If you’ve ever watched Doc TV, you’ve heard of a CBC. As a lab coder, you need to learn the rules for coding complete blood counts and other blood constituents that physicians commonly order. You also need to know about blood-clotting tests that CPT® includes in the same section.

1. Blood Counts

Because physicians may ask for a wide array of blood constituents, CPT® provides the following codes for reporting the tests:

- 85004 — Blood count; automated differential WBC count
- 85007 — ... blood smear, microscopic examination with manual differential WBC count
- 85008 — ...blood smear, microscopic examination without manual differential WBC count
- 85009 — ... manual differential WBC count, buffy coat
- 85013 — ... spun microhematocrit
- 85014 — ... hematocrit (Hct)
- 85018 — ... hemoglobin (Hgb)
- 85025 — ... complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
- 85027 — ... complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
- 85032 — ... manual cell count (erythrocyte, leukocyte, or platelet) each
- 85041 — ... red blood cell (RBC), automated
- 85044 — ... reticulocyte, manual
- 85045 — ... reticulocyte, automated
- 85046 — ... reticulocytes, automated, including 1 or more cellular parameters (eg, reticulocyte hemoglobin content (CHR), immature reticulocyte fraction (IRF), reticulocyte volume (MRV), RNA content), direct measurement
- 85048 — ... leukocyte (WBC), automated
- 85049 — ... platelet, automated

Know CBC and diff: The distinction between CPT’s two CBC codes is whether the lab performs an automated differential WBC (85025) or not (85027).

If the lab performs an automated test for some, but not all components of a CBC, report the separate components using 85014, 85018, 85041, 85048, or 85049. For individual-component manual counts, use 85032.

Distinguish differential: You should report a stand-alone automated differential count as 85004 and a stand-alone manual differential as 85007 (or rarely, 85009). Although CPT® provides a code for CBC and automated differential (85025), if the lab performs a CBC with manual differential, you’ll have to report the service with two codes: 85027 and 85007.

Clarify “without platelets”: Although physicians commonly order a CBC without platelets, you cannot use the CBC codes for the service. Instead, you’ll have to report the service by listing each of the component codes — unless the payer is Medicare. Then you should use one of the following codes to describe the group of tests:

- G0306 — Complete (CBC), automated (Hgb, Hct, RBC, WBC, without platelet count) and automated differential WBC count
- G0307 — Complete (CBC), automated (Hgb, Hct, RBC, WBC, without platelet count).

Report other blood components with the appropriate code based on lab method: 85044, 85045, or 85046 for reticulocyte, and 85013 for spun hematocrit.

Example: The physician orders RBC, WBC, and platelet count, which the lab performs on an automated system.
**Solution:** Because the physician does not request all the components of a CBC, you can't use 85027 for CBC without differential. You’ll have to use the separate codes for the individual components. Because the lab uses an automated system, you should report these codes: 85041 (RBC), 85048 (WBC), and 85049 (platelets).

2. Smears

For a blood or bone marrow smear, report the service with the appropriate code:

- **85008** — Blood smear, microscopic examination without manual differential WBC count
- **85060** — Blood smear, peripheral, interpretation by physician with written report
- **85097** — Bone marrow, smear interpretation

Code 85008 describes a non-physician manual microscopic peripheral blood review, usually when an automated CBC suggests a clinically significant abnormality such as thrombocytopenia. In contrast, 85060 describes a physician-service peripheral blood smear interpretation.

**Caution:** Medicare bundles 85008 with many other hematology codes because a microscopic smear review is part of a blood count service.

**Limitation:** Medicare only covers 85060 when you’re billing for a hospital inpatient. CMS’s logic for not paying 85060 for hospital outpatients or non-patients is that “payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS [prospective payment system] rate.” In other words, Medicare holds that it has paid for the peripheral blood smear interpretation by paying for the lab test on the clinical lab fee schedule (such as CBC).

**Example:** *A pathologist performs a bone marrow aspiration, examines direct smears, processes a clot from the remaining aspirate, and examines an iron stain on both the aspirate and the clot.*

**Solution:** For the bone marrow aspirate extraction, use 38220 (Bone marrow; aspiration only). This service involves removing bone-marrow cells through a needle, and a surgeon may do the work. Don’t bill for 38220 unless the pathology report documents that the pathologist actually performed the extraction.

The pathologist’s work to evaluate and interpret the bone-marrow aspirate is 85097. To process and evaluate the clot, you should report that the pathologist performed 88305 (Level IV — Surgical pathology, gross and microscopic examination, cell block, any source) in addition to the 85097 exam.

If the pathologist examined iron stains for both the bone-marrow aspirate and the clot, you should code two units of 88313 (Special stain including interpretation and report; Group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry). You should use the special stain code per specimen, not per slide.

3. Coagulation

A complex cascade of reactions involving various factors causes blood clotting, and CPT® provides a host of codes to evaluate coagulation function. Selecting the proper code in this range (most codes from 85170-85810) is generally straightforward based on the factor and procedure definitions.

**Know these common codes:** Because physicians often assess blood-thinning medication using two common tests, you need to be familiar with these codes: 85610 (Prothrombin time) (PT) and 85730 (Thromboplastin time, partial [PTT]; plasma or whole blood).

These tests evaluate the two converging pathways that result in clot formation — the extrinsic pathway, assessed using PT, often for the drug warfarin (Coumadin) — and the intrinsic pathway, assessed using PTT, often for the drug heparin.

**Find Bone Marrow Aspiration Codes Throughout CPT**

Bone marrow aspiration involves removing a small amount of fluid (aspirated cells) from the bone marrow through a needle attached to a syringe. Coding for the entire process can include codes from surgery, to hematology, to surgical pathology.

**Use surgical code for aspiration:** If your pathologist withdraws the needle specimen, report the service as (38220,
Bone marrow; aspiration only. Although the code for acquiring a bone marrow aspiration used to be in the hematology section, your pathologist can claim the surgical code if he performs the service. Medicare rule: For a bone marrow aspiration and biopsy from the same incision, you should report the aspiration as G0364 (Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service).

List hematology code for interpretation: Regardless of who removes the bone-marrow aspirate, a pathologist will examine and interpret the specimen. Report the pathologist’s interpretation using hematology code 85097 (Bone marrow, smear interpretation).

This code includes a technical and professional component — involving smear preparation and the pathologist’s interpretation, respectively. If a single billing entity performs the entire service, report 85097 without modifiers. If separate billing entities perform the technical and professional services (such a hospital lab and an independent pathologist), each entity should bill the code with the appropriate modifier, TC (Technical component) or 26 (Professional component).

Look for special stains: Pathologists often perform special stains on bone marrow aspirate smears. For example, the pathologist may use myeloperoxidase or Sudan black B to provide improved cytologic detail for evaluating leukemia patients. In addition to 85097, you should report that stain as 88342 (Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure).

Don’t miss cell block: After preparing smears, full evaluation of the bone marrow aspirate often entails processing the remainder of the specimen as a cell block. You should bill the pathologist’s evaluation of the cell block as 88305 (Level IV-surgical pathology, gross and microscopic examination, cell block, any source) in addition to 85097.

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