ANATOMIC PATHOLOGY CODING AND BILLING
CLINICAL LAB INTERPRETATIONS

• Requested by Pt’s physician
• Written report to Pt’s MR
• Requires medical judgment
• Use -26 modifier
• Hospital standing order policies
CLINICAL PATHOLOGY CONSULTATIONS

• CPT Definition—“a service, including a written report, rendered by the pathologist in response to a request from an attending physician in relation to a test result(s) requiring additional medical interpretive judgment.”

• 80500—limited
• 80502—comprehensive
CLINICAL PATHOLOGY INTERPRETATIONS

- 83020-26 Hb electrophoresis
- 83912-26 Genetic exam
- 84165-26 S PEP
- 84166-26 Urine/CSF PEP
- 84181-26 Western blot, fluid
- 84182-26 Western blot, fluid, immuno probe
- 85390-26 Fibrinolysin/coagulopathy screen
CLINICAL PATHOLOGY INTERPRETATIONS

- 85576-26 Platelet aggregation
- 86255-26 Fluorescent Ab, screen
- 86256-26 Fluorescent Ab, titer
- 86320-26 S IEP
- 86325-26 Urine/CSF IEP
- 86327-26 2-D IEP
- 86334-26 S immunofixation
CLINICAL PATHOLOGY INTERPRETATIONS

- 86335-26 Urine/CSF immunofixation
- 87164-26 Darkfield exam
- 87207-26 Smear, inclusion bodies/parasites
- 88371-26 Western blot, tissue
- 88372-26 Western blot, tissue, immuno probe
- 89060-26 Synovial fluid, crystals
CPT SURGICAL PATHOLOGY

- 88300—88309 include accession, gross & micro examination, and reporting
- Unit of service is the specimen
- Specimen is “tissue(s) that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis.”
CPT SURGICAL PATHOLOGY
88300

Gross exam only
Accurate dx can be made without micro exam
Gross and micro to confirm tissue identification and absence of disease
CPT SURGICAL PATHOLOGY
88304, 88305, 88307, 88309

Gross and micro exam with ascending levels of physician work
CPT SURGICAL PATHOLOGY
88311 thru 88365, & 88399

Add-on codes
incidental to primary
surgpath or cytopath exam codes
CPT MODIFIERS -59

• Procedure or service distinct or independent from other services performed on the same day
• Example—separate sites, procedures, patient encounter
• Avoid appearance of unbundling
CPT MODIFIERS
-59

• Example:
  88189—FCM interpretation, 16 or >
  88342-59—IHC

• Separate procedures, same day, necessary
  and not duplicative

• Nat’l Correct Coding Initiative edits
  must use -59 modifier
CPT MODIFIERS -22

- Unusual procedural service
- Greater work than usually required for the listed CPT code
- Use modifier instead of “upcoding”
- Usually no increase in payment
- Not recognized by most other payors
CPT MODIFIERS
-26

- Professional component
- Procedures that have both technical and professional component
- Global = TC + PC
- Used for clinical lab test interpretations
- Use when lab bills TC, physician bills PC separately
CPT CODING

- Unit of service is the specimen
- “tissue(s) submitted for individual and separate attention, requiring individual exam and pathologic diagnosis”
CPT CODING EXAMPLES

“Individual exam and path dx”

• 3 GI biopsies in same container—88305 X 1
• GI biopsies in three separate containers—88305 X 3
• Two polyps in same container separately identified as large and small—88305 X 2
CPT CODING

• Tissues usually removed together
  —Mandatory bundling
• Disregard # of specimens in container
• Disregard separate containers in some cases
CPT CODING EXAMPLES
LYMPH NODES

• If CPT specimen ordinarily includes LNs, do not code separately, e.g., mastectomy, laryngectomy, colectomy for CA

• Radical prostatectomy (88309)—regional LN resections reported and coded separately (88307 X 2)
CPT CODING EXAMPLES
LYMPH NODES

- LN—difficult lymphoma dx is still 88305
  —can use -22 modifier (in vain)
- Sentinel lymph node(s) (88307) are separately coded and may have multiple units if separately identified
CPT CODING EXAMPLES

• Breast (88307) and regional lymph nodes (88307) in separate containers—bundle as a breast with regional lymph nodes (88309)
• Prostate (88307) and seminal vesicles in separate containers—bundle as radical prostate (88309)
CPT CODING EXAMPLES
BREAST

- 88305—Reduction mammoplasty
  —Bx, not requiring eval of margins
- 88307—Breast excision, with evaluation of margins
  —Mastectomy—partial/simple
- 88309—Mastectomy w/regional LN
CPT CODING EXAMPLES
Tonsils & Adenoids

• Tonsils separately identified—88304 X 2
• Tonsils in same container—88304 X 1
• Adenoids only—88304
• Adenoids with tonsils—no separate charge

CPT code (88304) is “Tonsil and/or adenoids”
CPT CODING EXAMPLES

• R hemicolecctomy for CA (88309)—do not unbundle the appendix or terminal ileum
• Separately code for separate segments of bowel if removed for different indications
CPT CODING EXAMPLES

• Uterus CPTs are “with or without tubes and ovaries”
• Ovary CPTs are “with or without tubes”
• So, if specimens are incidental to the indications for resection, bundle even if in separate containers
CPT CODING EXAMPLES

• TAH for leiomyomata, R & L tubes and ovaries all in separate containers, incidental appendix
• Bundle TAH, BSO as 88307 or 88309
• Code appendix as 88302 or 88304
CPT CODING EXAMPLES
MULITPLE ORGANS

• Radical cystoprostatectomy
  —if independent diseases, separate codes
    e.g. bladder & prostate CA 88309 X 2
  —if extension of dz from one organ to
    contiguous organ, 88309 + 88307
CPT CODING EXAMPLES
MULTIPLE ORGANS

• Radical neck dissection (LNs, vessels, muscle, salivary gland)—code LNs 88307 + salivary gland 88307 +/- add’l 88307 if soft tissue extension requiring evaluation of margins
CPT CODING EXAMPLES

- Twin placentas—88307 X 2 if separately identified and reported
- Multiple LEEPs—88307 (similar to cone bx) or 88305 (similar to small bx or ECC) depending on work
CPT CODING - STILLBORNS

• ? Autopsy or SP ?
• Follow state and local laws defining fetal viability (e.g. MA—20 weeks or 350 g.)
• If non-viable—88309
• If viable—autopsy codes 88014, 88016, or 88029. Consent required.
CPT CODING EXAMPLES

• Scant tissue, non-diagnostic—ok to bill because gross and micro exam performed
• Specimen container with no tissue identified—no charge
CPT CODING EXAMPLES
INTRAOP CONSULTS

• Gross only—88329
  —charge per separate specimen and diagnosis
  —cannot use with other intra-op consult codes (88331/2/3/4) for same specimen
CPT CODING EXAMPLES
INTRAOP CONSULTS

• 88331—first tissue block, FS, single specimen. Only one unit per specimen
• 88332—each add’l block with FS. Multiple units possible
• Document all units of service
CPT CODING EXAMPLES
INTRAOP CONSULTS

• 88333—cyto exam, initial site; do not use with 88329
• 88334—cyto exam, each add’l site
• If 88331+ cyto, use + 88334
  – Separate analyses
  – Medically reasonable & necessary
• can unit code
CPT CODING EXAMPLES
SPECIAL STAINS

• Units are per stain type, per specimen
• One specimen with one stain on multiple blocks/slides—one unit of service
• One specimen with multiple different stains, code separately for each special stain
CPT CODING EXAMPLES
SPECIAL STAINS

• 88312—Group I, for microorganisms
• 88313—Group II, all others
• 88314—Stains on frozen sections (oil red O)
• 88318—To identify chemical components (Cu)
• 88319—To identify enzyme constituents
• 88342—Immunohistochemistry (Impx), ea Ab
• DOCUMENT!!!!!
CPT CODING EXAMPLES
ER/PR

• 88342—IHC, each Ab, pos or neg
• 88360—morphometric analysis, tumor IHC, quant or semiquant, each Ab, manual
• 88361—morphometric analysis, tumor IHC, using computer assisted technology
• Do not use chemistry CPT codes 84233 or 84234 receptor assay
FCM CODES (2005)

• 88180 deleted; no unit coding
• PC and TC now distinct codes
• 88187—2-8 markers
• 88188—9-15 markers
• 88189—16 or greater markers
• Bill only one code!
FCM Interpretation

• Medicare does not pay for duplicate testing
  —cannot bill for multiple specimens on same date of service
  —exception: morphology or other clinical info suggest different path processes
  —document reason for multiple studies
FCM Interpretation

• When cytopathology is to confirm cells gated or select markers, CMS considers this inherent in the flow cytometry procedure
• Do not separately code for this
• CMS allows -59 modifier if cytopathology is for separate diagnostic purposes unrelated to the flow cytometry procedure
• Separately code for this, but document
FCM AND IHC

- Medicare does not pay for “duplicate” testing.
- Can bill both codes, if:
  - initial method is non-diagnostic
  - one method does not explain histology
- Use -59 modifier to override NCCI edits
- Document reason for both codes.
FCM and IHC

• If two or more specimens show same pathology and FCM or IHC establishes diagnosis on one specimen, do not bill for similar specimen.

• E.g., blood and bone marrow; BM aspirate and BM biopsy; two separate lymph nodes; LN and other tissue with same lymphoid infiltrate.
CPT CODING
CYTO-HISTO REVIEW

• 88500 CP consult, limited to determine discrepant results
  Must meet criteria for CP consult
  Not appropriate for QC reviews
• 88321 consult and report on referred slides if from another institution
CPT CODING FNAs

• Always coded as 88173, regardless of # of slides, prep techniques, or stains
• Do not use 88162 extended study >5 slides
• Do not use 88108—concentration or 88112—cell enhancement
CPT CODING FNAs

- FNA performance 10021 or 10022
- 88172 FNA adequacy can be unit coded
- 88173 FNA interpretation and report
coded only once per site
CPT CODING FNAs WITH NEEDLE CORE BXs

- Needle core bx—88305 or 88307
- Adequacy by touch prep—intraop consult with TP—88333
CPT CODING CYTO

- 88104 cyto, fluids, washings, brushings
- 88108 cytopath, concentration technique
- 88112—ThinPrep, Surepath
  Cyto, selective cell enhancement technique
- Cell block (88305) is additional code
Cytopathology codes

• Code to the highest level of specificity and complexity when multiple prep methods on same specimen (e.g., fluid—88112, no 88104)
• Bill only one code from the cyto group of related codes—881XX
• Separate specimens (e.g. bronchial washings & brushings)—use -59
• Document!
Cytopathology codes

- Cytopathology, fluids, washing, or brushing — bill only one code from 88104-88112.
- Smears are included in 88104-112 codes
- Do not add 88161-62 — smears, other source
BONE & BM EVALUATION

- Multiple CPT codes for bone and BM
- Skeletal structure/tumor vs. heme exam.
- 20220—Biopsy, bone, superficial (procure)
- 88307—Bone bx—skeletal structure, tumor
- 38220—BM aspiration—heme (procure)
- 88305—BM biopsy exam—heme
BONE & BM EVALUATION

• Two separate biopsies needed to evaluate bone structure and bone marrow (heme) — report 88307 + 88305-59

• One specimen submitted — bill only one code (88307) for eval of bone structure and BM
BM EXAMINATION

• 85060—Blood smear interpretation
• 85097—BM, smear interpretation
• 88305—BM aspirate cell block exam
• 88305—BM biopsy exam
• 88311—Decal
• 88313—Special stain for iron
• 88342—IHC (as needed)
E & M CODES

• Pathologists are physicians
• Coding based on level of service and time
• Document
  — “problem focused history
  — problem focused exam
  — medical decision making”
TELEPATHOLOGY

- No specific CPT codes
- Code as limited (88321) or comprehensive (88325) consultation
MOLECULAR DIAGNOSTICS

• 83912 interpretation and report
• Used only once for each patient study/date of service
• Not unit coded per probe or procedure
AP CONSULTATIONS

“SECOND OPINIONS”

• 88321—referred slides, prepared elsewhere
• 88323—referred material, prep of slides
• 88325—comprehensive, review of records and specimens, referred material.

• Do not bill for intradepartmental consults
AP CONSULTATIONS
SECOND OPINIONS

• Cannot bill any add-on codes (e.g. 88313, 88342) on material previously interpreted by another pathologist.

• Bill add-on codes with 88323 when performed and interpreted de novo.
TEACHING PATHOLOGIST’S BILLING

• Supervision of trainee—pathologist will:
  — exam specimen and review interpretation
  — exam and interpretation is agreed with and documented in report
  — present for the key portion of any service and document that attendance
NO SPECIFIC CPT CODE?

• Assign code that most closely reflects work performed
• “Good faith” effort for accuracy
Physician Billing Practices
“PROFESSIONAL COURTESY”

- Physicians, families, office staff
- Waiving all or part of the fee
- Waiving coinsurance obligations or other out-of-pocket expenses (i.e., "insurance only")
- Accepting similar payment arrangements hospitals or institutions provide to their medical staff or employees.
- ?Fraud and abuse—if perceived as an inducement for referral
Physician Billing Practices
“PROFESSIONAL COURTESY”

• May not be “fraud and abuse” if:
  – Regular and consistent practice
  – Entire fee is waived
  – Consistently applies to a group of persons (physicians, family members, employees,)
  – Does not take into account any group member's ability to refer to the physician
  – Prudent practice—don’t do it!
WAIVER OF CHARGES

• Indigent patient or severe financial hardship
• Billing error or honest misunderstanding of charges
• Cost of collection exceeds likely financial recovery
• Document
• Professional courtesy—a NO, NO!
PRICE DISCOUNTS

- Services at “fair market value”
- Justify discounts by actual cost savings
- Consider competition in the marketplace
- Cannot bill M-care substantially more than the “usual” charge for a service
MEDICARE BILLING

• Physician is responsible for bills sent with their signature or in their name, even without actual knowledge of billing improprieties.

• Physician's ignorance no defense.
ICD-9 Coding

Diagnostic tests ordered due to signs and/or symptoms

- If diagnosis made/confirmed by path
  —code pathologist's diagnosis

- If no diagnosis/normal
  —code signs/sx

- If test normal/non-dx and clinical dx indicates uncertainty (r/o, ?, probable)
  —code signs/sx
ICD-9 Coding
Determine the Reason for the Test

• Referring physician must provide diagnostic info when test is ordered
• All tests must be ordered by treating physician
ICD-9 Coding
Determine the Reason for the Test

• Order—forms of communication:
  1. Signed written document
  2. Telephone call (document)
  3. Electronic mail

• Can be obtained from Pt or MR, attempt to confirm
ICD-9 Coding

• **Incidental Findings**
  — Never code as primary diagnosis
  — May code as secondary diagnosis

• **Unrelated/Co-Existing Conditions/Dx**
  — May code as secondary diagnosis
ICD-9 Coding

Diagnostic test ordered in absence of signs and/or sx (e.g. screening tests)
—code reason for test (i.e. screening)
—test result may be coded as additional diagnosis
CPT CODING RESOURCES

• AMA CPT 2006
• CPT Assistant & CPT Companion
• CAP Today
• CAP www.cap.org Advocacy
• CAP Washington office
• M-care Correct Coding Policy Manual