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Deciphering the alphanumeric soup

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To ameliorate perceived inequities in reimbursement across specialties, Medicare in 1992 implemented a standardized physician payment schedule based on the resource costs incurred in providing professional services. The resource-based relative value scale, or RBRVS, determines payments for services based on physician work and the costs associated with providing the services. The total relative value units (RVUs) assigned to each CPT code are based on three components: physician work, physician practice expense (PE), and the professional liability (PLI) cost for that code. Each component is allocated RVUs and is adjusted by a geographic practice cost index (GPCI) to account for many regional differences in costs. Total payment for a service is calculated by multiplying the total RVUs by the annually adjusted conversion factor (CF). The conversion factor is derived through Centers for Medicare and Medicaid Services computations using the sustainable growth rate, which is heavily weighted by the Medicare economic index, which poorly reflects the deleterious effects of physician costs and inflation on payment. This system allows all physician services to be linked on a common scale through a single equation for each CPT code:

$$\text{Payment} = CF \times [(RVU_{work} \times GPCI) + (RVU_{PE} \times GPCI) + (RVU_{PLI} \times GPCI)]$$

For example, the global 88108 paid in Alabama would be:

$$88108 = \$37.90 \times [(.56 \times 1.00) + (1.21 \times 0.858) + (0.04 \times 0.752)] = \$61.71$$

On average the physician work component accounts for 55 percent of the total relative value for each service. Initially, physician work RVUs were based on the original Hsiao studies (also known as the Harvard-based relative values studies). Annual updates to the physician work component are now based on recommendations by the AMA/Specialty Society RVS Update Committee. Established in 1991, the committee provides recommendations to the CMS, which generally accepts the input. (Currently about 95 percent of RVS Update Committee recommendations are unchanged in the final rule for payment each year.)

The primary vehicle for establishing new work values is through RVS Update Committee surveys, instruments designed to capture in relative value unit form the physician work it takes to perform the service. All physician services are surveyed using the same basic template that gathers data for the following: technical skill with respect to knowledge, training, and experience; required mental effort and judgment; physical effort; and psychological stress due to the potential risk to the patient. The survey provides a way to compare these aspects of physician work to the work of an established code on the physician fee schedule.

The AMA does not administer the surveys. Rather, they are administered by individual medical societies. The CAP as a founding member of the RVS Update Committee participated in initial studies and remains the leading organization for pathology RVS Update Committee data collection, a voluminous task that is made possible only through the participation of CAP membership. The CAP also provides recommendations on the practice expense portion of the RVS Update Committee process, through the work of the committee's workgroup of the CAP Economic Affairs Committee. Practice expense inputs include clinical staff time, medical supplies, and equipment.

CPT codes that describe laboratory nonphysician services are not valued as a part of the Update Committee process. Instead, the CMS places them on the clinical laboratory fee schedule. These payment values, unlike those for physician services, are not formed through a consensus process. The CMS statutorily mandates payment as a percentage of payment from past fee schedules. Unlike Pap test interpretation, which is a physician service, Pap test screening is paid under the clinical laboratory fee schedule. However, the CMS holds

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annual hearings to receive input from organized medicine, the laboratory industry, and manufacturers to determine pricing. In general, the CMS' pricing tends to reflect consensus opinions presented in these hearings, with carrier medical directors having significant input.

Current Procedural Terminology. CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures that physicians perform for payment. CPT is the intellectual property of the AMA and is copyright protected. Medicare recognizes it, and other third-party payers including Medicaid use the bulk of the codes as such or in a modified fashion. The purpose of the terminology is to provide a uniform language that accurately describes medical, surgical, and diagnostic services and which thereby provides an effective, reliable way for physicians, patients, and third-party payers across the country to communicate.

Tables 1 and **2** list the category 1 cytology codes from CPT 2005, which is the most recent revision of that which first appeared in 1966. CPT descriptive terms and identifying codes now serve a variety of important functions in the field of medical procedural nomenclature. CPT category 1 codes are updated annually through the deliberations of the AMA CPT editorial panel, which is ultimately responsible for the integrity of the codes. This process uses CPT advisors from many medical specialty societies as well as input

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Table 1

2005 Medicare relative values for cytology services

Conversion factor = 37.8976

Nongynecologic cytology

CPT	Description	Physician work RVU	Non-facility PE RVU	Facility PE RVU	Malpractice RVU	Non-facility total	Facility total	OPPS filed units of service (2003)	Comments
10021	FNA without imaging guidance	1.27	2.15	0.54	0.10	3.52	1.91	53,856	Prior code 88170. Is a PC only code but facility and nonfacility charges exist.
TC	None as professional only code								
10022	FNA with imaging guidance	1.27	2.54	0.42	0.08	3.89	1.77	47,864	Prior code 88171.
TC	None as professional only code								
88104, global	Cytopathology, fluids, washings, or brushings, except cervical or vaginal; smears with interpretation (Global)	0.58	0.85	0.85	0.04	1.45	1.45	106,536	Example is bronchial brushings, direct smears, although applies to any specimen prepared or submitted as smears.
TC	Technical component	0.00	0.61	0.61	0.02	0.63	0.63	6,970	
26	Professional component	0.58	0.24	0.24	0.02	0.82	0.82	267,786	
88106, global	Filter method only with interpretation	0.58	1.36	1.36	0.04	1.95	1.95	22,386	Example is old millipore filters. Thinlayer preps should not be coded as this. Cannot bill with 88173, etc.
TC		0.00	1.11	1.11	0.02	1.13	1.13	6,186	
26		0.58	0.24	0.24	0.02	0.82	0.82	36,728	
88107, global	Smears and filter preparation with interpretation	0.76	1.54	1.54	0.05	2.35	2.35	7,941	As in 88106 with smears.
TC		0.00	1.21	1.21	0.02	1.23	1.23	2,092	
26		0.76	0.33	0.33	0.03	1.12	1.12	26,811	
88108, global	Cytopathology, concentration technique, smears and interpretation (e.g., Saccomanno technique)	0.58	1.21	1.21	0.04	1.81	1.81	227,580	E.g. Cytospin. Usually body fluids or washings or brushings in liquid. Do not bill with 88173, 88112, 88160–2, or 88104–7 unless separate specimen.
TC		0.00	0.97	0.97	0.02	0.99	0.99	15,862	
26		0.58	0.24	0.24	0.02	0.82	0.82	451,079	
88112, global	Cytopathology, selective cellular enhancement technique with interpretation (e.g., liquid-based slide preparation method), except cervical or vaginal	1.18	1.97	1.97	0.04	3.19	3.19	no data (code not in existence in 2003)	ThinPrep and SurePrep preparations. Do not bill with 88173 or 88104–08 unless separate specimen.
TC		0.00	1.46	1.46	0.02	1.48	1.48	no data (code not in existence)	
26		1.18	0.51	0.51	0.02	1.71	1.71		
88160, global	Cytopathology, smears, any other source; screening and interpretation	0.50	0.83	0.83	0.04	1.37	1.37	10,209	This code is for "other" (not fluids, brushings and washings, FNAs), e.g. sputums, tissue scrapings.
TC		0.00	0.62	0.62	0.02	0.64	0.64	482	
26		0.50	0.21	0.21	0.02	0.73	0.73	30,555	
88161, global	Preparation, screening and interpretation	0.50	0.94	0.94	0.04	1.48	1.48	8,014	Can use for intraoperative cytology consultation. Cannot bill a frozen section and intraoperative touch prep as part of the same evaluation (e.g. squash prep on portion and fs on portion). However, can use in conjunction with intraoperative consultation (non-frozen). Append modifier –59 for NCCI to bypass edit for 88304–9 on permanent section.
TC		0.00	0.73	0.73	0.02	0.75	0.75	2,970	
26		0.50	0.21	0.21	0.02	0.73	0.73	57,391	

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from the Pathology Coding Caucus, a group that the CAP staffs and chairs and that allows laboratory-based CPT advisors and nonphysician laboratory groups to work together to optimize the laboratory sections of the code set.

For pathology, the use of CPT modifiers is essential for Medicare billing and for some other payers in certain situations. The majority of codes can be separated into professional and technical components. For those laboratories in which the component services are separately billed to Medicare, modifier –26 may be appended to the professional component and modifier –TC to the technical component. Additionally, Medicare in certain defined situations will not pay for a particular service when another service is performed on the same patient on the same day by the same provider. The national correct coding initiative was created to provide a coding edit set that addresses these situations. Mutually exclusive and comprehensive edits eliminate payment on secondary codes identified in coding initiative lists unless the code is billed with a modifier –59 as allowable. This modifier should not be used indiscriminately to bypass edits but to indicate that the procedure performed on the same patient on the same day was on a separately identifiable specimen from a distinct, separate procedure. For quarterly updates on these edits, see the CMS Web site at www.cms.hhs.gov/physicians/cciedits for downloadable lists.

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Table 1

Nongynecologic cytology

CPT	Description	Physician work RVU	Non-facility PE RVU	Facility PE RVU	Non-facility total	Facility total	OEIS Allowed units of service (2003)	Comments
88162	Extended study involving over five slides and/or multiple stains	0.76	1.02	1.02	0.05	1.83	1.83	7,920	This code has limited usefulness. It is appropriate only for non-fluid/brushing/washings or non-FNA specimens where over five slides are prepared, e.g. six sputum direct smears or fewer if stained with Pap and Diff-Quik or H and E. Low number suggests that sputums are being prepared by other methods or there is a coding problem.
TC		0.00	0.69	0.69	0.02	0.71	0.71	669	
26		0.76	0.33	0.33	0.03	1.12	1.12	13,854	
88172	Cytopathology, evaluation of fine-needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)	0.60	0.79	0.79	0.04	1.37	1.37	15,832	Do not code "per pass" per se but per evaluation, e.g. the radiologist does three passes but you receive all as a single evaluation, then it is one unit. However, if first rapid evaluation suggests the need for an additional pass, then an additional unit can be billed if performed and documented.
TC		0.00	0.47	0.47	0.02	0.49	0.49	1,287	
26		0.60	0.26	0.26	0.02	0.88	0.88	100,464	
88173	Interpretation and report	1.39	2.14	2.14	0.07	3.60	3.60	49,038	Can charge with 88305, and other add-on special stains/IHC, but not with 88104–07, 88108, 88160, and 88112 families of codes unless done on separate specimen. Do not bill per pass, but do bill for each separate site sampled.
TC		0.00	1.55	1.55	0.02	1.57	1.57	9,507	
26		1.39	0.59	0.59	0.05	2.03	2.03	188,883	
88300	Cell block (This code is the level IV surg path code.)	0.75	1.91	1.91	0.07	2.73	2.73	5,241,950*	Can charge with 88173 or 88104–08 and 88112.
TC		0	1.58	1.58	0.04	1.62	1.62	1,616,199	
26		0.73	0.33	0.33	0.03	1.11	1.11	8,955,029	
88312	Special stain, microorganisms	0.54	1.52	1.52	0.03	2.09	2.09	294,601*	Can charge with 88173 or 88104–07, 88108, 88160–2, and 88112.
TC		0	1.29	1.29	0.01	1.3	1.3	46,436	
26		0.54	0.23	0.23	0.02	0.79	0.79	720,126	
88313	Special stain, nonmicroorganisms	0.24	1.25	1.25	0.02	1.51	1.51	327,220 *	Can charge with 88173 or 88104–07, 88108, 88160–2, and 88112.
TC		0	1.15	1.15	0.01	1.16	1.16	48,406	
26		0.24	0.1	0.1	0.01	0.35	0.35	673,478	
88342	Immunohistochemistry	0.85	1.48	1.48	0.05	2.36	2.36	468,809 *	Can charge with 88173 or 88104–07, 88108, 88160–2, and 88112.
TC		0	1.1	1.1	0.02	1.12	1.12	105,068	
26		0.85	0.36	0.36	0.03	1.24	1.24	1,034,389	
88305	In situ hybridization (e.g. FISH)	1.2	2.13	2.13	0.05	3.38	3.38	22,996	Can charge with 88173 or 88104–07, 88108, 88160–2, and 88112. Same is true for 88367 and 88368 (not included in table).
TC		0	1.62	1.62	0.02	1.64	1.64	128	
26		1.2	0.51	0.51	0.03	1.74	1.74	7,423	
88321	Consultation and report on referred slides (outside consults)	1.3	0.79	0.93	0.05	2.14	1.91	154,037	Does not apply to intradepartmental or intragroup consults as determined by the site of service. The same group billing from a separate site or institution with a different CLIA number may use this. However, a separate report from the consultant pathologist would be in order. Note the unit of service is the outside accession number, not individual specimens.

Note: In most cases technical component + professional component does not equal global as some TCs are bundled with APCs and DRGs.
* Includes a total of surgical pathology and cytopathology volumes

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Healthcare Common Procedural Coding System. HCPCS level 2 codes are analogous to CPT codes. Level 2 codes are used to document coding for certain mandated screening benefits, which may have frequency limitations. These include Pap tests and, more recently, diabetes and cholesterol screening. These are alphanumeric codes that are five units long. For screening Paps, conventional, use the P30xx series, and for liquid-based and automated Paps, use G01xx series. See **Table 2**.

International Classification of Diseases, 9th revision, Clinical Modification. ICD-9 CM is based on the official version of the World Health Organization's International classification of diseases. ICD-9 classifies morbidity and mortality information for statistical purposes and for indexing of hospital records by disease and operations, as well as for data storage and retrieval. Since the passage of the Medicare Catastrophic Coverage Act of 1988, the law has required physicians to submit diagnosis code(s)

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Table 2

CPT codes with descriptions—gynecologic cytology

CPT/ HCPCS	Description	Physician work RVU	Non-facility PE RVU	Facility PE RVU	Malpractice RVU	Non-facility total	Facility total	OCE filled units of service (2003)	Comments Note: CPT codes used for diagnostic Paps; HCPCS for screening Paps.
88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician (List separately in addition to code for technical service.)	0.42	0.15	0.15	0.02	0.59	0.59	136,079	Professional component to be billed on Paps reviewed by pathologists, liquid-based or conventionals, any reporting system.
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thinlayer preparation, manual screening under physician supervision)	n/a as on clinical lab fee schedule	n/a	n/a	n/a	n/a	n/a	500,809	Technical component on liquid-based Pap tests, any reporting system.
88143	With manual screening and rescreening under physician supervision	n/a as on clinical lab fee schedule	n/a	n/a	n/a	n/a	n/a	4,047	Liquid-based, manual rescreen. No $ amount attached to code. Use for cases in which the physician requests rescreening, not for QC review.
88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision	n/a as on clinical lab fee schedule	n/a	n/a	n/a	n/a	n/a	2,038	Applies to conventional Paps, see 88174–5 for liquid-based.
88148	Screening by automated system with manual rescreening under physician supervision	n/a as on clinical lab fee schedule	n/a	n/a	n/a	n/a	n/a	15,125	Applies to conventional Paps. See 88175 for liquid-based. Use for cases in which the physician requests rescreening, not for QC review.
88160	Cytopathology, slides, cervical or vaginal (definitive hormonal evaluation (e.g. maturation index, karyopyknotic index, estrogenic index). List separately in addition to code(s) or other technical and interpretive services.	n/a as on clinical lab fee schedule	n/a	n/a	n/a	n/a	n/a	16,202	Like 88141, P3001, G0124 is an add-on code, billed with primary screening methodology code.
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision	n/a as on clinical lab fee schedule	n/a	n/a	n/a	n/a	n/a	188,542	Conventional Pap smears, technical component, TBS. Non-TBS code is 88160.
88166	With manual screening and rescreening under physician supervision	n/a as on clinical lab fee schedule	n/a	n/a	n/a	n/a	n/a	1,783	Manual rescreening, TBS, no $ amount attached. Use for cases in which the physician requests rescreening, not for QC review. Non-TBS code is 88162.
88174	With manual screen and computer rescreen	n/a as on clinical lab fee schedule	n/a	n/a	n/a	n/a	n/a	773	Automated screening on liquid-based Pap. The "no further review" signed out by machine. E.g. FocalPoint.
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thinlayer preparation, screening by automated system, under physician supervision	n/a as on clinical lab fee schedule	n/a	n/a	n/a	n/a	n/a	5,487	Location-guided screening with review/rescreen. E.g. Cytyc Imager and FocalPoint slides needing manual screen.
P3000	Screening Pap, no pathologist review; conventional smear, any reporting system	n/a as on clinical lab fee schedule	n/a	n/a	n/a	n/a	n/a		For screening type pap smear, HCPCS code for Medicare.
P3001	As above requiring interpretation by pathologist	n/a as on clinical lab fee schedule	n/a	n/a	n/a	n/a	n/a	13,410	Screening type conventional Pap reviewed by pathologist (instead of 88141) for Medicare. Use with P3000 and G0147.
G0123	Screening liquid-based Pap, any reporting system	n/a as on clinical lab fee schedule	n/a	n/a	n/a	n/a	n/a		To be used for Medicare liquid-based screening Paps instead of CPT 88142.
G0124	All liquid-based Paps requiring interpretation by pathologist	0.42	0.15	0.15	0.02	0.59	0.59	48,808	Pathologist interpretation of primary codes G0123, G0143, G0144, and G0145, screening liquid-based Pap, instead of CPT code 88141 for Medicare patients.
G0141	Screening cervicovaginal cytology, automated system, with manual rescreening, conventional Pap, requiring interpretation by pathologist	0.42	0.15	0.15	0.02	0.59	0.59	1,577	To be used for Medicare patients with code G0148 for the primary screening instead of 88141.
G0143	Screening liquid-based Pap, any reporting system with manual screening and rescreening, under physician supervision	n/a as on clinical lab fee schedule	n/a	n/a	n/a	n/a	n/a	New code, no volume for 2003	HCPCS code analogous to CPT code 88143 for Medicare patients.
G0144	Screening liquid-based Pap, automated (location-guided)	n/a as on clinical lab fee schedule	n/a	n/a	n/a	n/a	n/a	New code, no volume for 2003	HCPCS code analogous to CPT code 88174 for Medicare patients.
G0145	Like G0144 but with manual rescreening	n/a as on clinical lab fee schedule	n/a	n/a	n/a	n/a	n/a	New code, no volume for 2003	HCPCS code analogous to CPT 88175 for Medicare patients.

Note: Some codes not included due to low utilization volumes.

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for Medicare reimbursements. To document medical necessity, this act requires physician offices to include the appropriate diagnosis codes when billing for services provided to Medicare beneficiaries on or after April 1, 1989. The CMS has designated ICD-9 as the coding system physicians must use.

It is important to assign the correct and most specific ICD-9 code because this documents the procedure's medical necessity. For pathology the proper ICD-9 code may be based on the results of the interpretation the pathologist performed. If the results were normal and the test was not for screening, use the physician's submitted code. For example, if urine is submitted for hematuria (599.7) and the finding is urothelial carcinoma, submit diagnosis code 188.9 (malignant neoplasm of bladder, part unspecified). If negative, use the submitting code, 599.7.

ICD codes are also required as documentation of necessity for screening tests, including the Pap test which is covered every two years for average-risk patients and every year for high-risk patients. At present, while a number of codes govern documentation for the clinical comprehensive exam and pelvic exam and ensure clinician payment, only four are considered acceptable documentation for payment to laboratories for screening Paps. These are V76.2 (routine cervical Pap smear, intact cervix), V76.47 (routine vaginal Pap-status post hysterectomy for nonmalignant condition), V76.49 (Pap smear, other site NOS—can also use for patients without cervix), and V15.89 (other specified personal history representing hazards to health—use for high-risk Paps).

As of 2005, ICD-9 codes for biopsy diagnosis of dysplasia are separate from those for cytologic diagnosis for dysplasia. In addition, changes in individual assignation for codes have been made—for example, unsatisfactory Pap is no longer 795.09 but now is 795.08. These new and revised codes are in **Table 3.**

The ICD-9 codes must be coded to the highest degree of specificity. For example 622.1 dysplasia of cervix has been subdivided into 622.10 unspecified, 622.11 mild dysplasia, and 622.12 moderate dysplasia.

The commonly used ICD-9 codes for cervicovaginal cytology are listed in **Table 3.**

Coding rules. Screening Paps must be distinguished from diagnostic Paps because this distinction will determine whether to use CPT or HCPCS codes for Medicare. For diagnostic (medical) Medicare Paps and for most other third-party payer Pap tests, CPT codes are used exclusively. The designation of a Pap as diagnostic is based on information the referring physician provides. This may be in the form of ICD-9 codes, signs and symptoms, or a written narrative. These include the following: (1) prior or current cancer of cervix, uterus, or vagina; (2) previous abnormal Pap smear; (3) abnormal findings in lower abdomen or gynecologic tract; (4) complaint referable to female genital tract; and (5) any sign or symptom that the clinician deems to be related to a gynecologic disorder. Diagnostic Paps are not limited by frequency and are payable as submitted with information that documents medical necessity. In the absence of such information, it may be necessary to contact the clinician's office. Use of archival laboratory results on a patient is not acceptable in lieu of this information.

For screening Medicare Paps, HCPCS codes are used (**Table 2**). A screening or routine Pap is that which is performed in the absence of signs and symptoms and is payable only when billed with certain ICD-9 codes. (See ICD section and **Table 3**.) These should be billed for payment with HCPCS codes. This includes the professional interpretation (for example, P3001 for conventional, G0124 for liquid-based). Confusion may arise over ICD-9 coding when a

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Table 3

Common ICD-9 codes for Pap tests

ICD-9 code	Description	Comments
Screening (no signs or symptoms of disease)		
V72.31	Routine gynecologic exam, with or without Pap test	Covers physician retrieval of Pap
V72.32	Encounter for Pap test to confirm recent normal test following initial abnormal test	Covers physician retrieval of Pap
V76.2	Routine screening Pap test, intact cervix	Reimbursed every two years
V76.47	Routine vaginal Pap test	Reimbursed every two years
V76.49	Routine vaginal Pap test, history of neoplasm, other site	Reimbursed every two years
V15.89	Screening Pap test for high-risk patients (Defined as: onset of sexual activity before 16 yrs of age, multiple sexual partners, STDs, < 3 negative Paps in last seven years, DES-exposed daughters.)	Annual coverage
Diagnostic (signs or symptoms of cervical/vaginal disease)		
795.00	Atypical glandular cells, endocervicals, endometrials	Excludes CIN, SIL, CIS, CA
795.01	ASC-US on Pap	
795.02	ASC-H on Pap	
795.03	LGSIL on Pap	
795.04	HGSIL on Pap	
795.05	High-risk HPV DNA test positive	
795.08	Unsatisfactory smear (inadequate sample)	Used to be 795.09
795.09	Other abnormal Pap smear of cervix and cervical HPV	Low-risk HPV positive
795.10	Nonspecific abnormal Pap smear of other site	
622.10	Dysplasia of cervix, NOS (622.10)	
622.11	CIN I, mild dysplasia	
622.12	CIN II, moderate dysplasia	
623.0	VAIN I and II	
233.1	CIN III, cervix	
233.3	Vaginal CIS (VAIN III)	
616	Cervicitis	
616.10-616.11	Vaginitis and vulvovaginitis	
616.50-616.51	Vulvar ulcer	
617.0	Endometriosis, uterus	
616.9	Unspecified inflammatory disease of cervix, vagina, and vulva	
623.5	Vaginal discharge	
626.2	Menometrorrhagia	
626.4	Irregular menstrual cycle	
626.6	Metrorrhagia	
626.8	Dysfunctional uterine bleeding	
627.1	Postmenopausal bleeding	
180.1	Malignant neoplasm of cervix (squamous cell carcinoma)	
182.0-182.8	Malignant neoplasm of body of uterus	
183.0-183.8	Ovarian malignancy	
112.1-112.2	Candidiasis, vulvovaginal and other sites	
054.1	Genital herpes	

Note: The 795 series is meant for Bethesda cytology use. 622.1 and 233 series to be used for histologically verified CIN/CIS/dysplasia.

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screening Pap has findings that prompt pathologist review. The correct protocol is to document the reason for the Pap—that is, screening as the first ICD code (for example, V76.2) with the interpretive findings (for example, 795.03 LGSIL) as the second code. The followup Pap will then be a diagnostic Pap billed with 795.03 as the primary ICD-9 and will not be subject to frequency limitations. The same is true for unsatisfactory Paps (ICD-9 795.08). It may be necessary to provide an advance beneficiary notice to allow for billing the patient if Medicare is expected to deny payment. Modifier –GA is appended to the code to indicate that the beneficiary was given notice and the service may be denied.

The CPT codes for interpretation and hormonal assessment are add-on codes and at present can be billed only when a simultaneous screening code is billed. CPT codes can be billed as Bethesda or non-Bethesda, conventional or liquid-based, and those inputs will determine ultimate coding.

For nongynecologic cytology, coding for payment is based entirely on CPT. Unlike Pap tests, in which the technical screening portion and the professional interpretive function have separate codes, each nongyn code is separable into a PC and a TC payment, or it can be billed as a global charge. They are divisible into code families: 88104–88112 for washings, brushings, and body fluids; 88160–88162 for specified specimen types with prepared smears; and 88172–88173 for fine-needle aspiration specimens.

In contradistinction to the primary surgical codes in which the specimen type defines the code, in nongyn cytology the overall type of preparation determines the code. The same specimen (for example, bronchial washings) may be prepared as smears, direct or post centrifugation (88104); as direct filters mounted on a slide (88106; 88107 if smears also prepared); as cytospins (88108); or as cellular enhancement preparations, for example, ThinPrep, SurePath (88112). The use of technologies that employ a filter for concentration and enhancement of cytological preparations but transfer the cellular material to a glass slide before further processing and evaluation (that is, ThinPreps) should be coded as 88112, not 88106 or 88107.

88160–2 is a code family of exclusion used for sources other than washings, brushings, body fluids, FNA, or lower gyn tract. Sputums prepared as smears are coded with this family as are direct smears—for example, Tzanck preps and, currently, intraoperative touch preps from tissue prepared by the pathologist. Code 88162 can be billed if more than five slides are used or more than one stain is used. Direct evaluation of smears for cellular inclusions by microbiology is coded as 87207 when the evaluation is limited to mere reporting of the specific type of inclusion without consideration of etiology. National correct coding initiative edits prohibit use of these *or any cytology code* in combination with codes 88304–9. If performed on a separate specimen or intraoperatively on the same specimen, modifier –59 must be appended to the cytology code.

FNA code 88173 is used for all FNA definitive reports regardless of specimen submission, for example, smears or rinsings with cellular concentration/enhancement. Additional codes from the 88104–88112 family are not used regardless of the number of slides or preparations used. For material procured by clinicians as aspirated cysts, code according to the collection technique. If submitted as FNA, code as such; if as cyst aspiration, either clarify aspiration technique with the clinician or code from the 88104–88112 family. Code 88172 is used for the immediate evaluation of an FNA specimen. These are billable per number of passes and separate evaluations documented by the pathologist. Assessment of adequacy by a technologist is not billable as 88172. It is acceptable for the cytotechnologist to screen the specimen, which is then also immediately reviewed by a pathologist for coding 88172.

Edits govern a number of the cytology codes. In general, one cannot bill Medicare Pap codes with nongynecologic codes for the same patient, same date of service, without a modifier signifying it is a separate and distinct specimen. Likewise, FNA specimens and nongynecologic codes cannot be billed along with certain additional nongynecologic codes without –59. Cytology codes will be denied for payment by Medicare if billed along with consultation codes 88321–5 unless performed on a separate specimen.

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