You’d think that coding for surgical pathology specimens would be easy — after all, you only have the following six codes to choose from:

- 88300 — Level I — Surgical pathology, gross examination only
- 88302 — Level II — Surgical pathology, gross and microscopic examination
- 88304 — Level III — Surgical pathology, gross and microscopic examination
- 88305 — Level IV — Surgical pathology, gross and microscopic examination
- 88307 — Level V — Surgical pathology, gross and microscopic examination
- 88309 — Level VI — Surgical pathology, gross and microscopic examination.

But then, each code has between 12 and 66 specific tissue specimens listed — and that’s where it gets difficult. You won’t find the specimens indexed in the CPT® manual, either.

**Beware:** Knowing the organ or anatomic site is not enough to choose the proper surgical pathology code. Many organs appear under multiple codes for surgical pathology; some even appear at every level of service.

**For instance:** CPT® lists “testis,” with various modifying terms, under each of the codes 88302-88309. That’s why you need to learn the many factors that determine the level of service for a particular organ or tissue type.

**Specimen is key:** The unit of service for surgical pathology codes 88300-88309 is the specimen, which CPT® defines as “tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis.” A list of specimens follows each surgical pathology code descriptor in the CPT® manual. You must assign listed specimens to the appropriate code.

**Know what the service includes:** The service your pathologist provides for each specimen is “accession, examination and reporting.” Except for 88300, the work involves gross and microscopic examination of the tissue, including routine staining such as hematoxylin and eosin (H&E). The codes represent ascending levels of physician work.

**Watch for unlisted specimens:** If the pathologist examines a specimen that CPT® does not list under any of the codes, you should assign the code that “most closely reflects the physician work involved when compared to other specimens assigned to that code,” according to CPT®.

**Caution:** You can assign codes for *unlisted* specimens only using this “comparative work” method — never upcode a listed specimen because it was “more work than usual.”

**Do this:** To ensure accurate surgical pathology coding, the pathologist must provide a diagnosis and specimen description, and you, the coder, must understand what factors will impact code assignment, beyond the name of the organ or anatomic site. Study the following four issues to optimize your specimen coding:

1. **Know the Diagnosis Before Coding**

   Many surgical pathology codes rely not just on the type and extent of tissue that the pathologist examines, but also on the final diagnosis. CPT® assigns several tissues to a different level of surgical pathology depending on whether the diagnosis is neoplastic.

   **For instance:** You should report a uterus exam that a surgeon submits with a clinical diagnosis of endometriosis (617.0) as 88307 (*... uterus, with or without tubes and ovaries, other than neoplastic/prolapse*) if the pathologist’s examination confirms the suspected diagnosis. However, if the pathologist diagnoses adenocarcinoma of the endometrium (182.0, *Malignant neoplasm of the corpus uteri, except isthmus*) based on the gross and microscopic examination, you should report 88309 (*... uterus, with or without tubes and ovaries, neoplastic*).
Another example: CPT® lists tissues that physicians remove with no expected pathology under 88302. The pathologist’s work for these specimens is to confirm identification and the absence of disease. If the tissue is indeed disease-free, list the specimen as 88302. But in the event of pathologic findings, you should find the higher CPT® service level that lists the pathological specimen and code accordingly.

2. Understand the Reason for Excision

CPT® sometimes lists the same tissue under different surgical pathology levels based on the reason the surgeon excised the tissue.

For example: If the surgeon removes a normal fallopian tube for sterilization, you should report 88302 (fallopian tube, sterilization). On the other hand, if the surgeon removes a fallopian tube for suspected pathology, you should use 88305 (fallopian tube, biopsy) or (fallopian tube, ectopic pregnancy).

Code “for tumor” regardless of diagnosis: CPT® assigns certain tissues to a higher code if the pathologist evaluates them for tumor, regardless of the final diagnosis. For example, a colon resection from a patient with a history of a malignant polyp represents an evaluation “for tumor” regardless of the final diagnosis. The correct code would be 88309 (colon, segmental resection for tumor), not 88307 (colon, segmental resection, other than for tumor), regardless of the final diagnosis.

3. Distinguish Between Biopsy and Resection

The same organ or tissue may appear under multiple surgical-pathology service codes based on the following distinctions: whether the specimen is a biopsy or a resection; whether the resection is total or partial; and whether the resection is with or without lymph nodes. To ensure accurate coding, pathologists should clearly define the specimen, avoiding nondescript terms such as “kidney tissue.”

Do this: As much as possible, pathology reports should describe the tissue using the language of CPT®, such as “biopsy,” “curetting,” and “partial resection.” Using this type of terminology in no way compromises the pathologist’s reporting, but it assists in ensuring accurate billing and payment for services.

For example: You should list a polyp of the small intestine as 88305 (breast, biopsy, not requiring microscopic evaluation of surgical margins). On the other hand, when the surgeon excises a lesion and the pathologist documents margin exam, you should report 88307 (breast, excision of lesion, requiring microscopic evaluation of surgical margins). Also report a partial mastectomy, which you might see under names such as “lumpectomy,” “simple mastectomy,” “tylectomy,” or “quadrantectomy,” using 88307 (breast, mastectomy - partial/simple).

If the surgeon removes breast tissue with contiguous lymph nodes, report 88309 (breast, mastectomy - with regional lymph nodes). The pathology report might describe this type of specimen using different names, such as “simple mastectomy with axillary dissection,” or “modified radical mastectomy,” or “total mastectomy.”

Bottom line: If you remember the principles for assigning breast codes, such as margin or lymph evaluation, you won’t be
fooled by the many different names that surgeons use to describe breast specimens.

**Example 1:** The surgeon identified a specimen as “soft tissue mass, right side of the neck,” but the pathologist wrote the final diagnosis as “lipoma.”

**Solution 1:** You should use the most definitive information available — in this case the pathologist’s final diagnosis — to assign the procedure code. That means the specimen is a lipoma, and you should code the pathologist’s work as 88304 (soft tissue, lipoma). You should not code this specimen as 88307 (soft tissue mass [except lipoma] -biopsy/simple excision). The code definition specifically excludes lipoma.

**Example 2:** A patient had a partial mastectomy with cancer findings, including margins that were not clear. At a later date, the pathologist examines a breast re-excision specimen, including margin evaluation.

**Solution 2:** The CPT® code for breast excisions does not depend on the diagnosis. For that reason, you will select the same code whether or not the pathologist finds any remaining malignancy in the re-excision specimen. Because the pathologist’s examination of the re-excision specimen involves margin evaluation, you should report this specimen as 88307 (Breast, excision of lesion, requiring microscopic evaluation of surgical margins).

**Example 3:** When the pathologist examines a hysterectomy specimen for fibroids, should you code the case as a neoplastic uterus since fibroids are a benign neoplasm?

**Solution 3:** ICD-9 defines uterine leiomyoma (218) as a “benign tumor” and states that the category includes uterine fibroids, fibromyoma, and myoma. Because it is a neoplasm, you would expect to code the pathology exam of a hysterectomy with fibroid tumors as 88309 (uterus, with or without tubes and ovaries, neoplastic).

**Exception:** But uterine leiomyomas represent an “unwritten” exception among listed specimens in the CPT® surgical pathology section. Several sources concur on this point:

The AMA in the December 2003 CPT® Assistant states that “leiomyomas do not require the same degree of evaluation as other uterine neoplasms,” and therefore concludes that when leiomyoma of the uterus is the principal diagnosis for a hysterectomy specimen, you should report 88307 (uterus, with or without tubes and ovaries, other than neoplastic/prolapse) rather than 88309.

The College of American Pathologists has also published coding advice indicating that you should use 88307 for uterine leiomyoma in addition to non-neoplastic uterine conditions (CAP Today, July 1999)

**Exception:** When the pathologist examines a myomectomy specimen, which is a resection that involves removing fibroids from the uterus without performing a complete hysterectomy, don’t use 88307. CPT® lists this specimen as 88305 (leiomyoma[s], uterine myomectomy - without uterus).

**Note:** Ease your surgical pathology coding by referring to the appendix for a comprehensive, alphabetical list of specimens and their codes.

**Capture Pathologist’s Tissue Prep for Molecular Pathology**

Pathologists sometimes prepare tissue for further study, such as molecular pathology testing. CPT® provides several codes to capture that work, depending on when and how the pathologist performs the service. Code 88363 (Examination and selection of retrieved archival [i.e., previously diagnosed] tissue[s] for molecular analysis [e.g., KRAS mutational analysis]) describes the work when a pathologist retrieves a signed-out case to select appropriate tissue for molecular analysis. Make sure you know the difference between 88363 and codes from the following two code families.

**Watch 88380-88381 Bundles**

Pathologists sometimes obtain target tumor cells for molecular analysis by using manual or laser capture microdissection techniques. You report the service using 88380 (Microdissection [i.e., sample preparation of microscopically identified target]; laser capture) or 88381 (manual).

It’s conceivable that a pathologist will select archival tissue for a molecular analysis ordered by the patient’s physician and then perform microdissection on the archival tissue to prepare it for the test.
**Beware edits:** Medicare’s Correct Coding Initiative (CCI) bundles 88363 with 88380 or 88381. That means you shouldn’t bill the codes together when the pathologist selects archive material and performs microdissection for the same molecular analysis.

**Do this:** Bill the code that represents the most comprehensive documented service, such as 88381 versus 88363, which pays considerably less.

**Choose 88387 Family or 88363**

Sometimes pathologists perform sterile macroscopic dissection to prep fresh tissue for molecular diagnostics testing. CPT® provides the following two codes to capture the service:

- 88387 — *Macroscopic examination, dissection, and preparation of tissue for nonmicroscopic analytical studies (e.g., nucleic acid-based molecular studies); each tissue preparation (e.g., a single lymph node)*
- +88388 — *... in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (e.g., a single lymph node) (List separately in addition to code for primary procedure).*

**For instance:** The pathologist might process a sentinel lymph node biopsy and provide distinct sterile macroscopic examination and sectioning for T or B clonality evaluation.

**Distinguish 88363:** When preparing a specimen for molecular studies, 88387 and +88388 refer to specific pathologist macroscopic work that takes place before the pathologist performs the microscopic examination (such as 88307, Level V — *Surgical pathology, gross and microscopic examination*). In contrast, 88363 takes place on archival tissue after the pathologist has completed the surgical pathology service and signed out the case.

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