CHAP10-CPTcodes80000-89999_final103116.doc
Revision Date: 1/1/2017

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*.

CMS policy prohibits separate payment for duplicate testing or testing for the same analyte by more than one methodology. (See definition of analyte in Section M (General Policy Statements), subsection #2.) 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 (1) unit of service rather than two (2).

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, ZZZ, or MMM. 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. Procedures with a global period of MMM are maternity procedures.

Since NCCI PTP 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 preoperative 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. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the 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 contains many, but not 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.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 ("Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period").

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. (CPT code 80440 was deleted January 1, 2015.)

E. Drug Testing

1. HCPCS code G0434 (drug screen..., by CLIA waived test or moderate complexity test, per patient encounter) is utilized to report urine drug screening performed by a test that is CLIA waived or CLIA moderate complex. The code is reported with only

one (1) unit of service regardless of the number of drugs screened. HCPCS code G0431 (drug screen... by high complexity test method..., per patient encounter) is utilized to report drug urine screening performed by a CLIA high complexity test method. This code is also reported with only one (1) unit of service regardless of the number of drugs screened. If a provider performs urine drug screening, it is generally not necessary for that provider to send an additional specimen from the patient to another laboratory for urine drug screening for the same drugs. *(HCPCS codes G0431 and G0434 were deleted January 1, 2016.)*

For Calendar Year 2016, urine drug presumptive testing should have been reported with HCPCS codes G0477-G0479. These codes differed based on the level of complexity of the testing methodology. Only one code from this code range should have been reported per date of service. These codes were deleted January 1, 2017.

Beginning January 1, 2017, urine drug presumptive testing may be reported with CPT codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

Beginning January 1, 2016, urine drug definitive testing may be reported with HCPCS codes G0480-G0483. These codes differ based on the number of drug classes including metabolites tested. Only one code from this code range may be reported per date of service.

2. Providers performing validity testing on urine specimens utilized for drug testing should not separately bill the validity testing. For example, if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed.

F. Molecular Pathology

1. Physician (M.D. or D.O.) interpretation of a molecular pathology procedure (e.g., CPT codes 81161-81408) may be reported with HCPCS code G0452 when medically reasonable and necessary. It should not be reported with CPT code 88291 (cytogenetics and molecular cytogenetics, interpretation and report). (See Section L (Medically Unlikely Edits (MUEs)), Paragraph 4 for reporting requirements related to HCPCS code G0452.)

2. Molecular pathology procedures (e.g., CPT codes 81161-81408) include all aspects of sample preparation, cell lysis, internal measures to assure adequate quantity of DNA or RNA, and performance of the assay. These procedures include DNA analysis and*/or* RNA analysis.

3. Quantitation of extracted DNA and/or RNA is included in the payment for a molecular pathology procedure (e.g., CPT codes 81161-81408). Other HCPCS/CPT codes such as CPT code 84311 (spectrophotometry...) should not be reported for this quantitation.

4. Scraping tumor off an unstained slide, if performed, is included in the payment for a molecular pathology procedure (e.g., CPT codes 81161-81408). A physician should not report microdissection (CPT codes 88380 or 88381) for this process. The microdissection CPT codes require a pathologist to use laser capture microdissection (CPT code 88380) or a dissecting microscope (CPT code 88381) to *distinguish* malignant cells from *nonmalignant* cells.

5. CPT codes 81445, 81450, and 81455 describe targeted genomic sequence analysis. The codes differ based on the type of neoplasm (hematolymphoid or solid organ) and the number of genes analyzed. CMS payment policy requires that a physician report only one of these codes for a hematolymphoid or solid organ neoplasm on a single date of service depending upon the total number of genes analyzed.

G. 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. (CPT codes 83890-83909 and 83912 were deleted January 1, 2013.)

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.

4. *This subsection was moved to Section E (Drug Testing), subsection #1.*

5. CPT code 83704 (lipoprotein, blood; quantitation of lipoprotein particle numbers...(eg, by nuclear magnetic resonance spectroscopy)) (NMR lipoprotein panel) is generally not reported on the same date of service as CPT codes 80061 (lipid panel...), 82465 (cholesterol,...total), 84478 (triglycerides), and 83718 (lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)). Typically a lipid panel is performed, and if necessary, the physician may order an NMR lipoprotein panel as a follow-up study to further characterize the abnormality. However, uncommonly a patient might have a previously diagnosed lipid panel abnormality and separate NMR lipoprotein panel abnormality that require retesting after a therapeutic intervention.

H. 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.

I. Transfusion Medicine

Blood products are described by HCPCS Level II P codes. If a P code describes an irradiated blood product, CPT code 86945

(irradiation of blood product, each unit) should not be reported separately since the P code includes irradiation of the blood product. If a P code describes a CMV negative blood product, CPT codes 86644 and/or 86645 (CMV antibody) should not be reported separately for that blood product since the P code includes the CMV antibody testing. If a P code describes a deglycerolized blood product, CPT codes 86930 (frozen blood, each unit; freezing...), 86931 (frozen blood, each unit; thawing), and/or 86932 (frozen blood, each unit; freezing (includes preparation) and thawing) should not be reported separately since the P code includes the freezing and thawing processes. If a P code describes a pooled blood product, CPT code 86965 (pooling of platelets or other blood products) should not be reported separately since the P code includes the pooling of the blood products. If the P code describes a “frozen” plasma product, CPT code 86927 (fresh frozen plasma, thawing, each unit) should not be reported separately since the P code includes the thawing process.

J. 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. (CPT codes 83890-83913 were deleted January 1, 2013.)

3. CPT codes 87631-87633 describe infectious agent detection by nucleic acid for respiratory viruses for multiple types or subtypes of viral targets at one time. The codes differ

based on the number of viral targets tested. CPT codes 87501-87503 describe infectious agent detection by nucleic acid for influenza viruses. If multiplex testing is performed for multiple respiratory viral targets including influenza viral targets, this testing would be reported with CPT codes 87631-87633. CPT codes 87501-87503 should not be reported separately for the influenza viral target testing.

If multiplex testing is initially performed for multiple respiratory viral targets including one or more influenza viral targets and based on those results it is medically reasonable and necessary that additional testing for different influenza types or subtypes is performed, CPT codes 87501-87503 may be reported for the additional influenza virus testing.

4. The test described by CPT code 87624 (Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)) generally includes detection of HPV types 16, 18, and 45 as well as other high risk types. CPT code 87625 (Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed) describes detection of the subset of HPV types 16, 18 and 45. It would be incorrect to report CPT code 87625 as a component of screening for a larger number of HPV types (CPT code 87624) as CPT code 87624 specifies any combination of high risk types, and therefore should not be broken down and billed separately for subgroups when the HPV types are tested at the same time. However, there are some clinical scenarios defined by nationally accepted guidelines where identifying a particular subset of types (CPT code 87625) may be medically reasonable and necessary on a patient with a positive test result for the test described by CPT code 87624. In those instances in which two separate sequential services are medically necessary, such as when a national guideline supports the use of specific type identification after a positive result on a broad assay, CPT code 87625 may be reported separately and billed with an appropriate modifier.

5. With one exception CMS policy prohibits separate payment for testing for a single microorganism from an anatomic site by more than one methodology. For example, if a physician performs tests for cytomegalovirus antigen at an anatomic site by immunoassay (CPT code 87332) and by nucleic acid direct probe (CPT code 87495), only one of these codes may be reported for the testing.

If a culture independent diagnostic testing method is positive for a microorganism, it may be medically reasonable and necessary to additionally culture the microorganism for drug sensitivity testing or rarely for community surveillance identification.

6. CPT codes 87483 (multiplex infectious agent detection by nuclei acid methodology for central nervous system pathogens), 87505-87507 (multiplex infectious agent detection by nuclei acid methodology for gastrointestinal pathogens), and 87631-87633 (multiplex infectious agent detection by nuclei acid methodology for respiratory virus) describe multiplex testing procedures for multiple microorganisms utilizing reverse transcription and/or amplified probe techniques. The codes describe an anatomic region and the number of "targets" tested. If one of these multiplex tests is performed and additional testing by these methodologies for additional microorganisms that might cause disease in the anatomic region described by the code descriptor is performed, only one multiplex testing code summing the testing for all "targets" should be reported. The code descriptors identify some microorganisms, but not all, that might be tested by these methodologies for the respective anatomic regions. The physician should not report separate CPT codes for nucleic acid testing by these methodologies for other microorganisms that might cause disease in the respective anatomic region. If it is medically reasonable and necessary to test by a different methodology for other microorganisms not included in the multiplex test that might cause disease in the respective anatomic region, the test may be reported separately.

K. 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, 88187, 88188, 88189, 88342, 88341, 88344, etc., for interpretation of stains, slides or other material previously interpreted by another pathologist. CPT codes 88312, 88313, 88342, 88341, and 88344 may be reported with CPT codes 88321-88325 only if the physician performs these staining procedure(s) and interprets these newly stained slide(s). CPT code 88323 may be reported for consultation and report on referred material if the physician performs additional necessary de novo routine staining (e.g., hematoxylin-eosin, giemsa) on additional slides.
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. Immunocytochemistry (e.g., CPT codes 88342, 88341, 88344, 88360, 88361) and flow cytometry (e.g., CPT codes 88184-88189) 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 (CPT codes 88184, 88187, 88188, 88189, 88342, 88341, and 88344) 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 codes 88342, 88341 and 88344 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 codes 88342, 88341, and 88344.

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.). After 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, 88373, or 88374 when performed by a

physician (limited to M.D./D.O.). After January 1, 2005, quantitative or semi-quantitative in situ hybridization (tissue or cellular) performed by manual methods should be reported as CPT code 88368, 88369, or 88377 when performed by a physician (limited to M.D./D.O.). Do not report more than one in situ hybridization CPT code (88364-88369, 88373, 88374, 88377) for the same probe tested on a specimen. In situ hybridization reported with qualitative grading such as 1^+ to 4^+ should be reported as CPT code 88365, 88364, or 88366.

7. When *in situ* hybridization is performed on tissue or cellular 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 code group 88364-88369, 88373, 88374, 88377 and the range 88271-88275. *In situ* hybridization reported as CPT codes *8*8364-88369, 88373, 88374, 88377 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 88364-88369, 88373, 88374, 88377 requires that a physician (limited to M.D./D.O.) rather than laboratory scientist or technician read, quantitate (88367-88369, 88373, 88374, 88377), 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 88367-88369, 88373, 88374,88377) and interprets (CPT codes 88364-88369, 88373, 88374, 88377) 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 88364-88369, 88373, 88374, 88377 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 88367-88369, 88373, 88374, and 88377, and a hospital reporting an outpatient laboratory test should not report CPT codes 88367-88369, 88373, 88374, 88377. The laboratory or hospital may report these services with CPT codes 88271-88275.

8. 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. (CPT codes 86064, 86379, and 86587 were deleted January 1, 2006.)

9. 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. (CPT codes 88384-88386 were deleted January 1, 2013.)

10. 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.

11. In accordance with code descriptor changes for HCPCS codes G0416-G0419 effective January 1, 2015, CMS requires that surgical pathology, including gross and microscopic examination, of any and all submitted prostate needle biopsy specimens from a single patient be reported with one unit of service of HCPCS code G0416 rather than CPT code 88305. *(HCPCS codes G0417-G0419 were deleted January 1, 2015.)*

Instructions for HCPCS codes G0416-G0419 in this Manual have undergone changes from year to year. For historical purposes, the prior instructions are reproduced.

From the calendar year 2015 Manual:

“13. HCPCS codes G0416-G0419 describe surgical pathology, including gross and microscopic examination, of separately identified and submitted prostate needle biopsy specimens from a saturation biopsy sampling procedure. CMS requires that these codes rather than CPT code 88305 be utilized to report surgical pathology on prostate needle biopsy specimens only if the number of separately identified and submitted needle biopsy specimens is ten or more. Surgical pathology on nine or fewer separately identified and submitted prostate needle biopsy specimens should be reported with CPT code 88305 with the unit of service corresponding to the number of separately identified and submitted biopsy specimens.”

From the calendar year 2014 Manual:

“13. HCPCS codes G0416-G0419 describe surgical pathology, including gross and microscopic examination, of separately identified and submitted prostate needle biopsy specimens from a saturation biopsy sampling procedure. CMS requires that these codes rather than CPT code 88305 be utilized to report surgical pathology on prostate needle biopsy specimens only if the number of separately identified and submitted needle biopsy specimens is ten or more. Surgical pathology on nine or fewer separately identified and submitted prostate needle biopsy specimens should be reported with CPT code 88305 with the unit of service corresponding to the number of separately identified and submitted biopsy specimens.”

From the calendar year 2013 Manual:

“13. HCPCS codes G0416-G0419 describe surgical pathology, including gross and microscopic examination, of separately identified and submitted prostate needle biopsy specimens from a saturation biopsy sampling procedure. CMS requires that these codes rather than CPT code 88305 be utilized to report surgical pathology on prostate needle biopsy specimens only if the number of separately identified and submitted needle biopsy specimens is ten or more. Surgical pathology on nine or fewer separately identified and submitted prostate needle biopsy specimens should be reported with CPT code 88305 with the unit of service corresponding to the number of separately identified and submitted biopsy specimens.”

L. 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. (CPT code 83912 was deleted January 1, 2013.)

On January 1, 2013 HCPCS code G0452 (molecular pathology procedure; physician interpretation and report) was implemented to report medically reasonable and necessary interpretations of molecular pathology procedures by physicians (M.D. or D.O.). This code may be reported if: (1) the interpretation is requested by the attending physician; (2) the interpretation results in a written narrative report; and (3) the interpretation requires the exercise of medical judgment. This code may not be reported for an interpretation by a laboratory scientist. This code may be

reported with a maximum of one (1) unit of service (UOS) for a Tier 1 molecular pathology procedure CPT code for each distinct source of a specimen. For example, if separate interpretations and reports for the same CPT coded Tier 1 molecular pathology procedure are reported for testing on a bone marrow specimen and a lymph node specimen, two UOS may be reported for the G0452. Since each Tier 2 molecular pathology procedure CPT code includes a list of numerous specific molecular pathology procedures, one UOS may be reported for each physician interpretation for each separately listed molecular pathology procedure for each distinct source of a specimen. A physician should not report more than one UOS for any Tier 1 molecular pathology CPT code for testing on a specimen from a single source. For Tier 2 molecular pathology CPT codes, a physician should not report more than one UOS for each listed molecular pathology procedure on a specimen from a single source.

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 (UOS) for CPT codes 88172 (cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site) and 88177 (cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site...) is the evaluation episode. An evaluation episode consists of examination of a set of cytologic material to determine whether the material is adequate for diagnosis. The evaluation episode ends when a pathologist renders an assessment advising the operating physician whether the submitted material is adequate. The operating physician utilizes the cytologic diagnosis to determine whether additional cytologic material should be obtained for examination. The evaluation episode is independent of the number of passes of the needle into a lesion and the number of slides examined. A second or additional evaluation episode (i.e., CPT code 88177) cannot begin before an assessment is rendered by the pathologist to the operating physician, and the operating physician uses the assessment to determine whether additional needle passes should be performed. If the operating physician performs multiple needle passes into a lesion while the pathologist is examining the material from each pass as rapidly

as possible, only one evaluation episode may be reported since the operating physician does not wait for the pathologic result to determine whether additional passes are necessary. CPT code 88172 may be reported with one UOS for each separate lesion evaluated.

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. Separate specimens are usually submitted in separate containers. 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. Multiple biopsies of the same polyp are usually submitted as a single specimen. (CPT code 88349 was deleted January 1, 2015.)

8. The unit of service for special stains (CPT codes 88312-88313) 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 *may* 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.

For cytology specimens from a single anatomic site only one unit of service may be reported for each special stain regardless of the number of slides from that site stained with the special stain.

For hematology smears only one unit of service may be reported for each special stain regardless of the number of smears from an anatomic site stained with the special stain. For example if

multiple smears of peripheral blood are stained with an iron stain, only one unit of service may be reported. Similarly, if three smears from a bone marrow aspirate are stained with an acid fast stain, only one unit of service may be reported. Smears from peripheral blood, one iliac crest, and contralateral iliac crest are from three separate anatomic sites.

The unit of service for immunohistochemistry/immunocytochemistry (*e.g.,* CPT codes 88342, 88341, and 88344) is each single or multiplex antibody stain procedure per specimen. *A multiplex antibody immunohistochemical staining procedure is one that utilizes multiple antibodies to obtain multiple separately reportable results that are medically reasonable and necessary. An antibody stain containing multiple antibodies that yields a single reportable result is not a multiplex stain and should be reported with a single antibody staining procedure CPT code. An immunohistochemistry stain procedure with multiple antibodies that are not separately interpretable (e.g., antibody cocktail) may only be reported as one (1) unit of service per specimen.*

If a single immunohistochemical/immunocytochemistry stain procedure for one or more antibodies is performed on multiple blocks from a surgical specimen, multiple slides from a cytologic specimen, or multiple slides from a hematologic specimen, only one unit of service may be reported for each separate specimen.

For immunohistochemistry reported as CPT codes 88360 or 88361 the unit of service is each single or multiplex antibody(s) stain procedure per specimen. If a single or multiplex antibody immunohistochemical stain procedure reported as CPT codes 88360 or 88361 is performed on multiple blocks from a surgical specimen, multiple slides from a cytologic specimen, or multiple slides from a hematologic specimen, only one unit of service may be reported for each separate specimen. Physicians should not report more than one unit of service for CPT codes 88360 or 88361 per specimen for an immunohistochemical multiplex antibody stain procedure even if it contains multiple separately interpretable antibodies.

9. Morphometric analysis of tumor immunohistochemistry utilizing a multiplex antibody stain should be reported with one (1) unit of service of CPT code 88360 or 88361 per specimen. It should not be reported with one or more units of service of CPT codes 88341, 88342, or 88344.

10. The unit of service for in situ hybridization reported as CPT codes 88364-88369, 88373, 88374, 88377 is each single or

multiplex probe staining procedure per specimen. If a single or multiplex probe staining procedure is performed on multiple blocks from a surgical specimen, multiple slides from a cytologic specimen, or multiple slides from a hematologic specimen, only one unit of service may be reported for each separate specimen. Physicians should not report more than one unit of service for CPT codes 88366, 88374, or 88377 per specimen for each multiplex probe staining procedure even if it contains multiple separately interpretable probes.

A multiplex probe staining procedure is one that utilizes multiple probes to obtain multiple separately reportable results that are medically reasonable and necessary. A probe stain containing multiple probes that yields a single reportable result is not a multiplex stain and should be reported with a single probe staining procedure CPT code.

11. The unit of service for immunofluorescent antibody studies (e.g., CPT codes 88346, 88350) is each antibody staining procedure per specimen. If a single antibody staining procedure for one or more antibodies is performed on multiple blocks from a surgical specimen, multiple slides from a cytologic specimen, or multiple slides from a hematologic specimen, only one unit of service may be reported for each separate specimen. Physicians should not report more than one unit of service for an immunofluorescent antibody stain per specimen for an immunofluorescent antibody staining procedure even if it contains multiple separately interpretable antibodies.

12. The MUE value for CPT code 86807 (Serum screening for cytotoxic percent reactive antibody (PRA); standard method) is two (2). One unit of service may be reported for a PRA test result for class I HLA antigens, and one unit of service may be reported for a PRA test result for class II HLA antigens. Payment for this procedure is based on the test result, not the methodologic steps utilized to obtain the test result. If multiple steps each utilizing cytotoxic antibody testing of a panel of lymphocytes are performed to obtain the final PRA test result for the class I HLA antigens, only one unit of service for 86807 may be reported. The same principle applies to the final PRA test result for class II HLA antigens.

13. CPT codes 88380 and 88381 describe microdissection procedures and include sample preparation of microscopically identified target cells. Microdissection of “normal tissue” to compare to target tumor tissue is not separately reportable as an additional unit of service. Comparison to “normal tissue” is a

necessary component of the test since an interpretation of the tumor tissue cannot be rendered without it.

14. The *CPT Manual* instructions preceding CPT codes 87260-87660 (infectious agent antigen detection) state that separate results for different species or strain of organism should be coded separately with modifier 59. *(This instruction is clarified in the paragraph following this one.)* Based on this instruction the MUE value for each of these codes, except CPT code 87400, was one (1) when these edits were claim line edits. For these codes each claim line was adjudicated separately against the MUE value for the code on that claim line. *When* these MUEs *were* converted to date of service edits, the MUE values *were* based on data reflecting the total number of units of service of each code paid on a single date of service.

If a single infectious agent antigen detection test procedure produces results for more than one species or strain of organism, report only one (1) code with one (1) unit of service (UOS) for the procedure. Based on the methodology utilized and the strains or species tested by that procedure, the physician may report one UOS of a CPT code describing the testing for a specific infectious agent or one UOS of a CPT code describing testing for multiple organisms (e.g., 87300, 87451, 87800, 87801). A physician may report more than one UOS for testing different strains or species of an organism if and only if different test procedures are performed for the different strains or species. A physician should never report more UOS than the number of independent test procedures performed.

For example, if a test kit contains a card with five different spots each testing for a different species of an infectious agent, only one UOS for that test procedure may be reported. However, if a physician tests for three different species of that infectious agent by using three different test kits each containing a card testing for one species, the physician may report three UOS of the appropriate CPT code.

15. Since CPT code 87400 (Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Influenza, A or B, each) allows separate UOS for influenza A and influenza B, the MUE value for CPT code 87400 is two (2).

16. Infectious agents may be identified by antigen detection (e.g., CPT codes 87301-87450), immunofluorescence microscopy (e.g., CPT codes 87260-87299), or nucleic acid probe (e.g., CPT codes 87470-87501, 87510-87592, 87640-87799) techniques. If a single test procedure produces results for multiple species or strains of an organism, only one (1) unit of service (UOS) of a CPT code may be reported for that test procedure. However, if separate medically reasonable and necessary test procedures are performed for different species or strains of an organism, the same CPT code may be reported for each test procedure utilizing modifier 59 for the second and additional test procedures. For example, if a single amplified probe nucleic acid detection test procedure identifies more than one species of Candida organisms, only one (1) UOS may be reported for CPT code 87481 (infectious agent detection by nucleic acid (DNA or RNA); Candida species, amplified probe technique).

17. CPT code 81373 (HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, -B, or -C), each) is reported with one (1) unit of service (UOS) for each HLA Class I locus typed. This code may be reported with a maximum of two (2) UOS even though there are three HLA Class I loci. If all three loci are typed, the laboratory would report one (1) UOS of CPT code 81372 (HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)) rather than three (3) UOS of CPT code 81373. Similarly, CPT code 81380 (HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or -C), each) may also be reported with a maximum of two (2) UOS even though there are three HLA Class I loci. If all three loci are typed, the laboratory would report one (1) UOS of CPT code 81379 (HLA Class I typing, high resolution (ie, alleles or allele groups)); complete (ie, HLA-A, -B, and -C)) rather than three (3) UOS of CPT code 81380.

18. For calendar year 2016, urine drug presumptive testing should have been reported with HCPCS codes G0477-G0479. These codes were reported "per date of service" and should not have been reported with more than one UOS per day. These codes were deleted January 1, 2017.

Beginning January 1, 2017, urine drug presumptive testing may be reported with HCPCS codes 80305-80307. These codes are reported "per date of service" and should not be reported with more than one UOS per day.

Beginning January 1, 2016, urine drug definitive testing may be reported with HCPCS codes G0480-G0483. These codes are reported "per day" and should not be reported with more than one UOS per day.

M. General Policy Statements

1. *MUE and NCCI PTP edits are based on services provided by the same physician to the same beneficiary on the same date of service. Physicians should not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.*

2. *An analyte as used in this Manual refers to the entity measured by a quantitative or qualitative laboratory test or assay. Examples of analytes include, but are not limited to, the results of drug tests, urinalysis tests, molecular pathology tests, genomic sequence and molecular multianalyte tests, multianalyte assays with algorithmic analyses, chemistry tests, hematology and coagulation tests, immunology tests, tissue typing, transfusion medicine tests, microbiology tests, anatomic pathology (including surgical pathology and cytopathology) tests, cytogenetic tests, reproductive medicine tests, and other procedures/tests/assays listed in the Pathology and Laboratory section of the CPT Manual as well as clinical laboratory tests or assays assigned HCPCS level II codes.*

3. 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 [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 50(Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

4. Providers reporting services under Medicare's hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-only Manual* (*IOM*) instructions.

5. 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*.

6. 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*.

7. 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. A standing order is not an acceptable substitute for an individual written order by the treating physician. (Federal Register, Volume 62, Number 211, October 31, 1997, Page 59077) 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.

8. 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.