CPT® 2013

Maneuver CPT® and CMS Instructions’ Split Decision for MAAA Coding

To use or not to use the new codes: that is the question.

As with last year’s new molecular pathology codes, you probably won’t be able to use the eight new CPT® 2013 codes for multi-analyte assays with algorithmic analyses (MAAAs).

That’s because CMS states, “we will not recognize these nine MAAA codes for CY 2013,” and places the codes in the physician fee schedule with a procedure status indicator of I (Not valid for Medicare purposes. Medicare uses another code for the reporting and payment of these services).

Find out: So what are these tests, and how does coding instruction for these services vary depending on whether you’re consulting CPT® or CMS? Read on to let the experts help you sort it out.

Recognize MAAA Tests

CPT® 2013 introduces a new section for MAAAs, which are “procedures that utilize multiple results derived from assays of various types … as well as other patient information (if used)” to perform algorithmic analysis and report findings as a numeric score or probability. The assays involved in the MAAA could include molecular pathology tests, fluorescent in situ hybridization (FISH), as well as other procedures such as protein, polypeptide, lipid and carbohydrate tests.

MAAAs are “tests developed to answer particular clinical questions” that analyte results alone would not necessarily answer for treating physicians, according to Paul Radensky, M.D., representing McDermott Will & Emery at the annual CMS public meeting for pricing 2013 lab codes on the Clinical Laboratory Fee Schedule (CLFS).

There’s more: MAAAs are not just a panel of tests. Instead, the algorithm represents a substantial component of the test, according to Peter Kazon, speaking on behalf of American Clinical Laboratory Association (ACLA) at the CLFS public meeting.

Be specific: MAAAs are generally uniquely available through a single lab or vendor, according to Mark S. Synovec, M.D., College of American Pathologists, AMA CPT® Editorial Panel member at the AMA’s annual CPT® and RBRVS Symposium, held Nov. 14-16 in Chicago.

See a complete list of the new CPT® 2013 Category I MAAA codes in “MAAA Line-up: Get Familiar With 9 New Algorithm Codes” on page 11.

That’s not all: Because MAAAs are typically unique to a single clinical lab or manufacturer, and because there’s ongoing development of new MAAAs, CPT® 2013
created Appendix O. The appendix lists the proprietary name and manufacturer with the associated code and descriptor.

**Keep up with administrative codes:** You’ll find the eight new CPT® Category I MAAA codes in appendix O, but you’ll also see different MAAAs listed with an “administrative code.” These are tests that have not been assigned a Category I code. The AMA may add new administrative MAAA codes on the CPT® Website in March, June, and November, corresponding to the CPT® Editorial Panel actions, explained Mark S. Synovec, M.D., College of American Pathologists, AMA CPT® Editorial Panel member at the AMA's annual CPT® and RBRVS Symposium, held Nov. 14-16 in Chicago.

**What’s Included**

Each MAAA code, whether Category I or an administrative code, “encompasses all analytical services required for the algorithmic analysis … in addition to the algorithmic analysis itself” according to CPT® instruction.

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**ICD-10**

543.9 Ruptures into Many More-Specific ICD-10 Appendix Codes

Go beyond ‘other’ and ‘unspecified’.

When ICD-9 yields to ICD-10 in Oct. 2014, you’ll need to broaden the diagnosis code choices for your appendix pathology reports.

In fact, you’ll find five, more-specific ICD-10 codes for appendix conditions that ICD-9 lumps under “other and unspecified” (543.9, Other and unspecified diseases of appendix), including concretions, diverticulum, and fistula.

**Get familiar with K38**

Instead of 543.9, you’ll choose one of the following ICD-10 codes starting Oct. 1, 2014:

- K38.1 — Appendicular concretions
- K38.2 — Diverticulum of appendix
- K38.3 — Fistula of appendix
- K38.8 — Other specified diseases of appendix
- K38.9 — Disease of appendix, unspecified.

**Notice:** You’ll still have codes in ICD-10 for other specific appendix conditions, and unspecified appendix conditions. Unlike ICD-9, however, ICD-10 distinguishes whether the pathology report doesn’t specify the appendix condition (K38.9) or the pathology report specifies a condition that ICD-10 doesn’t specifically list (K38.8).
That means the codes include any or all of the following services, if performed:

- Chemistry assays
- Biochemical assays
- FISH
- Patient data
- Any of the following steps for molecular analyses:
  - Cell lysis
  - Nucleic acid stabilization
  - Extraction
  - Digestion
  - Amplification
  - Hybridization and detection
- Algorithmic analysis
- Report

Extra services: If the MAAA requires any tissue preparation prior to cell lysis, you can separately code that procedure. For instance, you might perform and report one of the following services before performing a molecular analysis that is part of a MAAA test:

- Microdissection (88380-88381, Microdissection [i.e., sample preparation of microscopically identified target] …)
- Macro tissue prep (88387-88388, Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies [e.g., nucleic acid-based molecular studies]…)

» Archived specimen selection (88363, Examination and selection of retrieved archival [i.e., previously diagnosed] tissue[s] for molecular analysis [e.g., KRAS mutational analysis])

Caution: Make sure you abide by restrictions for reporting any of these services together, such as a Correct Coding Initiative (CCI) edit for 88380 and 88381 with 88363. Select only the most extensive procedure your lab performs.

CPT® Says Bill This Way

The CPT® 2013 instruction for MAAs indicate that you should select the single, specific Category I code or administrative code from Appendix O that describes the analysis. As explained in the prior section, “What’s Included,” the code describes all the assays, molecular or otherwise, and the algorithm analysis and report.

Even if the report lists the results of the individual component procedures, “these assays are not reported separately using additional codes,” according to CPT® instruction. In other words, don’t report a MAAA code plus the code for the underlying tests.

For example: The lab performs the ROMA (Risk of Ovarian Malignancy Algorithm) assessment, which combines the results of an HE4 and a CA 125 test, along with menopausal status, into a numeric score. This MAAA helps to identify patients presenting with adnexal mass as high or low likelihood for…

(Continued on next page)
find malignancy with surgery. For this service, report 81500 (Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score), not 81500 plus 86304 (Immunoassay for tumor antigen, quantitative: CA 125) and 86305 (Human epididymis protein 4 (HE4)), according to CPT® instruction.

No specific code? Report the unlisted MAAA code (81599) only if CPT® doesn’t provide either a Category I or administrative code for the MAAA.

CMS Says Bill That Way

If you’re billing Medicare for a MAAA procedure, forget everything you just read. CMS “does not recommend separately pricing the MAAA codes,” according to the CLFS final payment determination. That means you won’t get paid if you bill a code from the range 81500-81599 to a Medicare payer.

Instead, CMS intends for labs to use “other codes for payment of the underlying clinical laboratory tests on which the MAAA is done.”

Prior example: For the ROMA procedure described in the earlier example, you should bill Medicare payers using 86304 (CA 125) and 86305 (HE4).

Here’s why: CMS states that the agency “does not recognize algorithmically derived rate or result as a clinical laboratory test.”

2013 Fee Schedules

Prep for These Cuts Under Medicare CLFS and PFS

Watch for SRG relief by year’s end.

The word is in — expect less pay for your lab in 2013 whether your procedures cluster on the Clinical Laboratory Fee Schedule (CLFS) or the Medicare Physician Fee Schedule (PFS).

Here’s the low-down on what you can expect based on the final PFS published in the Nov. 16, 2012 Federal Register, and the final CLFS 2013 payment decision posted in CMS’ Transmittal R2612CP.

Pathologists Play Second Fiddle to Primary Care

To offset a pay increase to some physicians under the primary care initiative, CMS is decreasing pay for all non-primary care physicians, including pathologists. Expect a 1 percent reduction for pathology, according to CMS.

Here’s why: CMS implements a 7 percent pay increase for family practitioners in 2013, and between 3 and 5 percent increases for other primary-care practitioners. “Helping primary care doctors will help improve patient care and lower health care costs long term,” said CMS Acting Administrator, Marilyn B. Tavenner in a statement about the PFS.

Don’t forget that you’re already facing a 1 percent reduction for pathology in 2013 as the final year of the four-year practice-expense (PE) transition. That totals two percent down for pathology.

There’s more: The PFS shows a net reduction in Relative Value Units (RVUs) for pathology services of about 4 percent, much of it due to Technical Component (TC) revaluation and RVU changes to high-volume codes based on Affordable Care Act direction. For instance, you’ll see a - 33.4 percent pay change for 88305 (Level IV - Surgical pathology, gross and microscopic examination) (global fee, non-facility).

Because 88305 is one of the highest-volume procedures for us and for many pathology practices, this payment change will have a significant impact on earnings in 2013,” says R.M. Stainton Jr., MD, president of Doctors’ Anatomic Pathology Services in Jonesboro, Ark.

Final bad news: If congress doesn’t act to halt changes due to the Sustainable Growth Rate (SGR) formula, you’ll also see a significant across the board cut in PFS payment under the final rule’s stated 26.5 percent conversion factor reduction.

“The President’s budget calls for an aversion of the cut and a permanent fix,” said Kathy Bryant, deputy director of the department of physician services at CMS at the AMA’s annual CPT® and RBRVS Symposium in Chicago.

CLFS a Downer, Too

Look for a 4.95 percent payment cut in 2013 for tests paid on the CLFS, based on current law. The following adjustments show how it adds up:

» 2 percent cut passed by Congress to help pay for 2012 PFS fix
» 2 percent reduction in lab fee schedule payments over 10 years as part of the 2011 deficit reduction deal
» Net 0.95 percent cut based on the health care reform law fee schedule update formula that includes a 1.75 percent cut each year from 2011 through 2015 and a positive consumer price index adjustment (1.7 percent) minus a productivity adjustment (currently 0.9 percent).

Prior example: The PFS shows a net reduction in Relative Value Units (RVUs) for pathology services of about 4 percent, much of it due to Technical Component (TC) revaluation and RVU changes to high-volume codes based on Affordable Care Act direction. For instance, you’ll see a - 33.4 percent pay change for 88305 (Level IV - Surgical pathology, gross and microscopic examination) (global fee, non-facility).
the CLFS, the agency will use gap-fill payment methodology. That means you can expect your Medicare contractors to price the codes this year while CMS gathers information to establish a national payment rate for 2014.

Editor’s note: Congress passed a bill on New Year’s Day that halts the 26.5 percent conversion factor reduction on the PFS for one year. The bill also puts off the 2 percent cut to the CLFS until March. ☐

Medical Records

Audit Proof Your Pathology Reports

Follow new CMS guidelines when you must make changes.

Pretty much every pathologist has faced this scenario: You look over your report only to realize that you left out some important information.

Now when you face this situation, you’ll have some new direction from CMS, according to Transmittal 442.

Strive for Completeness

CMS encourages providers to “enter all relevant documents and entries” into the record at the time of service, but notes that “occasionally, upon review a provider may discover that certain entries, related to actions that were actually performed at the time of service but not properly documented, need to be amended, corrected, or entered after rendering the service.”

Survive audit: If an auditor ever reviews your files, CMS directs them to consider your amended entries — but only if you follow the rules. For instance, auditors “shall not consider undated or unsigned entries handwritten in the margin of the document,” the Transmittal advises.

Do this: When adding, correcting, or entering information after the date of service, you should identify it as an amendment, and the practitioner should sign and date it. Never delete the original entry — instead, ensure that all original content is identifiable. You can do this on a paper record by using a single strike line through the original content. For an EHR, you must “provide a reliable means to clearly identify the original content, the modified content, and the date of authorship of each modification of the record,” CMS says in the transmittal.

CMS advises MACs and auditors that see potential fraud in the documentation to refer those cases to the ZPIC auditors. To read the complete transmittal, visit www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R442PI.pdf. ☐

Reader Questions

88141 Still a Roadblock for Some Payers

Question:
We are having problems with 88141 for Aetna patients. They are denying them as “N303 Missing/incomplete/invalid principal procedure date.” We even appealed one claim and the response was only that the original determination was correct. Have you ever seen this rejection, and what can we do to overcome the problem?

Pennsylvania Subscriber

Answer:
Yes, others have reported similar rejections, although it is becoming much less frequent. You’ll need to talk with your payer representative to resolve the issue, but we can give you some ammunition:

You use a different code for the Pap smear itself, depending on the lab method used, which you can select from the following list:

» 88142 — Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid,

(Continued on next page)

You Be the Coder

Beware ‘Noncontributory’ Language

Question:
Our pathologist examined three distinct cytology specimens and documented cell blocks for each specimen. However, the diagnosis section of the report designates two of the cell blocks as “noncontributory.” Can we bill the technical and professional components of those tests anyway?

Texas Subscriber

Answer: See page 15. ☐
automated thin layer preparation, manual screening under physician supervision
- 88143 — with manual screening and rescreening under physician supervision
- 88147 — Cytopathology smears, cervical or vaginal, screening by automated system under physician supervision
- 88148 — screening by automated system with manual rescreening under physician supervision
- 88150 — Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
- 88152 — with manual screening and computer-assisted rescreening under physician supervision
- 88153 — with manual screening and rescreening under physician supervision
- 88154 — with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
- 88164 — Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
- 88165 — with manual screening and rescreening under physician supervision
- 88166 — with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
- 88174 — Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision
- 88175 — with screening by automated system and manual rescreening or review, under physician supervision.

Prior to 2006, 88141 was an add-on code and the definition instructed, “list separately in addition to code for technical service.” A text note following the code added to the confusion by stating, “Use 88141 in conjunction with 88142-88154, 88164-88167, 88174-88175.”

Some payers interpreted ‘in conjunction with’ to mean that both codes must be on the same bill.

CPT® 2006 changed 88141 by removing the “+” and the part of the code definition that states, “(list separately in addition to code for technical service).” However, the text note following 88141 still says, “Use 88141 in conjunction with 88142-88154, 88164-88167, 88174-88175.”

But using 88141 “in conjunction with” a Pap test code does not mean that the physician or facility must necessarily bill both services. The terminology change accommodates the situation in which an independent lab provides and bills the technical service separate from the pathologist, who bills only the interpretation.

According to the AMA’s CPT® Changes 2006, An Insider’s View, eliminating add-on status for 88141 “will allow reporting for professional interpretation by a physician or pathologist who is not associated with the laboratory providing the technical component.”

**Bottom line:** You should talk to a payer representative and show them the documentation indicating that you should be allowed to bill 88141 without billing the Pap technical test code on the same claim.

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**Method Dictates Cytology Code**

**Question:**

Our pathologist received 2cc colorless, slightly hazy fluid from bronchial lavage, concentrated the specimen using cytospin, and examined slides prepared from the concentrated sample. Should we report this as 88104 or 88112, since those are the two cytology codes that describe “fluids” or “liquid” specimens?

**Tennessee Subscriber**

**Answer:**

Neither 88104 (Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation) nor 88112 (Cytopathology, selective cellular enhancement technique with interpretation [e.g., liquid based slide preparation method], except cervical or vaginal) best describes the service your pathologist performs.

Non-gyn cytopathology (cytology) specimens are usually fluids (washings, or aspirations of fluids such as cyst or cerebrospinal fluid) or brushings or sputum (88104-88112). How you prepare the specimen is the key to code choice (88104-88112), not whether the specimen is a fluid or a brushing to begin with.
If the pathologist processes the specimen as a direct smear (simply smearing some of the specimen on a slide), you choose 88104. If the pathologist concentrates the specimen (such as cytospin), choose 88108 (Cytopathology, concentration technique, smears and interpretation [e.g., Saccomanno technique]). That’s the best code choice for the scenario you describe.

If the pathologist processes the specimen by a special method that “selectively enhances the cells” that you see on the slide (usually by a combination of removing unwanted cells and concentrating the desired cells), choose 88112. Code 88112 is often called “liquid based cytology,” but that has nothing to do with whether you started with a liquid – it has to do with how the specimen is processed. You might also see 88112 called thin-prep. You’d code 88112 if your lab prepares the cytology specimen by either of the commercially available cellular enhancement methods: ThinPrep™ or SurePath™.

**Hematologist Might Use ED Codes**

**Question:**
An emergency department (ED) physician asked our hematologist/pathologist to treat a patient in the ER for a blood transfusion reaction. This isn’t a consult because our physician took responsibility for patient care. Can we report the ED codes for our pathologist/hematologist even though he is not an ED physician?

**Answer:**
A common misconception is that only emergency department (ED) physicians can report emergency room services (99281-99285, Emergency department visit for the E/M of a patient...). In fact, any physician can report the ED codes if he provides a service in the ER. This does not mean, however, that an ED code is the only choice when a physician sees a patient in the ED.

According to the Medicare Carriers Manual section 15507, primary-care physicians and specialists should report an ED visit for services rendered in the ED, unless:

- the service provided meets the criteria for a consult.
- the physician delivers critical care services (99291-99292) upon arriving at the ED, or
- the physician admits the patient to the hospital (99221-99223, Initial hospital care, per day, for the E/M of a patient...; 99218-99220, Initial observation care, per day, for the E/M of a patient...; 99234-99236, Observation or inpatient hospital care, for the E/M of a patient including admission and discharge on the same date...).

If your pathologist/hematologist provided any of these three services, you should report the respective E/M service code instead of the ED visit.

In your case, the pathologist/hematologist clearly accepted full care for the patient, so a consult is not an option. You don’t mention any critical care services, so you wouldn’t report 99291-99292, either.

If the doctor subsequently admits the patient to the hospital (99221-99223) or orders observation (99218-99220) on the same date of service, you should report that service instead of the ED visit codes. For a same-day observation order and discharge, use 99234-99236.

As you describe your case, and because the ED physician transfers care to your pathologist/hematologist, you could report an ED visit, such as 99282.

**Private payers may not play ball:** Some non-Medicare guidelines may indeed insist that only ED physicians can use ED service codes 99281-99285, which can force you to report outpatient E/M or consult services in defiance of CPT® and CMS rules to keep within the individual payer’s guidelines and receive payment for services rendered. Or, they may stipulate that only one ED service can be reported per date of service and if the ED physician is billing for seeing the patient, your physician may not be allowed to do so. If your payer stipulates such rules, be sure to get its recommendations in writing and follow them to the letter.

**You Be the Coder**

**Beware ‘Noncontributory’ Language**

**(Question on page 13)**

**Answer:**
Yes, you can charge for the technical and professional components of the cell blocks that the pathologist evaluated and reported, even if the report states that they are “noncontributory.” Report each cell block as 88305 (Level IV - Surgical pathology, gross and microscopic examination, Cell block, any source).

When the pathologist documents a stain or study that doesn’t result in clear diagnostic information, he might use the term “noncontributory,” but there’s a better way. Because “noncontributory” might imply to an auditor that the procedure wasn’t medically necessary, it’s not a good word choice. For the same reason, you should avoid words like “routine” or “normal” when describing pathology findings.

**Better:** You might encourage the pathologist to use terms like, “stain negative for [whatever he was looking for]” or “study did not result in differential diagnosis.”

**Reader Questions** and You Be the Coder were prepared with the assistance of R.M. Stainton Jr., MD, president of Doctors’ Anatomic Pathology Services in Jonesboro, Ark.
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