

APS Update

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Coding For Cytology Specimens

Proper CPT reporting of a non-gyn cytology specimen depends principally on the type of preparation that's performed for screening and examination. The most common non-gyn cytology specimens submitted are washings, such as bronchial, bladder, esophageal, brushings, urines (voided or catheterized) and body fluid aspirates (pleural fluid, peritoneal fluid, spinal fluid). The type of specimen isn't relevant to the coding decision. The most common preparations are:

- ◆ Direct Smear
88104-Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation
- ◆ Concentrated/Cytospin Smear
88108-Cytopathology, concentration technique, smears and interpretation (Saccomanno technique)
- ◆ Cellular/Enriched Smear
88112-Cytopathology, selective cellular enhancement technique with interpretation (liquid-based slide preparation method, thin-prep), except cervical or vaginal
Note-Per CPT not to be reported with 88108 for the same specimen
- ◆ Smears; any other source
88160-Cytopathology, smears, any other source; screening and interpretation.
"Any other source" is mainly sputum, nipple discharge (when not concentrated) and Tzanck smears.

Cell block slides are typically ordered to clarify the diagnosis from the smears prepared from a non-gyn cytology specimen. This is charged separately using CPT code 88305. If special stains are performed such as the GMS, acid-fast, etc., that are not routine, they also can be reported with the appropriate CPT code.

When documenting a cytology case, for audit purposes the method used should be clearly stated and if stains are performed, the documentation should include the stain used and its results.



CMS Places a Hold on Physician Claims Payment

CMS has advised all Medicare providers that they have begun holding all Medicare payments as of July 1st for a period of at least 14 days.

U.S. House and Senate News

The U.S. House and U.S. Senate override of the presidential veto of legislation that would have allowed for a 10% reduction in the Medicare physician fee schedule, expiration of the grandfather provision of the technical component billing by independent labs and laboratory competitive bidding project was passed on July 15, 2008.

The passage of this new piece of legislation will replace the 10% reduction with a 1.1% fee increase and extend the technical component grandfather provision out for 18 months.

2008 EDUCATION CALENDAR Hope to see you there!

Sept 19-21: Ashland, OR
Pacific NW Society of Pathologists

Sept 25-28: San Diego, CA
CAP '08

Oct 4: Columbus, OH
OH Society of Pathologists

Oct 17-18: San Diego, CA
MGMA Pathology Mgmt. Assembly

Dec 3-6: Los Angeles, CA
CA Society of Pathologists

Dec 6: Plymouth, MI
MI Society of Pathologists

ICD-9 - CM Codes Are Out For 2009

With October fast approaching, it's time to think ahead to all the ICD-9 coding changes that will take place. There will be many new, revised and deleted codes for 2009. The number of new codes this year will be the most in more than a decade. More than 330 new diagnosis codes are proposed. Included will be 27 new leukemia codes in categories 203.xx due to a new fifth digit--"2" (in relapse) being added and also the rewording changes of the fifth digit--"0" (without mention of having achieved remission) to clarify the intent. More good news is 43 proposed new ICD-9 codes for carcinoid tumors. They will be based on location and behavior, whether benign or malignant and there will be a new 209.xx category of codes. For example, if the diagnosis is a malignant carcinoid tumor of the bronchus and lung, the new way for Oct. 1 will be 209.21 (Malignant neoplasm carcinoid tumor of the bronchus and lung). The current code used is 162.9 (Malignant neoplasm of trachea, bronchus and lung, unspecified).

An area of codes expanding will be the 795.00 pap codes. More than a dozen codes associated with Pap smears and HPV are proposed. New ICD-9 codes 795.10-795.19 will be reported for findings on vaginal pap smears and 796.70-796.79 for findings on anal pap smears. Gone will be code 599.7 (Hematuria, benign, essential), replaced by three new choices 599.70 (Hematuria, unspecified), 599.71 (Gross hematuria) and 599.72 (Microscopic hematuria) and there will be a new code for pleural fluid, code 511.81 to be used when pleural fluid is cancerous.

These are just some of the ICD-9 codes related to laboratory and pathology expected to take effect October 1, 2008. Remember, per HIPAA there no longer is a grace period to implement these new and changed ICD-9 codes. An incorrect ICD-9 code after October 1st will likely result in a denial. Revisions typically will include expanded ICD-9 codes for some common conditions by adding an additional digit and deleting some codes you may know from memory. To ensure current, accurate diagnosis coding, make sure you consult the 2009 ICD-9 manual.

CMS Plans to Expand PQRI Program for 2008

The Centers for Medicare & Medicaid Services will offer new reporting options to encourage physicians to submit quality data. The Physician Quality Reporting Initiative allows the use of 119 measures, including two "structural measures" focusing on the use of electronic health records and electronic prescribing technology. The other 117 measures are clinical performance measures, developed by leading physician organizations. These measures include factors such as percentage of patients who are receiving cancer screenings and flu shots.

**Information provided by Healthcare Finance News*

Coding Corner

Can I report CPT code 88309 when a specimen labeled Modified Radical Mastectomy is submitted with sentinel lymph nodes?

To report code 88309 for a mastectomy specimen, it must include the regional lymph nodes. If a regional lymph node resection is not included, code 88307 would be reported. For each separately identified sentinel node submitted and examined, report code 88307.

If we receive a lung biopsy which shows to be positive for malignancy, followed by the lobectomy specimen, do we have to bundle the biopsy into the lobectomy specimen?

Biopsies that sometimes immediately precede major surgical resections can always be billed separately. Report either code 88305 or code 88307 if the lung biopsy submitted is a wedge biopsy/resection. Add code 88309 for the lobectomy, total or segmental.

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