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PATHOLOGY SERVICE CODING HANDBOOK



Medical Service, Procedure, and Diagnosis Reporting Policies and Practices for the Pathology Profession

Version 13.3 | July 1, 2013

- CPT® Code Reporting
- HCPCS Code Reporting
- CPT/HCPCS Modifiers
- ICD-9-CM Diagnosis Coding
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Contents

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Chapter 1
Introduction to CPT®/HCPCS
(with basic ground rules)

Navigation Assistant:

This chapter provides an overview of the "language" of medical billing: CPT and HCPCS codes. Section 1 describes the American Medical Association's *Current Procedural Terminology* text and taxonomy, more commonly known simply as CPT. The *Healthcare Common Procedure Coding System* (HCPCS), maintained under the auspices of the U.S. Department of Health and Human Services' (DHHS) Centers for Medicare and Medicaid Services (CMS), is described in section 2. The fundamental rules for using CPT and HCPCS are discussed there as well.

Section 3 presents the CPT and HCPCS code modifiers that pathologists and pathology laboratories need to use (or at least be aware of) to assure prompt claim processing and proper payment by third-party payers and private medical insurers.

Chapter 2
ICD-9-CM Diagnosis Coding Requirements

Navigation Assistant:

Whereas CPT® is this country's universal "language" for describing medical procedures and services, ICD-9 is the common "tongue" spoken by healthcare professionals, providers, payers, and insurers when discussing diseases and disorders that afflict patients—diagnoses, in other words. ICD-9 is used by payers and insurers to determine whether the medical procedures billed by providers are *medically necessary*, in which case they're typically a *covered benefit* for the beneficiary or insured person, all other things equal.

ICD-9 is the acronym we use here to refer to the text *International Classification of Diseases, Ninth Revision, Clinical Modification* (formal acronym, ICD-9-CM). ICD-9-CM is the "gold standard" for reporting patient diagnostic information to payers and insurers; in fact, reporting diagnostic information on insurance claims using ICD-9 is mandated by federal law, including the Health Insurance Portability and Accountability Act (HIPAA).

The objective of this chapter is to provide practical guidance for selecting and reporting ICD-9 codes for the pathology and laboratory procedures you deal with day in and day out. Tools to

Chapter 3
NCCI, NCD, LCD, MUE, PQRS and MOCP

Navigation Assistant:

Medicare's National Correct Coding Initiative (NCCI) controls how pathologists and laboratories report CPT® or HCPCS codes in combination with one another when filing claims with Part A or Part B Medicare Administrative Contractors for histology, cytology, and clinical pathology services to program beneficiaries. Sometimes NCCI's advice for reporting professional and/or technical services is directly at odds with the way the American Medical Association (AMA) tells you to report those same services.

National coverage determinations (NCD) by CMS (Centers for Medicare and Medicaid Services within the U.S. Department of Health and Human Services) influence the ICD-9-CM diagnosis codes you report for lab services to Medicare beneficiaries, and they can mean the difference between getting paid for your services and having to write off all or part of the patient

Chapter 4
Surgical Pathology 88300-88309 Unit of Service

Navigation Assistant:

Section 4.1 – Think "specimen" when reporting 88300-88309
- A. Tissue or tissues
- B. Individual and separate attention
- C. Individual examination and pathologic diagnosis
- D. More exceptions/more rules
- E. A Policy you can live with

Section 4.2 – Purebred specimen vignettes
- A. General rule: multiple undifferentiated purebred specimens
- B. General rule: multiple separate purebred specimens

  [For example: biopsy, cervix and many other organs; brain, biopsy/tumor resection/other than tumor resection; breast/brain, image-guided core needle biopsy; breast lumpectomy, tylectomy, etc. (partial mastectomies); breast reduction mammoplasty; cervix, conization; curettings, endocervix/endometrium; hemorrhoids; lymph node biopsy; parathyroid gland; pituitary tumor; polyp, colon/cervical/upper GI; polyps, nasal/sinusoidal; sentinel lymph node; sterilization specimens; tag, anus or skin; thyroid lobe; tonsil; turbinates (concha); upper GI biopsies]

Section 4.3 – Hybrid specimen vignettes
- A. Naturally occurring hybrid specimens [*Subsidiary navigation tool provided*]

  [Chiefly, but not limited to: abortion; abscess; bone fragments; bone resection; brachial (branchial) cleft cyst; cyst; ethmoid tissue; extremity amputation or disarticulation; femoral head; fetus; finger; hernia sac; joint resection; placenta; products of conception; sinus contents/ethmoid tissue; skin; thyroglossal duct cyst; toe]
- B. Artificially construed hybrid specimens [*Subsidiary navigation tool provided*]

  [Chiefly, but not limited to: acromioclavicular joint; appendix with cecum; calculi (stones) with gallbladder; cervix with uterus; lymph node(s) with gallbladder; omentum; regional lymph nodes with colon or small bowel; regional lymph nodes with other major organs; seminal vesicles with prostate; terminal ileum]

Section 4.4 – Multiple specimens in one bucket

[For example: colectomy; cystectomy; cystoprostatectomy; esophagogastrectomy; lung lobectomy; neck dissection, radical; nephrectomy; prostatectomy; thyroidectomy; Whipple]

Section 4.5 – One specimen in multiple buckets

[Tonsil(s) with or without adenoids; uterus with Leiomyomas (fibroids); Ovary with or without fallopian tube; Breast mastectomy with regional lymph nodes; Larynx resection with regional lymph nodes; Uterus with or without tubes and ovaries]

Gross and microscopic tissue examinations are the "bread and butter" work of pathologists, so it's appropriate that we spend a considerable amount of time in this Handbook on the principles, rules, and nuances governing CPT® coding for this class of medical services. But, realistically, the information you need to know about coding this work is too vast to effectively convey in a single chapter. Hence, we're splitting up the topic between this chapter and the next, devoted to service unit versus level of service respectively.

Chapter 5
Surgical Pathology 88300-88309 Code Selection

Navigation Assistant:

This chapter presents the principles, rules, and nuances for reporting procedure codes for the "bread and butter" work of a pathologist: gross and microscopic tissue examinations. Process considerations—for example, who should code and when—are also discussed. CPT® (HCPCS Level I) codes 88300-88309 are featured in this chapter.

Section 1 presents the fundamental concepts, principles, and rules that apply to these codes. The general Medicare National Correct Coding Initiative (NCCI) rules that implicate H&E light microscopy examinations are also discussed.

Chapter 6
Surgical Pathology Add-On Procedures

Navigation Assistant:

This chapter focuses on pathology procedures performed ancillary to the primary examination of tissue specimens, defined as the microscopic review of routine H&E slide preparations. Adjunct and ancillary procedures such as decalcification, staining for a particular organism or cellular anomaly, in situ hybridization, and electron microscopy significantly expand the pathologist's ability to develop a definitive diagnosis for individual specimens.

In the chapter sections that follow you'll learn which adjunct/ancillary procedures can be charged apart from a macro- or microscopic examination of tissue (CPT® codes 88300-88309), when a separate charge for such a procedure is appropriate, what CPT code to report for the particular adjunct/ancillary procedure you've just performed, how many units (charge count) of that code you can report, and how to adequately document the extra service in your medical report to facilitate charge determination and audit support.

Chapter 8
Fine Needle Aspiration Cytology Services

Navigation Assistant:

This chapter is devoted to pathologist fine needle aspiration (FNA) cytology services. They include, in *à la carte* fashion from a CPT® reporting perspective: specimen procurement (i.e., the surgical procedure itself); immediate study for specimen adequacy or rapid diagnosis; evaluation of the primary preparation (i.e., smears); examination of cell block, cytospin, and other adjunct preparations; and review of ancillary (add-on) preparations like special stains. Less frequently encountered ultrasound procedures and evaluation and management (E/M) consultation services are also discussed in this chapter.

The FNA technique uses a long, thin needle to extract a mixture of fluid and suspended bits of tissue from a palpated or visualized mass. The mixture is expelled onto glass slides—either directly or after processing—stained, and examined through a microscope by a cytopathologist. During and/or at the end of the process the cytopathologist reports an interpretive finding to the patient's attending physician. The cytopathologist is commonly supported by a cytotechnologist at key points in this process.

FNA is widely used as a primary diagnostic procedure with patients who have a palpable or radiologically identified firm mass in a breast, salivary gland, or superficial lymph node. The thyroid, prostate, and some soft tissues are candidates for the fine needle technique as well. When guided by ultrasound or other imaging device, FNA can be used to procure diagnostic material from deep organs such as the liver, pancreas, or esophagus.

Chapter 9
Nongynecological Cytology Services

Navigation Assistant:

This chapter focuses on pathologist diagnostic services related to nongynecological (NGYN) cytology specimens. The specimens of interest in these regards exclude those procured by fine needle aspiration (FNA) surgical technique: FNA specimens, while technically in the NGYN class, have CPT codes that are unique to them (see 10021-10022 and 88172-88173), as more fully explained in chapter 8. For information on reporting gynecological (GYN) cytology smears (commonly referred to as Pap tests or Pap smears), please go to chapter 10.

Cytopathologists rarely if ever procure NGYN cytology specimens like washings, brushings, sputum, urine, or fluid by thoracentesis (for example), so counterparts to fine needle aspiration codes 10021-10022, to the extent they exist as separate procedures, aren't discussed herein. Likewise, a pathologist almost never conducts the equivalent of an FNA immediate study in relation to a general NGYN cytology sample, so a unique code isn't provided in CPT for that activity. (Nonetheless, refer to the 88333 topic in section 9.3B for information on reporting an intraoperative consultation and/or rapid assessment on a non-FNA NGYN cytology specimen.) The laboratory and physician services involved with NGYN cytology specimens consist almost exclusively of specimen preparation, screening, and interpretation and report.

Proper CPT reporting of NGYN cytology specimens depends principally on the type of preparation that's developed for screening and examination. Therefore, in section 1 you'll learn about the primary NGYN smear preparation methods and the CPT code that goes with each. The three designated "other source" codes (88160-88162) for odds-and-ends specimens like Tzanck smear are also discussed in section 1, together with three other codes that are rarely used.

Section 2 discusses the unit of service (charge count) for NGYN cytology professional and technical work. Section 3 talks about adjunct preparations (e.g., cell block slides) sometimes ordered secondary to the primary NGYN smears. That section also explains when ancillary services like special stains can be billed as separate services with NGYN cytology cases.

Section 4 spells out in detail the Medicare NCCI bundling/unbundling restrictions for NGYN cytology adjunct and ancillary preparations. Suggestions for medical report format and content to

Chapter 10
Cervical/Vaginal Cytology (Pap Test) Services

Navigation Assistant:

This chapter is devoted to the topics of CPT®, HCPCS and ICD-9 reporting of cervical/vaginal cytology smears, most commonly referred to simply as a "Pap test." (Cervical/vaginal cytology, known as "gynecological" cytology—abbreviated "GYN"—is a subspecialty within the field of cytopathology.) As you'll learn in a moment, to a substantial degree you can "throw out the window" everything you know about CPT and ICD-9 reporting for pathology services when it comes to Pap tests: They're subject to unique rules that can't be surmised or extrapolated from the fine needle or non-GYN cytology rules you learned in chapters 8 and 9.

What makes the Pap test unique is that, first and foremost, it's a cancer *screening* test; that is, the majority of the time it's ordered in the absence of a sign or symptom of a problem with the patient's cervix or vagina that might be attributable to cancer or a precursor of same. (Pap tests are, of course, also ordered to monitor women who have a history of cervical or vaginal cancer or a pre-cancer condition, or who are otherwise at high risk of developing cervical or vaginal cancer.) Manifestations of this unique attribute include the following:

- Only a small percentage of Pap tests—typically 12% or less—require the intervention of a physician to determine whether the cells on the glass slide are abnormal or atypical in appearance.
- No one CPT code captures both a cytotechnologist's evaluative service and a pathologist's diagnostic review, when the latter is medically indicated; in other words, there's no "global service" code in CPT for a Pap test. Instead, one code (88141) is provided solely for the physician's interpretive service, and several codes describe the cytotechnologist's service, depending on the processing and/or reporting method used.
- Medicare and basically all other payers/insurers treat the cytotechnologist's screening service associated with a GYN cytology smear as a clinical laboratory test for billing, payment, and compliance purposes, notwithstanding the fact that the codes are listed in the cytopathology section of the CPT codebook.
- Medicare coverage and proper payment for Pap tests are unusually sensitive to correct ICD-9 diagnosis coding as well as accurate CPT vs. HCPCS Level II code reporting.

Section 1 of this chapter explains the general principles and practices that should be observed when reporting and billing Pap tests. Sections 2 and 3 provide specific CPT procedure coding information for the cytotechnologist and pathologist service components of these tests. Section 4 explains the primary coverage, coding, and billing rules you must follow when performing Pap tests for Medicare beneficiaries; Medicare's ICD-9 diagnosis coding rules for Pap test screening and physician services are included in section 4.

Heads-Up: You won't find information in this chapter about anal-rectal cytology smears—sometimes called "anal Pap tests"—or endocervical brushings, a modern-day surgical procedure

Chapter 11
Consultations on Outside Slides/Materials

Navigation Assistant:

Complete and accurate diagnosis of surgical pathology, cytopathology, and other anatomic pathology cases not infrequently relies on the input of an outside pathology consultant who's especially knowledgeable in a particular organ system or disease. By the same token, incoming consultations form a significant business line for many academic departments of pathology, and they're an important source of varied and interesting cases for resident education as well.

This chapter describes the CPT® coding rules and charge support principles for pathology consultation cases. Section 1 explores the fundamental ground rules: What is a "consultation" case? Can you consult with yourself? Are intra-group consults billable? What's separately billable with a consult case, and what's not? Who can bill a consult case to Medicare?

Section 2 describes the three service levels and CPT codes that apply to outside consult cases and explains when each is reportable. The approved unit of service (charge unit) for consultation codes 88321, 88323 and 88325 is explained in section 3.

Section 4 explains when procedures like special stains are and aren't chargeable in addition to the basic consultation code (88321-88325); the commonly encountered add-on services are identified and briefly discussed as well.

Medical report considerations from the standpoint of charge determination and audit support are explained in section 5.

§11.1 – Ground Rules

CPT codes 88321, 88323 and 88325 describe the pathology service known as consultation and report on referred slides and/or materials. Standard add-on procedure codes like 88184-88189, 88312-88319 and 88342 for flow cytometry immunophenotyping, histologic special stains, and immunoperoxidase are chargeable as well under certain circumstances. You can consult on a case involving surgical pathology, cytopathology (GYN, NGYN and FNA), neuropathology, hematopathology, renal pathology, or dermatopathology slides and/or material, but codes 88321-88325 don't pertain to confirmatory or other second reviews of clinical lab medicine events. (For clinical lab medicine consultative services, please see Handbook chapter 14.)

In general, when a pathologist microscopically examines and diagnoses an H&E slide, he or she's entitled to bill a primary service code for the work. Whether the primary service code that's appropriate for reporting for a particular case is from the 88302-88309 or the 88321-88325 range depends on whether that slide (or a related slide) was earlier examined by another pathologist. (We're using surgical tissue for illustrative purposes here, but the underlying ground rule applies

Chapter 12
Molecular and Cytogenetics Testing Services

Navigation Assistant:

This chapter is devoted to molecular and cytogenetics testing services. We're still in process of fully developing this chapter, so the information is admittedly somewhat limited. We apologize for any inconvenience this may cause.

The introduction to the CPT codebook includes guidance on the difference between test results and the interpretation of tests. In brief, the AMA says that "testing" and "test results" describe facility *technical* activities or the output of those activities, while an "interpretation" describes a physician *professional* service. Furthermore, the AMA House of Delegates in November 2006 adopted a resolution that equates a "diagnosis" or an "interpretation" with the practice of medicine; as reported in the Nov. 30, 2006 edition of *Statline* (College of American Pathologists), "… the AMA now recognizes as a matter of policy that the diagnosis of disease and diagnostic interpretation of a study or studies for a specific patient constitutes the practice of medicine."

Molecular and cytogenetics tests frequently are resulted by doctorate-level (PhD) laboratory professionals alone, without the hands-on intervention of a pathologist (MD or DO) to render an interpretation of the test, at least so far as that term is applied by the AMA. In these instances, we strongly recommend that the commentary attributed to the PhD in the report be referenced as a "result", "impression", or similar word that is not generally deemed to be directly equivalent to or synonymous with "interpretation" or "diagnosis". The suggested terminology recognizes that the services of doctorate-level laboratory professionals are not covered under Medicare Part B, nor does any other payer or insurer with which we are familiar intend to cover such services as *physician* professional services. Furthermore, the suggested terminology is consistent with the applicable AMA guidance, and it should, therefore, avoid any medical/legal dispute involving state practice of medicine law.

Another third-party payer compliance issue often associated with molecular and cytogenetics test reports has to do with the focus of the commentary that constitutes or is an integral part of either a PhD result or an MD/DO interpretation. In particular, boilerplate frequently appears in these reports pertaining to clinical outcomes or treatment modalities described in the scientific and professional literature. For example, the result or interpretation may include a generalized statement such as "all patients found to have specific genetic mutations should consider entering a genetic counseling program." Generalized boilerplate typically is heavily discounted by third-party payer and private insurer auditors as evidence of medical necessity and the exercise of professional judgment. Therefore, to the maximum extent reasonable to the circumstances, result or treatment commentary that's based primarily on broad clinical studies should be phrased in a way that focuses on the specific patient at hand; for example, the aforementioned boilerplate

Pathology Service ICD-9 Code Crib Sheet

(**Warning:** This crib sheet *is not* a substitute for the full, formal ICD-9 text.)

With two exceptions, this crib sheet can be used with all types of pathology cases, such as surgical, fine needle and other nongynecological cytology, molecular diagnostics, hematopathology, transfusion medicine, and clinical pathology in general. Cervical/vaginal (GYN) cytology smears (Pap tests) and cytogenetics tests (both conventional and molecular) aren't represented in this crib sheet: refer to chapter 10 for the ICD-9 diagnosis codes most frequently reportable with Pap tests and chapter 12, section 2, for those reportable with non-neoplastic conditions evaluated by a cytogenetics methodology.

Don't make extensive use of this crib sheet until you've used it side-by-side with the formal text with a large number of cases sufficient to gain comfort with its logic and premises. Never select an ICD-9 code using this crib sheet when the shortcut diagnosis doesn't match that per the patient record in every material respect. Realize that this crib sheet doesn't alert you to situations where the text recommends a second code to clarify or elaborate (e.g., cause, infectious agent).

In general, a noun (e.g., appendicitis) without an adjective (e.g., acute, chronic) is "unspecified" per the patient's medical record, so it's classified that way below. Also, a main condition is presumed to exist "without mention of" a frequent companion (e.g., perforation or rupture) when the second condition isn't listed. Never report an "unspecified" or "without mention of" code when the pathologic diagnosis is more definitive; this may mean you have to use the formal ICD-9 text—not this crib sheet—to code a particular case.

In general, a noun ending in "itis" is the organ- or tissue-specific form of the generic "inflammation" (or inflamed). When an "itis" is available, we don't list "inflammation" as a condition; for example, "inflamed appendix" is listed as "appendicitis"—the two are the same from an ICD-9 reporting perspective.

Refer to chapter 2 of the main Handbook for basic information on ICD-9 diagnosis coding principles to be applied to anatomic pathology specimens and pathologist clinical laboratory medicine services. Additional advice is provided throughout the text in conjunction with specific pathology services when appropriate to the circumstances.

Adenoids (alone)

acute adenoiditis (463)
adenoiditis (474.01)
chronic adenoiditis (474.01)
hypertrophic adenoids with adenoiditis (474.01)
hypertrophic adenoids with chronic adenoiditis (474.01)
hypertrophy (474.12)

Adrenal Gland

epithelioid cell proliferation (255.8)

Anal Cytology (Pap) Smear

Abnormal smear NOS (796.79)
ASC-H (796.72)
ASCUS (796.71)
LGSIL (796.73)
HGSIL (796.74)
High-risk HPV positive (796.75)
Unsatisfactory (796.78)

Appendix

acute appendicitis (540.9)
acute gangrenous appendicitis (540.9)
appendicitis (541)
appendix (543.9)
goblet cell carcinoid (209.11)
hyperplasia (543.0)
incidental appendix (543.9)
perforated appendix (540.0)
ruptured appendix (540.0)

Bladder

acute cystitis (595.0)
benign squamous cells (596.8)
carcinoma in situ (233.7)
chronic cystitis (595.2)
chronic interstitial cystitis (595.1)
cystitis (595.9)
degenerated urothelial cells (596.8)
hematuria NOS (599.70)
high grade transitional cell carcinoma (188.x) [see 4th digit list at 'transitional cell carcinoma']
necrosis (596.8)
poorly differentiated transitional cell carcinoma (188.x) [see 4th digit list at 'transitional cell carcinoma']
transitional cell carcinoma (188.x) [x = 0 trigone; 1 dome; 2 lateral wall; 3 anterior wall; 4 posterior wall; 5 neck; 6 ureteric orifice; 7 urachus; 8 other specified site; 9 site not specified]
urinary retention (788.20)
urothelial carcinoma (188.x) [see 4th digit list at 'transitional cell carcinoma']
urothelial carcinoma (188.9)

Blood

(see Peripheral Blood)
(see Transfusion Medicine)

Appendix 7

SPECIMEN TO CHARGE CODE RAPID FINDER LIST
(Revised April 1, 2013)

Warning: This crib sheet is only suggestive; for definitive coding information, see chapters 4 and 5 of the Handbook.

88304 Abortion—induced
88305 Abortion—spontaneous or missed
88304 Abscess
88302 Accessory digit, identification & report
88305 Accessory digit, diagnostic
88304 Acrochordon, anus/skin
88305 Acromioclavicular joint
88304 Adenoid(s)
88304 Adhesions, pelvic
88304 Adipose tissue (fat/fatty tissue)
88307 Adnexa—ovary with or without tube, neoplastic
88305 Adnexa—ovary with or without tube, nonneoplastic
88307 Adrenal gland resection
88305 Ampulla of Vater
88309 Amputation—extremity disarticulation
88307 Amputation—extremity, nontraumatic
88305 Amputation—extremity, traumatic
88305 Amputation—finger or toe, nontraumatic
88302 Amputation—finger or toe, traumatic
88304 Aneurysm—aortic, arterial, cerebral or ventricular
88304 Anus tag
88304 Aortic aneurysm (eg, abdominal, thoracic)
88302 Appendix—incidental
88304 Appendix—other than incidental
88304 Appendix, testis/epididymis
88305 Arachnoid mater—other than tumor resection
88307 Arachnoid mater—tumor resection
88304 Arterial (artery) aneurysm
88307 Arteriovenous malformation (AVM), complex
88305 Arteriovenous malformation (AVM), simple
88304 Artery atheromatous plaque
88305 Artery biopsy/segment
88305 Axillary tail/axilla—lymph node biopsy
88307 Axillary tail/axilla—lymph nodes regional resection
88304 Bartholin's gland cyst
88305 Bladder biopsy
88309 Bladder partial or total resection
88307 Bladder transurethral resection (TUR)
88307 Bleb, pulmonary, complicated
88305 Bleb, pulmonary, uncomplicated
88304 Blood clot
88307 Bone (except bone marrow) biopsy or curetting
88307 Bone cyst
88305 Bone exostosis
88304 Bone fragment(s)—other than pathologic fracture
88307 Bone fragment(s)—pathologic fracture
88305 Bone marrow biopsy
88305 Bone marrow particle clot
88309 Bone resection
88305 Brachial (branchial) cleft cyst
88307 Brain biopsy
88305 Brain—other than tumor resection or biopsy
88307 Brain tumor resection
88305 Breast biopsy, without margin exam
88304 Breast capsule
88305 Breast, excision of discrete lesion (eg, fibroadenoma)
88307 Breast, excision of lesion, with margin exam
88305 Breast, gynecomastia (male breast reduction)
88305 Breast, incisional biopsy
88307 Breast, lumpectomy
88307 Breast mastectomy—partial or simple w/o lymph nodes
88309 Breast mastectomy—radical/modified radical
88309 Breast mastectomy—simple with lymph nodes
88305 Breast needle core tissue biopsy
88307 Breast, quadrantectomy
88305 Breast reduction mammoplasty
88307 Breast, segmentectomy
88307 Breast, tylectomy
88305 Bronchus (bronchial) biopsy
88304 Bunion
88304 Bursa cyst
88304 Carpal tunnel tissue
88304 Cartilage shavings
88305 Cell block (any source)
88304 Cerebral aneurysm
88305 Cervical biopsy
88307 Cervical cone/conization/cone biopsy
88305 Cervical cyst/polyp
88307 Cervix amputation without uterus
88307 Chips (TURB)—bladder
88305 Chips (TURP)—prostate
88304 Cholesteatoma
88304 Cicatrix (skin scar)
88302 Circumcision—newborn
88304 Circumcision—other than newborn
88305 Clot—bone marrow particle clot
88305 Colon biopsy
88304 Colon colostomy stoma
88304 Colon diverticulum
88305 Colon 'donut' (eg, primary tissue for tumor)
88304 Colon 'donut' (eg, primary tissue not for tumor)
88305 Colon polyp
88309 Colon total resection w/ or w/o mesenteric lymph nodes
88309 Colon w/ or w/o mesenteric lymph nodes—segmental resection for tumor
88307 Colon w/ or w/o mesenteric lymph nodes—segmental resection other than for tumor
88304 Colostomy stoma
88307 Cone biopsy of cervix
88307 Conization of cervix (cone biopsy)
88304 Conjunctiva biopsy or pterygium
88304 Contracture—Dupuytren's contracture tissue
88304 Cornea
88304 Cutaneous papilloma (tag), anus/skin
88304 Cyst—Bartholin's gland
88307 Cyst—bone
88305 Cyst—brachial (branchial) cleft
88304 Cyst—bursa
88305 Cyst—cervix
88305 Cyst—dental/oral
88307 Cyst—dermoid, of soft tissue/ovary (eg, teratoma)
88304 Cyst—dermoid, skin
88304 Cyst—epidermoid
88304 Cyst—ganglion
88304 Cyst—hydatid
88304 Cyst—mucus retention (salivary)

Appendix 18

Medicare Medically Unlikely Edits (MUE)
For Pathologists and Clinical Labs

The CPT/HCPCS codes used by pathologists and laboratories that are implicated by Medicare's medically unlikely edit (MUE) initiative as of July 1, 2013 according to the CMS website are listed below, together with the edit limit for each code. Codes and limits highlighted in yellow affect pathologist professional component billing and payment under the Medicare physician fee schedule. **Warning:** CMS has withheld publication of several MUE limits affecting pathologists and laboratories; therefore, don't consider the following list to be all inclusive. Furthermore, as a result of the CMS embargo on certain data, you may well experience MUE limit denials for CPT/HCPCS codes not included in the following list (e.g., 88304, 88305, 88307, 88342, 88185). **Heads-Up:** Evaluation and management consultation codes 99241-99245 and 99251-99255 are not accepted by Medicare; see 99201-99215 instead.

36511	1
36512	1
36513	1
36514	1
36515	1
36516	1
36522	1
38205	1
38206	1
38220	1
38221	1
38230	1
38232	1
76536	1
76604	1
76645	1
76705	2
76775	2
76942	1
80047	2
80048	2
80051	2
80053	1
80061	1
80069	1
80074	1
80076	1
80103	2
80104	1
80150	2
80152	2
80154	2
80156	2
80157	2
80158	2
80160	2
80162	2
80164	2
80166	2
80168	2
80170	2
80172	2
80173	2
80174	2
80176	1
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80186	2
80188	2
80190	2
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80195	2
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80201	2
80202	2
80299	3
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80406	1
80408	1
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80412	1
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80424	1
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80430	1
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80435	1
80436	1
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80439	1
80440	1
80500	1
80502	1
81000	2
81001	2
81002	2
81003	2
81005	2
81007	1
81015	1
81020	1
81025	1
81050	2
81161	1
81200	1
81201	1
81202	1
81203	1
81205	1
81206	1
81207	1
81208	1
81209	1
81210	1
81211	1
81212	1
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81300	1
81301	1
81302	1
81303	1
81304	1
81310	1
81315	1
81316	1
81317	1
81318	1