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CHAPTER X
PATHOLOGY / LABORATORY SERVICES
CPT CODES 80000 - 89999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter X
Pathology and Laboratory Services
CPT Codes 80000 - 89999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 80000-89999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this Chapter.

Pathology and laboratory CPT codes describe services to evaluate specimens (e.g., blood, body fluid, tissue) obtained from patients in order to provide information to the treating physician.

Generally, pathology and laboratory specimens are prepared, screened, and/or tested 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 or interpreted 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. If a pathologist provides significant, separately identifiable face-to-face patient care services that satisfy the criteria set forth in the E&M guidelines developed by CMS and the AMA, a pathologist may report

the appropriate code 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 verify the result, these would be considered part of the ordered test. For example, if a patient with leukemia has a thrombocytopenia, and a manual platelet count (CPT code 85032) is performed in addition to the performance of an automated hemogram with automated platelet count (CPT code 85027), it would be inappropriate to report CPT codes 85032 and 85027 because the former provides verification for the automated hemogram and platelet count (CPT code 85027). 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.

By contrast some laboratory tests if positive require additional separate follow-up testing which is implicit in the physician's order. For example, if an RBC antibody screen (CPT code 86850) is positive, the laboratory routinely proceeds to identify the RBC antibody. The latter testing is separately reportable. Similarly, if a urine culture is positive, the laboratory proceeds to organism identification testing which is separately reportable. In these cases, the initial positive results have limited clinical value without the additional testing. The additional testing is separately reportable because it is not performed to complete the ordered test. Furthermore, the ordered test if positive requires the additional testing in order to have clinical value. This type of testing is a category of reflex testing that must be distinguished from other reflex testing performed on a positive test result which may have clinical value without additional testing. An example of a latter type of test is a serum protein electrophoresis with a monoclonal protein band. A laboratory should not routinely perform serum immunofixation or serum immunoelectrophoresis to identify the type of monoclonal protein unless ordered by the treating physician. If the patient has a known monoclonal gammopathy, perhaps identified at another laboratory, the serum immunofixation or immunoelectrophoresis would not be appropriate unless ordered by the treating physician.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, or ZZZ. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure.

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same

date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

Procedures with a global surgery indicator of “XXX” are not covered by these rules. Many of these “XXX” procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other “XXX” procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most “XXX” procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the “XXX” procedure but cannot include any work inherent in the “XXX” procedure, supervision of others performing the “XXX” procedure, or time for interpreting the result of the “XXX” procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an “XXX” procedure is correct coding.

C. Organ or Disease Oriented Panels

The *CPT Manual* assigns CPT codes to organ or disease oriented panels consisting of groups of specified tests. If all tests of a CPT defined panel are performed, the provider may bill the panel code or the individual component test codes. The panel codes may be used when the tests are ordered as that panel or if

the individual component tests of a panel are ordered separately. For example, if the individually ordered tests are cholesterol (CPT code 82465), triglycerides (CPT code 84478), and HDL cholesterol (CPT code 83718), the service may be reported as a lipid panel (CPT code 80061).

NCCI contains edits pairing each panel CPT code (column one code) with each CPT code corresponding to the individual laboratory tests that are included in the panel (column two code). These edits allow use of NCCI-associated modifiers to bypass them if one or more of the individual laboratory tests are repeated on the same date of service. The repeat testing must be medically reasonable and necessary. Modifier 91 may be utilized to report this repeat testing. Based on the *Internet-Only Manuals(IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 16, Section 100.5.1, the repeat testing cannot be performed to "confirm initial results; due to testing problems with specimens and equipment or for any other reason when a normal, one-time, reportable result is all that is required."

D. Evocative/Suppression Testing

Evocative/suppression testing requires the administration of pharmaceutical agents to determine a patient's response to those agents. CPT codes 80400-80440 describe the laboratory components of the testing. Administration of the pharmaceutical agent may be reported with CPT codes 96365-96376. In the facility setting, these codes may be reported by the facility, but not the physician. In the non-facility setting, these codes may be reported by the physician. While supplies necessary to perform the testing are included in the testing CPT codes, the appropriate HCPCS level II J code for the pharmacologic agent may be reported separately. Separate evaluation and management services including prolonged services (e.g., prolonged infusion) should not be reported separately unless a significant, separately identifiable service medically reasonable and necessary E&M is provided and documented.

E. Chemistry

1. CPT code 83721 (lipoprotein, direct measurement; direct measurement, LDL cholesterol) describes direct measurement of LDL cholesterol. It should not be used to report a calculated LDL cholesterol. Direct measurement of LDL cholesterol in addition

to total cholesterol (CPT code 82465)or lipid panel (CPT code 80061) may be reasonable and necessary if the triglyceride level is too high (greater than or equal to 400 mg/dl) to permit calculation of the LDL cholesterol. In such situations, CPT code 83721 should be reported with modifier 59.

2. CPT code 83912 describes a medically reasonable and necessary “interpretation and report” associated with molecular diagnostic testing described with CPT codes 83890-83909. CPT code 83912 should not be reported as an “interpretation and report” with CPT codes 87470-87801, 87901-87904 or 88271-88275.

3. Free thyroxine (CPT code 84439) is generally considered to be a better measure of the hypothyroid or hyperthyroid state than total thyroxine (CPT code 84436). If free thyroxine is measured, it is not considered appropriate to measure total thyroxine with or without thyroid hormone binding ratio (CPT code 84479). NCCI does not permit payment of CPT codes 84436 or 84479 with CPT code 84439.

F. Hematology and Coagulation

1. If a treating physician orders an automated complete blood count with automated differential WBC count (CPT code 85025) or without automated differential WBC count (CPT code 85027), the laboratory sometimes examines a blood smear in order to complete the ordered test based on laboratory selected criteria flagging the results for additional verification. The laboratory should NOT report CPT code 85007 (microscopic blood smear examination with manual WBC differential count) or CPT code 85008 (microscopic blood smear examination without manual WBC differential count) for the examination of a blood smear to complete the ordered automated hemogram test (CPT codes 85025 or 85027). The same principle applies if the treating physician orders any type of blood count and the laboratory’s practice is to perform an automated complete blood count with or without automated differential WBC count.

2. If a treating physician orders an automated hemogram (CPT code 85027) and a manual differential WBC count (CPT code 85007), both codes may be reported. However, a provider may not report an automated hemogram with automated differential WBC count (CPT code 85025) with a manual differential WBC count (CPT code 85007) because this combination of codes results in

duplicate payment for the differential WBC count. CMS does not pay twice for the same laboratory test result even if performed by two different methods unless the two methods are medically reasonable and necessary.

3. Multiple CPT codes describe bone and bone marrow biopsy and/or aspiration and interpretation of the specimens. If a bone biopsy is performed for evaluation of bone matrix structure, the appropriate CPT codes to report are CPT code 20220 for the biopsy and CPT code 88307 for the surgical pathology interpretation.

If a bone marrow aspiration is performed without biopsy, the procedure may be reported as CPT code 38220. Interpretation of the aspirate smear may be reported as CPT code 85097. Both codes may be reported by the same physician if both the procedure and interpretation are performed by that physician. If a cell block is prepared from the bone marrow aspirate, interpretation of the cell block should be reported as CPT code 88305.

Bone marrow biopsy may be reported with CPT code 38221. If bone marrow aspiration is also performed through the same skin incision, it should be reported with HCPCS code G0364. However, it should not be reported with CPT code 38220. Interpretation of the bone marrow biopsy may be reported with CPT code 88305.

The bone marrow aspiration procedure (CPT code 38220) should not be reported separately with the bone marrow biopsy procedure (CPT code 38221) unless the two procedures are performed through medically reasonable and necessary separate skin incisions or at separate patient encounters on the same date of service.

When it is medically necessary to evaluate both bone structure and bone marrow and both can be evaluated from a single biopsy, only one code (CPT code 38221 or 20220) should be reported for the surgical procedure. If two separate biopsies are medically necessary, both may be reported appending modifier 59 to one of the codes. If only one specimen is submitted for surgical pathology, only one surgical pathology code (CPT codes 88305 or 88307 as appropriate) may be reported even if the report includes evaluation of both bone structure and bone marrow morphology.

G. Microbiology

1. CPT codes 87040-87158 describe microbiological culture studies. The type of culture is coded to the highest level of specificity regarding source, type, etc. When a culture is processed by a commercial kit, report the code that describes the test to its highest level of specificity. 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.

2. Infectious agent molecular diagnostic testing utilizing nucleic acid probes is reported with CPT codes 87470-87801, 87901-87904. These CPT codes include all the molecular diagnostic processes, and CPT codes 83890-83913 should not be additionally reported with these CPT codes. If the provider performs infectious agent molecular diagnostic testing utilizing nucleic acid probes (87470-87801, 87901-87904) on the same date of service as non-infectious agent molecular diagnostic testing or infectious agent molecular diagnostic testing utilizing methodology that does not incorporate nucleic acid probes, the molecular diagnostic testing CPT codes 83890-83913 may be reported separately with an NCCI-associated modifier.

H. Anatomic Pathology (Cytopathology and Surgical Pathology)

1. Cytopathology codes describe varying methods of preparation and examination of different types of specimens. For a single specimen, only one code from a group of related codes describing a group of services that could be performed on the specimen with the same end result (e.g., 88104-88112, 88142-88143, 88150-88154, 88164-88167, etc.) should be reported. If multiple services (i.e., separate specimens from different anatomic sites) are reported, modifier 59 should be utilized to indicate that different levels of service were provided for different specimens from different anatomic sites. This information should be documented in the cytopathology reports. A cytopathology preparation from a fluid, washing, or brushing should be reported using one code from the CPT code range 88104-88112. It is inappropriate to additionally report CPT codes 88160-88162 because the smears are included in the codes referable to fluids (or washings or brushings) and CPT codes

88160-88162 reference “any other source” which would exclude fluids, washings, or brushings.

2. CPT codes 88321-88325 describe surgical pathology consultation services to review slides, tissues, or other material obtained, prepared, and interpreted at a different location by a different pathologist and referred to another pathologist for a second opinion. These codes should not be reported by pathologists reporting a second opinion on slides, tissue, or other material also examined and reported by another pathologist in the same provider group. Medicare generally does not pay twice for an interpretation of a given technical service (e.g., ECGs, radiographs, etc.). CPT codes 88321-88325 are reported with one unit of service regardless of the number of specimens, paraffin blocks, stained slides, etc.

When reporting CPT codes 88321-88325, physicians should not report other pathology CPT codes such as 88312, 88313, 88342, 88187, 88188, 88189, etc., for interpretation of stains, slides or other material previously interpreted by another pathologist. CPT codes 88312, 88313 and 88342 may be reported with CPT code 88323 if the physician performs and interprets these stains *de novo*.

CPT codes 88321-88325 should not be reported with a face-to-face evaluation of a patient. If a physician provides an evaluation and management (E&M) service to a patient, and, in the course of the E&M service, specimens obtained elsewhere are reviewed as well, this review is part of the E&M service and is not reported separately. Only the E&M service should be reported.

3. Medicare does not pay for duplicate testing. CPT codes 88342 (immunocytochemistry, each antibody) and 88184, 88187, 88188, 88189 (flow cytometry) should not in general be reported for the same or similar specimens. The diagnosis should be established using one of these methods. The physician may report both CPT codes if both methods are required because the initial method does not explain all the light microscopic findings. The physician may report both methods utilizing modifier 59 and document the need for both methods in the medical record.

If the abnormal cells in two or more specimens are morphologically similar and testing on one specimen by one method (88342 or 88184, 88187, 88188, 88189) establishes the diagnosis,

the same or other method should not be reported on the same or similar specimen. Similar specimens would include, but are not limited to:

(1) blood and bone marrow;
(2) bone marrow aspiration and bone marrow biopsy;
(3) two separate lymph nodes; or
(4) lymph node and other tissue with lymphoid infiltrate.

4. Quantitative or semi-quantitative immunohistochemistry using computer-assisted technology (digital cellular imaging) should not be reported as CPT code 88342 with CPT code 88358. Prior to January 1, 2004, it should have been reported as CPT code 88342. Beginning January 1, 2004, it should be reported as CPT code 88361. CPT code 88361 should not be used to report any service other than quantitative or semi-quantitative immunohistochemistry using computer-assisted technology (digital cellular imaging). Digital cellular imaging includes computer software analysis of stained microscopic slides. Beginning January 1, 2005, quantitative or semi-quantitative immunohistochemistry performed by manual techniques should be reported as CPT code 88360. Immunohistochemistry reported with qualitative grading such as 1^+ to 4^+ should be reported as CPT code 88342.

5. DNA ploidy and S-phase analysis of tumor by digital cellular imaging technique should not be reported as CPT code 88313 with CPT code 88358. Prior to January 1, 2004, it should have been reported as CPT code 88313. Beginning January 1, 2004, it should be reported as CPT code 88358. Prior to January 1, 2004, CPT code 88358 should have been utilized to report DNA ploidy and S-phase analysis of tumor by non-digital cellular imaging techniques. CPT code 88358 should not be used to report any service other than DNA ploidy and S-phase analysis. One unit of service for CPT code 88358 includes both DNA ploidy and S-phase analysis.

6. Prior to January 1, 2005, qualitative, semi-quantitative, and quantitative (tissue) *in situ* hybridization should have been reported as CPT code 88365 when performed by a physician (limited to M.D./D.O.). Beginning January 1, 2005, quantitative or semi-quantitative *in situ* hybridization (tissue or cellular) performed by computer-assisted technology should be reported as CPT code 88367 when performed by a physician (limited

to M.D./D.O.). Beginning January 1, 2005, quantitative or semi-quantitative *in situ* hybridization (tissue or cellular) performed by manual methods should be reported as CPT code 88368 when performed by a physician (limited to M.D./D.O.). Do not report CPT code 88365 with CPT codes 88367 or 88368 for the same probe. *In situ* hybridization reported with qualitative grading such as 1^+ to 4^+ should be reported as CPT code 88365. Only one unit of service may be reported for CPT code 88365, 88367 or 88368 for each reportable probe. When *in situ* hybridization is performed on tissue or cytology specimens by a non-physician (provider other than M.D./D.O.), it should be reported using appropriate CPT codes in the range 88271-88275. For each reportable probe, a provider should not report CPT codes both from the range 88365-88368 and the range 88271-88275. *In situ* hybridization reported as CPT codes 88365-88368 includes both physician (limited to M.D./D.O.) and non-physician (non-M.D./D.O.) services to obtain a reportable probe result. The physician (limited to M.D./D.O.) work component of 88365-88368 requires that a physician (limited to M.D./D.O.) rather than laboratory scientist or technician read, quantitate (88367,88368), and interpret the tissues/cells stained with the probe(s). If this work is performed by a laboratory scientist or technician, CPT codes 88271-88275 should be reported.

When a physician (limited to M.D./D.O.) reads/quantitates (CPT codes 88367, 88368) and interprets (CPT codes 88365-88368) the tissues/cells stained with the probe(s), the provider may report the global code or professional component (modifier 26) as appropriate. When the professional component of CPT codes 88365-88368 is reported by the physician (limited to M.D./D.O.), the laboratory may report the technical component (modifier TC), and a hospital reporting an outpatient laboratory test may report the appropriate CPT code. If a non-physician (provider other than M.D./D.O.) reads and quantitates the tissues/cells stained with the probe(s), the laboratory should not report the technical component (-TC) of CPT codes 88367-88368, and a hospital reporting an outpatient laboratory test should not report CPT codes 88367 or 88368. The laboratory or hospital may report these services with CPT codes 88271-88275.

7. Beginning January 1, 2005, flow cytometry interpretation should be reported using CPT codes 88187-88189. Only one code should be reported for all flow cytometry performed on a specimen. Since Medicare does not pay for duplicate testing, do

not report flow cytometry on multiple specimens on the same date of service unless the morphology or other clinical factors suggest differing results on the different specimens. There is no CPT code for interpretation of one marker. The provider should not bill for interpretation of a single marker using another CPT code. Quantitative cell counts performed by flow cytometry (e.g., CPT codes 86064, 86359-86361, 86379, and 86587) should not be reported with the flow cytometry interpretation CPT codes 88187-88189 since there is no interpretative service for these quantitative cell counts.

8. CPT codes 88384-88386 describe array-based evaluations of multiple molecular probes. Although CPT code 88384 is Carrier (A/B MAC processing practitioner service claims)priced, CPT codes 88385 and 88386 are payable from the Medicare Physician Fee Schedule and include significant physician work. If array-based evaluation of multiple molecular probes is performed by a laboratory scientist or technician rather than a physician, it should not be reported with global CPT code 88385 or 88386 since these codes include physician work. Rather, it should be reported as 88385-TC or 88386-TC which includes the non-physician work including interpretation.

9. Gross examination of a specimen is an integral component of pathology consultation during surgery (CPT codes 88329-88334) and surgical pathology gross and microscopic examination (CPT codes 88302-88309). CPT code 88300 (level I – surgical pathology, gross examination only) should not be reported with any of the previously listed CPT codes for examination of the same specimen.

I. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform

the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. CMS payment policy allows only one unit of service for CPT codes 88321, 88323, and 88325 per beneficiary per provider on a single date of service. Providers should not report these codes on separate lines of a claim utilizing CPT modifiers to bypass the MUEs for these codes.

4. The code descriptors for CPT codes 83912 (molecular diagnostics; interpretation and report) and 88291 (cytogenetics and molecular cytogenetics, interpretation and report) do not define the units of service for these codes. The MUE value for each of these codes is “1”. CMS interprets these codes to include the synthesis with interpretation and report of all molecular diagnostic testing or cytogenetic/molecular cytogenetic testing respectively performed on a single date of service. These codes should not be reported with separate units of service based on the number of specimens or tests on a single date of service.

5. The MUE values for CPT codes 86021 (antibody identification; leukocyte antibodies) and 86022 (antibody identification; platelet antibodies) are “1”. The code descriptors are plural, and CMS priced each of these codes to include all antibodies to leukocytes and platelets respectively in a single unit of service.

6. The unit of service for CPT code 88172 (cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)) is the separately identifiable lesion (tumor). Per the code descriptor all specimens from a single lesion are included in a single unit of service. If a physician performs multiple “passes” into the same lesion to obtain multiple specimens for immediate cytohistologic study, all specimens from the lesion are included in the single unit of service. If a physician evaluates fine needle aspirate specimens from more than one distinct, separate lesion, a separate unit of service may be reported for each lesion. The

same concept applies to the unit of service for CPT code 88173 (cytopathology, evaluation of fine needle aspirate; interpretation and report). A separate unit of service may be reported for each distinct, separate lesion, but only one unit of service may be reported for all specimens from a single lesion.

7. The unit of service for gross and microscopic surgical pathology (CPT codes 88300-88309), pathology consultation during surgery (CPT codes 88329, 88331, 88333), electron microscopy (CPT codes 88348, 88349) and morphometric analysis (CPT codes 88355-88358) is the specimen. A specimen is defined as tissue(s) that are submitted for individual and separate attention, examination, and diagnosis. It must be medically reasonable and necessary to submit the specimens for individual attention, examination, and diagnosis. For example, if colonoscopy identifies two separate polyps at 15 cm and 25 cm, it may be medically reasonable and necessary to submit them as separate specimens. If one of the polyps is malignant, it may be important to know for future therapy which one was malignant.

8. The unit of service for special stains (CPT codes 88312-88313) and immunohistochemistry (CPT codes 88342, 88360, 88361) is each stain. If it is medically reasonable and necessary to perform the same stain on more than one specimen or more than one block of tissue from the same specimen, additional units of service may be reported for the additional specimen(s) or block(s). Physicians should not report more than one unit of service for a stain performed on a single tissue block. For example it is common practice to cut multiple levels from a tissue block and stain each level with the same stain. The multiple levels from the same block of tissue stained with the same stain should not be reported as additional units of service. Only one unit of service should be reported for the stain on multiple levels from the single tissue block. Additionally, controls performed with special stains should not be reported as separate units of service for the stain.

J. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to

applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual.*

3. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the “Repair (Closure)” section of the *CPT Manual*.

4. CPT codes 80500 and 80502 describe clinical pathology consultation services. CMS has specific rules for reporting these services. There must be a written order for the clinical pathology consultation from the treating physician. The consultation must be related to an abnormal test result that requires medical judgment by a physician (M.D. or D.O.). Since the clinical pathology consultation requires that medical judgment be exercised, the nature of the consultation must include information that could not be provided by a laboratory

scientist, technologist, or technician. A written report documenting the consultation must appear in the medical record. A clinical pathology consultation does not require face-to-face patient contact. If face-to-face contact is medically reasonable and necessary, an evaluation and management (E&M) CPT code may be reported in lieu of a clinical pathology consultation code. Since E&M services include interpretation of laboratory test results, a clinical pathology consultation code should never be reported with an E&M code on the same date of service. CPT codes 80500 and 80502 should never be reported for consultation related to a pathology or laboratory service that includes a physician interpretation.

5. Medicare does not pay for duplicate testing. Multiple tests to identify the same analyte, marker, or infectious agent should not be reported separately. For example, it would not be appropriate to report both direct probe and amplified probe technique tests for the same infectious agent.