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

CMS issues the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

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A. Introduction

The principles of correct coding discussed in Chapter I apply to the Current Procedural Terminology (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.

Providers/suppliers shall report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code shall be reported only if all services described by the code are performed. A provider/supplier shall 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 provider/supplier shall not separately report these services simply because HCPCS/CPT codes exist for them.

The Centers for Medicare & Medicaid Services (CMS) often publishes coding instructions in its rules, manuals, and notices. Providers/suppliers must use these instructions when reporting services rendered to Medicare patients.

The *CPT Professional* codebook also includes coding instructions which may be found in the introduction, individual chapters, and appendices. In individual chapters, the instructions may appear at the beginning of a chapter, at the beginning of a subsection of the chapter, or after specific CPT codes. Providers/suppliers should follow *CPT Professional* codebook instructions unless CMS has provided different coding or reporting instructions.

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 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 & Management (E&M) 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 E&M section of the *CPT Professional* codebook.

CMS policy prohibits separate payment for duplicate testing or testing for the same analyte by more than one methodology. (See definition of analyte in this chapter, Section N (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 1 unit of service rather than 2.

By contrast, some laboratory test results typically require separate follow-up testing which is implicit in the physician's order. Such tests are termed reflex tests. For example, if an RBC antibody screen (CPT code 86850) is positive, the laboratory proceeds to identify the RBC antibody. The reflex test is separately reportable. Similarly, if a urine culture is positive, the laboratory proceeds to organism identification testing which is separately reportable. In these examples, the initial results have limited clinical value without the separate follow-up test.

Other laboratory test results may or may not require additional testing to have clinical value. This type of additional testing must be distinguished from reflex testing. The additional testing is not implicit in the initial physician order. An example is a test for a monoclonal protein band. The physician's initial order does not implicitly include any additional testing. A laboratory shall not routinely perform additional testing to identify the type of monoclonal protein unless ordered by the treating physician. If the patient has a known monoclonal gammopathy, the additional testing would not be appropriate unless ordered by the treating physician.

If a laboratory procedure produces multiple reportable test results, only a single HCPCS/CPT code shall be reported for the procedure. If there is no HCPCS/CPT code that describes the procedure, the laboratory shall report a miscellaneous or unlisted procedure code with a single unit of service.

Proprietary Laboratory Analyses (PLA) codes are alpha-numeric codes describing manufacturers' tests.

B. Evaluation & Management (E&M) Services

This section summarizes some of the Medicare Global Surgery Rules for reporting Evaluation & Management (E&M) services in the global period.

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 Medicare Administrative Contractor (MAC). 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 National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits are applied to same day services by the same provider/supplier to the same beneficiary, certain Global Surgery Rules are applicable to the NCCI program. 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 days 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 service is performed on the same date of service as a major surgical procedure to decide 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. The NCCI program does not contain edits based on this rule because MACs 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 shall 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/supplier is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. The NCCI program contains many, but not all, possible edits based on these principles.

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 shall not 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 provider/supplier shall not 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 that is above and beyond the usual pre- and post-operative work of the procedure 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 a "XXX" procedure may be appropriate in some instances.

C. Organ or Disease Oriented Panels

The *CPT Professional* codebook 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/supplier shall bill the panel code. The panel codes shall be used when the tests are ordered as that panel. For example, if the individually ordered tests are cholesterol (CPT code 82465), triglycerides (CPT code 84478), and HDL cholesterol (CPT code 83718), the service should be reported as a lipid panel (CPT code 80061). (See Chapter I, Section N (Laboratory Panel)).

The NCCI program 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 PTP-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. Modifiers 59 or 91 may be used to report this repeat testing. Based on the *Internet-Only Manual* (IOM), *Medicare Claims Processing Manual* (MCPM), 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 80400-80439 describe the laboratory components of the testing**.** Administration of the pharmaceutical agent may be reported with CPT codes 96365-96379. In the facility setting, these codes may be reported by the facility, but not the provider/supplier. In the non-facility setting, these codes may be reported by the provider/supplier. 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**.** E&M services, including prolonged services, should not be reported separately unless a significant, separately identifiable service medically reasonable and necessary E&M is provided and documented.

E. Drug Testing

1. Presumptive drug 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.

   Definitive drug testing may be reported with HCPCS codes G0480-G0483 and G0659. These codes differ based on the number of drug classes including metabolites tested. Only one code from this group of codes may be reported per date of service.

2. Providers performing validity testing on urine specimens used for drug testing shall 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 shall not be reported with CPT code 88291 (Cytogenetics and molecular cytogenetics, interpretation and report).

   Several criteria must be satisfied to report HCPCS code G0452. (See this chapter, Section M (Medically Unlikely Edits (MUEs)), Subsection 4 for reporting requirements related to HCPCS code G0452). One criterion is that it requires the exercise of medical judgment. If the information could ordinarily be furnished by a nonphysician laboratory specialist, the service does not require the exercise of medical judgment.

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...not elsewhere specified) shall 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 provider/supplier shall not report microdissection (CPT codes 88380 or 88381) for this process.

5. CPT codes 81445, 81450, and 81455 describe targeted genomic sequence, DNA analysis or combined DNA and RNA analysis. 81445 applies to solid organ neoplasm type (5-50 genes) and 81450 applies to hematolymphoid neoplasm type (5-50 genes), while 81455 applies to the number of genes analyzed for either a solid or hematolymphoid neoplasm (51 or greater genes). Providers/suppliers may not report 81455 with either 81445 or 81450. CPT codes 81449, 81451, and 81456 describe targeted genomic sequence RNA analysis using a separate method.

6. All genomic sequencing procedures and molecular multianalyte assays (e.g., CPT codes 81410-81471), many multianalyte assays with algorithmic analyses (e.g., CPT codes 81490-81599, 0004M-XXXXM), and many Proprietary Laboratory Analyses (PLA) (e.g., CPT codes 0001U-XXXXU) are DNA or RNA analytic methods that simultaneously assay multiple genes or genetic regions. A provider/supplier shall not additionally separately report testing for the same gene or genetic region by a different

methodology (e.g., CPT codes 81105-81408, 81479, 88364-88377). CMS payment policy does not allow separate payment for multiple methods to test for the same analyte.

7. A Tier 1 or Tier 2 molecular pathology procedure CPT code should not, in general, be reported with a genomic sequencing procedure, molecular multianalyte assay, multianalyte assay with algorithmic analysis, or proprietary laboratory analysis CPT code where the CPT code descriptor includes testing for the analyte described by the Tier 1 or Tier 2 molecular pathology code. Procedures reported together must be both medically reasonable and necessary (e.g., sequencing of procedures) and ordered by the physician who is treating the beneficiary and using the results in the management of the beneficiary's specific medical problem.

8. If one laboratory procedure evaluates multiple genes using a next generation sequencing procedure, the laboratory shall report only one unit of service of one genomic sequencing procedure, molecular multianalyte assay, multianalyte assay with algorithmic analysis, or proprietary laboratory analysis CPT code. If no CPT code accurately describes the procedure performed, the laboratory may report CPT code 81479 (Unlisted molecular pathology procedure) with one unit of service or may report multiple individual CPT codes describing the component test results when medically reasonable and necessary. Procedures reported together must be both medically reasonable and necessary (e.g., sequencing of procedures) and ordered by the physician who is treating the beneficiary and using the results in the management of the beneficiary's specific medical problem.

9. PTP edits bundling two Tier 1 molecular pathology procedure CPT codes describe procedures that should not, in general, be reported together. For example, CPT code 81292 describes full sequence gene analysis of MLH1, and CPT code 81294 describes duplication/deletion variant gene analysis of MLH1. In evaluating a patient with colon carcinoma (vs. constitutional genetic disorder), it may be appropriate to perform duplication/deletion testing if the disease variant(s) is (are) not identified by performing full gene sequencing. The same principle applies to other code pair combinations of testing for the same gene (e.g., 81295/81297, 81298/81300). Procedures reported together must be both medically reasonable and necessary (e.g., sequencing of procedures) and ordered by the physician who is treating the beneficiary and using the results in the management of the beneficiary's specific medical problem.

G. Chemistry

1. CPT code 83721 (Lipoprotein, direct measurement; LDL cholesterol) describes direct measurement of LDL cholesterol. It shall not be used to report a calculated LDL cholesterol.

2. 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). The NCCI program does not permit payment of CPT codes 84436 or 84479 with CPT code 84439.

3. Reserved for future use.

4. CPT code 83704 (Lipoprotein, blood; quantitation of lipoprotein particle number(s) (eg, by nuclear magnetic resonance spectroscopy) includes lipoprotein particle subclass(es), when performed) 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 to complete the ordered test based on laboratory selected criteria flagging the results for additional verification. The laboratory shall not report CPT code 85007 (Blood count; blood smear, microscopic examination with manual WBC differential count) or CPT code 85008 (Blood count; blood smear, microscopic examination without manual WBC differential count) for the examination of a blood smear to complete the ordered automated complete blood count (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/supplier 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 2 different methods unless the 2 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 diagnostic bone marrow aspiration(s) is(are) performed without biopsy, the procedure may be reported as CPT code 38220. Interpretation of the aspirate smear(s) may be reported as CPT code 85097. Both codes may be reported by the same provider/supplier if both the procedure and interpretation are performed by that physician. If a cell block is prepared from the bone marrow aspirate(s), interpretation of the cell block may be reported as CPT code 88305.

Diagnostic bone marrow biopsy(ies) may be reported with CPT code 38221. If bone marrow aspiration(s) is(are) also performed on the same bone, the biopsy(ies) and aspirations(s)may be reported with CPT code 38222. However, CPT code 38221 shall not be reported with CPT code 38220 for the same bone. Interpretation of the bone marrow biopsy(ies) may be reported with CPT code 88305.

The bone marrow aspiration(s) procedure (CPT code 38220) shall not be reported separately with the bone marrow biopsy(ies) procedure (CPT code 38221) unless the 2 procedures are performed on different bones 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) shall be reported for the surgical procedure. If 2 separate biopsies are medically necessary, both may be reported appending modifier 59 or XS 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.

Bone marrow biopsy(ies) is(are) typically performed with a Jamshidi needle yielding a cylindrical core of bone and marrow. The surgical pathology interpretation of this type of specimen is reported with CPT code 88305. A bone biopsy is typically performed with a different instrument and yields a larger non-cylindrical bony specimen which may include some bone marrow. The surgical pathology interpretation of this type of specimen may be reported with CPT code 88307.

I. Immunology

Allergen specific IgE testing may be performed using crude allergen extracts (CPT code 86003) or recombinant or purified components (CPT code 86008). Both procedures may be reported for the same date of service if the 2 types of testing are performed for different allergens. Both procedures may also be reported for the same date of service if allergen specific IgE crude extract testing is positive and allergen specific IgE component testing for that crude allergen is ordered by the treating physician and is used for management of the patient's specific medical problem. The laboratory shall not routinely perform allergen specific IgE component testing when the allergen specific IgE crude allergen extract test is positive.

J. 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) shall 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) shall 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 (includes preparation)), 86931 (Frozen blood, each unit; thawing), and/or 86932 (Frozen blood, each unit; freezing (includes preparation) and thawing) shall 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) shall 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) shall not be reported separately since the P code includes the thawing process.

K. 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 using nucleic acid probes is reported with CPT codes such as 87471-87801, 87910, 87901, 87906, 87912, 87902, 87903, and 87904. These CPT codes include all the molecular diagnostic analyses/processes.

3. 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 shall 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 2 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.

4. 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.

5. CPT codes 87483 (Multiplex infectious agent detection by nucleic acid methodology for central nervous system pathogens), 87505-87507 (Multiplex infectious agent detection by nucleic acid methodology for gastrointestinal pathogens), and 87631-87633 (Multiplex infectious agent detection by nucleic acid methodology for respiratory virus) describe multiplex testing procedures for multiple microorganisms using 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" shall be reported. The code descriptors identify some microorganisms, but not all, that might be tested by these methodologies for the respective anatomic regions. If it is medically reasonable and necessary to test by a different methodology or for other types of microorganisms not included in the multiplex test that might cause disease in the respective anatomic region, the test may be reported separately.

   The same organism could be a target in one panel reflecting one organ system and also a target in a different organ system when testing a different specimen. The same organism could be the target tested on each of 2 or more specimens from different anatomic sites.

L. 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, 88150-88153, 88164-88167, etc.) shall be reported. If multiple services (i.e., separate specimens from different anatomic sites) are reported, modifier 59 or XS may be used to indicate that different levels of service were provided for different specimens from different anatomic sites. This information shall be documented in the cytopathology reports. A cytopathology preparation from a fluid, washing, or brushing shall 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 shall 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, providers/suppliers shall 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 shall not be reported with a face-to-face evaluation of a patient. If a physician provides an 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 shall 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 generally not be reported for the same or similar specimens. The diagnosis should be established using one of these methods. The provider/supplier may report both CPT codes if both methods are required because the initial method does not explain all the light microscopic findings. The provider/supplier may report both methods using modifier 59 or XU and document the need for both methods in the medical record.

   If the abnormal cells in 2 or more specimens are morphologically similar and testing on one specimen by one method (CPT codes 88184, 88185, 88187, 88188, 88189, 88342, 88341, and 88344) establishes the diagnosis, the same or other method shall 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 be reported with CPT code 88361, not with CPT code 88358 in addition to CPT codes 88342, 88341 and/or 88344. Digital cellular imaging includes computer software analysis of stained microscopic slides. 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+ shall be reported as CPT codes 88342, 88341, and 88344.

5. DNA ploidy and S-phase analysis of tumor by digital cellular imaging technique should be reported with CPT code 88358. CPT code 88358 shall 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. 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.). 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+ shall 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/supplier other than M.D./D.O.), it shall be reported using appropriate CPT codes in the range 88271-88275. For each reportable probe, a provider/supplier shall 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 88364-88369, 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 shall 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/supplier 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/supplier other than M.D./D.O.) reads and quantitates the tissues/cells stained with the probe(s), the laboratory shall not report the technical component (-TC) of CPT codes 88367-88369, 88373, 88374, and 88377, and a hospital reporting an outpatient laboratory test shall not report CPT codes 88367-88369, 88373, 88374, 88377. The laboratory or hospital may report these services with CPT codes 88271-88275.

8. Flow cytometry interpretation shall be reported using CPT codes 88187-88189. Only one code shall 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/supplier shall not bill for interpretation of a single marker using another CPT code. Quantitative cell counts performed by flow cytometry (e.g., CPT codes 86355-86367) shall not be reported with the flow cytometry interpretation CPT codes 88187-88189 since there is no interpretative service for these quantitative cell counts.

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) shall not be reported with any of the previously listed CPT codes for examination of the same specimen.

10. 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.

    Instructions for HCPCS codes G0416 in this manual have undergone changes from year to year. For historical purposes, see the archived manuals on the NCCI webpage.

M. Medically Unlikely Edits (MUEs)

1. Medically Unlikely Edits (MUEs) are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim using modifiers to bypass MUEs. The MUE values are 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 (UOS) incorrectly. The provider/supplier may consider contacting their national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of UOS.

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

4. The code descriptor for CPT code 88291 (Cytogenetics and molecular cytogenetics, interpretation and report) does not define the unit of service for the code. The MUE value for this code is "one." CMS interprets this code to include the synthesis with interpretation and report of all cytogenetic/molecular cytogenetic testing respectively performed on a single date of service. This code should not be reported with separate UOS based on the number of specimens nor tests on a single date of service.

   HCPCS code G0452 (Molecular pathology procedure; physician interpretation and report) may be reported for 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. (If the information could ordinarily be furnished by a nonphysician laboratory specialist, the service does not require the exercise of medical judgement.) This code shall not be reported for an interpretation by a laboratory scientist. This code may be reported with a maximum of 1 unit of service 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, 2 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, 1 unit of service may be reported for each physician interpretation for each separately listed molecular pathology procedure for each distinct source of a specimen. A provider/supplier shall not report more than 1 unit of service 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 provider/supplier shall not report more than 1 unit of service for each listed molecular pathology procedure on a specimen from a single source.

5. The procedure described by CPT code 88264 (Chromosome analysis; analyze 20-25 cells) includes analysis of 20-25 cells with a count of all chromosomes in each cell and a karyotype for each cell. Thus, reporting 1 unit of service includes up to 25 karyotypes.

   The code descriptor for CPT code 88280 (Chromosome analysis; additional karyotypes, each study) includes the term "karyotypes." One unit of service includes all karyotypes determined per study. Each study refers to evaluation of a separate tumor. For example, if a provider performs chromosome analysis on an additional 10 cells from a single tumor determining the karyotype for each cell, only 1 unit of service of CPT code 88280 may be reported.

6. 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.

7. The unit of service 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 uses 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 unit of service for each separate lesion evaluated.

8. 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 code 88348) 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 2 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.

9. The unit of service for special stains (CPT codes 88312-88319) 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 UOS may be reported for the additional specimen(s) or block(s). Providers/suppliers shall 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 shall not be reported as additional UOS. Only one unit of service shall be reported for the stain on multiple levels from the single tissue block. Additionally, controls performed with special stains shall not be reported as separate UOS for the stain.

   For cytology specimens from a single anatomic site, only one unit of service shall 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 shall 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 1 unit of service shall be reported. Similarly, if 3 smears from a bone marrow aspirate are stained with an acid-fast stain, only 1 unit of service shall be reported. Smears from peripheral blood, 1 iliac crest, and contralateral iliac crest are from 3 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 uses multiple antibodies to obtain multiple separately reportable medically reasonable and necessary results. An antibody stain containing multiple antibodies that yields a single reportable result is not a multiplex stain and shall 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) shall only be reported as one 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 shall 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 shall be reported for each separate specimen. Providers/suppliers shall 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.

10. Morphometric analysis of tumor immunohistochemistry using a multiplex antibody stain shall be reported with one unit of service of CPT code 88360 or 88361 per specimen. It shall not be reported with one or more UOS of CPT codes 88341, 88342, or 88344.

11. 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 shall be reported for each separate specimen. Providers/suppliers shall 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 uses multiple probes to obtain multiple separately reportable medically reasonable and necessary results. A probe stain containing multiple probes that yields a single reportable result is not a multiplex stain and shall be reported with a single probe staining procedure CPT code.

12. 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 shall be reported for each separate specimen. Providers/suppliers shall 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.

13. The MUE value for CPT code 86807 (Serum screening for cytotoxic percent reactive antibody (PRA); standard method) is "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 used to obtain the test result. If multiple steps each using 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.

14. 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.

15. In the case of tests for infectious agents, methodologies include detection by immunofluorescence, immunoassay, or nucleic acid probe techniques. A single laboratory procedure shall be reported as one unit of service whether it generates one or multiple results. CPT codes that test for a single infectious agent that employ one procedure, one methodology, or one test kit are reported with one unit of service.

    CPT codes that test for multiple infectious agents are reported with one unit of service if one procedure, one methodology, or one test kit is used to perform the test (e.g., 87300, 87451, 87800, 87801). When multiple procedures, multiple methodologies, or multiple kits are medically necessary and used to perform a test for multiple infectious agents, the units of service reported for CPT codes that identify multiple infectious agents equals the number of different procedures, methodologies, or kits used to perform the test.

    For example, if a provider/supplier tests for 5 different species of an infectious agent using a single multiple-result test kit, only 1 unit of service for that test kit may be reported. However, if a provider/supplier tests for 3 different species of an infectious agent by using 3 different single result test kits, the provider/supplier may report 3 UOS of the appropriate CPT code.

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

17. Reserved for future use.

18. 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 unit of service for each HLA Class I locus typed. This code may be reported with a maximum of 2 UOS even though there are

3 HLA Class I loci. If all 3 loci are typed, the laboratory would report 1 unit of service of CPT code 81372 (HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)) rather than 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 2 UOS even though there are 3 HLA Class I loci. If all 3 loci are typed, the laboratory would report 1 unit of service of CPT code 81379 (HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)) rather than 3 UOS of CPT code 81380.

19. Beginning January 1, 2017, presumptive drug testing may be reported with CPT codes 80305-80307. These codes are reported "per date of service" and shall not be reported with more than one unit of service per day.

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

20. Definitive drug testing HCPCS code G0659 was implemented January 1, 2017. This code is reported "per day" and shall not be reported with more than one unit of service per day.

21. CPT code 86334 describes serum immunofixation electrophoresis and has an MUE value of "2." This procedure is usually performed only once on a single date of service to characterize a monoclonal protein. It may occasionally be necessary to perform the procedure a second time in a patient with multiple myeloma producing a monoclonal IgG kappa protein in certain situations. For example, if the patient is being treated with similar monoclonal proteins that mimic an IgG kappa myeloma protein on immunofixation electrophoresis.

N. General Policy Statements

1. The MUE values and NCCI PTP edits are based on services provided by the same provider/supplier to the same beneficiary on the same date of service. Physicians shall 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 Professional* codebook as well as clinical laboratory tests or assays assigned HCPCS level II codes.

3. In this manual, many policies are described using the term "physician." Unless indicated differently the use 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, CMS IOM Publication 100-04 MCPM, Chapter 12 (Physician/Nonphysician Practitioners), Section 50 (Payment for Anesthesiology Services) and Global Surgery Rules, CMS IOM, Publication 100-04 MCPM, Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery) do not apply to hospitals.

4. Providers/suppliers reporting services under Medicare's hospital Outpatient Prospective Payment System (OPPS) shall report all services in accordance with appropriate Medicare IOM instructions.

5. In 2010, the *CPT Professional* codebook modified the numbering of codes so that the sequence of codes as they appear in the *CPT Professional* codebook does not necessarily correspond to a sequential numbering of codes. In the *Medicare NCCI Policy Manual*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Professional* codebook.

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 using 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 using tissue adhesive may be reported separately. If a practitioner uses 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 uses 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 the OPPS, HCPCS code G0168 is not recognized and paid. Facilities may report wound closure using sutures, staples, or tissue adhesives, singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Professional* codebook.

7. CPT codes 80503-80506 describe clinical pathology consultation services. CMS has specific rules for reporting consultation services. Reporting of these services may be based on either the total time for pathology clinical consultation services performed on the date of consultation or level of medical decision making. 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 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 shall not be reported with an E&M code on the same date of service. CPT codes 80503-80506 shall not be reported for consultation related to a pathology or laboratory service that includes a physician interpretation. (CPT codes 80500 and 80502 were deleted January 1, 2022.)

8. Medicare does not pay for duplicate testing. Multiple tests to identify the same analyte**,** marker, or infectious agent shall 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.

9. CPT code 36591 describes "collection of blood specimen from a completely implantable venous access device." CPT code 36592 describes "collection of blood specimen using an established central or peripheral catheter, venous, not otherwise specified." These codes shall not be reported with any service other than a laboratory service. However, these codes may be reported if the only non-laboratory service performed is the collection of a blood specimen by one of these methods.

10. CPT code 96523 describes "irrigation of implanted venous access…" This code may be reported only if no other service is reported for the patient encounter.