Preview Your Code Changes for Lab and Pathology With These 5 Highlights

Grasp changes for immunology, molecular studies, and more.

The waiting is over — the AMA has released its preproduction version of the updated CPT® code set, so let’s take a look at changes you’ll face for your lab or pathology practice beginning January 1.

Read on to get an overview of what you can expect next year, and stay tuned to future issues of Pathology/Lab Coding Alert for in-depth analysis of these code changes.

1. Greet New OB Panel Code

CPT® 2016 adds a new option for billing an obstetric panel — an option that includes screening for human immunodeficiency virus (HIV) infection. Here’s the new code:

80081 — Obstetric panel (includes HIV testing)

This panel must include the following:

- Blood count, complete (CBC), and automated differential WBC count (85025 or 85027 and 85004)
- OR
- Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009)
- Hepatitis B surface antigen (HBsAg) (87340)
- HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result (87389)
- Antibody, rubella (86762)
- Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART) (86592)
- Antibody screen, RBC, each serum technique (86850)
- Blood typing, ABO (86900)

- AND
- Blood typing, Rh (D) (86901)

This code varies from the current OB panel code, 80055 (Obstetric panel…) only in the addition of the 87389 test. Next year, labs may perform either 80055 or 80081, depending on physician orders.
2. Anticipate Molecular Code Changes — But Wait for Payment News

You’ll have nine new Tier 1 molecular pathology codes next year to aid in genetic counseling, diagnosis, and treatment for the following conditions:

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Gene(s)/Analysis</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>81162</td>
<td>BRCA1, BRCA2 full sequence and duplication/deletion</td>
<td>Cancers: breast, ovarian, prostate, pancreatic, and melanoma</td>
</tr>
<tr>
<td>81170</td>
<td>ALB1 kinase domain variants</td>
<td>Chronic myeloid leukemia</td>
</tr>
<tr>
<td>81218</td>
<td>CEBPA full sequence</td>
<td>Acute myeloid leukemia</td>
</tr>
<tr>
<td>81219</td>
<td>CALR exon 9 variants</td>
<td>Essential thrombocythemia, primary myelofibrosis</td>
</tr>
<tr>
<td>81272</td>
<td>KIT exons 8,11,13,17,18 variants</td>
<td>Gastrointestinal stromal tumor (GIST), acute myeloid leukemia, melanoma</td>
</tr>
<tr>
<td>81273</td>
<td>KIT D816 variant(s)</td>
<td>Systemic mastocytosis, mast cell leukemias</td>
</tr>
<tr>
<td>81276</td>
<td>KRAS non exon 2 variants</td>
<td>Colorectal cancer</td>
</tr>
<tr>
<td>81311</td>
<td>NRAS exons 2, 3 variants</td>
<td>Anti-EGFR therapy for colorectal cancer, melanoma</td>
</tr>
<tr>
<td>81314</td>
<td>PDGFRα exons 12,18 variants</td>
<td>Gastrointestinal stromal tumor (GIST)</td>
</tr>
</tbody>
</table>

As with many molecular pathology tests that take time and analysis before coverage determinations appear, “we shall see what payers say about coverage,” cautions Melanie Witt, CPC, COBGC, MA, an independent coding consultant in Guadalupita, N.M.

Revisions happen: CPT® 2016 revises a few Tier 1 codes, primarily to update the gene name to more current nomenclature. But you’ll also see revisions to Tier 2 molecular pathology codes 81401-81406 (Molecular pathology procedure, Level [2-7] ...). Most of the changes involve removing a listed test that becomes a new Tier 1 test this year, or adding a test to the specific Tier 2 service level.

3. Look for Genomic and MAAA Update, Too

You’ll find several revised codes in the “Genomic Sequencing Procedures and Other Molecular Multianalyte Assays” section. Most of the changes involve updating specific listed genes to better align with current protocols. Some of the changes are “housecleaning” issues, like stating that the codes include RNA analysis, “if performed.”

The more significant changes to the “genomic” section involve adding several new panels, as follows:

› 81412 — Panel for Ashkenazi Jewish genetic disorders such as Bloom syndrome, Canavan disease, cystic fibrosis, and more
## Drug Coding

### CPT® 2016 Pares Down Chromatography Choices

Changes compliment 2015 drug overhaul.

By now, you should have adjusted to last years’ massive CPT® drug coding facelift, but today it’s time to prepare for some related coding changes you can expect in 2016.

**Simplify Non-Drug Chromatography**

You currently have 12 codes for reporting chromatography and/or mass spectrometry (MS) procedures to identify analytes that CPT® does not specifically list in another code.

Now CPT® 2016 has plans to delete 10 of those codes (82486-82492, 82541, 82543, 82544, and 83788).

Beginning January 1, you’ll have just two codes left to choose from for reporting these procedures. CPT® 2016 revises the codes as follows:

- **82542** — *Column chromatography, includes mass spectrometry, if performed (e.g., HPLC, LC, LC/MS, LC/MS-MS, GC, GC/MS-MS, GC/MS, HPLC/MS), non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen*

- **83789** — *Mass spectrometry and tandem mass spectrometry (e.g., MS, MS/MS, MALDI, MS-TOF, QTOF), non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen.*

**Non-drug:** Both codes now specify that you should use these codes only for “nondrug” analytes. That meshes with the 2015 drug-coding overhaul that provides other codes for testing for drug analytes that are not otherwise specified (NOS). For drug testing, use one of the following codes, even if the procedure uses chromatography or MS methodology:

- **80375-80377** — *Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified…*

- **80299** — *Quantitation of drug, not elsewhere specified.*

**Watch for Medicare Rules**

Medicare still won’t recognize the CPT® drug testing codes, but now the agency seems poised to overthrow its own recommendation that labs use just two drug codes for 2016.

You read about CMS’s drug coding proposal in “Toxicology: Expect Just Two Medicare Drug Test Codes for 2016” (Pathology/Lab Coding Alert Volume 16, Number 9). Now CMS’s preliminary payment determinations are available (www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CLFS-CY2016-Preliminary-Payment-Determinations.pdf), and the agency replaced the two-code solution with a different proposal that aligns with some prior stakeholder recommendations.

**For instance:** Create two codes for presumptive testing and four codes for definitive testing, recommended JoAnne Glisson, senior vice president of the American Clinical Laboratory Association (ACLA) in an open letter to CMS.

**Done:** For presumptive drug testing, the current CMS proposal creates three G codes representing ascending test difficulty. For definitive drug testing, the CMS proposal creates four tiered G codes based on number of drug classes tested. The agency has not yet assigned code numbers or finalized the proposal.

**Look ahead:** Watch future issues of Pathology/Lab Coding Alert to get the skinny on Medicare’s final coding and payment decisions for drug testing.

(Continued on next page)
You’ve arrived — after years of preparation, you’re finally using ICD-10 to report diagnoses that your pathologist documents in the written report. So how are you doing with coding neoplasms? Let us help you zero in on what you need to know when you’re faced with the common experience of reporting a cancer diagnosis from a pathology report.

Step 1: Start with Histologic Term

Just as with ICD-9, if the pathology report documents a histological term for the neoplasm, such as “adenocarcinoma” or “myolipoma,” you should first look it up in the Alphabetical Index. That’s where you can find the code reference and any other instructions about the condition that you need to know.

Histologic terms in the Alphabetical Index typically include direction about how to categorize the neoplasm behavior. You’ll need that information when you take Step 2 — which is turning to the Neoplasm Table — to help you zero in on the right code.

Don’t miss: There are certain histological terms that list the correct codes in the Alphabetical Index and do not refer to the Neoplasm Table. Examples include melanoma and Merkel cell carcinoma.

That’s why you should “always check the Alphabetical Index first,” says Lisa Selman-Holman, JD, BSN, RN, COS-C, HCS-D, HCS-O, AHIMA approved ICD-10-

4 Steps Focus Neoplasm Coding

Look for clues in the pathology report.

You’ll see a CPT® 2016 systematic change to codes for infectious agent antigen detection by immunoassay technique (parent code 87301 through indented code 87430, and parent code 87449 through indented code 87451). The change appears in the common portion of the code descriptors, and simply provides examples of immunoassay technique, such as enzyme immunoassay (EIA), enzyme-linked immunosorbent assay (ELISA), immunochemiluminometric assay (IMCA). “The change shouldn’t alter how you use these codes,” says William Dettwyler, MT AMT, president of Codus Medicus, a laboratory coding consulting firm in Salem, Ore.

Also expect some minor revisions to influenza virus codes 87502 and +87503 for infectious agent antigen detection by nucleic acid, to include multiplex reverse transcription “when performed.”

Finally, CPT® 2016 makes minor revisions to the wording of immunology codes 86708-86709 for Hepatitis A antibody. The changes shouldn’t alter how you use the codes.

5. Renovate Immunofluorescence Coding

One code revision, one code deletion, and one code addition — that’s how CPT® 2016 revamps coding for immunofluorescence studies that your pathologist might perform for tissue or cellular specimens. The existing two-code structure distinguishes codes 88346 (Immunofluorescent study, each antibody; direct method) and 88347 (… indirect method) based on whether the method is direct or indirect immunofluorescence.

Beginning January 1, you’ll report immunofluorescence by either direct or indirect methods using two codes — revised code 88346 for “initial single antibody stain procedure,” and new code +88350 for “each additional single antibody stain procedure.” CPT® 2016 deletes 88347.

ICD-10 Know How
Step 2: Turn to the Neoplasm Table

After checking the Alphabetical Index, your next stop when using ICD-10 to code for a neoplasm is the Neoplasm Table. You’ll find the table just after the end of the Alphabetical Index in your coding manual, rather than under “N” in the Alphabetical Index as it was in ICD-10, says Joan Usher, BS, RHIA, COS-C, ACE, AHIMA-Approved ICD-10-CM Trainer with JLU Health Record Systems in Pembroke, Mass.

To locate the appropriate code in the Neoplasm Table, you’ll need to know the affected anatomical site (such as skin, breast, liver, or other site) and the neoplasm “behavior.” The primary classifications of behavior are “malignant,” which means that the cancer has the capacity to spread to distant sites, “benign,” which means that the cancer type does not spread, and “uncertain behavior,” which means that the cancer is not clearly a type that is benign or malignant. The neoplasm table also lists codes for “unspecified behavior,” which you should use if the pathology report does not provide a clear indication of the cancer specimen behavior.

There’s more to malignant: The neoplasm table further subdivides malignant cancers based on certain characteristics of the specific tumor specimen. For instance, the table lists “Carcinoma in situ” (Ca in situ), which means that the cancer is currently contained at the site, even though it is a malignant type that has the potential to spread. Other malignant cancer designations in the Neoplasm Table include “primary,” which means that the cancer being diagnosed is at its site of origin, or “secondary,” which means that the cancer being diagnosed has spread to the current site from a distant, primary site.

Step 3: Verify Using Tabular List

Once you locate your pathologist’s description in the Alphabetical Index and the Neoplasm Table, you should have a code number. But you shouldn’t just assign that code and stop there. Never finalize a diagnosis without verifying the code in the Tabular List.

Checking the code against the Tabular List provides guidance on laterality, site location, gender, whether you need to use an additional code to report your patient’s condition, as well as any excludes notes, Usher says.

Step 4: Follow Sequencing and Site Guidance

If you’re coding a malignant cancer, you might be dealing with a metastatic condition where the neoplasm has spread from one site to another. When coding a neoplasm that has metastasized to a secondary site, you’ll usually code the primary site before the metastasis.

Exception: If the secondary site is the focus of care, or if the primary site has been resolved, you can code for the metastasis first.

Site rules: When coding for a malignant neoplasm that overlaps two or more contiguous sites, you’ll report the “multiple sites” code ending with character “8” in most cases, such as C00.8 (Malignant neoplasm of overlapping sites of lip). But when a patient has multiple neoplasms of the same site that aren’t next to each other, such as tumors in different quadrants of the same breast, you’ll assign codes for each affected site.

You Be the Coder

Count Bone Marrow Special Iron Stains

Question: The pathology report for a bone marrow case documents iron stains on blocks A1 and A2 of a bone marrow biopsy, plus iron stains on three direct smears from a bone marrow aspiration specimen, plus an iron stain on the cell block from the bone marrow aspiration. How many iron stains can I bill?

Answer: See page 87. Maine Subscriber

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- What topics would you like to see us cover?
- What can we improve on?

We’d love to hear from you.

Please email Ellen Garver at elleng@codinginstitute.us

Thank you in advance for your input!
Neoplasm Coding

Practice Your ICD-10 Cancer Coding With These Examples

Make sure you’re ready to use the tools for ICD-10 neoplasm coding that you read about in “4 Steps Focus Neoplasm Coding.”

Heed Different Sites

Study the following examples and solutions to hone your skills:

Scenario: The pathologist examines a biopsy from the right lower lobe of the lung, a bone biopsy from a surrounding rib, and intrathoracic lymph nodes. The pathology report identifies unresolved non-small cell carcinoma of the right lower lobe of the lung with metastasis to the intrathoracic lymph nodes and right rib.

Solution: Code this patient’s diagnoses as follows, says Judy Adams, RN, BSN, HCS-D, HCS-O, with a consulting firm in Asheville, N.C.:

- C34.31 — Malignant neoplasm of lower lobe, right bronchus or lung
- C77.1 — Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
- C79.51 — Secondary malignant neoplasm of bone.

Take the steps: To begin coding for this patient, you should start with the Alphabetical Index, because you know the histological term — “Carcinoma.” The Alphabetical Index will refer you to the Neoplasm Table, by site, malignant.

The neoplasm of the primary site is unresolved in this patient’s situation, so you’ll list this code first, Adams says. Next, list the secondary sites. These areas aren’t contiguous, so you’ll list a code for each site.

Tricky: Codes for neuroendocrine tumors can be difficult to find when verifying the code because the code looks different than the other neoplasm codes, says Joan Usher, BS, RHIA, COS-C, ACE, AHIMA-Approved ICD-10-CM Trainer with JLU Health Record Systems in Pembroke, Mass.

For example, C7A.090 (Malignant carcinoid tumor of bronchus and lung) has an “A” as its third character, rather than a number like the other neoplasm codes. If you’re having difficulty finding a code in the Tabular List, go to the beginning of the chapter and review the list of broad groups of neoplasms, Usher suggests. “This defines the different grouping of the codes within the chapter.” And you’ll see that the C7A codes follow C73-C75.

Another Example: How would you code for the diagnosis “benign carcinoid of the jejunum?”

Look up the term “carcinoid” in the Alphabetical Index, since you know the morphology of this patient’s neoplasm, Adams says. You’ll be directed to “see Tumor, carcinoid.” When you look under “Tumor, carcinoid,” you’ll find that the codes are divided up between benign and malignant, and categorized by site.

Look under “Tumor, carcinoid, benign, jejunum,” and you’ll be directed to code D3A.011. Check this code in the Tabular List and you’ll see notes directing you to “Code also any associated multiple endocrine neoplasia [MEN] syndromes (E31.2-)” and “Use additional codes to identify any associated endocrine syndrome such as: Carcinoid syndrome (E34.0).” Your diagnosis code for this patient is D3A.011 (Benign carcinoid tumor of the jejunum).

Reader Questions

Update Your Medicare Opt-Out Procedure

Question:
Our pathology practice currently opts out of Medicare, and I heard that there’s a change in how we should do that. Is there a change, and if so, what is it?

California Subscriber

Answer:
Yes, there has been a recent change to the Medicare opt-out procedures.

Thanks to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), any opt-out affidavit that you sign on or after June 16, 2015 will auto-renew every two
The Coding Institute —

The best code choice in this case appears to be 88112 (Cytopathology, selective cellular enhancement technique with interpretation [e.g., liquid based slide preparation method], except cervical or vaginal).

Treating a Baker’s cyst by draining it using aspiration is a common procedure, and it is different from a fine needle aspiration (FNA). Physicians typically perform FNA to help diagnose conditions that may demonstrate abnormal cells in the aspirate fluid, such as a thyroid mass.

You may need to check with the pathologist to ensure that this really is a cyst drainage aspiration specimen, not a fine needle aspirate (FNA).

If you get clarification that the specimen is indeed an FNA, you should report the service as 88173 (Cytopathology; evaluation of fine needle aspirate; interpretation and report) regardless of the way the lab prepared the slides (such as direct smear or liquid-based preparation).

You Be the Coder

Count Bone Marrow Special Iron Stains

(Question on page 85)

Answer:
The correct coding for this case is six units of 88313 (Special stain including interpretation and report; Group II, all other [e.g., iron, trichrome], except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry).

Here’s why: A CPT® text note following code 88313 states, “Report one unit of 88313 for each special stain, on each surgical pathology block, cytologic specimen, or hematologic smear.”

With that instruction, you should count the iron stains as follows:

- bone marrow biopsy block A1 iron stain - one unit 88313
- bone marrow biopsy block A2 iron stain - one unit 88313
- iron stains on three direct smears from bone marrow aspiration - three units 88313
- iron stain on cell block from bone marrow aspiration - one unit 88313.

Distinguish FNA, Cyst Aspiration

Question:
The pathology report states that the specimen is an “FNA cyst aspirate,” of a Baker’s cyst from the back of the patient’s knee. The lab prepares the slides using thin layer preparation methodology: how should we code the pathologist’s exam?

Answer:
The best code choice in this case appears to be 88112 (Cytology, selective cellular enhancement technique with interpretation [e.g., liquid based slide preparation method], except cervical or vaginal).

Follow Lab Method for Histoplasmosis Code

Question:
The lab receives a blood specimen with a request for a test to “rule out histoplasmosis” for a patient who works on a farm in the Ohio Valley and presents with prolonged fever, tiredness, headache, and body aches. How should we report the test?

Answer:
The answer depends on the type of test the lab performs. The most common test is an infectious agent antigen detection test, 87385 (Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Histoplasma capsulatum).

The lab may perform an antibody test, however, to help investigate if there is active infection with the organism. Report the antibody test as 86698 (Antibody; Histoplasma). CPT® provides a third code for histoplasmosis testing, but it involves a skin test rather than evaluating a blood specimen (86510, Skin test; histoplasmosis).

Histoplasmosis is caused by infection with the fungus Histoplasma capsulatum. The fungus lives in soil throughout the United States, especially around the Ohio and Mississippi River valley regions, and human infection can begin by breathing fungal spores in the air. The patient may experience flu like symptoms such as fever, tiredness, headache, and body aches that generally resolve within a month. However, in some patients with a weakened immune system, histoplasmosis may develop into an ongoing lung infection or, rarely, a brain or spinal cord infection.

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.
We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to Pathology/Lab Coding Alert to the Editor indicated below.

Mary Compton, PhD, CPC
maryc@codinginstitute.us
Editorial Director and Publisher

Jennifer Godreau, CPC, CPMA, CPEDC
jenniferg@codinginstitute.com
Director of Development & Operations

Ellen Garver, CPC
eling@codinginstitute.us
Editor

R.M. Stainton Jr., MD
Consulting Editor

Leesa Israel, CPC, CUC, CMBS
leesai@codinginstitute.com
Executive Editor

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