Solving the Cytology Coding Puzzle

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Conference Objectives

- Learn how to appropriately code cervical/vaginal (Pap) Tests and associated ancillary testing.
- Learn how to appropriately code nongynecologic cytopathology tests and associated ancillary tests.
- Learn how to appropriately code fine needle aspiration cytopathology and associated tests.
- Learn how to appropriately code needle core biopsy cytopathology and associated tests.
References:

Questions to consider:

- Can a non-medical person read and understand the report?
- Can a coder find the key words and codes to enable correct billing?
- Is there a distinct section in the report to address each distinct code?
- Are the types of specimen preparations stated with clarity in the report?
Pap Tests:

- No global CPT code for Paps
  - Pathologist service - 88141
  - Cytotechnologist service - multiple possible codes (treated as clinical laboratory test)
  - Medicare payment sensitive to correct ICD-9 code and accurate CPT versus HCPCS Level II code
  - Unsatisfactory Paps should be billed
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<th>Categories of Pap Tests</th>
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<td><strong>Routine Screening Pap</strong></td>
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<td>- Absence of sign, symptom or history indicative of unusual risk for cervical/vaginal cancer</td>
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<td>- Medicare coverage every 2 years</td>
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<td>- ABN necessary</td>
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<td>- ICD-9 codes: V76.2, V72.31, V76.47, V76.49</td>
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<td>- History must be consistent</td>
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Categories of Pap Tests

- **High-Risk Screening Pap**
  - Women of childbearing age
    - Exam abnormality during preceding 3 years indicative of cervical/vaginal abnormality/cancer
    - High-Risk criteria met (below)
  - All other women – High-Risk Criteria
    - Sexual activity of early onset (< 16 years of age)
    - Multiple sexual partners (5+)
    - History of sexually transmitted disease
    - Less than 3 negative Paps in preceding 7 years
    - DES exposure
High-Risk Screening Paps

- Medicare coverage – 1x/11 months
- Need High-Risk ICD-9 code (ie V15.89) and add ICD-9 pathology diagnosis if established
- Requisition must contain patient history and/or current sign/symptom to support high-risk classification
- Some labs require ABN on all Medicare Paps to ensure payment (modifier GA utilized)
Categories of Pap Tests

Diagnostic Pap Tests:

- Includes patients with current abnormal findings, prior abnormal Pap, prior cervical/vaginal/uterine cancer, patient complaint of reproductive system, current sign/symptom of gynecologic disorder
- No frequency limits (no ABN necessary)
- Need ICD-9 to support medical necessity (numerous codes)
- Always use CPT codes (no HCPCS codes)
Pap Tests – No global codes

- Often a screening test with no pathologist report
- Typically 12% or less require physician intervention
- Physician service – 88141
- What Paps are eligible?
  - screener suspects an abnormality
  - do not include QC
  - may be signed out as WNL by pathologist
Pap Test Screening CPT Technical Codes

- Conventional Pap without Bethesda
  - 88150, 88152, 88153, 88154

- Conventional Pap with Bethesda
  - **88164** - manual screening
  - 88165 - manual screening and rescreening (not QC)
  - 88166 - manual screening and computer assisted rescreening
  - 88167 – manual screening and computer assisted rescreening using cell selection

- Thin layer Pap – manual
  - **88142**, 88143

- Primary automated screening – FDA approved
  - Conventional - 88147, 88148
  - Thin layer - **88174, 88175, 8817552 (rejected by automated screener)**
Medicare Coding Rules – HCPCS Codes

- Diagnostic Medicare Paps use CPT (not HCPCS)
- Screening Medicare Paps
  - Physician Interpretation
    - 88141 changed to **P3001** – conventional Pap
    - 88141 changed to **G0124** – Thin layer
    - 88141 changed to **G0141** – primary auto screen
  - Technical Component
    - 88164 changed to **P3000**
    - 88142 changed to **G0123**
    - 88174 changed to **G0144**
    - 88175 changed to **G0145**
    - 88147 changed to **G0147**
    - 88148 changed to **G0148**
Modifiers

ABN on file:
- GA: Lab may or may not know if Pap is before allowed time interval

ABN not on file:
- GY: Lab is aware that patient had a Pap before allowed time interval
- GZ: Lab is unsure about allowed time interval – 7/11 – denial will result
Should patients be billed for “inadequate/insufficient” Paps?

- If due to broken/irreparable slide, patient information problem - no charge
- If due to clinical reason – CPT code reported with ICD-9 795.08 and charged
- 795.08: unsatisfactory cervical/vaginal cytology smear
Diagnostic Endocervical Brushings and Anal Pap Tests

- Fall into category of nongynecologic cytopathology and billed accordingly
- Cell blocks – when utilized bill 88305
Nongynecological Cytology

- Focus on specimen preparation, screening and interpretation
- No procurement codes – no procurement by pathologists
- Rare intraoperative consultation and/or rapid assessment
- Generally coded by method of preparation rather than specimen type
Nongynecological CPT Codes

- **Direct smear preparation - 88104**
  - Number of slides is not relevant
  - Includes multiple routine stains (Papanicolaou and Giemsa)

- **Concentrated smear preparation – 88108**
  - Includes multiple routine stains (Papanicolaou and Giemsa)
  - Number of slides is not relevant

- **Enriched/Concentrated smear preparation – 88112**
  - Fluid, washing, endocervical or other brushing, anal-rectal cytology
  - Includes multiple routine stains (Papanicolaou and Giemsa)
  - Number of slides is not relevant
Other Source Preparations

- Sputum direct smear – 88160 (staining outside lab)/88161 (staining performed by lab) and > 5 slides or more than one routine stain = 88162
- Nipple Discharge direct smear – 88160/88161 and >5 slides or more than one routine stain = 88162
- Tzanck direct smear – 87207/8720726 (pathologist) for inclusion bodies or etiology of inclusions 88160/88161
- Anal-rectal cytology – 88160/88161 and > 5 slides or more than one routine stain = 88162
- Ascites Fluid Direct Smears - 88160/88161 and > 5 slides or more than one routine stain = 88162
Filter Preparations

- Filter Preparation – 88106
- Direct Smears + Filter bundled as 88107 – Deleted – report either 88104 or 88106
Touch Preparations

- Intra-operative – Touch preparation (or squash preparation 88333 (initial site) and 88334 (each additional site))
- Must be immediate interpretations that alter course of action (additional passes)
- Must document in report – “Rapid Interpretation” (separate report section helpful)
Adjunct/Ancillary Tests

- **Cell Block – 88305**
  - Additional preparation must be documented in report including evidence that it was considered in the diagnosis
  - One unit of 88305/cytology specimen allowed (even if more than one cell block prepared)
Adjunct/Ancillary Tests

- Histologic special stain for microorganisms: 88312
- Histologic special stain other than for microorganisms: 88313
- Immunoperoxidase Stain: 88342 (88343) and G0461 (G0462)
  - (cannot bill with flow cytometry (88184-88189) unless one method is nondiagnostic)
Medicare versus Non-Medicare

- Non-Medicare - Report and bill for each preparation type
  - Direct smears 88104
  - Cytospins 88108
  - Selective cellular enhancement technique 88112
  - 88108 cannot be billed with 88112
  - Cannot use 88162 even if 12 slides are prepared from a bronchial brushing
Medicare versus Non-Medicare

Medicare – additional restrictions

- Cannot bill 88112 with 88104
- Cannot bill 88112 with 88108
- Cannot bill 88104 with 88108

Choose highest paying code (88112 > 88108 > 88104)

Note: 88112 payment reduction in 2014
Global Billing Permitted

- Modifier 26 added to physician fee schedule if professional component is billed separately from technical component.
- Modifier TC added to facility technical fee if billed separately from professional component (except for hospitals billing inpatients or registered outpatients).
- Modifier 59 – separate procedure.
- Modifier GC added when Medicare part B billed by faculty group.
Don’t . . .

- bill 88104 with 88173 (FNA)
- bill 88108 with 88112
- bill 88160 - 88162 with 88304 – 88309
- bill 88108/88112 with 88184 (flow cytometry)
- set up the charge capture based on specimen type since the complete charge code(s) cannot be predicted in advance
Do . . .

- Clearly distinguish between separate specimens received on the same day for a patient (from gross description to final diagnosis).
- Report must unequivocally declare method by which each specimen is prepared for screening and interpretation.
- Report must clearly demonstrate that multiple preparations were developed and considered in the diagnosis when appropriate to facts of the case.
Breast Cyst Aspirate?

- Generally classified as a NonGyn rather than as an FNA
- If called “breast cyst fine needle aspirate” by clinician bill as FNA
Fine Needle Aspiration (FNA) Cytology

- FNA = surgical procedure
- Image-guidance versus non image guidance
- No bill for anesthesia administration
- Neither immediate study or final interpretation is part of the surgery package
- Cannot use surgical assistant modifiers
- Teaching physician must be “physically present” to bill – use GC modifier
Pathologist performs FNA

- Procedure note should appear in pathology report (documentation for auditor)
- 10021 = FNA without imaging guidance
- 10022 = FNA with imaging guidance
- Codes are in General Surgery section of handbook
- Imaging = ultrasound, CT scan or another radiologic device
10021/10022 = Global Services

- Do not use modifiers 26 or TC
- No mechanism exists to split a designated global service into a professional/technical components
- If resident performs FNA without staff pathologist – facility entitled to bill appropriate surgical code on UB-04 claim
- Unsatisfactory Sample – pathologist still bills if FNA performed provided a medical report is issued
Unit of Service

- Billing units per separate site does not equal number of passes/aspirates
- Preparation of unstained smears from the aspirate is part of the surgical procedure
- Techs sent to prepare smears cannot charge
- Cost of staining smears is part of 88172/88173
- Diagnostic procedures not bundled with surgical procedure
Diagnostic FNA Procedure Codes

- **88172**: Immediate assessment charge
  - Cannot use for Non-gyn (use 59 modifier if separate specimens are collected – ie bronchial wash and Wang FNA)
  - Use separate report section – such as “Rapid Interpretation” when formal intraoperative immediate study is conducted

- **88177**: additional evaluation episodes
  - Use for multiple additional immediate studies with all interpretations recorded for documentation

- Medical necessity: When adequate specimen is obtained, no additional 88177 charges should occur
Exceptions

- Report one 88172 per lesion when FNA is performed by pathologist with rapid evaluation (in conjunction with 10021 or 10022 codes – do not use 88177)
- Report one 88172/88177 code per batch of slides reviewed (record an interpretation for each charge)
Example

- Rapid Interpretations:
  - A. Liver, Fine Needle Aspiration:
    Pass 1: Nondiagnostic.
    Pass 2: Positive for malignant cells.
  - B. Peripancreatic Lymph Node:
    Pass 3: Nondiagnostic.
    Passes 4-5: Positive for malignant cells.
Answer

- $88172 \times 2$ and $88177 \times 2$
Do not . . .

- Use 88172 when lab drops everything at once to quickly process specimen in typical routine manner.
- Code additionally if final diagnosis rather than adequacy is rendered immediately.
- Require cytotechnologist to be present in order to bill charge.
- Use 88172/88177 for non-FNA specimens.
88173 – Primary Preparation Interpretation Service

- Cytopathology, evaluation of fine needle aspirate; interpretation and report
- Report only with FNA specimens – make sure FNA is mentioned in the report
- Do not report with core biopsy specimens
- FNA can be performed anywhere and by any type of physician
- Does not include thoracentesis, puncture aspiration/does include Wang FNA
When not to report 88173

- Core biopsy specimens
- Completely acellular specimens (do use on scant cellular specimens)
- Do not add on or use extended study code 88162 if an unusually large number of slides are prepared
Global versus separately charged 88173

- Can bill with global charge
- Can bill separately with 26 and TC modifiers
- Number of 88173 charges should equal number of 10021/10022 charges (charge per site)
- pass = aspirate but does not = specimen
88173 for all Types of FNA Preps

- If aspirate into liquid-based vial and ThinPrep/SurePath prepared = 88173
- Do not add on or use extended study code 88162 if an unusually large number of slides is prepared
- Use 88173 if sample is made into a cytospin
- Don’t use 88173 with 88108 or 88112 on Medicare patients (others may reimburse)
- Never use 88173 with 88321 unless separate specimens with 59 modifier
Ancillary (Add-On) Services

- Can bill for cell block (88305) with fine needle aspirate (88173)
- Can bill 88312 (microorganisms) and 88313 (other than for microorganisms) for special stains
- Can bill 88342 for additional immunohistochemical stains
FNA versus Core Biopsy

- For core biopsy rapid interpretation bill 88333/88334/permenant tissue evaluation bill 88305/88307
- In combination cases – report all specimens clearly and use the 59 modifier to bypass the edit
Example

- FNA - 2 passes performed on lung mass for 2 immediate interpretations. Two subsequent core biopsies performed with 2 immediate touch preparation interpretations for adequacy. Cores submitted for histologic evaluation and cell block prepared from FNA.

- What should be billed?
Answer

- **FNA:**
  - 88172
  - 88177
  - 88173
  - 88305

- **Core Biopsy**
  - 8833359
  - (8833459)
  - 88305
Additional Notes:

- Evaluation/Management Consultation Adjunct Service
  - Clinician writes order for pathologist to perform FNA Evaluation and Consultation
  - Pathologist must obtain relevant patient history, conduct pertinent physical exam and review lab/radiologic test results and document
  - Report must include clinical conclusion and treatment suggestion – Consultation Summary
CPT Codes for E/M Consultation

- 99241 – typically 15 minutes, non-inpatient
- 99242 – typically 30 minutes, non-inpatient
- 99243 – typically 40 minutes, non-inpatient
- 99244 – typically 60 minutes, non-inpatient
- 99245 – typically 80 minutes, non-inpatient
- 99251 – 20 minutes or less, inpatient
- 99252 – 21-40 minutes, inpatient
- 99253 – 41-55 minutes, inpatient
Outside Consultations

- Slides received and reviewed – 88321
- Block received and immunohistochemical stains performed – add 88342/stain
- Slides received and reviewed and cell block recut at your lab for additional routine-stained slides = 88323
Molecular Pathology

“Stacking codes (83890-83914) obsolete and replaced with Tier 1, Tier 2 or HLA codes effective Jan 1, 2013

- Tier 1 – frequently performed
- Tier 2 – less frequently performed

Unlisted molecular test – 81479
Molecular Pathology

- 81161-81479 - Clinical Lab Fee Schedule Codes
- Pathologist interpretation – HCPCS Level II code G0452 with modifier 26 (G045226 replaces 8391226)
  - must be ordered by patient’s physician
  - a written interpretative report must be released by pathologist (MD/DO)
Molecular Pathology

- All analyses are qualitative unless otherwise noted
- ISH – 88271-88275 and 88365-88368
- Can bill 2 units of a particular code when 2 different specimens are tested
Molecular Pathology

- 88380/88381 - additional charge allowable for microdissection
- 88363 - additional charge allowable for tumor cell identification in archival tissue
2014 Immunohistochemistry

88342 – Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide

88343 – each additional separately identifiable antibody per slide
2014 Immunohistochemistry

- G0461 - Immunohistochemistry or immunocytochemistry, per specimen; first single or multiplex antibody stain
- G0462 – each additional single or multiplex antibody stain