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Flow Cytometry

The CPT® text defines different CPT codes for the professional interpretation of flow cytometry studies vs. the technical component. Following is a breakdown of the two types:

Technical Billing:
There are two codes to report the technical side, the work done to prepare the specimen and run the test, 88184 and add-on code 88185. For billing this component, you are allowed to bill "per marker." One unit of 88184 and one unit of 88185 for each additional marker. Modifier -TC is not required.

- 88184: Flow Cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker
- 88185: Each additional marker (list separately in addition to code for first marker)

Professional Billing:
There are three codes for the professional service report, 88187, 88188 or 88189 depending on the number of markers. CPT does not provide a code for the interpretation of one marker since typically there will be multiple markers. Modifier -26 is not required.

- 88187: Flow Cytometry, interpretation; 2 to 8 markers
- 88188: 9 to 15 markers
- 88189: 16 or more markers

Billing/Documentation Rules:
Only one code should be reported for all flow cytometry performed on a specimen. Since Medicare will not pay for duplicate testing, do not report flow cytometry on multiple specimens on the same date of service unless the morphology or other clinical factors suggest differing results on the different specimens.

When counting markers, each unique CD# (or other marker name) is counted one time. Never count the same marker name more than once. So when using the same antibody in various multi-colored tubes that make up a panel or if using the antibody for "gating" (involves finding a specific population of cells by looking at the repeat antibody in combination with other antibodies), it is only counted once for each marker.

Medicare in many states has what is called an LCD (Local Coverage Determination) Policy for Flow Cytometry Studies. An LCD is a decision made by a Medicare Administrative Contractor (MAC) on whether a particular service is reasonable and necessary to be covered for reimbursement. Coverage criteria is defined within each LCD including lists of HCPCS/CPT codes and ICD-10 codes for which the service is covered or considered not reasonable or necessary.

For diagnostic tests, you are to report the results of the test if known, otherwise the signs/symptoms prompting the performance of the test should be reported. When the study has no findings and you have no pre-clinical information there is no ICD-10 code that can be reported. This is why providing clinical information is so important.

Information provided by APS Medical Billing, February 2022

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It is the responsibility of the provider to code to the highest level specified in the ICD-10 and must best describe the patient's condition for which the service was performed. But keep in mind, the correct use of an ICD-10 code does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in the LCD. Please reach out to your APS Practice Manager if you need a copy of your LCD.

Documentation in the pathology report must:

- Reflect medical necessity including clinical and morphologic findings
- Cell counts (quantitative values)
- Radiology and cytogenetic findings when available
- Support that the results of the flow cytometry will be utilized in the management of the patient's condition

The referring/ordering physician must provide the most specific suspected diagnosis or differential diagnoses that will allow the performing laboratory to determine an appropriate panel of cell markers. This must be documented in the orders provided to the performing laboratory.

As always, should you have questions, feel free to reach out to your APS Practice Manager.