen”. As one specimen is examined, with two separate special stains, two units of 88312 (“special stains, group I, for microorganisms”) is appropriate.

Case # 11

A 72-year-old man presents with a frontal cerebral mass for possible resection. During the operative procedure the Pathologist is consulted twice for frozen section analysis. The first specimen is designated “L frontal cerebrum ? tumor”. The FS diagnosis is “Gliosis negative for neoplasm”. A second biopsy designated “L frontal cerebrum ? Tumor, #2”. The FS diagnosis is “Glioblastoma”. A third specimen labeled “L frontal glioma” is received for permanent section only.

How is this entire exam coded?

Case # 11

- A. 88305x3, 88331, & 88332
- B. 88307x3, 88331, & 88332
- C. 88305x3, & 88331x2
- D. 88307x3, & 88331x2

Case # 11

The answer is D (88307x3, & 88331x2)

Two codes may be used for brain tissue examination 88307 (brain biopsy and brain/meninges tumor resection) and 88305 (brain/meninges other than for tumor resection). Clearly, the three specimen were biopsies/resections related to the neoplastic process and hence should be coded 88307.

The unit of intraoperative pathology consultations is also based on the “specimen” as the unit of service. Since only one FS slide was made per specimen two units of 88331 are appropriate.

Case # 12

A 42-year-old woman presents with menometrorrhagia for hysterectomy. A fibroid uterus is examined with a diagnosis of “multiple benign leiomyomata” rendered following histologic evaluation.

How is this entire exam coded?

- A. 88305
- B. 88307
- C. 88309

Case # 12

The answer is B (88307)

There are three codes applicable to the hysterectomy specimen: 88305 (“for prolapse”), 88307 (“other than neoplasia/prolapse”), & 88309 (“Neoplastic”). Although leiomyoma is a benign smooth muscle neoplasm, the work involved absolutely reflects the work of an 88307 and hence this code should be used. Various written opinions have been published conflicting with this assessment, however this has been clarified in *CPT Assistant*.

Case # 12

“The AMA has previously advised that a uterus with a benign smooth muscle tumor, known as leiomyoma, is reported with code 88307 (CPT Assistant, Winter 1991, Principles of CPT Coding 1st and 2nd editions) because, although they are neoplasms, many leiomyomas do not require the extensive evaluation that other uterine neoplasms received. A uterus with a more uncommon benign tumor or any malignant tumor would be reported using 88309.”

Case # 13

A pathologist goes to the radiology suite where the radiologist performs a core needle biopsy from a right lung lesion. The pathologist immediately performs a touch prep evaluation and provides the following diagnosis: “Specimen #1: scar tissue; no malignancy present.” A second core needle biopsy is then done separately submitted from a different site of the same lesion. The pathologist immediately performs a touch prep evaluation and diagnosis: “Specimen #2: adenocarcinoma.” Both specimens are submitted for routine histopathologic evaluation.

How is this entire exam coded?

Case # 13

- A. 88333x1 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site
- 88334x1 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site
- 88305x1
- B. 88333x1
- 88334x1
- 88305x2
- C. 88333x2
- 88305x2

Case # 13

The answer is C (88333x2 and 88305x2)

Two separately received and separately designated specimens are received. Both require immediate cytologic examination by touch prep methodology and routine histologic evaluation. 88333 is used for both touch preps as each represent the initial site of each specimen.

Case # 14

A 45-year-old woman with right mammary carcinoma previously diagnosed by needle biopsy presents for lumpectomy surgery. The surgeon requests an intraoperative evaluation of the margins of the specimen. The pathologist evaluates the superior, inferior, lateral, and medial resections margins by 4 touch prep examinations (one slide each) and renders an intraoperative diagnosis of “Superior, inferior, and medial resections margins free of malignancy by cytologic examination. Malignant cells present on lateral resection margin by cytologic examination”. The specimen is then submitted for histologic evaluation after margins are marked.

Case # 14

The surgeon re-excises the lateral margin requesting routine histologic examination only.

How is this entire exam coded?

Case # 14 (cont.)

- A. 88329 Pathology consultation during surgery
88161x4 Cytopathology, smears, any other source;
preparation, screening and interpretation
88305
88307

- B. 88333x4 Pathology consultation during surgery; cytologic
examination (eg, touch prep, squash prep), initial
site
88305x2

- C. 88333x1 Pathology consultation during surgery; cytologic
examination (eg, touch prep, squash prep), initial
site
88334x3 Pathology consultation during surgery; cytologic
examination (eg, touch prep, squash prep), each
additional site
88307x2

Case # 14 (cont.)

The answer is C (88333x1, 88334x3, and 88307x2)

Two separately received and separately designated specimens are received. Only one requires immediate cytologic examination. 88333 is used for the initial touch prep and 88334 is used x3 to account for the three additional sites that were intraoperatively evaluated cytologically. As both specimens require histologic evaluation of margins the histopathology is coded using two units of 88307.

Case # 15

A 45-year-old woman with previously excised breast carcinoma presents for sentinel lymph node biopsy. The lymph node is received and an intraoperative scrape prep is performed. The pathologist performs the examination and renders a diagnosis of “rare atypical cells, suspicious but not diagnostic of metastatic carcinoma”. The surgeon requests frozen section confirmation and a follow-up cytostat interpretation of small focus of metastatic carcinoma consistent with lobular carcinoma of breast is rendered.

Case # 15

The specimen is submitted for sentinel lymph node protocol but immunohistochemistry is not deemed necessary by the pathologist.

How is this entire exam coded?

Case # 15

- A. 88331 Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen
88333 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site
88307

- B. 88333 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site
88332 Pathology consultation during surgery; each additional tissue block with frozen section(s)
88307

- C. 88331
88334
88307

Case # 15

The answer is C (again!) (88331, 88334, 88307)

If the frozen section and touch prep are performed simultaneously, complementarily aiding in the same diagnosis, the touch preparation shouldn't be separately coded. If however the touch preparation was performed to provide a separate diagnosis (i.e., margin assessment versus tumor classification, or to yield a specific tissue diagnosis when definitive cytologic diagnosis could not be rendered) they may be coded together. CCI coding edits require that you indicate that the additional examination is distinct (-59 modifier).

Case # 15

As a parenthetical exists in the CPT book to define usage of these codes “(For intra-operative consultation on a specimen requiring both frozen section and cytologic evaluation, use 88331 and 88334)”, the temporal relationship between the touch prep and the frozen section do not dictate the code pair (88331/88334 vs. 88332/88333 or 88331/88333).

Case # 16

A 23-year-old man presents with cervical adenopathy and the specimen is received fresh in the laboratory for routine analysis. Prior to placing the node in a two cassettes an aliquot is harvested for referral to an outside institution for flow cytometric immunophenotyping and touch preparations are made to be analyzed with the histologic sections.

How is this entire exam coded?

Case # 16 (continued)

- A. 88329 Pathology consultation during surgery
- 88161 Cytopathology, smears, any other source;
preparation, screening and interpretation
- 88305

- B. 88305

- C. 88333 Pathology consultation during surgery; cytologic
examination (eg, touch prep, squash prep), initial
site
- 88305

Case # 16 (continued)

The answer is B (88305)

As the touch prep being performed is not be interpreted intra-procedurally the use of intraoperative consultation codes are inappropriate.

NCCI has determined that touch preparations, used in conjunction with routine histopathology (88302-9) should not be separately coded.



MISTAKES

**It could be that the purpose of your life is
only to serve as a warning to others.**

Goals

- Better understand the AMA-CPT coding system as it pertains to the clinical laboratory and pathology.
- More efficiently use of CPT coding for clinical laboratory and pathology coding.
- Review coding concepts through the use of sample vignettes.

Thank you for
participating!

Please complete the course
evaluation before you leave.

Education by the Experts

