The Coding Institute

AVOID AUDITS . IMPROVE REIMBURSEMENT . REDUCE DENIALS . INCREASE REVENUE

Pathology/Lab Coding Alert

Your practical adviser for ethically optimizing coding, payment, and efficiency in pathology practices and clinical laboratories

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CCI 19.0

Additional Bundles Target New CPT® 2013 Codes

Add hundreds of pairs to your 'restricted list.'

Each year brings new, revised, and deleted CPT® codes that you have to learn to keep your lab's pay on the up and up. And hot on the heels of code changes are Medicare's Correct Coding Initiative (CCI) first quarter changes — many of which involve the CPT® code changes.

CCI 19.0, which took effect on January 1, 2013, adds 37,587 new bundles and deletes 16, 716. Read on to find out which CCI changes might affect your lab and pathology coding.

Steer Clear of MoPath with FISH, Molecular Cytogenetics

If your lab bills for any of the Tier 1 (81200-81355) or Tier 2 (81400-81408) molecular pathology codes, you'll need to make sure you don't bill the codes with any of the following codes for the same specimen:

» 88271-88275 — *Molecular cytogenetics ….*
» 88365 — *In situ hybridization (e.g., FISH), each probe*
» 88367-88368 — *Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe ….*

CCI 19.0 lists these edit pairs with a "1" modifier indicator. "That means you can bill a molecular pathology test and a molecular cytogenetics or FISH test together for the same patient on the same day if your lab performs separate analyses on distinct specimen sources," says **William Dettwyler, MTAMT,** president of Codus Medicus, a laboratory coding consulting firm in Salem, Ore.

Pick one variant group: CCI 19.0 also bundles many molecular pathology codes for the same gene, different variants. For example, you can't report together 81202 (*APC [adenomatous polyposis coli] [e.g., familial adenomatosis polyposis (FAP), attenuated FAP] gene analysis; known familial variants*) and 81203 (*… duplication/deletion variants*).

Most of these CCI "variant bundles" are listed with a "0" modifier indicator. "That means you can't override the edit pairs under any circumstances," Dettwyler says.

More Tier 2 bundles: CCI 19.0 also creates many more edit pairs, with each of the Tier 2 codes (81400-81408) listed as column 2 codes with culture typing (87140-87158, *Culture, typing …*) and codes for infectious agent identification by nucleic acid (87470-87801).

Pick One HLA Tissue Typing Method

CCI 19.0 dishes up plenty of new edit pairs for human leukocyte antigen (HLA) tissue typing codes.

First: More than 75 new edit pairs bar you from reporting any HLA Class I and/or Class II typing by molecular methods (81370-81383) with any other code from the same range — or with any code from the range 86812-86817 (*HLA typing …*) for Class I or Class II antigens (*A, B, C, DR/DQ*). In other words, select just one code that accurately describes the method and HLA antigen(s) tested; don't report multiple HLA tissue typing codes for a single test.

ICD-10

277.0 to E84 Scrambles Cystic Fibrosis Codes

Prepare to change Dx coding for CF screening.

If you're reporting the screening diagnosis — or the results — when your lab runs molecular tests for cystic fibrosis (CF) such as 81220 (*CFTR [cystic fibrosis transmembrane conductance regulator] [e.g., cystic fibrosis] gene analysis; common variants [e.g., ACMG/ACOG guidelines]*), you have some changes coming.

When ICD-10 goes into effect Oct. 1, 2014, you'll no longer use the following codes:

» V77.6 — *Screening for cystic fibrosis*
» V83.81 — *Cystic fibrosis gene carrier*

Instead, you should report the screening order and the carrier status as follows:

» Z13.228 — *Encounter for screening for other metabolic disorders*
» Z14.1 — *Cystic fibrosis carrier*

Change Focus for CF manifestations

ICD-9 uses the fifth digit to define symptoms associated with a patient's CF diagnosis, as follows:

» 277.00 — *Cystic fibrosis without meconium ileus*
» 277.01 — *... with meconium ileus*
» 277.02 — *... with pulmonary manifestations*
» 277.03 — *... with gastrointestinal manifestations*
» 277.09 — *... with other manifestations*

But ICD-10 changes the hierarchy, categorizing CF based on pulmonary, intestinal, or other manifestations, as follows

» E84.0 — *Cystic fibrosis with pulmonary manifestations*
» E84.1 — *Cystic fibrosis with intestinal manifestations*
  o E84.11 — *Meconium ileus in cystic fibrosis*
  o E84.19 — *Cystic fibrosis with other intestinal manifestations*

» E84.8 — *Cystic fibrosis with other manifestations*
» E84.9 — *Cystic fibrosis, unspecified*

Remember: You must report the fifth digit for E84.1_. ❑

Second: CPT® 2013 adds eight new codes for HLA Class I and/or Class II tissue typing: 86828-86834 (*Antibody to human leukocyte antigens [HLA], solid phase assays [e.g., microspheres or beads, ELISA, flow cytometry] …*). CCI 19.0 adds 60 new edit pairs to keep you from reporting these codes together (you should pick just one), and to restrict reporting an HLA typing code in addition to codes for the lab method (such as flow cytometry). That means bundling the new codes with method codes 88184-88189 (*Flow cytometry …*) and 86807-86808 (*Serum screening for cytotoxic percent reactive antibody [PRA]…*).

Watch modifier: You'll find modifier indicator "0" for most edit pairs that restrict you to "pick one" code for the HLA tissue typing test, meaning that you can't unbundle the codes. However, most of the new edit pairs for HLA typing with "method" codes show a modifier indicator of "1," meaning that you can override the edit pair if you're performing two tests on separate specimens.

Don't Bill Components With MAAAs

You read last month how CPT® and CMS give different instructions for reporting multi-analyte assays with algorithmic analyses (MAAAs) (*Pathology/Lab Coding Alert* Vol 14 No. 2 "Maneuver CPT® and CMS Instructions' Split Decision for MAAA Coding"). Now CCI 19.0 weighs in on the issue.

Background: MAAAs are procedures that use results of various assays to perform an algorithmic analysis and report a "score" or similar numeric indicator for diagnostic or prognostic purposes.

You'll find nearly 30 new edit pairs for MAAA codes 81500-81512 in CCI 19.0. Each edit pair bundles the MAAA code with a component assay.

For instance: CCI bundles 81500 (*Oncology [ovarian], biochemical assays of two proteins [CA-125 and HE4], utilizing serum, with menopausal status, algorithm reported as a risk score*) with 86304 (*Immunoassay for tumor antigen, quantitative; CA 125*) and 86305 (*Human epididymis protein 4 [HE4]*).

"It's interesting that CCI 19.0 creates edit pairs for the MAAA codes in light of the fact that CMS doesn't not recognize the codes for payment," Dettwyler observes.

Other Cells Out with CTC

New CPT® 2013 codes for circulating tumor cells (CTC) 86152 (*Cell enumeration using immunologic selection and identification in fluid specimen [e.g., circulating tumor cells in blood]*) and 86153 (*... physician interpretation and report, when required*) are the focus of nearly 40 new CCI edit pairs.

CCI 19.0 bundles 86152 and 86153 . as column 1 codes, with other immunology codes for cell identification as column 2 codes — 86255-86256 (*Fluorescent noninfectious agent*

antibody …) and codes for B cells, NK cells, stem cells, T cells, and unspecified cell antigens (86355-86357).

The edit list also bundles 86152 and 86153 in column 1 with method codes in column 2, as follows:

  » 88184-88189 — *Flow cytometry …*
  » 88313 — *Special stain including interpretation and report; Group II, all other (e.g., iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry*
  » 88342 — *Immunohistochemistry (including tissue immunoperoxidase), each antibody*
  » 88346-88347 — *Immunofluorescent study, each antibody …*
  » 88358-88361 — *Morphometric analysis …*

Opportunity: If you perform any of these tests on a separate specimen on the same day as the CTC test, you can override the edit pair by using modifier 59 (*Distinct procedural service*) on the column 2 code.

Check Deletions, Too

CCI 19.0 boasts a host of code pair deletions, primarily related to deleted codes.

You'll no longer have edit pairs dealing with deleted molecular diagnostics stacking codes (83890-83914) or array codes (88384-88386).

Look ahead: In addition to the many CCI edits discussed here, other recent CCI changes will have a big impact on your lab. Stay tuned to future issues of *Pathology/Lab Coding Alert* to see how CCI *Policy Manual* changes and other CCI edits will affect your bottom line. ❑

81401: Find 32 'Camouflaged' Tier 2 Tests

Check out online AMA errata and symposium resources.

Glancing through the Tier 2 molecular pathology test lists in CPT® 2013, you might think no new tests were added under 81401 (*Molecular pathology procedure, Level 2 …*) — but you'd be wrong.

In fact, CPT® 2013 adds 31 new tests under 81401, but the new analytes don't show up in green text with "bowtie" (►◄) identifiers as they should.

Find Errata Online

The AMA has made corrections for CPT® 2013 in the online "Errata," which add green text and bowties for all 31 new analytes under 81401.

The AMA updates the corrections throughout the year, so it's smart to check it regularly. You can access it from www.ama-assn.org/go/cpt-errata, according to **Peter Hollmann, MD,** chair of the CPT® Editorial Panel in his AMA CPT® and RBRVS 2013 Annual Symposium presentation, "Moving CPT® Into the Future." Corrections are made based on review and comments from staff, panel, specialty societies, and anyone else interested in CPT®, said Hollmann.

Note other lab changes: The "Errata" also add a new molecular pathology analyte under each of two other Tier 2 molecular pathology codes 81402 (*Molecular pathology procedure, Level 3…*) and 81407 (*Molecular pathology procedure, Level 8…*). Other changes predominantly correct

misspellings, although you'll also find that the AMA removes the text note following 86891 (*Autologous blood or component, collection processing and storage; intra- or postoperative salvage*) (For physician services to autologous donors, see 99201-99204).

Peruse Symposium Notes, Too

CPT® 2013 brings more inclusive language for healthcare providers — so said speakers at the AMA's annual CPT® and RBRVS Symposium, with presenters sharing the latest news on fee schedules, new codes for 2013, and more.

If you missed the symposium, you can still get a glimpse of the presentation slides online at www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/cpt-rbrvs-symposium.page.

Qualified healthcare provider: The most widespread change in CPT® 2013 — the switch to more inclusive or provider-neutral language — shouldn't be difficult for physician practices to put into place.

"The concepts are pretty straightforward," said **Richard Duszak, Jr., M.D**., an AMA CPT® Editorial Panel member. "There's been an evolution in CPT® for how codes report services by non-physicians."

Hundreds of codes were revised for 2013 to include "provider neutral language." Codes throughout the book, such as 80 E/M codes, have replaced designations of "physician" with "individual" or "qualified health care provider."

Not for labs: None of the "provider neutral" changes appear in the Pathology and Laboratory CPT® chapter. Nor do the changes mean that non-physician lab professionals can bill pathology physician services — those billing restrictions are governed by law.

Check pathology: You can review dozens of presentation slides at the AMA site, but pathologists will find most useful the presentation, "Pathology Changes, 2013," by **Mark. S. Synovec, MD**, College of American Pathologists, and AMA CPT Editorial Panel member.

Synovec highlights CPT® 2013 changes in molecular pathology, multianalyte assays with algorithmic analyses (MAAAs), chemistry, immunology, tissue typing, microbiology, surgical pathology, and more. ❑

News You Can Use

You're Saved From 26.5 Percent Physician Pay Cut

But RVU changes still in effect.

Pathologists, along with all practitioners paid on the Medicare Physician Fee Schedule (PFS), can breathe a sigh of relief. Congress voted to halt the 26.5 percent rate cut for 2013 that was tied to the sustainable grown rate (SGR) formula.

The action freezes Medicare payment rates at the 2012 level through Dec. 31, 2013. The bill also defers the automatic 2 percent across-the-board sequestration cuts for two months. Congress fixed the new 2013 conversion factor at $34.0230.

Reactions Mixed

Although medical associations were relieved about the continuing Medicare payments for 2013, they lamented the fact that the government had not permanently fixed the problem by overhauling the sustainable growth rate (SGR) formula.

"This patch temporarily alleviates the problem, but Congress' work is not complete," said AMA president **Jeremy Lazarus** in a statement. "It has simply delayed this massive, unsustainable cut for one year. Over the next months, it must act to eliminate this ongoing problem once and for all."

"The conversion rate from 2012 will now apply to the 2013 CPT Relative values for each code," explains **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPCH, CPC-P, CPC-I, CHCC**, president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. "Please check your Medicare MAC's website and make sure it has been updated to reflect this change as of the January 1st congressional vote. Your encoder, such as Supercoder, will be reflecting this continuation of the 2012 conversion factor."

"Note that the fees from 2012 will not necessarily be the same in 2013, because the RVUs for many CPT codes have changed," Cobuzzi explains.

For instance: You'll see a 33.4 percent pay reduction for 88305 (*Level IV - Surgical pathology, gross and microscopic examination*) (global fee, non-facility) based on RVU changes. The 88305-TC payment reflects a 51.7 percent pay cut. ❑

Reader Questions

Exercise Caution With Lumpectomy Margins

Question:
The pathologist examines a specimen that the surgeon labels "breast lumpectomy." Additionally, the surgeon sends two more containers, each with a small fragment of breast tissue, one submitted as "medial margin," and the other as "deep margin," which our pathologist examines. Should we bill this as 88307 and 88305 x 2?

Pennsylvania Subscriber

Answer:
Based on the information provided, you could code this case as 88307 (*Level V - Surgical pathology, gross and microscopic examination, Breast, mastectomy, partial/simple*) and 88305 x 2 (*Level IV - Surgical pathology, gross and microscopic examination, breast, biopsy, not requiring microscopic evaluation of surgical margins*).

If the pathologist specifically documents margin exam for the separately-submitted medial margin and deep margin specimens, you could code the case as 88307 x 3.

Margin rule: You should bill the lumpectomy as a partial mastectomy (88307) whether or not the pathology report mentions a margin exam, because it is a listed specimen at that code level.

However, the code for an adjacent piece of breast tissue — effectively a biopsy or excision — depends on whether the pathologist documents a margin exam. CPT® provides two different codes for breast tissue (other than mastectomy or mammoplasty):

» 88305 — … *Breast, biopsy, not requiring microscopic evaluation of surgical margins*

You Be the Coder

Solve Dx for 'Normal Tissue' Dilemma

Question:
Our pathologist examines a portion of rib removed for thoracic outlet syndrome, but doesn't report a pathologic diagnosis. The path report states, "portion of rib, gross identification only." What code should we assign?

Ohio Subscriber

Answer: See page 23. ❑

» 88307 — … *Breast, excision of lesion, requiring microscopic evaluation of surgical margins*

Caution: A lumpectomy specimen includes the margins, so you would expect submission of a separate lumpectomy margin to be uncommon. The surgeon may take an additional margin if he sees something suspicious, or if there's some evidence (such as an intraoperative touch prep) that the additional specimen is necessary because a margin is not clear.

AMA concurs: You'll find the following documentation regarding separate breast specimens in *CPT® Assistant*, July 1999: "Based on the surgical pathology guidelines in CPT, a specimen is defined as tissue or tissues submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. Two or more such specimens from the same patient are each appropriately assigned an individual code that reflects the proper level of service. … if both breast specimens are submitted separately, and are examined and assigned a pathologic diagnosis, then it would be appropriate to report each specimen separately." ❑

Use Ordering ICD-9 for Clinical Tests

Question:
A physician orders an IFE test for a patient with protein in the urine. What CPT® and ICD-9 codes should we report if the test demonstrates lambda free light chain monoclonal protein?

         Ohio Subscriber

Answer:
You should report the test as 86335 (*Immunofixation electrophoresis; other fluids with concentration [e.g., urine, CSF]*).

Because this is a clinical lab test, you should list the ICD-9 code based on the diagnosis assigned by the referring physician: 791.0 (*Proteinuria*).

If you're billing for a pathologist interpretation of the test (86335-26, *Professional component*), you could select an ICD-9 code based on the pathologist's findings rather than the ordering diagnosis. ❑

Pick Most Extensive Respiratory Virus Code

Question:
Our lab tests a bronchial lavage specimen for respiratory viruses by multiplex amplified probe technique and identifies two influenza virus subtypes and three adenovirus subtypes. Should we report 87502 and 87631?

         Texas Subscriber

Answer:
No, you should not report together 87631 (*Infectious agent detection by nucleic acid [DNA or RNA]; respiratory virus [e.g., adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus], multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 3-5 targets*) and 87502 (*Infectious agent detection by nucleic acid [DNA or RNA]; influenza virus, for multiple types or sub-types, multiplex reverse transcription and amplified probe technique, first 2 types or sub-types*) for the same specimen.

Instead, you should report the single code that most accurately describes the test you performed, which is 87631.

New codes: CPT® 2013 adds three new codes for respiratory virus detection, distinguished by the number of type or subtype targets: 87631, 87632 (*…6-11 targets*), and 87633 (*…12-25 targets*).

These codes describe multiplex tests for any or all of the respiratory viruses. CPT® also provides separate codes for the individual virus types by similar methodology.

Principle: You should select the single, most-specific code that describes the virus and method for a single specimen and test.

Correct Coding Initiative (CCI) 19.0 confirms this principle by bundling each of the new codes (87631-87633) with the following specific respiratory virus tests.

» 87275 — … *influenza B virus*
» 87276 — … *influenza A virus*
» 87279 — …*parainfluenza virus, each type*
» 87280 — … *respiratory syncytial virus*
» 87301 — *Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; adenovirus enteric types 40/41*
» 87400 — … *influenza, A or B, each*
» 87501 — *Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, reverse transcription and amplified probe technique, each type or subtype*
» 87502 — … *influenza virus, for multiple types or sub-types, multiplex reverse transcription and amplified probe technique, first 2 types or sub-types*
» 87503 — … *influenza virus, for multiple types or sub-types, multiplex reverse transcription and amplified probe technique, each additional influenza virus type or sub-type beyond 2 (List separately in addition to code for primary procedure)*
» 87801 — *Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique*
» 87260 — *Infectious agent antigen detection by immuno-fluorescent technique; adenovirus.*

CCI assigns a modifier indicator of "0" to many of these edit pairs, meaning that you can't unbundle the codes under any circumstances. ❑

Avoid Billing "Reflex" Manual Diff

Question:
In our lab, when a CBC with automated diff is ordered and then flagged by the instrument, the CBC (85025) is credited and a hemogram (85027) and manual diff (85007) are charged. Is this correct?

Michigan Subscriber

Answer:
No, that's not correct billing, particularly for Medicare. Even if the CBC "reflexes" to a manual differential, you should bill Medicare only for the ordered test — 85025 (*Blood count; complete [CBC], automated [Hgb, Hct, RBC, WBC and platelet count] and automated differential WBC count*).

Scenario: Sometimes the physician orders a CBC plus automated differential (85025), but the test result parameters indicate the need for additional evaluation, such as a manual differential count.

But that doesn't mean you should add 85007 (*Blood count; blood smear, microscopic examination with manual differential WBC count*) to your 85025 claim. Correct Coding Initiative (CCI) edits prohibit billing together 85007 and 85025 "because this combination of codes results in duplicate payment for the differential WBC count," according to the CCI *Policy Manual*. The 85025/85007 edit pair has a modifier indicator of "0," meaning that you cannot override the edit pair under any circumstances.

Nor should you "switch" your claim from 85025 to 85027 (*Blood count; complete [CBC], automated [Hgb, Hct, RBC, WBC and platelet count]*) and 85007, as you mentioned doing. You shouldn't change the coding from what the physician ordered (85025) to something different (85027 plus 85007) based on lab protocols.

Do this: For the reflex scenario, report the service as 85025 to Medicare. According to the CCI *Policy Manual*, "If, after a test is ordered and performed, additional related procedures are necessary to provide or confirm the result, these would be considered part of the ordered test." Other payers may allow you to charge for the additional manual differential, but you should get that in writing.

Caveat: If the physician specifically orders a CBC and manual differential, you can report 85027 and 85007. ❑

786.50 Updates PT NCD

Question:
When our lab bills for PT ordered for a patient with unspecified chest pain, we get denials from Medicare. We don't have the same problem when performing PTT with the same diagnosis. What is the problem, and how can we resolve it?

Nebraska Subscriber

Answer:
Presumably you're reporting unspecified chest pain as 786.50 (*Unspecified chest pain*). The problem may be that your Medicare contractor hasn't updated to the current National Coverage Determination (NCD). You should talk to your MAC, because 786.50 was added in 2012 as a "payable diagnosis" for PT (85610, *Prothrombin Time*).

Back story: Blood coagulation function can be assessed with Partial Thromboplastin Time (PTT), and Prothrombin Time (PT), among other tests. PTT assesses the intrinsic branch of the coagulation pathway, while PT assesses the extrinsic branch. The reasons for ordering the two tests can be very similar, including patients presenting with chest pain.

For some reason, the lab NCD for PT and PTT originally included 786.59 (*Other chest pain*) on the list of ICD-9 codes that showed medical necessity for the test, but only PTT (not PT) included 786.50 as a payable diagnosis.

However, the lab NCDs were updated in 2012, adding both 786.50 and 786.51 (*Precordial pain*) to the list of ICD-9 codes that show medical necessity for PT (85610).

If you're still receiving denials in these cases, you should contact your Medicare contractor and discuss the issue. You can find the PT NCD at www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=80&ncdver=1&bc=AAEAAAAAAAAA&. ❑

You Be the Coder

Solve Dx for 'Normal Tissue' Dilemma

(Question on page 21)

Answer:
The correct procedure code is 88300 (*Level I - Surgical pathology, gross examination only*), but perhaps the ICD-9 code is the bigger concern. You should assign the diagnosis code in this case based on the ordering diagnosis. For thoracic outlet syndrome, use 353.0 (*Brachial plexus lesions*).

Here's why: ICD-9 (and ICD-10) don't have codes for "normal tissue." Whether for 88300 or any other surgical pathology service, if the pathologist doesn't reach a definitive diagnosis, you should revert to the ordering diagnosis. That's true even if you only have signs or symptoms, or a reason for the encounter. ❑

Reader Questions and You Be the Coder were prepared with the assistance of R.M. Stainton Jr., MD, president of Doctors' Anatomic Pathology Services in Jonesboro, Ark.

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