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Clinical Examples Used in this Study Guide

AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides and exams are *actual, redacted* office visit and procedure notes donated by AAPC members.

To preserve the *real world* quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially, they are as one would find them in a coding setting.

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Chapter 8

Pathology and Laboratory

Introduction

Pathology and laboratory CPT® coding includes services primarily reported to evaluate specimens obtained from patients (body fluids, cytological specimens, or tissue specimens obtained by invasive/surgical procedures) to provide information to the treating physician. This information, coupled with information obtained from history and examination findings and other data, provides the physician with the background for the decision making component of the evaluation and management codes.

Pathology and laboratory services are broken down into distinct category groupings according to procedure classification, and coders should become familiar with the various subcategories contained in CPT®. As with any other sections of CPT®, all introductory paragraphs and parenthetical notes should be carefully reviewed prior to code assignment. In general, clinical laboratory services are considered technical only and should be coded and billed by the facility. Very few modifiers are required for reporting clinical laboratory services.

CPT® laboratory services are delineated into distinct category groupings according to procedure classification. When locating or identifying a specific lab test for coding accuracy, it is essential to be familiar with the various lab subgroupings. They are listed as follows:

- Organ/Disease Panels
- Drug Assay
- Therapeutic Drug Assays
- Evocative/Suppression Testing
- Consultations (Clinical Pathology)
- Urinalysis
- Molecular Pathology
- Genomic Sequencing (GSPs) and Other Molecular Multianalyte Assays
- Multianalyte Assays with Algorithmic Analyses
- Chemistry
- Hematology and Coagulation
- Immunology
- Transfusion Medicine
- Microbiology
- Anatomic Pathology
- Cytopathology
- Cytogenetic Studies
- Surgical Pathology
- In Vivo Laboratory Procedures
- Other Procedures
- Reproductive Medicine Procedures
- Proprietary Laboratory Analyses

Pathology and laboratory procedures are typically paid based on a fee schedule (status indicator A) or not paid under Outpatient Prospective Payment System (OPPS) for hospital facilities when services are performed in the hospital (status indicators B, E, and M). Some procedures in this section of CPT® are paid if they are not reported with another code that has a status indicator of S, T, or V with a status indicator of Q1. Other procedures in this section are paid under the Clinical Laboratory Fee Schedule when not reported with another code that has a status indicator of J1, J2, S, T, V, Q1, Q2, or Q3 with a status indicator of Q4 or packaged under a more extensive procedure with a status indicator of N.

Modifiers Used in Laboratory and Pathology Services

Modifier 59—Appended to the procedure code to indicate a procedure was independent from other services performed on the same day

Modifier 90—Appended to the procedure code when an entity other than the treating or reporting physician performs an outside laboratory procedure

Modifier 91—Appended to the procedure code when it is necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results

Modifier 92—Alternative Laboratory Platform Testing

Code Location

When determining the correct code for a specific laboratory assay, use the CPT® Index to locate the procedural code if the formal name, condition, or abbreviation of the procedure is known. See the following examples for reference:

EXAMPLE

1. Test performed
   Urinalysis
2. Anatomical site
   Skin, test, tuberculosis
3. Condition
   Syphilis test
4. Abbreviation
   RBC (red blood cell)
5. Procedure or methodology
   Immunoassay
6. Organ or Disease Oriented Panel
   Basic Metabolic Panel

Organ or Disease Oriented Panels (80047–80081)

These panels were developed for coding purposes only and should not be interpreted as clinical parameters. The tests listed within each panel identifies the defined components of that panel. These panel components are not intended to limit the performance of other tests. If additional tests are performed other than those specifically indicated, they should be reported separately in addition to the panel code. When billing one of these panel codes, the lab must perform all the specific tests defined in the panel. For example, CPT® code 80061 *Lipid panel* must include serum cholesterol (82465), HDL cholesterol (83718) and triglycerides (84478). When only a portion of the defined tests in a panel are performed, each test performed is billed separately, rather than the CPT® panel code. When assigning a procedure code for a combination of laboratory tests, review the test names and select the CPT® panel code, when applicable, instead of assigning a code to each individual test. The following coding guidelines apply to laboratory panels:

1. CPT® panel codes that include all the test ordered by a physician, should be coded to the CPT® panel code and not billed individually.
2. When an additional test (not included in the panel description) is performed, code the test separately.
3. When a physician does not order all the tests in a panel, the laboratory should perform and code only those individual tests ordered. Do not automatically perform all the panel tests and code a panel.

Laboratory panels and all laboratory tests must meet payer criteria for medical necessity and be ordered by the physician actively treating the patient to be reimbursed.

Drug Assay (80305–80377)

Drug screening is reported with codes in the 80305 to 80377 range. CPT® codes 80305-80307 report drug screening based on any number of drug classes, any number of devices or procedures (for example, utilizing immunoassay) or by instrument chemistry analyzers, chromatography, and mass spectrometry either with or without chromatography for testing the specimen Codes 80320–80377 report screening of specific types of drugs – such as alcohol, amphetamines, and anabolic steroids as well as drugs or substances that are not otherwise specified.

Therapeutic Drug Assays (80150–80377)

This set of CPT® codes is used when ordering or describing quantitative determinations of therapeutic drugs. These assays are often performed frequently on a timed basis (for example, peak and trough). Regardless of specific timing, the same code is used to describe the assay, for example, a Gentamicin peak or trough is coded using CPT® code 80170.

Therapeutic drug assays should not be confused with qualitative drug testing and the following guidelines must be used when selecting the appropriate CPT® code.

1. Determine the purpose of an assay; if the assay is presumptive, definitive, or quantitative. A urine lithium assay with mass spectrometry to determine a patient's compliance with a therapy program would be coded using CPT® code 80307, which shows the presence or absence of lithium. CPT® code 80178 is a quantitative test to show how much lithium is in the specimen provided.
2. If the assay is presumptive, see CPT® codes 80305–80307. This set of tests simply identifies the presence or absence of a drug class. Definitive tests identify individual drugs.
3. If the assay is quantitative, look in the Chemistry section of the CPT® for a specific code. The manual generally contains only generic names. Quantitative assays tell how much of a substance is in the body and whether therapeutic levels of a drug have been attained.
4. If no code is found in the Chemistry section, look for a proper code in the Therapeutic Drug Assay (TDA) section.
5. If no specific code is found in the TDA section and the purpose for conducting the assay is to determine a level of drug in the patient, use CPT® code 80299.

57. **Pre- and Postoperative Diagnosis:** Nonunion, right long finger, proximal phalanx.

This four-year-old right hand dominant male sustained a fracture to his right long finger proximal phalanx that was treated nonoperatively at an outside facility. The patient presented with a nonunion with overlap of his index and long fingers. After the risks and benefits of the surgery were discussed with the patient's parents in detail, they chose to proceed with operative fixation. The patient was taken to the operating room suite after the induction of axillary block anesthetic. He was found to have inadequate anesthesia and, therefore, this was converted to laryngeal mask anesthesia without difficulty. He had been given one gram of preoperative antibiotics. A well-padded tourniquet was placed around his proximal arm and his right upper extremity was prepped with Betadine and draped in standard sterile surgical fashion. An Esmarch bandage was used to exsanguinate his arm and the tourniquet was inflated. An incision was made dorsally along the central portion of his proximal phalanx. This was taken sharply through the skin. Subcutaneous hemostasis was achieved with electrocautery. A scalpel was used to incise the extensor tendons and the periosteum sharply. This was dissected with the freer elevator around the radial and ulnar portions of the phalanx. The site for the proposed osteotomy was planned. A plate was selected. A six-hole plate from the 1.5 cm screw set and the 2" module head set was selected. One hole of this was cut off. The proximal two holes were placed and drilled without difficulty. A mark was placed for the planned osteotomy which was through the previous fracture site. The plate was removed. An osteotomy was made with an oscillating saw without difficulty through the nonunion fracture site. Care was taken to ensure that this did not enter the flexor tendons. After the osteotomy was created, the distal fragment was dissected. There was a spike of bone on the distal palmar portion of the phalanx, which was impeding flexion. This bone was removed with the rongeur and the osteotomy was again examined. It was found to be cut in a small bit of extension and, therefore, a second cut was made taking off only a volar portion of the distal fragment. This found adequate alignment. The plate was replaced in a standard AO technique. The small piece of bone that was removed with the second cut of the osteotomy was placed in the intermedullary canal as graft. The plate was placed with compression and was found to have excellent screw purchase and all filled holes. The finger was able to go through nearly full range of motion. The PIP joint was able to flex to 90 degrees and had full extension. The wound was irrigated copiously. The periosteum was closed with interrupted 4-0 Vicryl suture. The extensor tendon cut was closed with a running 4-0 Vicryl suture and the skin was closed with a running 4-0 nylon suture. A second incision was made on the palmar side of the hand, just proximal to the wrist crease for approximately 3 cm. This was taken sharply through the skin. The flexor tendons were identified. A tendon hook was used to pull on the flexor tendon to the long finger. Both FDS and FDP were retracted and were found to have full range of motion with no evidence of adhesions. This wound was also irrigated thoroughly and was closed with subcuticular nylon. The patient was taken to the recovery room having tolerated the procedure very well. All sponge, needle and instrument counts were correct. Blood loss was minimal. The patient was released from the outpatient surgery department to home in good condition. What CPT® and ICD-10-CM codes are reported by the facility coder?

A. 26548, S62.612A

B. 26545, Q74.0

C. 26546, S62.612K

D. 26548, Q71.30

58. **Procedure Performed:** Implantation of dual chamber pacemaker.

Indications for Procedure: Sick sinus syndrome with Mobitz type II block with symptoms of fatigue.

Indications for Procedure: The risks, benefits and alternatives to the procedure were explained to the patient prior to the procedure and accepted.

Description of Procedure: The patient was brought to the Electrophysiology Lab where he received 1.5 grams of IV Cefuroxime. The left pectoral area was prepared in the usual fashion. The area was infiltrated with a 2% Xylocaine solution ordered by local anesthesia. A 4 cm incision was made in the left deltopectoral groove. The cephalic vein was isolated and ligated distally with 0 silk. Guide wire was introduced into the cephalic vein. The 9 French peel-away introducer was used to place the ventricular lead and using retained guide wire technique a 7 French peel-away introducer was used to place the atrial lead. The atrial lead was the Pacesetter 1488T/46 cm. The ventricular lead was the Pacesetter 1488T/52 cm. These were active fixation leads. Atrial and ventricular mapping was performed. Thresholds were as follows; in the atrium pacing 0.5 volts, current 1.3 ma, impedance 400 ohms, P-waves 4.6 millivolts. In the ventricle, pacing 0.5 volts, current 0.7 ma,

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