ASC Roundtable
Cytopathology Coding

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Disclosure and CV

• No conflicts of interest
• Served as Consultant for I Health Technologies
• CAP Delegate RUC 2008 to present
• ASC RUC Advisor, 1999 to 2008
Course Objectives

- Describe recent changes to CPT codes and NCCI edits as they pertain to cytopathology
- More accurately code challenging cases not routinely encountered in cytopathology practice
- Obtain coding information tailored to your individual needs and level of coding expertise
AMA RBRVS Is Used by CMS and Most Payers

- Resource-Based Relative Value Scale, implemented January 1, 1992
- Standardized physician payment schedule: for services determined by the resources and costs needed to provide them
- Utilizes methodology to determine MD payment (based on Surveys) and expense inputs (based on inputs from SS as approved at the RUC)
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
Physician Work

• Survey-based
• Determined by:
  - Time to perform the service
  - Technical skill and physical effort
  - Mental effort and judgment
  - Stress due to potential risk to the patient
RUC Survey Issues

Physician Work = Time x Intensity
Practice Expense

- Initially, allocated as % MD work
- In 1999, CMS transitioned to a resource-based practice expense relative value for each CPT code ("Harvard Studies")
- Direct expenses: eg scalpel blades, reagents, slides
- Indirect: eg secretarial, computer, rent
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:

\[
\text{Total RVU} = \left[ (\text{wRVU} \times \text{wGPCI}) + (\text{peRVU} \times \text{peGPCI}) + (\text{pliRVU} \times \text{pliGPCI}) \right]
\]

\[
\text{Total RVU} \times \text{Conversion Factor}^* = \text{Medicare Payment}
\]

*The Conversion Factor for CY 2010 = 36.87
(For 2009 was $36.0666)
RVUs Are Important

- Conversion factor changes annually (SGR dependent)
- RVUs are the base for pay
- RVUs are determined by the surveys
  - 88141: global -- PC .76
  - 88104: 1.69 .76
  - 88108: 1.96 .75
  - 88112: 2.76 1.57
  - 88161/2: 1.45/2.04 .66/1.01
  - 88173: 3.64 1.89
  - 88305: 2.82 1.80
ABN

APC

TO

RBRVU

DOB

CAC

CMS OIG

Alphabet Soup

GPCI
Coding Rules, Basic Tools

- Current Procedural Terminology
- International Classification of Diseases-9th modification
- National Correct Coding Initiative
- Medically Unlikely Edits
Overview of CPT Coding

- **Category I** - 5-digit codes to specify a procedure; revised annually by CPT effective January 1st
- **Category II** - optional codes used for tracking & collecting data, eg. PFP or QA
- **Category III** - Temporary codes for emerging technology
- **HCPCS Codes**
  - Analogous to CPT
  - Alphanumeric codes for screening services, DME, drugs, mandated svc's, e.g. P3000 screening pap
• Indicate **special circumstance** in a procedure code (Medicare)

• Laboratory/Pathology service modifiers include:
  
  - -TC Technical Component
  - -25 Separate E and M service (with FNA)
  - -26 Professional Component
  - -59* Distinct and separate Procedure
  - -90 Reference Laboratory Test
  - -91* Repeat Clinical Diagnostic Lab Test

*Most commonly used modifiers to meet lab/path NCCI and MUE edits
Add On Codes

• Whereas with multiple different standalone procedures for a patient on the same day, report as multiple codes.

• An “add-on” code is one that’s never reported by itself; instead, it always requires an accompanying primary procedure code.

• Add-on codes are identified in CPT by a plus sign (+), and often accompanied by a parenthetical note as well.
ICD-9 OVERVIEW

• 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
CPT vs ICD-9

- 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.
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
Diagnostic ICD-9’s (not “V” codes) that support 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  
      796.70-.79: Anal Pap abnormalities

*May allow for more frequent/repeat Pap screening with coverage of followup smear*
National Correct Coding Initiative Edits

• Originally instituted to “correct billing errors, typographical and unintentionally erroneous claims”
• All claims are processed against edits
• Code pairs that are not normally or never recognized as separate services when performed...
  - By the same provider
  - On the same patient, same site
  - For the same date of service
• Bypassable with:
  - Modifier -59, appropriate for most pathology edits
### Example of NCCI Edit Table - Col 1/Col 2

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>*- In Existence prior to</th>
<th>Effective Date</th>
<th>Deletion Date *-no data</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>88141</td>
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<td></td>
<td>20000605</td>
<td>*</td>
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<td>19980401</td>
<td>*</td>
<td>1</td>
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<td></td>
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<td>1</td>
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<td>88342</td>
<td></td>
<td>20050101</td>
<td>*</td>
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<tr>
<td>88305</td>
<td>88161</td>
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<td>1</td>
<td></td>
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<td>1</td>
<td></td>
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<td>88323</td>
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<tr>
<td>88323</td>
<td>88346</td>
<td></td>
<td>20030701</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

- **Comprehensive Code** – this is the primary or major procedure.
- **Component Code** – append the modifier to this code if appropriate.

**Edit Indicator** – if a “0” is listed, these codes cannot be filed together. A modifier can be used if a “1” is listed. Code pairs with a “9” can be ignored as the edit has been deleted from the list.
NC I C EDITS

• Edits are updated on a quarterly basis - current version 16.2 effective 7-01-10 to 9-30-10

• Policy manual, modifier rules and edits at http://www.cms.hhs.gov/NationalCorrectCodInitEd/

• Link to Physician NCCI edits page) http://www.cms.gov/NationalCorrectCodInitEd/NC CIEP/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS 046542&intNumPerPage=10
Medically Unlikely Edits

Just when you think you have all the rules figured out....they change them or add more!!!!
Medically Unlikely Edits

- Limit units of same svc per beneficiary/DOS/MD

- Initiated 1-1-07, released q 2-3 months with 6 wks for comment

- MC checks each claim against the MUE on one line w/ denial of full claim if MUE exceeded
  - You are instructed to correct “typographical error and resubmit”
  - Modifier -59 can allow claims to appear on separate lines and bypass edits

- [http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage](http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage)
# Medically Unlikely Edits

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Classification</th>
<th>Count</th>
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</thead>
<tbody>
<tr>
<td>88104</td>
<td>Cytopathology, smears any source, prep., screening, and interpretation</td>
<td>Published</td>
<td>4</td>
</tr>
<tr>
<td>88108</td>
<td>Cytopathology, concentration technique, smears &amp; interpretation</td>
<td>Confidential</td>
<td></td>
</tr>
<tr>
<td>88112</td>
<td>Cytopathology, cellular enhancement technique</td>
<td>Confidential</td>
<td></td>
</tr>
<tr>
<td>Paps</td>
<td>Screening and interpretation</td>
<td>Published</td>
<td>1</td>
</tr>
<tr>
<td>88172/3</td>
<td>Cytopathology, FNA, immediate evaluation/interpretation</td>
<td>Published</td>
<td>3</td>
</tr>
<tr>
<td>88160/1</td>
<td>Cytopathology, smears any source, screening, and interpretation/prep</td>
<td>Published</td>
<td>4</td>
</tr>
<tr>
<td>88162</td>
<td>Cytopathology, smears any source, extended study, screening, and interpretation</td>
<td>Published</td>
<td>3</td>
</tr>
</tbody>
</table>
The reality is...

- With MUEs, the real payment is 2 x the MUE
  - Enter the first MUE limit on one line of HCFA 1500
  - Enter the next number of code on line 2 with modifier
    - Eg 88104 x 4 and 88104 x 2-59

- Some codes (88321-5) cannot be over-ridden by modifier
PAYMENT POLICY

RULES AND REGULATIONS

for

MEDICARE
CMS RULES AND REGULATIONS
(Applies to Many 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- Must be legible, maintained in Medical record and signed by physician, eg. IE on FNA
CMS RULES AND REGULATIONS

- 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...
CMS RULES AND REGULATIONS

- 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. Otherwise physician order is required, e.g. HPV testing on ASCUS Pap.
Coding for Cytopathology

• Pap tests

• Diagnostic vs Screening
  – Diagnostics paps are those for which there is a medical reason to perform
  – Screening pap are statutorily defined as from patients without signs or symptoms
# Codes for Diagnostic Paps Medicare

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<td>88165</td>
<td>88166</td>
<td>88167</td>
<td>88147</td>
<td>88148</td>
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<tr>
<td>Conventional Non-TBS</td>
<td>88150</td>
<td>88153</td>
<td>88152</td>
<td>88154</td>
<td>88147</td>
<td>88148</td>
</tr>
<tr>
<td>LBP-any vendor ARS</td>
<td>88142</td>
<td>88143</td>
<td></td>
<td></td>
<td>88174</td>
<td>88175</td>
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<tr>
<td>Pathol. Interpret.</td>
<td>88141</td>
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<td>88141</td>
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## “The Rules” for Screening Paps Medicare

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Conventional Pap-ARS</td>
<td><strong>P3000</strong></td>
<td><strong>P3000</strong></td>
<td><strong>P3000</strong></td>
<td><strong>P3000</strong></td>
<td><strong>G0147</strong></td>
<td><strong>G0148</strong></td>
</tr>
<tr>
<td>Conventional Path. Interpret.</td>
<td><strong>P3001</strong></td>
<td><strong>P3001</strong></td>
<td><strong>P3001</strong></td>
<td><strong>P3001</strong></td>
<td><strong>P3001</strong></td>
<td><strong>G0141</strong></td>
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<tr>
<td>LBP-ARS</td>
<td><strong>G0123</strong></td>
<td><strong>G0143</strong></td>
<td></td>
<td></td>
<td><strong>G0144</strong></td>
<td><strong>G0145</strong></td>
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<tr>
<td>LBP- Path. Interpret.</td>
<td><strong>G0124</strong></td>
<td><strong>G0124</strong></td>
<td><strong>G0124</strong></td>
<td><strong>G0124</strong></td>
<td><strong>G0124</strong></td>
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</table>

*Table shows the codes for different screening methods for Medicare.*
NON-GYN Code Families

- Code depends on both specimen type and preparation method, with families

- 88104-88112, washings, brushings and body fluids
  - 88104 Submitted or prepared slides
  - 88108 concentration: cytospins
  - 88106-7 Direct filtration s/w smears
  - 88112 Cellular enhancement
88160-88162: Smears Other Source

- 88160 screening and interpretation
- 88161 preparation, screening and interpretation
- 88162 extended study involving >5 slides and/or multiple stains
- For intra-op cytology see 88333-4 (effective 1-1-06)
- For Tzancks, sputum (Saccomano)
Fine Needle Aspiration

- 88172 Immediate adequacy evaluation
- 88173 Interpretation and report
- 10021-2, performance of FNA
  - Can code with 88305, 88312-3, 88342 etc
  - Documentation in Report*
  - Do not add other cytology codes if same specimen!

* CCI: “The medical record (eg operative report) should indicate the distinct nature of this service...The medical record should identify the precise location of each biopsy site.”
Intra-operative cytology

- 88333, Cytologic examination, initial site
- 88334, Cytologic examination, each additional site(s)
- May bill with 88331/88332, use -59 to indicate separate site(s) and/or separate specimen(s) if Medicare
- Can use for any intra-procedural evaluation, eg lymph node, bronchial brushings, liver bx under U/S, etc.
Question Time!
1. It is part of laboratory policy to have all pap smears f/ patients with endometrial cells, unsats or history of abnormalities, reviewed by a pathologist. A diagnostic LBP - UNSAT, reviewed by path is best coded as:

a. 88141  
b. 88142  
c. 88143  
d. 88141 & 88142  
e. None of the above
The correct answer is b. 88142

- **Code 88141** is eligible for billing...
  - If a pathologist’s interpretation is required for a GYN cytology smear judged by the screener to be abnormal, atypical, or potentially abnormal.
  - For diagnostic purposes—as opposed to quality assurance/control purposes.

- **For endometrial cells**, this may be billable in patient’s over 40 even if they are not abnormal morphologically
2. A TBS pap, non Medicare, is referred to the laboratory as a Thinprep. Screening diagnosis: Reactive/ reparative. The QC tech upgrades it to ASC US. The pathologist signs it out as NIL.

a. 88142
b. 88141, 88143
c. G0123, G0124
d. 88141, 88142
e. 88141
The correct answer is d. 88141, 88142

- Regardless of the final signout interpretation, the finding required pathologist review
- 88143 is a re-screening code for a requested review by the clinician
- 88141 and 88142 are billable even if the Pathologist performed the QC and called it ASC US or Repair
3. A screening Medicare LBP (pelvic exam) is submitted. It is screened showing blood only, unsatisfactory for interpretation. CPT/ICD code(s)?

a. P3000/V76.2, 795.09
b. P3000, P3001/ V76.2, 795.08
c. G0123/ V76.2, 795.08
d. G0123/ V76.2, 795.09
e. G0123,G0124/ V76.2, 795.08
The correct answer is c. G0123/ V76.2, 795.08

• It is important to include the 795.08 as this will ensure that the repeat Medicare screening Pap in 4 months will be reimbursed

• 795.09 is ICD for any other abnormal pap (used to be for Unsat before 2007)

• Cannot bill the pathologist’s review if no abnormality was present or suspected
4. A Medicare conventional smear (annual physical) is submitted for interpretation by TBS. No history is given but 2 abnormal Paps in the past 5 yrs. are retrieved on the Lab computer. Findings are NILM.

Billing code and ICD?

a. P3000 / V76.2
b. P3000 / V72.32
c. P3000 / V15.89
d. 88150 / V76.2
e. None of the above
The correct answer is e. None of the above

- June 10, 2003 CMS program memorandum:
  - Include the ICD-9-CM diagnosis code as furnished by the physician/practitioner
  - If a diagnosis or narrative diagnosis is not submitted by the physician/practitioner, laboratories must request this information from the practitioner who ordered the service.
5. Non Medicare Pap on 42 year old female is sent for TBS interpretation. Includes lateral vaginal wall scrape for maturation. The Pap smear is sent for QC review to the pathologist, NILM.

a. 88141, 88164  
b. 88141, 88142, 88155  
c. 88141, 88164, 88155  
d. 88164, 88155  
e. 88155
The correct answer is d. 88164, 88155

- Remember even if ordered alone, 88155 is a (+) code, cannot be billed alone
- Medicare does not pay for QA, so no Path review code allowed, unless an abnormality is detected or suspected.

a. P3000 / V15.89
b. G0123, G0124 / 76.2, 795.01
c. G0143 / V15.89, 795.02
d. G0143, G0124 / 622.1
e. G0144, G0124 / V15.89, 795.01
The correct answer is e. G0144, G0124 / V15.89, 795.01

- Computerized screening codes on LBPs are 88143 and 88144
- V76.2 is the code for pelvic exam low risk
- V15.89 is code for pelvic exam with pap, high risk
7. LB pap from screening shows AGUS. In workup I perform a cell block on the contents of the vial. I read it as BCC, can I bill for that review and the cell block? (best answer)

a. No
b. Yes
c. Yes, document medical necessity
d. Only to non Medicare payers
e. None of the above
The Best Answer is

c. Yes, document medical necessity

• It is appropriate to bill for work performed as the slide was referred to the pathologist as a suspected abnormality by the cytotech.
• The correct PC codes would be 88305 and 88142, 88141/ G0123, G0124 (documenting necessity)
• Is still billable even if NILM
• Use ICD9 795.09 (other abnormal)
1. Tzanck prep of a vesicular rash in a CLL patient from Medicine clinic as 2 ETOH smears and 2 air dried for difquik, w/ request: “R/O HSV, R/O staph, please do Gram stain”.

a. 88162, 88312
b. 88162, 88313
c. 88161, 88313
d. 88160 x 2, 88312 x 2
e. 88104, 88312
The correct answer is **a. 88162, 88312**

- 88160 is for previously prepared smears ≤ 5 without multiple stains
- 88160 cannot be billed x 2 just because two stains were used
- 88161 is for smears prepared in lab, ie simple sputum
- 88312 is not billed x 2 for the difquik and gram as difquik is for interp and not as a special stain (unless you used a control for PCP, then answer is 88160 and 88312 x 2)
2. A brush specimen is labeled as Lung, RUL, used to prepare 2 smears for immediate evaluation (pathologist present, specimen adequate). Remainder is rinsed in cytolyt processed as LBP x 2.

a) 88112
b) 88112 x 2
c) 88333, 88112
d) 88333, 88334, 88112
e) 88333, 88112 x 2
The correct answer is c) 88333, 88112

- This is analogous to Immediate evaluation performed on core biopsies billed as 88333, along with the appropriate 88300 code.
- Even if two LBPs are reviewed cannot bill twice on the same specimen.
- With second pass on same site, how to bill?
- With smears or cytospins (88104, 88108), bundle into the LBP (88112) due to NCCI edits.
3. A sputum is submitted from a transplant patient with fever and lung infiltrates. “R/O AFB, Fungus” Smears x 4 & CB are prepared and reviewed on Pap stains with a GMS & AFB on CB.

a. 88112, 88312 x 2
   b. 88104, 88305, 88312 x 2
   c. 88160, 88305, 88312, 88313
   d. 88161, 88305, 88312 x 2
   e. b ord
The correct answer is e. b or d

- Originally sputa were done by Saccomano technique defined as 88160 family, (here 88161) Use especially if multiple stains or > 5 slides (88162)
- Now 88112 is probably the code most frequently billed for sputa
- 88104 can be billed for sputum smears and 88108 for sputum cytospins
4. A cytology enrichment fluid vial on 67 yo MC pt. is labeled as Lung, RUL brushings, containing brush with adherent material, vortexed and used for cytospins and a cell block. Additionally, in the bag are 3 prefixed smears.

a. 88112, 88104, 88305
b. 88112, 88305
c. 88108, 88104-59, 88305
d. 88108, 88104, 88305
e. 88108, 88305
The correct answer is e. 88108, 88305

- NCCI edits do not allow coding on same pt/DOS/provider for two methods of preparation unless on separate specimens (Do not use -59 merely to bypass edit, MC will not pay 2x for same service)

- If submitted separately, but labeled the same, might call provider to ensure that is not the same specimen (brush used to make smear and also submitted).
5. 20 g cores of 8 cm liver mass are adequate on 3rd pass. Touch preps for Difquik (immediate evaluation) are reviewed on site. Codes?

a. 88333, 88334 x 2, 88307
b. 88333 x 3, 88307
c. 88333 x 3, 88307 x 3
d. 88172, 88173, 88307
e. a or c
The best answer is **e. a or c**

- Depends on the handling of the specimen and coding philosophy
- If a single core, would be 88333 and 88307 (+88312's, -3's or 88342's)
- Especially if simultaneously presented, may code as a. 88333, 88334 x 2 and 88307
- If singly, can argue for c. 88333 x 3 and 88307 x 3, analogous to 88329 family, however it is unclear how payers will view the medical necessity
6. You are consulted to perform FNA on a supraclavicular mass in a pt w/ hilar lung mass. You do FNA x 3 passes, adequate on second with 3rd pass for CB only.

a. 88172, 88173, 88305
b. 10021, 88172, 88173, 88305
c. 10022, 88172 x 2, 88173, 88305
d. 10021, 88172 x 2, 88173, 88305
e. b or d
The best answer is e. **b o r d**

- Payment is dependent on payer rules
- For Medicare only one 88172 is allowable per site/DOS/provider, limited by MUEs
- The MUE is bypassable with -59 modifier, however multiple 88172’s billed by the procuring pathologist may engender scrutiny as to self-referral
- If H and P is performed may use 99221 – 3 and 99231 – 3 families [used to be 99241 and 99251 families (hospital consultation codes) deleted 2010]
A Pathologist performs FNA on a 3 cm chest wall mass showing non small cell malignancy. She is asked to review prior separate skin and breast specimens from City and County Hospitals to assess the origin of the mets. After review and IHC x 4 on smears, metastatic carcinoma is confirmed. The diagnosis, review of the 2 cases and results of the IHCs is documented in the Final report.

a. 10021, 88173, 88313 x 4, 88321
b. 10022, 88173, 88342 x 4, 88321 x 2
c. 10021, 88172, 88173, 88342 x 4, 88321
d. 10021, 88173, 88342 x 4, 88321

e. 10021, 88173, 88342 x 4, 88321 x 2 (use -59 if Medicare)
The correct answer is
d. 10021, 88173, 88342 x 4, 88321

• No 88172 is billable as no Immediate Evaluation was documented

• Only a single 88321 is billable as MUE’s limit the consultation codes to one despite the number of separate cases reviewed
PEARLS OF PATHOLOGY AND REFERENCES

- Use the tools...
  - CAP Q and A’s (CAP Today)
  - CAP educational offerings at CAP.org (CPT Tutorials)
  - ASC CPT and RUC colleagues
    - Meg Neal mhneal@gmail.com
    - Carol Filomena carol.filomena@duke.edu
  - Online Resources
Pearls of Pathology

This new system is too complex......pass it on.
CPT CODING FOR CYTOPATHOLOGY

In order to ameliorate perceived inequities in reimbursement across specialties, Medicare in 1992 implemented a standardized physician payment schedule based on the actual 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 Relative Value Units (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 increasing 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:

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

For example, the global 88108 paid in Alabama in 2009 is:

88108 payment = $36.07 \times [(0.56 \times 1.027) + (1.38 \times 1.027) + (0.04 \times 1.027)] = $73.34

On average the physician work component accounts for 52 percent of the total relative value for each service for the professional component. 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 (RUC).

Established in 1991, the RUC provides annual recommendations to the CMS, which generally accepts the inputs. (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 RUC 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 format that gathers data for the following: 1) technical skill with respect to knowledge, training, and experience; 2) required mental effort and judgment; 3) physical effort; and 4) psychological stress due to the potential risk to the patient. The survey requires surveyees to compare these aspects of physician work to the work of an established code on the physician fee schedule, hence the derivation is that of a relative value.

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 such costs as 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 (CLFS). 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. For example, unlike Pap test interpretation, which is a physician service, Pap test screening is paid under the CLFS. However, the CMS holds annual hearings to receive input from organized medicine, the laboratory industry, and manufacturers to aid in determining 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 CPT as the official numeric code for procedures, 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.

There are three levels of coding. Category I codes are five digits and are specific for a procedure or medical service and are required for payment. To attain Category I status, a code must be widely used by multiple providers. Category II codes are optional tracking codes for data collection originally promoted for documenting quality assurance efforts, now important to Medicare providers for payment for PQRI. Category III codes are tracking codes for new technology which are not sufficiently widespread to qualify for Category I status and are temporary, expiring after five years unless evidence can be brought forth to demonstrate their generalized use.

**Table 1** lists the category I cytology codes from CPT 2010, which is the most recent revision of that which first appeared in 1966. It includes their RVUs and most current Medicare volumes. CPT descriptive terms and identifying codes now serve a variety of important functions in the field of medical procedural nomenclature. CPT category I 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 from the Pathology Coding Caucus, a group that the CAP staffs and chairs and that allows laboratory-based CPT advisors and non-physician laboratory groups to work together to optimize the laboratory sections of the code set.
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, durable medical goods and other services. These include Pap tests and, more recently, colorectal cancer, diabetes and cholesterol screening. These are alphanumeric codes that are five units long. For screening Paps, conventional, use the P30xx series, and for liquidbased and automated Paps, use G01xx series.

CPT Modifiers.
For pathology, the use of CPT modifiers is essential for Medicare billing and for some other payers in certain situations. These modifiers indicate special circumstances which apply to a procedure and its code and allow for the codes to bypass edits for non-payment.

Laboratory/Pathology service modifiers include:
- -TC Technical Component
- -25 Separate E and M service (with FNA)
- -26 Professional Component
- -59 Distinct and separate Procedure
- -90 Reference Laboratory Test
- -91 Repeat Clinical Diagnostic Lab Test

Most commonly used modifiers to meet lab/path NCCI and MUE edits (see below) are -59 for anatomic services and -91 for CLFS services. 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. Modifier -25 is required to bypass edits which prohibit payment of a procedure at the same time an evaluation and management code is billed to the same patient, most frequently seen in Pathology, when an FNA is billed simultaneously with a consultation code.

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) 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-CM as the coding system physicians must use, although it is slated to be replaced by ICD-10-CM in 2010. 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), 76.49 (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). V72.31 and V72.32 (routine annual exam, usual and high risk) are also acceptable screening codes.

The 795.xxx series identifies abnormalities on Pap that identify the specimen as a medical or diagnostic pap, not a screening pap.

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. 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 diagnostic paps are in Table 2.

National Correct Coding Initiative
Created by CMS in 1996, NCCI was originally instituted to “correct billing errors, typographical and unintentionally erroneous claims” under the premise that regardless of the number of methodologies used to arrive at the final diagnosis on one specimen, Medicare will pay only for one. This process bypasses CPT and RUC coding and payments rules and in actuality constitutes payment policy. All claims submitted to Medicare are processed against these edits. These are code pairs that are not normally or never recognized as a separate service when performed by the same provider on the same patient for the same site or specimen for the same date of service. These claims are of two types: Comprehensive/ component (also known as Column 1/Column 2 edits) and mutually exclusive codes. These edits are updated on a quarterly basis – (January 1, etc), downloadable at:
www.cms.hhs.gov/NationalCorrectCodiNitEd/01overview.asp Choose Column 1/Column 2 Edits (ccigrp10.xls) and Mutual Exclusive Edits (ccimeg09.xls).

The edits are in the form of tables with relevant CPT codes, the effective date, the date of deletion (as applicable) and whether a modifier is allowed (1), not allowed (0) or not applicable (9). Modifier -59 is the appropriate modifier, as noted above, to bypass the edits for payment for surgical and cytopathology codes with -91 used for tests on the Clinical Laboratory Fee Schedule. These modifiers should not be used merely to ensure payment but to identify the payment as legitimate on a separate procedure or specimen.
Example of NCCI Edit Table-Col 1/Col 2

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>*- In Existence prior to</th>
<th>Effective Date</th>
<th>Deletion Date *=no data</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>88141</td>
<td>G0124</td>
<td></td>
<td>20000605</td>
<td></td>
<td>0</td>
</tr>
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<td>88142</td>
<td>88108</td>
<td></td>
<td>19980401</td>
<td>*</td>
<td>1</td>
</tr>
<tr>
<td>88173</td>
<td>88333</td>
<td></td>
<td>20060101</td>
<td>*</td>
<td>1</td>
</tr>
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<td></td>
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<td></td>
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<td>88346</td>
<td></td>
<td>20030701</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

Medically Unlikely Edits (MUE)

Like NCCI, MUE is payment policy and never underwent the rigor of review within the national rule-making process. These edits were originally conceived to prevent unintentional and erroneous submission of billing “unbelievable” numbers of units per claim, but were subsequently modified to limit what was considered to be an excessive number of units of service. These edits limit units of same code per beneficiary, on the same date of service by the same provider. Initiated 1-1-07, these edits were released quarterly allowing 6 weeks for comment prior to institution. Utilizing these edits, Medicare checks each claim against the MUE on one line with denial of the full claim if MUE exceeded. The provider is to correct “typographical error and resubmit”. Modifiers (-59, -91) can allow claims to appear on separate lines and bypass edits. The problems with this policy include:

- Lack of definition of “medically unlikely” other than “rare”
- Lack of transparency of process in development
- Absence of consistent rationale, criteria and methodology for limits (other than many appear to be derived from LCDs or Local Coverage Decisions).
• Inconsistency with verbiage of codes; e.g Codes, designated as “each probe”; with MUE of 1!
• Lack of operational transparency with lack of disclosure of edit limits to providers refusing to make the edits public citing: “…unscrupulous providers may always bill at the MUE allowed level”

The major problem with MUE’s is the inability to know when to use a modifier for a code to override the edit since providers are not informed of the MUE limit for most codes.

Effective in 2009, based on negotiation with CAP and other societies, CMS decided to publish a number of the codes with lower limits. Included are a few cytology codes:

### Medically Unlikely Edits

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>88108</td>
<td>Cytopathology, concentration technique, smears &amp; interpretation</td>
<td>Confidential</td>
</tr>
<tr>
<td>88112</td>
<td>Cytopathology, selective cellular enhancement technique</td>
<td>Confidential</td>
</tr>
<tr>
<td>88172</td>
<td>Cytopathology, evaluation of fine needle aspirate; immediate...for adequacy</td>
<td>Published</td>
</tr>
<tr>
<td>88173</td>
<td>Cytopathology, evaluation of fine needle aspirate, interpretation and report</td>
<td>Published</td>
</tr>
<tr>
<td>88160</td>
<td>Cytopathology, smears any source, screening, and interpretation</td>
<td>Published</td>
</tr>
<tr>
<td>88162</td>
<td>Cytopathology, smears any source, prep., screening, and interpretation</td>
<td>Published</td>
</tr>
<tr>
<td>88162</td>
<td>Cytopathology, smears any source, extended study, screening, and interpretation</td>
<td>Published</td>
</tr>
</tbody>
</table>

### General 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 and for screening Paps, use HCPCS. 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 is necessary to contact the clinician’s office. Use of archival laboratory results on a patient is not acceptable in lieu of this information.
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) 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 screening Pap has findings that prompt pathologist review, subsequently found to be abnormal. 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 most commonly used and is appended to the code to indicate that the beneficiary was given notice and the service may be denied based on frequency limits. The CPT code for hormonal assessment is an add-on codes and at present can be billed only when a simultaneous screening code is billed. Until recently, the interpretation codes were also add on codes, but this was changed in 2007, billable without a simultaneous screening code. 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
- 88172–88173 for fine-needle aspiration specimens
- 88333-88334 for intra-operative cytology

In contradistinction to the primary surgical codes in which the specimen type defines the code, in nongyn cytology the overall type of preparation for the 88104 family 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 usual washings, brushings, body fluids, FNA, or lower gyn tract. Sputums prepared as smears are coded with this family as are other direct smears—for example, Tzanck preps. 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.

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 as limited by the MUE at present. 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. Because of the MUE limit of 3 (one per site), if more than that number of immediate assessments are performed, the first three must be billed on one line, with the others (up to 3) billed on the next line with a -59 modifier for a maximum of 6 for 3 sites.

Effective in 2006 two new codes were approved for immediate cytologic evaluations, replacing 88329 and 88161 for intra-procedural cytology. 88333 [(Pathology consultation during surgery…cytologic examination (eg squash prep, touch prep), initial site] and 88334 [Pathology consultation during surgery…cytologic examination (eg squash prep, touch prep), each additional site] are added to to 88329 family of codes. The use of these codes is not limited to intraoperative situations and may be applicable to any cytologic immediate evaluation on tissue requiring immediate evaluation, eg. CT guided core biopsy of liver mass or bronchial brushings. In the example of the latter, these codes are billable only if performed intra-procedurally and medically necessary to determine the necessity for additional sampling or performance of additional procedures.

88333 is intended only for the initial cytologic preparation of a specimen with each additional site codable as 88334. The 88334 is analogous to the 88332 for additional frozen blocks. In the event that both frozen section(s) and touch prep(s) are evaluated on the same specimen, bill the initial/additional frozen section(s), then code the touch preps as 88334, not 88333, since the portion of the touch prep service which is subsumed as gross examination is already included in the 88331 code.

As noted above 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.