# The Importance of Understanding CPT Coding

By Anthony Kurec, MS, H(ASCP)DLM

Keywords: Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), Reimbursement, National Correct Coding Initiative, Medically Unlikely Edits

## Abstract

Current Procedural Terminology (CPT™)[1] is a manual that identifies specific procedures, tests and services performed by healthcare providers. In order to accurately bill for laboratory services, CPT codes are used in conjunction with ICD9/ICD10 codes (International Classification of Diseases, a series of codes that identify diseases, disorders, and symptoms). While CPT codes identify what tests are performed, ICD9/10 codes ensure the appropriateness of the tests in relation to the current clinical problem. Understanding why CPT codes are needed and how they apply to laboratory testing is also important in meeting compliance regulations.

## Introduction

Current Procedural Terminology (CPT™) manual first appeared in 1966 as a shorthand mechanism to assist medical record clerks to better understand what surgical procedures were performed on patients.[2,3] In 1970, a second, expanded edition was released. In 1983, Centers for Medicare & Medicaid Services (previously the Health Care Financing Administration or HCFA) incorporated CPT codes to cover all physician services when reporting Medicare Part B benefits.[3]

The CPT manual is revised every year under the auspices of the American Medical Association (AMA) and made available in November so that any changes to charge masters can be implemented by Jan. 1 of the fol-

lowing year. The manual incorporates a set of descriptive terms that provides uniform language, useful in the administrative management of healthcare practices: claims submission, developing medical guidelines, establishing fee schedules, medical education, and research and development of new technologies.[1] CPT coding is primarily used for all Medicare, Medicaid and third-party payor reimbursement systems.

For many years, physician services, procedures and tests were billed to insurance companies and paid at 100 percent of those charges. In 1984, the prospective payment concept was launched primarily through Medicare and Medicaid programs for inpatient testing. This was the beginning of managed care and capitated payments.[4] Each CPT code is used to identify a service or test and linked to a reimbursement fee schedule.

CPT codes have also been useful in collecting data to measure productivity, test volume increases/decreases, revenue, expenses and other benchmarking metrics. Because all laboratory tests can be identified by CPT codes, one billable test relates to one code, thus making it a convenient way to set industry productivity standards.

Correct use of CPT codes is critical to ensure proper submission for reimbursement and to ensure compliance regulations are not violated. CPT codes are often automatically assigned at time of order entry by the Laboratory/Hospital Information System (LIS/HIS) and billed to the patient or third-party payors. These transactions occur behind the scenes and are not routinely apparent to laboratory personnel. Once billing information has been received by the payor, it also goes through a set of computer algorithms that evaluate/validate the CPT codes (test procedures) in conjunction with ICD9/ICD10 codes (stated clinical problem). Any discordance will generate a denial for payment.

## Healthcare Common Procedure Coding System (HCPCS)

CPT codes were incorporated into the Healthcare Common Procedure Coding System (HCPCS), currently in use today. HCPCS originally consisted of three levels[2,3]:

**Level I** – Standard CPT codes that reflect well-established services, procedures and tests (as recognized by the U.S. Food and Drug Administration [FDA]). Relative Value Units (RVUs) are assigned to most CPT codes including some laboratory codes (primarily anatomic pathology), based on physician work effort, practice expense and malpractice costs. CPT codes are arranged by discipline as noted below; almost all pathology/laboratory codes fall within the 8000 series. CPT codes consist of six sections:

| CPT Code | Service |
|---|---|
| 10000 – 19999 | Anesthesiology |
| 20000 – 69999 | Surgery |
| 70000 – 79999 | Radiology |
| 80000 – 89999 | Pathology and Laboratory |
| 90000 – 99999 | Medicine |
| 99201 – 99499 | Evaluation/Management |

**Level II** – HCPCS/National Codes are additional identifiers not covered by Level I codes and begin with a letter (A through V) followed by four numbers. Most HCPCS codes cover non-physician services such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).[5]

**Level III** – These were temporary codes used in identifying new tests or technology primarily used at a local/state level for services not identified under the other levels. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) discontinued Level III codes as of Dec. 31, 2003.[5]

## National Correct Coding Initiative and Medically Unlikely Edits

The National Correct Coding Initiative (NCCI) was initiated by Medicare to assist in standardizing CPT codes. Automated edits are constructed to identify certain CPT code pairings that are unlikely to be performed at the same time of service. A **table of edits** is provided and updated yearly. Column 1 lists CPT codes eligible for payment, while column 2 shows those CPT codes that would be inappropriate or are inclusive of the corresponding CPT codes in column 1. For example, 80047 (Basic metabolic panel) could be billed but not at the same time as 82374 (Carbon dioxide).

In addition, Medically Unlikely Edits (MUEs) are also used to address the maximum number of units of service (CPT) that are allowed to be submitted per patient on the same day of service. The maximum number of units per CPT is limited based on a reasonable number of expected occurrences at the same time. For example, prostate biopsies may consist of 10 samples or more (88305 x10), of which most will be denied unless one appeals the denial. Payors, other than Medicare, may have more restrictive MUEs and deny multiple units of the same CPT as duplicates.

## Add-on Codes[1]

Add-on codes are identified with a + sign and used only to supplement certain additional procedures/tests done in conjunction with a primary procedure/test. This code cannot be used as a standalone code and must always accompany the primary CPT code. Two examples are:

**+87503** – "influenza virus, for multiple types or subtypes, multiplex reverse transcriptase and amplified probe

technique, each additional influenza virus type or sub-type beyond 2," is an add-on to 87502, "influenza virus, for multiple types or sub-types, multiplex reverse transcriptase and amplified probe technique, first 2 types or subtypes"

**+88332** – each additional tissue block for frozen sections in conjunction with CPT 88331 (first tissue block, with frozen section(s), single specimen). If a lymph node is submitted for frozen sections and three tissues blocks are prepared, the first block would be assigned 88331 with the remaining two blocks as 88332. If a second lymph node is submitted, it would be assigned 88331 with an additional block as 88332.

## Place-of-service Codes and Revenue Codes[1]

Table 1: Common Place-of-Service Codes Used in Billing Laboratory Tests

| | |
|---|---|
| 03 | School: i.e., any facility whose primary purpose is education |
| 04 | Homeless shelter, emergency shelters, individual or family shelters |
| 15 | Mobile unit that moves from place to place that provides screening or diagnostic tests |
| 20 | Urgent care facility that is located somewhere other than a hospital emergency department, conditions requiring immediate attention |
| 21 | Inpatient hospital setting, other than a psychiatric facility. |
| 22 | Outpatient services provided in a hospital to patients not requiring hospitalization |
| 23 | Emergency department services provided in a hospital. |
| 24 | Ambulatory surgical center; a free-standing facility where surgical and diagnostic services are provided, usually as a one-day service. |
| 25 | Birthing center |
| 31 | Skilled nursing facility |
| 34 | Hospice |
| 49 | Independent clinic, not part of a hospital or other place-of-service location |
| 51 | Inpatient psychiatric facility |
| 65 | End-stage renal disease treatment facility |
| 71 | Public health clinic |
| 81 | Independent laboratory, not part of a hospital or physician's office |

Place-of-service codes are used when submitting professional charges to indicate where the service took place (see Table 1). Each payment claim must include this code and, if entered wrong, can result in payment denial and red flag accounts, especially when submitting to Medicare or Medicaid.

Revenue codes identify where the service was provided within the laboratory and are required for hospital inpatient and outpatient services. Most laboratory tests fall within the 300 series:

300 – General laboratory test ..... 307 – Urology
301 – Chemistry..... 309 – Other
302 – Immunology..... 310 – Pathology
303 – Renal (home)..... 311 – Cytology
304 – Non-routine dialysis..... 312 – Histology
305 – Hematology..... 314 –Pathology Biopsy
306 – Bacteriology/Microbiology .. 319 – Pathology Other

## Modifiers

Table 2: Common Laboratory Related Modifiers

| |
|---|
| 26 – Professional component. |
| 50 – Bilateral procedure performed during the same session |
| 59 – Distinct procedural service, services performed at different sites or at different patient encounters. If two procedures/services are performed at the same site, then this modifier cannot be used. |
| 77 – Repeat procedure/service by another physician |
| 90 – Modifier used when a laboratory test is sent to a reference laboratory |
| 91 – Repeat clinical diagnostic laboratory test. When a clinical laboratory test is repeated within the same day to obtain a multiple results, payment may be denied viewed as unnecessary testing unless this modifier is added. For example, if cultures from the eye, nose and mouth were taken in the same day, then the CPT codes would be 87070-91, 87070-91, 87070-91. |
| 92 – Alternative laboratory platform testing. Point-of-care testing where a kit or mobile instrument is used. Example: 86701-92; HIV-1 test using a single-use, disposable platform. |
| 99 – Modifier 99 must be included to indicate that there are more than two modifiers attached to a specific CPT code. Without modifier 99, many third-party payors will disregard the additional codes. |
| TC – Technical component, no professional services rendered, only technical preparation is provided. Example: 88305-TC; a surgical specimen is put into paraffin, sectioned, and stained by a histotechnologist. |
| GA – Used when a Medicare patient receives a test that requires an Advanced Beneficiary Notice (ABN) to be signed and kept on file |
| QW – CLIA-waived test |

Modifiers may be attached to a CPT code to indicate that an event not ordinarily encountered has occurred or if a circumstance needs further explanation. A modifier can be appended only if there is adequate clinical justification and is documented. The most common modifiers are modifiers –26 (professional component) and –TC (technical component). An example is a biopsy: 88305-26 identifies patholo-

gist interpretation while 88305-TC reflects histotechnologist preparation of the sample. Other common modifiers used when submitting laboratory CPTs are noted in Table 2.

Each of these components is paid at a different rate. In the example, if the biopsy charge was billed without a –26 or –TC, it would be processed as a "global" charge, generally, the sum of the two. One must take care not to submit a global charge in addition to submitting the same CPT with either the –26 or –TC modifier. Third-party payors would most likely reject all payments. A global payment would be appropriate if the laboratory personnel (technical and pathologist), equipment and supplies were paid for by a single entity ("the hospital"). If a global payment was received in addition to either a technical or professional payment, this would be a compliance violation.

## Other Modifiers

Laboratory managers/supervisors need to familiarize themselves with CPT codes and how they are submitted to insurance companies — first, to ensure that the correct code that best describes the test is used and that the correct modifier is appended when necessary. In most cases, laboratory personnel do not know what happens after a test has been completed and reported. If a modifier is required but not appended, one or more tests may be denied for payment.

Medical billers are responsible for all departments within a hospital and spend much of their time addressing denial issues. Be aware that they will often spend most of their time working on reimbursement denials for high-cost services (surgeries, MRIs, chemotherapy, pharmaceuticals, etc.) that reflect thousands of dollars in lost revenue. Addressing a denial for a single laboratory test that generally has low reimbursement becomes less of a priority and, due to the test volume, difficult to manage. However, when that single test is performed hundreds or thousands of times a month, a $25 or $30 reimbursement loss can add up quickly.

In working with medical billers, ask to review denials and the corresponding explanation of benefits (EOBs). While it is not practical for a laboratory manager to review all denials, selecting ones that recur is a good place to start. Periodically reviewing denials can be an eye-opening experience and can offer opportunities to assist medical billers to better understand and justify laboratory billing submissions. This partnership can potentially improve revenue and remain in compliance.

Below are some potential situations to consider when denials are received due to what the payor believes are duplicate or inclusive services. Refer to Table 2 for commonly used modifiers, and check with your medical biller to see which modifier would be most appropriate.

May be denied as a duplicate service:

- Bilateral bone marrow biopsy (88305 x 2)
- Pathologist-performed FNA (10021) may be charged though the patient is under the care of another physician/surgeon
- Bronchoscopic washing (88108) is performed with a corresponding cell block, in addition to a transbronchial biopsy (88305 x2)
- Compliment tests C3 and C4 (86160 x2)
- Multiple culture swabs, right/left eyes, right/left eyelids (87106 x4)
- Analyzing three stool samples (87045 x3)
- Allergy testing (86003) often includes multiple allergens

May be denied as an inclusive service:

- Tonsils (88300 – gross only) submitted in addition to an esophagus biopsy (88305)
- Pleural fluid submitted for cytology (88112) and flow cytometry also performed (88189 interpretation of flow cytometry, >16 markers)
- Fine Needle Aspiration (FNA, 88173) is performed on a lymph node and a biopsy (88305) is also required
- When flow cytometry (88184-88189) is performed on tissues samples (lymph node), it may be necessary to perform additional immunostaining (88342) with different antibodies not part of a flow panel. Immunostains may be denied as inclusive to flow.
- When slides and blocks are received for pathology consultation (88323) and additional immunostaining (88342) is performed by consulting laboratory
- Bronchoscopic washing (88108) is performed with an upper lingual brushing (88104); 88104 may be denied as inclusive to 88108
- Testing for autoantibodies – SM, RNP, SSB, SSA (86235 x4)

## Conclusion

It is important to develop a relationship with billing personnel and the compliance officer in order to ensure CPT codes are used correctly for the tests actually performed. It's important to remember that once a CPT code has been changed in your LIS, all future tests assigned to that code will be billed as such. Because the laboratory testing is generally high volume, a miscoded test can be replicated hundreds or even thousands of times, creating a compliance nightmare. In addition, one needs to correctly maximize reimbursement payments.

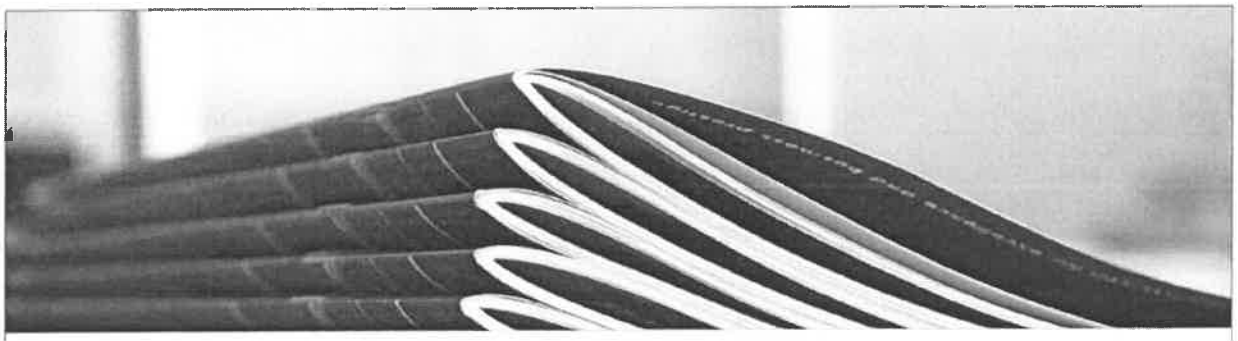
Though time consuming, an annual review of CPT codes is important to ensure that the CPT code best reflects the procedure being performed. Equally important is being confident that you will receive appropriate reimbursement for services rendered. While internal review is essential, an external review by a qualified CPT coding specialist will help assure that coding is current and correct. Hiring a consultant and implementing their suggestions can often offset the cost of the consultant. An internal review should be done every year and an external one every two to three years. One may then be confident that compliance regulations are met and fair payment for services received.

## References


1. Hollman PA, Brin K, Bothe AE, et al. American Medical Association. Current Procedural Terminology. (2014)
2. Coding Ahead. History and development of CPT. http://www.codingahead.com/2009/04/history-and-development-of-cpt.html (Last accessed 11/25/2013)
3. Department of Otolaryngology, The University of Texas at Houston. Current procedural terminology: History, structure, process, and controversies. https://med.uth.edu/orl/newsletter/current-procedural-technology-history-structure-process-controversies/ (Last accessed 11/25/2013)
4. Voorhees D. Coding, billing, and reimbursement management, in Management in Laboratory Medicine, 3rd ed. (1998) Snyder JR, Wilkinson DS, eds. Lippincott:Philadelphia. pp 509-517.
5. CMS. HCPCS General information. http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html (Last accessed 11/26/2013)

Anthony S. Kurec, MS, H(ASCP)DLM, is a past president of CLMA and is currently the editor-in-chief of CLMA's publications. He retired from SUNY Upstate Medical University in Syracuse, New York, as a practice plan administrator in pathology and holds an appointment as a clinical associate professor.





## CLMA Encourages Subject Matter Experts to Submit Manuscripts for Publication

Share your knowledge in CLMA's *Clinical Leadership & Management Review (CLMR)*. Publishing in peer-reviewed journals is a great way to build your personal resume and support your profession. *CLMR* authors explore the concepts and techniques of management – old, new, and improved! They also address broad issues and trends in healthcare (both in government and the private sector) that have an impact on the clinical laboratory.

Manuscripts in the following subject areas are considered for publication:

- Healthcare topics affecting laboratories
- Financial management
- General/operational management
- Marketing
- Medical information systems
- Human resource management
- Regulatory issues
- Patient and staff quality/safety
- Case studies

For more information, please review the **Author Guidelines PDF** or contact **Editor Dennis Coyle**.

Copyright of Clinical Leadership & Management Review is the property of Clinical Laboratory Management Association and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.