An insurer is looking for a code or codes that tell them ‘why’ this test was ordered in the first place and ‘why’ they should pay for the testing that was done. ICD-9 codes answer this question.

Understanding the basics of billing and coding of non-gynecologic cytology is not a “hot” topic but an essential building block to becoming an expert cytologist.

As more and more laboratories are becoming centered in non-gynecologic cytology, an understanding of this topic is becoming increasingly important.

So let’s break down the basics. Think of billing and coding in terms of ‘why’ and ‘how’ a test is ordered and billed. International Classification of Diseases (ICD-9) Codes are alphanumeric codes that provide an answer to ‘why’ a test is being ordered. Procedural codes, communicated through Current Procedural Terminology (CPT), answer the ‘how’ a test was done.

ICD-9 codes provide a common language for medical professionals to determine the medical necessity of a procedure billed to an insurer. ICD-9 codes are housed in three volumes. The first two volumes are used primarily for anyone billing for outpatient services and are distributed by the National Center for Health Statistics, a branch of the Centers for Disease Control (CDC). For non-gynecologic cytology, the ICD-9 codes are provided by the clinician ordering the test as well as the pathologist who interprets the specimen. Clinicians can provide a narrative diagnosis that will then be interpreted into a numeric ICD-9 code by the laboratory. Unlike gynecologic cytology, where the ICD-9 code is solely provided by the clinician, non-gynecologic cytology ICD-9 codes are also rendered based on the pathologic diagnosis.

An insurer is looking for a code or codes that tell them ‘why’ this test was ordered in the first place and ‘why’ they should pay for the testing that was done. ICD-9 codes answer this question. This is easily illustrated using a urine sample that is sent to the cytology lab for analysis. ‘Why’ was the sample sent? A clinician can provide the answer to this question via an ICD-9 code such as 599.7, or simply by indicating that the patient has hematuria on the order. If the clinician only provides the word hematuria, the laboratory must supply the correct ICD-9 code of 599.7. Once a sample is processed and interpreted by a pathologist, additional ICD-9 codes may be entered for a sample to further, more specifically, justify the need for testing. In the same example, the patient comes in with an ICD-9 code of 599.7 for hematuria, but after interpretation, the pathologist provides a diagnosis of 188.9, malignant neoplasm of the bladder, part unspecified. The ICD-9 code that provides the most specific explanation as to ‘why’ a test is performed is the code that should ultimately be reported out. Had the pathologist deemed the urine sample to be negative for malignant cells, the ICD-9 code of 599.7, for hematuria, would have been reported out.

Once an adequate ICD-9 code is provided indicating ‘why’ a specimen should be processed, the cytology lab processes it. Now we move to the codes that describe ‘how’ a non-gynecologic sample is processed to get to a point of diagnosis. CPT codes

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**Teaching Tool #1**

**Pleural Fluid arrives in the lab and the cytotechnologist prepares one (1) ThinPrep, two (2) Cytospins and one (1) cell block.**

**Applicable CPT codes?**

- 88108 (cytospin)
- 88112 (ThinPrep)
- 88305 (cell block)

**However, only one concentrated method can be billed so proper coding will be 88112 and 88305 only.**

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Basically non-gynecologic CPT codes are assigned to samples based on the preparation methods for each sample. These five-digit codes alone can tell an insurer exactly what was done to prepare a sample. Non FNA non-gynecologic samples have specific procedure codes that denote preparation of the sample.

Returning to the urine previously discussed: had the urine come into the lab described as cloudy, clotted golden fluid, likely an enriched or concentrated preparation (ThinPrep,) and a cell block would have been prepared. The CPT codes applied to this case would be 88112 and 88305. A CPT code exists for every type of preparation. For example, if a lab makes a ThinPrep, cytospin, direct smear and cell block on a fluid sample, there are codes for each of those preparations (88112, 88108, 88104 and 88305 respectively). However, that does not mean that each preparation gets billed.

Medicare-CPT rules dictate that when prepared together, only the ThinPrep and the cell block can be billed from the previous scenario. The ThinPrep (88112) and cytospin (888108) are both concentration methods and only one is billed, 88112. Additionally, in the presence of concentration methods and a smear, the smear (88104) is deemed medically unnecessary and should not be billed.

CPT code 88305 (cell block) has been making a lot of news in recent months, due to the health care reform act empowering CMS to revalue reimbursement for high value codes for all specialties. That being stated, reimbursement for 88305 was cut by 52 percent. This appears to be the first of many codes that will be revalued in the next few years.

Fine needle aspiration (FNA) specimens follow a slightly different set of CPT coding rules. Procedure codes for FNAs describe how the samples were collected and evaluated rather than how they were prepared. Extraction codes describe how the sample was obtained, whether by a pathologist via image guidance or without image guidance (10021 and 10022). Examination codes are applied depending on whether a pathologist renders an adequacy assessment on-site. All FNA samples that are interpreted and have a report issued get coded with 88173. This code encompasses all basic preparation methods. Cell block, special stain and immunohistochemical stain codes are added. If a ThinPrep and a cell block are made on a FNA sample, only the 88305 is billed with the interpretation code of 88173. If a cell block is made from an FNA and immunohistochemical stains are ordered, 88305 and 88342 can additionally be applied.
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On-site evaluation of FNA samples employs the use of immediate study codes 88172 and 88177, which follow their own set of rules. The immediate study codes are used when a pathologist goes onsite to evaluate the adequacy of an FNA sample. The initial evaluation code 88172 is applied to the first evaluation episode. If the first evaluation episode fails to be adequate, 88177 is applied for each additional evaluation episode until adequacy is reached. These codes should only be used if the pathologist determines adequacy of the sample. They should not be used if a cytotechnologist alone performs the adequacy assessment.

Those are the basics. CPT and ICD-9 codes systems are two languages that work together to provide insurers with the information they need to justify payment for testing. Understanding these “languages” is the key to understanding billing and coding.

Helpful Resources:
Cytology Diagnostic Principles and Clinical Correlates. E. Cibas and B. Ducatman, Chapter 17. Laboratory Management.
http://www.cap.org/apps/cap.portal

The Progressive Evaluation of Competency (PEC) program is offered to pathology residents and cytopathology fellows, through Program Directors who are current ASC Members. PEC is designed to track the progress of these professionals through the year and gauge their overall competency as they begin their careers in cytopathology. Also, PEC helps fulfill requirements of ACGME for training programs’ evaluation of residents and fellows during training and before issuing a completion certificate. The ASC is excited to help the future of cytopathology by providing this comprehensive program to ready the next generation of Cytopathology professionals.

New in the program is the successful implementation of descriptors to aid Program Directors in the education of their fellows. If you are interested in submitting a question to be considered for future PEC exams, please contact the ASC National Office at asc@cytopathology.org.

PEC for Cytopathology Fellows
PEC for fellows Mid-exam ended February 4, 2013 and the results are in:

PEC Comprehensive Results

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125 registered for pre-exam
106 took pre-exam
128 registered for mid-exam
116 took mid-exam

The Final-Exam is scheduled for May 6, 2013 – May 20, 2013

PEC for Pathology Residents
For the 2012-2013 Series, PEC for Residents Exams will be open 24 hours a day, 7 days a week beginning July 1, 2012 and ending June 30, 2013. This availability should accommodate all Programs and the various cytology rotation times.

PEC for Senior Residents
Offered to senior residents and/or Residency Program Directors, the PEC for Senior Residents is a preparation tool for the Anatomic Pathology Board exam. The exam is designed as a self-assessment test to assist senior residents in identifying areas of strength, weakness and/or improvement. PEC for Senior Residents is offered in online format and provides a single, 100-question exam, which is open the same exam periods as the PEC for Fellows Mid-Exam and Final Exam dates. Exam results are retuned immediately upon completion of the exam for printing and self-review or with the Program Director. Visit the ASC Web site for purchase information.