

# APS Update

## PATHOLOGY NEWSLETTER

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### Guidelines for Reporting Non-Diagnostic Specimens

An "insufficient" or "inadequate" tissue specimen doesn't mean not being reimbursed for the surgical pathology service. Per CAP, December 2003, "If the specimen contains material that is reviewed for diagnostic findings and a report is issued, then the pathologist can code the bill for the service, even if the material is too scant to exclude a particular disease process." Using the following steps will determine if you can charge for these types of cases when a non-diagnostic specimen is reviewed or how to document so it can make a difference between "charge" and "no charge."

#### RECOGNIZE THE WORK

- ◆ A surgical pathology exam must include an accession number, gross and/or micro examination and report
- ◆ The gross description should include terms as "specimen measured...", "fluid received...", "specimen processed..."
- ◆ The microscopic description should include terms as "sections exhibited...", "one slide shows...", "specimen examined..."
- ◆ When a specimen is documented as "no tissue present," "unsatisfactory," "insufficient" or "inadequate specimen for evaluation," this is a no charge

#### IDENTIFY WHAT YOU HAVE

- ◆ Identify what you have, not what you don't have
- ◆ Document a description of the specimen and the work involved in the examination
- ◆ Fluid example: "The specimen contains lymphocytes, macrophages and rare neutrophils"
- ◆ If not enough tissue is present to make a definitive diagnosis, use "scant tissue present and report what you do have and/or other phrases indicating actual findings"

#### SELECT APPROPRIATE SURGICAL/CYTOLOGY PATHOLOGY LEVEL

- ◆ Select the proper surgical/cytology pathology code based on the listed specimen under each code
- ◆ If the lab accessions a labeled jar that is empty, this is a no charge
- ◆ When a tissue specimen includes a gross description of a very small specimen, but the tissue does not survive processing so there are no results from a microscopic exam, report 88300

### Blue Cross Blue Shield Announces Electronic Payments

Blue Cross Blue Shield of Michigan has just joined a long list of carriers mandating that physicians accept electronic payment and remittances. The advantage to physicians includes quicker deposits of payments. The advantages to carriers include the elimination of paper generation and mailing costs. This change, however, creates a new task, that of verifying payments. Traditionally, electronic payments also indicate electronic remittance data. Payments and remittances must be matched or credit is given for payments when no payment has been received.

We have found significant differences between the payments indicated on the remittances and the payments received in bank accounts. By relying on electronic remittances as proof of payment, practices can be making substantial mistakes in posting payments resulting in lost revenue and poor relations with patients. Always verify that the payments that are claimed to have been made actually have been received before posting.

**2009 EDUCATION  
CALENDAR**  
**Hope to see you there!**

May 2: Plymouth, MI  
MI Society of Pathologists

May 2-5: Tampa, FL  
CLMA ThinkLab '09

May 8-9: Oak Brook, IL  
IL Society of Pathologists

June 13: Versailles, KY  
KY Society of Pathologists

Oct 10-11: Denver, CO  
MGMA Pathology Mgmt Assembly

Oct 11-14: Washington, DC  
CAP '09

Dec 2-5: San Francisco, CA  
CA Society of Pathologists

Dec 5: Plymouth, MI  
MI Society of Pathologists

## Coding for Physician Blood Bank Services

The AMA's CPT text provides for 3 different procedure codes that can be used when providing consultative services for physician blood bank services. The following activities more closely define which CPT code is used to properly charge and bill for these services. Of course, all consultative services are required to be in compliance with Medicare's requirements on report documentation.

### **86077 – Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report.**

The type of blood bank problems for individual patients that might give rise to use of this code include, but aren't limited to:

- Assess and resolve an unusual or complex cross match situation
- Evaluate an unusual or problematic antibody workup
- Study and recommend a solution to an autoimmune problem
- Evaluate an infant's jaundice condition

### **86078 – Blood bank physician services; investigation of transfusion reaction, including suspicion of transmissible disease, interpretation and written report.**

The type of blood bank problems for individual patients that might support reporting this code are self-explanatory.

### **86079 – Blood bank physician services; authorization for deviation from standard blood banking procedures (eg. use of outdated blood, transfusion of Rh incompatible units), with written report.**

The type of blood bank problems for individual patients that might give rise to use of this code include, but aren't limited to:

- Evaluation and authorization for transfusion of Rh incompatible blood
- Evaluation and authorization for transfusion of out-of-date blood or blood components
- Determination of the blood product(s) to be transfused in the case of an immunosuppressed patient
- Assessment of the blood additive or special processing (eg. irradiation) requirements for a particular patient
- Assessment of the patient's therapy needs, and communication with the attending physician, when the orders received by the blood bank are contra-indicated or contrary to established blood bank policy

The pathologist's medical report must be charted in the individual patient's medical record, but the method of charting is at the discretion of the pathologist and the general policies of the medical staff and/or lab. It can be one of the following:

- A handwritten comment in the progress notes section of the patient's chart
- A free-text entry in the patient's computerized lab record
- A handwritten or typed note on the blood bank worksheet that is then filed in the patient's medical record

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The pathologist's comment must demonstrate that he/she exercised medical judgment in relation to the individual patient, and a medical conclusion and/or recommendation for follow-up care, treatment, or testing must be in evidence. The report must provide information on the implications of a particular antibody being found in the patient's blood – it's not sufficient to merely state "patient is positive for 'xyz' antibody." The report must be signed and dated by the responsible pathologist, either handwritten or by secure electronic means.

## Coding Corner

### **This may not come up often, but how would you code for an "Anal Pap test?"**

This type of specimen can actually be reported a number of ways depending on preparation. Anal-rectal cytology that comes to the lab as a stained direct smear slide would be reported with code 88160 (smears, any other source). If the direct smear slide is stained in the lab, report 88161 (smears, any other source with preparation). In the event 5 or more slides are reviewed from one sample, report 88162 (extended study). As always, if the specimen is prepared by concentration method, report code 88108 or cellular enhancement (thin-prep), report 88112. Be sure to apply the new ICD-9 codes for 2009 for Abnormal cytologic smear of anus and anal HPV (ICD-9 codes 796.70-796.79).

### **When is it appropriate to report code 88329?**

To report 88329 the intra-op consultation must be conducted and the medical opinion of the pathologist rendered while the operation is still in progress. Some examples of when this code would be reported are: (1) evaluating margins to see if tumor free, (2) identify an adequate portion of tissue for special studies, (3) confirming an ovary specimen as cyst formation vs. tumor or (4) a breast specimen as fibrous fatty tissue.

Do you have a coding question or maybe a specimen that you just want clarification on or a comment or coding concern? E-mail it to me at [tscheanwald@ucbinc.com](mailto:tscheanwald@ucbinc.com) and I will provide answers and/or feedback.