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CHAPTER X
PATHOLOGY LABORATORY SERVICES
CPT CODES 80000 - 89999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter X
Pathology and Laboratory Services
CPT Codes 80000 - 89999

A. 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) in order 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 upon which medical decision making is established.

Generally, pathology and laboratory specimens are prepared and/or screened by laboratory personnel with a pathologist assuming responsibility for the integrity of the results generated by the laboratory. Certain types of specimens and tests are reviewed personally by the pathologist. CPT coding for this section includes few codes requiring patient contact or evaluation and management services rendered directly by the pathologist. On the occasion that a pathologist provides evaluation and management services (significant, separately identifiable, patient care services that satisfy the criteria set forth in the E & M guidelines developed by HCFA and the AMA), appropriate coding should be rendered from the evaluation and management section of the CPT 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. For example, if a patient with polycythemia vera has an elevated hemoglobin, and a manual hemogram must be performed instead of, or in addition to, the performance of an automated hemogram, it would be inappropriate to report CPT codes 85031 and 85025 because only the former provides valid results. As another example, if a patient has an abnormal test result and repeat performance of the test is done to verify the result, the test is reported as one unit of service rather than two.

B. Multichannel Testing

Multichannel testing is the performance of a group of laboratory determinations selected from a list of 22 chemistry tests defined

as automated multichannel tests. The number and type of the tests included in a multichannel test varies widely among laboratories due to variation in physician preference and available technology in the laboratory. Tests included in multichannel panels frequently aid in evaluation of a number of organ systems.

Automated tests may be billed by using the individual test codes or the various panel codes that contain automated tests. The panel codes may only be used when the tests were ordered as that panel or the diagnostic information on the order allows the laboratory to know that the panel is appropriate. For example, if the diagnosis information shows hypertension, then the individually ordered tests cholesterol (CPT code 82465), triglycerides (CPT code 84478) could be billed as a lipid panel (CPT code 80061) if the non-automated test HDL cholesterol (CPT code 83718) was also ordered.

C. Evocative/Suppression Testing

Evocative/suppression testing involves administration of agents to determine a patient's response to those agents (CPT codes 80400-80440 are to be used for reporting the laboratory components of the testing). When the test requires physician administration of the evocative/suppression agent as described by CPT codes 90780-90784 (therapeutic/diagnostic injections/infusions), these codes can be separately reported. However, when physician attendance is not required, and the agent is administered by ancillary personnel, these codes are not to be separately reported. In the inpatient setting, these codes are only reported if the physician performs the service personally. In the office setting, the service can be reported when performed by office personnel if the physician is directly supervising the service. While supplies necessary to perform the testing are included in the testing, the appropriate HCPCS J codes for the drugs can be separately reported for the diagnostic agents. Separate evaluation and management services are not to be reported, including prolonged services (in the case of prolonged infusions) unless a significant, separately identifiable service is provided and documented. If separate evaluation and management services are provided and reported, the injection procedure is included in this service and is not separately reported.

D. General Policy Statements

1. Multiple CPT codes are descriptive of services performed for bone and bone marrow evaluation. When a biopsy is performed for evaluation of bone matrix structure, the appropriate code to bill is CPT code 20220 for the biopsy and CPT code 88307 for the surgical pathology evaluation.

When a bone marrow aspiration is performed alone, the appropriate coding is CPT code 85095. Appropriate coding for the interpretation is CPT code 85097 when the only service provided is the interpretation of the bone marrow smear. When both are performed by the same provider, both may be reported. The pathological interpretations (CPT code 88300-88309) are not reported in addition to CPT code 85097 unless separate specimens are processed. When a bone marrow biopsy is performed for evaluation of bone marrow function or morphology, the appropriate code is CPT code 85102 (bone marrow biopsy); this code cannot be reported with CPT code 20220 (bone biopsy).

When it is medically necessary to evaluate both bone structure and bone marrow, and both services can be provided with one biopsy, only one code (CPT code 85102 or CPT code 20220) can be reported. If two separate biopsies are necessary, then both can be reported using the -59 modifier on one of the codes. Pathological interpretation codes 88300-88309 may be separately reported for multiple separately submitted specimens. If only one specimen is submitted, only one code can be reported regardless of whether the report includes evaluation of both bone structure and bone marrow morphology or not.

2. The family of CPT codes 87040-87163 refers to microbial culture studies. The type of culture is coded to the highest level of specificity regarding source, type, etc. Because there are a variety of commercial kits available to culture, identify and quantitate microbial organisms, several CPT codes have been developed for these kits (e.g. CPT codes 87072, 87082, 87087). When a culture is processed by a commercial kit, other culture codes are not to be separately reported for the same specimen. A screening culture and culture for definitive identification are not performed on the same day on the same specimen and therefore are not reported together.

3. When cytopathology codes are reported, the appropriate CPT

code to bill is that which describes, to the highest level of specificity, what services were rendered. Accordingly, for a given specimen, only one code from a family of progressive codes (subsequent codes include services described in previous CPT codes, e.g. 88104-88108, 88142-88145,88150-88154, 88164-88167, etc.) is to be reported. If multiple services (separate specimens) are reported, the -59 modifier should be used to indicate that different levels of service were provided for different specimens. This should be reflected in the cytopathologic reports. Cytopathology smears obtained from fluids are to be reported using the family of CPT codes 88104-88108; it is inappropriate to use the CPT codes 88160-88162 in addition because the preparation of smears is included in the codes referable to fluids.

4. The CPT codes 80500 and 80502 are used to indicate that a pathologist has reviewed and interpreted, with a subsequent written report, a clinical pathology test. These codes additionally are not to be used with any other pathology service that includes a physician interpretation (e.g. surgical pathology). If an evaluation and management service (face-to-face contact with the patient) takes place by the pathologist, then the appropriate E & M code is reported, rather than the clinical pathology consultation codes, even if, as part of the evaluation and management service, review of the test result is performed. Procurement of these services (CPT 80500 and 80502) requires the order of another physician.

5. The CPT codes 88321-88325 are to be used to review slides, tissues, or other material obtained and prepared at a different location and referred to a pathologist for a second opinion. Medicare generally does not pay twice for an interpretation of a given technical service (e.g. EKGs, radiographs, etc.). However, it is recognized that there are times that this service is indicated. These codes are not to be used for a face-to-face evaluation of a patient. In the event that a physician provides an evaluation and management service to a patient and, in the course of this service, specimens obtained elsewhere are reviewed as well, this is part of the evaluation and management service and is not to be reported separately. Only the evaluation and management service would be reported.