The Coding Institute AAPC CEU Approved

PATHOLOGY/LAB CODING ALERT

The practical monthly advisor for ethically optimizing coding, reimbursement and efficiency in pathology/lab practices

Vol. 2, No. 6 (Pages 41-48) June 2001

Receive Fair Payment for Physician Interpretation of Pap Smear

A Pap smear that appears abnormal requires interpretation by a physician, but some pathologists find it difficult to receive fair payment for it, especially if the payer is Medicare. Carriers often deny these claims because coders misapply one of four physician Pap interpretation codes: 88141 (*cytopathology, cervical or vaginal [any reporting system]; requiring interpretation by physician [list separately in addition to code for technical service]*), P3001 (*screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician*), G0124 (*screening cytopathology, cervical or vaginal [any reporting system], collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician*) or G0141 (*screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician*). Payment for physician interpretation of Pap smears depends on properly linking the diagnosis code, the Pap smear code and the physician interpretation code.

"By understanding when and how to use these codes, pathologists should be able to ensure fair payment for their work," says **Stacey Hall, RHIT, CPC, CCS-P,** director of corporate coding for Medical Management Professionals Inc., a billing and practice management firm headquartered in Chattanooga, Tenn.

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What's Inside

Enhance Compliance and Reimbursement with Chart Audits

Laboratories and pathology practices can strengthen compliance and optimize payment by using periodic audits to analyze coding habits. By scrutinizing coding at each step in the process from requisition through claims processing, practices can identify patterns that result in noncompliance or nonpayment. Audits should compare all documents for a given service, from requisition form to pathology report, to claims and remittance advice. Such a review can spotlight discrepancies that result in lost cash flow and possible charges of fraud.

"Chart audits are a method to identify weaknesses in your coding policies, processes and procedures," says **Dennis Padget, CPA, FHFMA,** president of Padget & Associates, a Kentucky-based pathology and laboratory billing and compliance consulting firm serving more than 150 clients in 25 states. "They are a good tool to ensure that you have complete and accurate information to file claims, and that claims are processed accordingly." You can then use the results of chart audits to educate your physicians and staff toward the end of enhanced compliance and payment.

The term "chart audit" can refer to both internal and external reviews of varying depth and breadth.

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(Pap *continued from page 41)*

Pap Coding Primer

A Pap smear involves preparing cervical or vaginal cytopathology smears and reviewing them for abnormal cell changes. There are multiple technical methods for providing this service, which may be carried out by a cytotechnologist or an automated system, under physician supervision. Fourteen CPT codes and seven HCPCS codes describe it. The differences in these codes are based on lab method, reporting system and whether the Pap smear was ordered for screening or diagnostic purposes.

Regardless of which Pap smear code is reported, if the review of the slides identifies abnormal cellular changes, a physician must provide an additional service of interpreting the smear. "The physician will interpret the slides and determine the diagnosis," Hall says. Regardless of whether the pathologist confirms abnormal cellular changes, he or she must write a report explaining the findings to justify the physician interpretation service.

Assigning the Correct Pap Smear Code

The first step in assigning the correct interpretation code is choosing the correct Pap smear code. "If the wrong Pap smear code is assigned, the wrong interpretation code will be assigned as well, and both services will be denied," Hall says. The Pap smear codes are first based on the reason the test was ordered: as a screening test in the absence of signs and symptoms of disease, or as a diagnostic test because of signs of disease.

"If the Pap smear is for screening in an asymptomatic patient, one of the HCPCS codes (P3000, G0123 or G0143-G0148) should be used," Hall says. If the Pap smear is ordered to aid in the diagnosis of a patient with signs or symptoms of disease, use the CPT codes (88142-88154, 88164-88167). Remember that the procedure code selection does not change regardless of whether the Pap results are positive or negative. For either HCPCS or CPT Pap codes, choose the code that accurately describes the laboratory technique, reporting system and screening/rescreening method employed.

1. Screening Pap smears: Most screening Pap smears are reported with P3000 (*screening Papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision*) or G0123 (*screening cytopathology, cervical or vaginal [any reporting system], collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision*). (For a full discussion on all HCPCS and CPT Pap test codes, see "How a Lab Can Avoid Medicare Denials for Pap Smears" in the April 2000 issue of *Pathology/Lab Coding Alert).*

"Remember that screening Pap tests are ordered in the absence of signs or symptoms of disease, so the appropriate diagnosis code would be one of the V codes," Hall says. In fact, Medicare requires the use of one of two codes, based on whether the patient is considered at high risk or low risk for developing cervical cancer. They are V76.2 (*special screening for malignant neoplasms, cervix*) for low-risk patients, and V15.89 (*other specified personal*

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Pathology/Lab Coding Alert readers are invited to submit comments, questions, tips, cases and/or suggestions for articles on any subject related to pathology/lab coding, reimbursement and/or compliance.

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Pathology/Lab Coding Alert (ISSN 1529-6075) (USPS # 019-443) is published monthly by The Coding Institute, a unit of Global Success Corporation. POSTMASTER: Send address changes to *Pathology/Lab Coding Alert*, 850 Sixth Ave. N., Naples, FL 34102
Periodical Postage Paid at Naples, FL, and additional offices.
Web: www.codinginstitute.com **Customer Service:** service@medville.com **Discussion Group:** www.coding911.com

Rates: USA: 1 yr. $399; 2 yrs. $778 (save $20); 3 yrs. $1147 (save $50).
Credit Cards Accepted: Visa, MasterCard, American Express, Discover

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history presenting hazards to health) for high-risk patients. High risk includes patients with any of the following histories: early onset of sexual activity, multiple sexual partners, history of sexually transmitted disease, having fewer than three negative Pap smears within seven years or being the daughter of a woman who took DES (diethylstilbestrol) during pregnancy.

Medicare has also established frequency limitations for administering screening Pap smears. Beginning July 1, 2001, one of those limits is changing. (See "Medicare Changes Pap Screening Frequency Rules" on page 47 for a description of the change.)

2. Diagnostic Pap smears: The majority of diagnostic Pap smears are reported with 88142 (*cytopathology, cervical or vaginal [any reporting system], collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision*) or 88164 (*cytopathology, slides, cervical or vaginal [the Bethesda System]; manual screening under physician supervision*)

There are 12 other CPT codes describing diagnostic Pap smears using various other review methods, lab techniques and reporting systems.

Medicare covers diagnostic Pap smears for a number of reasons that represent signs and symptoms of disease. These should be reported with the appropriate ICD-9 code for conditions such as previous cancer or other abnormal findings of the cervix, uterus, vagina or ovaries; previous abnormal Pap smear; or any other finding that the physician judges to be related to a gynecological disorder.

You Be the Coder

Specimen Transport

Question: *I am confused as to how and when to use 99000. We do the blood draws in our office, but send the specimen out (a lab picks it up at no charge). We also have patients with suspected urinary tract infection who come in to leave a specimen, which we send to the lab. We do not charge for preparing these specimens for transport. Can we report 99000 for this service?*

Maine Subscriber

Answer: Test your coding knowledge. Determine how you would code this situation before turning to page 46 for the answer. ❒

Assigning the Correct Interpretation Code

If any screening or diagnostic Pap smear reported with any HCPCS or CPT code results in the identification of an abnormality, a physician would interpret that smear. According to Hall, deciding which code should be used for physician interpretation of an abnormal Pap smear depends on which code describes the original Pap test. "Each CPT or HCPCS Pap smear code can only properly be paired with one of the Pap interpretation codes," Hall says. "If you mismatch the Pap test code with the Pap interpretation code, you probably won't be paid for the interpretation.

"If the interpretation is for a screening Pap, reported with a HCPCS code, then one of the HCPCS interpretation codes must be used," Hall says. "A rule of thumb will help you remember this: For screening Pap smears for Medicare patients, all codes should start with letters (i.e., the V codes and HCPCS codes)." Below is each of the HCPCS Pap interpretation codes, with the associated Pap smear codes:

• **Code P3001** (*screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician*) should be used to report physician interpretation of a Pap smear coded P3000 or G0147

•**Code G0141** (*screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician*) should be used with G0148

• **Code G0124** (*screening cytopathology, cervical or vaginal [any reporting system], collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician*) should be reported with G0123, G0143, G0144 or G0145.

"These physician interpretation services are payable in addition to the Pap screening service, so you should report both codes (e.g., P3000 and P3001) when both services are provided," Hall advises. This has been true since Jan. 1, 1999, before which time the interpretation codes were not all separately reportable.

In the same way, if the physician interpretation is for a diagnostic Pap smear reported with one of the 14 CPT Pap test codes, use 88141 (the only CPT physician Pap interpretation code). "Note that 88141 is an add-on code, meaning that it is always reported separately in addition to the original Pap smear code," Hall says.

"We had experienced problems in the past with Medicare denials for physician interpretation of Pap smears," reports **Stan Werner, MT (ASCP),** adminis-

(Continued on next page)

trative director and corporate compliance officer of Peterson Clinical Laboratory in Manhattan, Kan. "We were able to stop the denials by billing 88141 for interpretation following the 88164 or 88142 service, billing P3001 for interpretation following the P3000 service, and billing G0124 for interpretation following the G0123 service." ❑

(Audits *continued from page 41)*

"Most labs or pathology practices should have external audits periodically, ranging from quarterly to annually depending on the size and needs of the practice," Padget says. "But equally important are ongoing, internal audits that, although less far-reaching, are much more frequent — say, every week." The weekly audits will generally be limited to fewer elements, while the periodic external audits will be more comprehensive. Chart audits should include review of some or all of the following four elements: pathology or laboratory reports, requisition forms, claim forms and remittance advice.

Review of Pathology or Laboratory Reports

"Reviewing a sample of pathology reports is the centerpiece of any chart audit," Padget says. This may involve 25 or more reports for the weekly audit, to 100 or more cases for the periodic external review, depending on the size of the practice.

Some auditors recommend reviewing a specific number of reports from each pathologist, but Padget recommends a frequent, random sampling of charts. "A weekly peer review of 25 reports should ensure that the entire cross section of participants is represented," he says. In addition to a larger random sample (e.g., 100 charts) for the periodic external audits, Padget also recommends that these include review of charts for high-risk cases. For example, charts reporting two or more 88309 (*level VI — surgical pathology, gross and microscopic examination*) services or more than four frozen sections (88331 and 88332) should be flagged for review because these are more likely to have coding errors.

The audit should also ensure that ICD-9 codes are accurately assigned and support the medical necessity of the services.

1. Procedure Coding: "The first question in the chart review is, do the procedure codes accurately describe the service that was ordered and provided?" Padget says. For example, the listed codes must not involve upcoding to maximize payment. As a case in point, the examination of an epidermoid inclusion cyst (706.2) should be coded 88304 (*level III — surgical pathology, gross and microscopic examination; skin - cyst/tag/debridement*). If the report shows a code of 88305 (*level IV — surgical pathology, gross and microscopic examination; skin other than cyst/tag/debridement/plastic repair*), which has a higher payment but does not accurately describe the specimen, it would be considered inappropriate upcoding.

Similarly, reviewing the reports for coding accuracy should identify any potential cases of unbundling of services. For example, if a patient undergoes surgery for a malignant neoplasm of the colon (153.x), and the pathologist receives a total colon resection with attached pericolonic tissue including lymph nodes, the correct procedure code would be 88309 (*… colon, total resection*). Coding separately for the attached lymph nodes (88307, *level V — surgical pathology, gross and microscopic examination; lymph nodes, regional resection*) would be considered unbundling, because associated lymph nodes are generally considered a part of the resected 88309 specimen.

Reviewing the pathology reports can also identify undercoding. For example, if a sentinel lymph node biopsy (88307) is reported simply as a lymph node biopsy (88305), the error could cost the practice legitimate revenue.

"The periodic review of pathology reports should turn up any such coding inaccuracies," Padget says. This

Clarification:

Codes 88329 and 88331 are Bundled

In the article "To Boost Bottom Line, Avoid Bundling Hysterectomy Specimens that Require Individual Diagnoses" in the April 2001 issue of *Pathology/Lab Coding Alert* a reference to 88329 and 88331 on page 28 created some confusion. The parenthetic listing of the codes following the procedure name was intended to identify the code for each procedure, not to imply that the two codes should be reported together. Codes 88329 *(pathology consultation during surgery*) and 88331 (*pathology consultation during surgery; first tissue block, with frozen section[s], single specimen*) should not be reported together for a single specimen, as they are considered bundled. Explanations of this fact can be found in previous issues of *Pathology/Lab Coding Alert* (July and September 2000). We apologize for any confusion this may have caused. ❑

information can then be used to educate pathologists about correct coding practices. "That is why the weekly review is so important. A lot of mistakes can be made in a year, and the continuous review keeps practices in compliance and receiving fair payment for their services."

2. Diagnosis Coding and Medical Necessity:
Periodic audits should also ensure that the pathology or lab report includes accurate diagnosis information that supports the medical necessity of the tests ordered, as well as accurate ICD-9 codes to report the results of the tests.

"Medicare has some national and many local medical review policies (LMRPs) that stipulate which diagnoses uphold medical necessity for which pathology services," explains **Laurie Castillo, MA, CPC, CPC-H, CCS-P**, member of the National Advisory Board of the American Academy of Professional Coders. "A periodic review of a sampling of pathology reports should ensure that procedures are only carried out for conditions that justify medical necessity."

For example, coding for Pap smears is a major source of errors in the agreement between diagnosis and procedure coding. "First of all, HCFA makes a distinction between diagnostic and screening Pap smears, both in terms of the code used to describe the procedure and the diagnoses that support the medical necessity of the test," Castillo says.

For a screening Pap smear, the patient should not have any signs or symptoms of disease, and beginning July 1, 2001, the patient can have the test only once every two years (or more often if the patient is "high risk") for the service to be covered. "A screening Pap smear must be reported with V76.2 (*special screening for malignant neoplasms, cervix*) for low-risk patients, or V15.89 (*other specified personal history presenting hazards to health*) for high-risk patients," Castillo says. The correct procedure code for a screening Pap smear is one of the HCPCS codes, e.g., P3000 or G0123. "For a diagnostic Pap smear, an ICD-9 code for signs or symptoms of disease must be reported, and the procedure should be listed with the appropriate CPT code, e.g., 88142 or 88164," Castillo says. (For more on Pap smear coding, see "Receive Fair Payment For Physician Interpretation of Pap Smear" on page 41.)

"Finally, the audit of lab reports should ascertain if the pathologists are accurately assigning ICD-9 codes based on the test results," Castillo says. "Two common errors that turn up in chart reviews are due to not reporting the diagnosis to the highest degree of specificity." This can occur either by assigning a truncated code (i.e., reporting codes that require a fourth or fifth digit as only three or four digits) or by overusing "unspecified" codes. Medicare and many third-party payers consider truncated coding invalid and question the overuse of "unspecified" codes. These errors in diagnosis coding can lead to claims denials.

Review of Requisition Forms

The requisition form is the starting point of an expanded chart audit that should take place one to four times a year. "Information regarding each pathology and laboratory service begins with the requisition form from the referring physician," Padget says. "The information on this form should be scrutinized in the audit to ensure that it matches the information on the pathology report."

By comparing the requisition form to the pathology report, you can confirm that the test ordered was the test carried out and coded. You can also ascertain that the diagnosis supports medical necessity, and that the diagnosis given by the referring physician agrees with the diagnosis on the pathology claim when directed (e.g., Pap tests), or when a definitive pathologic diagnosis is not available. Padget explains that if the requisition form is not in agreement with the pathology claim regarding the reason for the test or which test is ordered, there is not appropriate documentation to back up the charge.

For example, if the referring physician orders a Pap smear and indicates that it is a diagnostic test, the requisition form should include an indication of history of disease or a diagnosis for signs and symptoms of disease, such as cervical dysplasia, 622.1. "If the referring

(Continued on next page)

physician only assigns one of the V codes and orders a diagnostic Pap, there is a problem," Padget says. If the pathology claim provides an ICD-9 code that supports the diagnostic Pap smear, there must also be documentation that the referring physician was contacted and provided additional information after the requisition was submitted.

"The lab must get the diagnosis information from the referring physician; it cannot assign a diagnosis just because it will result in payment," Padget says. If a new requisition form is required with the correct diagnosis, be sure to have the physician's office fax a corrected form immediately and keep it in the medical record. Accepting a new diagnosis over the phone without documentation can become troublesome in an audit.

Review of Claim Forms (HCFA 1500)

Billing forms should also be reviewed in the expanded audit that takes place at least annually. By selecting certain pathology reports and reviewing the associated HCFA 1500, an audit can help ensure that the intended charges reflect what is actually posted.

"This is the place in the audit where we typically find problems like multiple units of service that are not accurately reported. For example, the pathology report may show two nevi submitted from distinct locations on the body, but the claim form may report one unit of 88305 instead of two," Castillo says.

Another common error in translating information from the pathology report to the claim form is applying the diagnosis information incorrectly. Although more than one diagnosis may appear on the lab report, it is important that these are put on the HCFA 1500 in the proper order. For example, if a pathologist evaluates a neoplastic ovary (88307), the definitive pathologic diagnosis (e.g., malignant teratoma, 183.0) must be listed first on the HCFA 1500 to support the medical necessity of the service. Although the patient may have presented with pelvic pain (625.9) as the initial symptom that led to the oophorectomy, that ICD-9 code must be reported second on the HCFA 1500 because it does not support medical necessity for 88307.

Review of Remittance Advice

HCFA provides an explanation of benefits (EOB), and most third-party payers provide a similar clarification when a claim is denied. According to Padget, the remittance advice can provide valuable information about ICD-9 and/or CPT coding errors that may have caused a claim rejection.

By comparing the remittance advice to the other information, including the requisition, the pathology report and the claim form, the source of the error can often be identified. For example, the EOB may indicate that a claim for 88329 (*pathology consultation during surgery*) and 88331 (*pathology consultation during surgery; first tissue block, with frozen section[s], single specimen*) is denied based on a Correct Coding Initiative (CCI) edit. CCI prohibits reporting these two codes together for a single consultation because the services of 88329 are a component of (bundled into) 88331.

However, if the pathology report makes it clear that the codes represented two distinct consultation sessions, both services could have been reported by appending modifier -59 (*distinct procedural service*). For example, if a pathologist was called to surgery for a consultation involving a frozen section to establish a diagnosis of neoplasm of the colon, the appropriate code would be 88331. If the pathologist was later called back into surgery to consult on margins of the colon resection, the service would be coded 88329.

"Reviewing the EOB can reveal all sorts of coding errors, such as unbundling, upcoding, or improper use (or lack of use) of modifiers," Castillo says. "It can also uncover problems such as laboratories reporting tests for which it is not approved under the Clinical Laboratory Improvement Amendments (CLIA), and tests for which the lab should have an advance beneficiary notice (ABN) on file."

The remittance advice can also alert pathology practices and laboratories to coding requirements that they

You Be the Coder

(Question on page 43)

Specimen Transport

Answer: Handling and/or transporting a specimen to the laboratory can be reported with 99000 (*handling and/or conveyance of specimen for transfer from the physician's office to laboratory*). The code can be used whether a courier picks up the specimen, as you indicated, or the physician office delivers the specimen. This is according to a clarification published in *CPT Assistant*, October 1999.

Preparation of the specimen may include processes such as centrifugation, labeling and packaging, and completing laboratory and insurance forms related to the specimen. So you may report the code, but most insurers, including Medicare, do not pay for it. You may contact your third-party payers to see if they recognize 99000.

*— Answered by **Laurie Castillo, MA, CPC, CPC-H, CCS-P**, member of the National Advisory Board of the American Academy of Professional Coders.* ❑

may have missed. If a lab failed to use updated CPT codes for certain tests, or missed a policy update, the EOB could alert them to the source of the claims denials. However, if the remittance advice is reviewed only in an annual audit, much of this valuable information is lost. "That is why I recommend the laboratory or pathology practice sit down once a month with the billing agent to discuss any trends that might point to a problem," Padget says.

*Note: For more on compliance, call 800-508-2582 for a sample issue of our new newsletter "*Medical Office Compliance Alert.*"* ❑

News Brief:

Medicare Changes Pap Screening Frequency Rules

Beginning July 1, 2001, Medicare will pay for a screening Pap smear for low-risk patients once every two years, rather than once every three years as previously covered. Frequency guidelines for high-risk patients do not change.

A screening Pap smear is carried out to screen for cervical or vaginal cancer in the absence of signs or symptoms of disease. For patients with a personal history that increases risk for these diseases, the screening Pap smear has been, and may continue to be, conducted once a year.

However, for patients with no symptoms and no personal history indicating high risk for cervical or vaginal cancer, Medicare will now cover Pap smears once every two years. This change is due to the Consolidated Appropriations Act of 2001, to provide coverage for biennial Pap smears, modifying the existing law that provides coverage once every three years. All other coverage and payment requirements remain the same.

Under the new rules, for claims with dates of service on or after July 1, 2001, Medicare will pay for a screening Pap smear for a low-risk patient after at least 23 months have passed following the month during which the patient received her last covered screening Pap smear. For example, if the patient's last screening Pap smear was August 1999, start your count with September 1999. The patient is eligible to receive another screening Pap smear in August 2001, the month after 23 months have passed.

For Medicare's announcement of this change, visit HCFA's program transmittal page: www.hcfa.gov/pubforms/transmit/transmittals/comm_date_dsc.htm and select file R1823.A3 from the file column. ❑

READER QUESTIONS

Wright's Stain Slide

Question: *If the lab prepares a Wright's stain slide for a bone marrow aspirate for the pathologist, is there a separate code that can be billed, such as 87205? Or is this stain bundled into the technical component of 88305? The lab personnel only stain the slides; they do not interpret the stained slides. Also, if the laboratory prepares the differential cell count of the bone marrow aspirate for the pathologist, can the lab bill the technical component of 85097, since the pathologist prepares the final interpretation and report?*

Missouri Subscriber

Answer: You should not report 87205 (*smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types*) for a bone marrow aspirate, as this code describes the preparation, staining (Gram or Giemsa) and interpretation of smears from a primary source such as sputum or cerebrospinal fluid. Nor should you report any special stain code for the Wright's stain of a bone marrow aspiration because this is the standard staining technique used to prepare the smears. Although, based on the note in CPT 2001, "special stains" can be reported in addition to 85095 (*bone marrow; aspiration only*) and 85097 (*bone marrow; smear interpretation only, with or without differential cell count*), the Wright's stain is not a special stain, but is considered the basic stain for bone marrow aspiration smears.

You should not report 88305 (*level IV — surgical pathology, gross and microscopic examination, bone marrow, biopsy*) for the examination of a bone marrow aspirate. This code refers to a bone marrow biopsy, meaning intact tissue obtained through a needle or trocar, for example, rather than the fluid containing cells obtained by aspiration. Instead, 85097 should be used to describe the evaluation of a bone marrow aspirate. You do not code separately for the differential cell count because that service is included in 85097. In other words, 85097 describes the evaluation of bone marrow aspirate whether or not a differential cell count is conducted.

To clarify coding for bone marrow aspiration, the service is broken down into two parts and reported using two codes. The bone marrow aspiration, which involves inserting a needle and aspirating cells from the marrow and preparing smears, is reported using 85095. The interpretation of the smears, including differential cell count, if done, is reported using 85097.

*— Answered by **R.M. Stainton Jr., MD,** president of Doctor's Anatomic Pathology Services, an independent pathology laboratory in Jonesboro, Ark.*

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(Continued on next page)

E/M With Bone Marrow Aspiration

Question: *Medicare is denying an E/M code when our pathologist bills it with the procedures for a bone marrow aspiration. We have only recently been getting these denials. The pathologist performs a complete history and physical exam of the patient, including a detailed drug history in order to render a final diagnosis.*

The final diagnosis is a combined clinical and pathological diagnosis. Orders are often written to complete the final evaluation. Which E/M code would be appropriate for these circumstances? Possibly an E/M code with a -25 modifier?

Illinois Subscriber

Answer: Bone marrow aspiration 85095 (*bone marrow; aspiration only*) was bundled with E/M services in the Correct Coding Initiative (CCI) edits version 6.3. This included E/M codes for many hospital inpatient or outpatient, and office visit services. However, these edits were suspended and should no longer affect your claims.

As long as you have documentation supporting the E/M service provided, you should be paid for that service. As to which E/M code to select: That depends on the circumstances surrounding the visit. E/M codes are divided into broad categories, such as office visits or hospital visits, and further subdivided by categories such as new patient and established patient. Within these categories, codes are assigned based on the content of the service, such as the level of history and examination and the medical decision-making involved. You should contact your carrier to discuss these denials. Some carriers have recommended using modifier -25 (*significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) to override inappropriate denials based on the implementation of CCI version 6.3 edits.

*— Answered by **Laurie Castillo, MA, CPC, CPC-H, CCS-P**, member of the National Advisory Board of the American Academy of Professional Coders.* ❑