Advances in Cytology and Small Biopsy Course
–
CMS Cytology Billing Compliance

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Monday, June 12th, 2023, 15:30-16:00

Conflicts of Interest

- None

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Key Points

- What the are CMS compliant billing requirements?
- Which of these specifically applies to cytopathology?
- Service Coding – Screening versus Diagnostic Cytopathology
- National Correct Coding Initiative – Procedure to Procedure Edits for Flow Cytometry and Cytopathology Services
- Medically Unlikely Edits for Cytopathology Services and Adjudication Indicators
- FNA Services – Coding for Immediate Assessments – Units of Service and Evaluation and Management Services

Institutional Payment (CMS "Part A")

(for professional services not provided to individual patients)

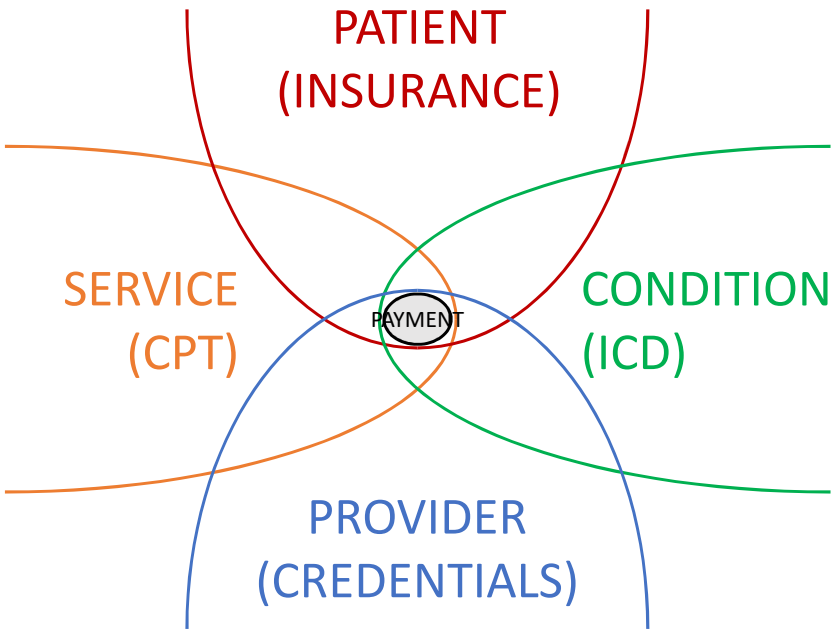
Specialty	RCE Limits updated to 2012*
Total	$206,300
General/Family Practice	174,600
Internal Medicine	192,700
Surgery	240,300
Pediatrics	165,500
OB/GYN	231,200
Radiology	265,200
Psychiatry	176,800
Anesthesiology	233,500
Pathology	253,900

FINAL CY 2015 RCE LIMITS

Total	$211,500
General/Family Practice	179,000
Internal Medicine	197,500
Surgery	246,400
Pediatrics	169,700
OB/GYN	237,100
Radiology	271,900
Psychiatry	181,300
Anesthesiology	239,400
Pathology	260,300

Professional Billing (CMS "Part B")

(for professional services provided to individual patients)

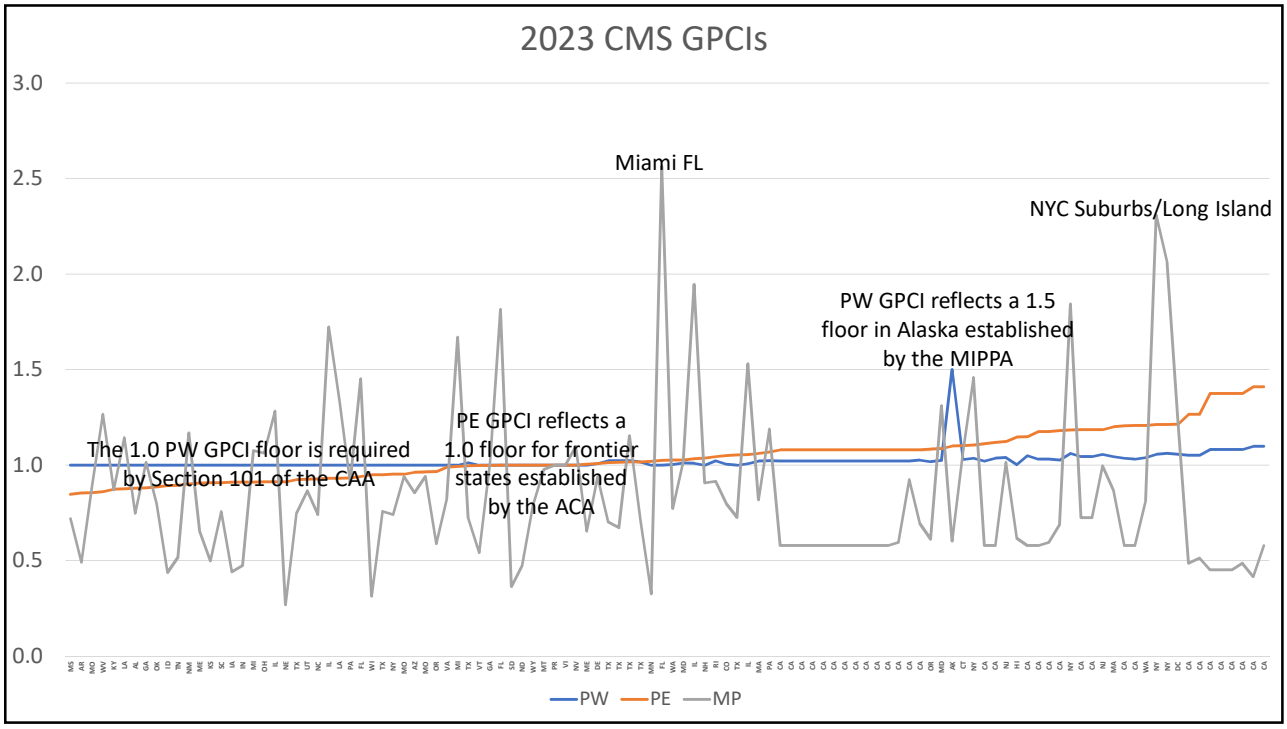


Cytopathology services

- Services are described by Current Procedural Terminology (CPT) codes, which are developed for approval by the American Medical Association (AMA) CPT Editorial Panel through its Pathology Coding Caucus (PCC), which is staffed by the College of American Pathologists
- Services on the Physician Fee Schedule (PFS) are initially valued by the AMA Relative Value Scale (RVS) Update Committee (RUC) in Relative Value Units (RVUs) for approval by the Centers for Medicare and Medicaid Services (CMS)
- The other services are on the Clinical Laboratory Fee Schedule (CLFS); these are initially priced either by cross-walking to existing services or are gap-filled by local Medicare Administrative Contractors (MACs)

Calculating Payment

- RVU Elements
  - Physician Work (PW) – Only Professional (26) Component
  - Practice Expense (PE) – Both Professional (26) and Technical (TC) Components
  - Malpractice Cost (MP) – Both Professional (26) and Technical (TC) Components
- Each locality has a Geographic Practice Cost Index (GPCI) multiplier for each component
  - RVU = (PW x $GPCI_{PW}$) + (PE x $GPCI_{PE}$) + (MP x $GPCI_{MP}$)
- Conversion Factor (CF) = $ per RVU
- Payment = CF x RVU
- Global RVU = Professional (26) RVU + Technical (TC) RVU



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HCPCS	MOD	DESCRIPTION	WORK RVU	PE RVU	MP RVU	TOTAL RVU	CONV FACTOR
88104		Cytopath fl nongyn smears	0.56	1.47	0.03	2.06	33.8872
88104	TC	Cytopath fl nongyn smears	0.00	1.25	0.02	1.27	33.8872
88104	26	Cytopath fl nongyn smears	0.56	0.22	0.01	0.79	33.8872
88106		Cytopath fl nongyn filter	0.37	1.69	0.02	2.08	33.8872
88106	TC	Cytopath fl nongyn filter	0.00	1.51	0.01	1.52	33.8872
88106	26	Cytopath fl nongyn filter	0.37	0.18	0.01	0.56	33.8872
88108		Cytopath concentrate tech	0.44	1.51	0.02	1.97	33.8872
88108	TC	Cytopath concentrate tech	0.00	1.31	0.01	1.32	33.8872
88108	26	Cytopath concentrate tech	0.44	0.20	0.01	0.65	33.8872
88112		Cytopath cell enhance tech	0.56	1.41	0.02	1.99	33.8872
88112	TC	Cytopath cell enhance tech	0.00	1.18	0.01	1.19	33.8872
88112	26	Cytopath cell enhance tech	0.56	0.23	0.01	0.80	33.8872
88125		Forensic cytopathology	0.26	0.56	0.02	0.84	33.8872
88125	TC	Forensic cytopathology	0.00	0.43	0.01	0.44	33.8872
88125	26	Forensic cytopathology	0.26	0.13	0.01	0.40	33.8872
88141		Cytopath c/v interpret	0.26	0.41	0.01	0.68	33.8872
G0141		Scr c/v cyto,autosys and md	0.26	0.41	0.01	0.68	33.8872
G0124		Screen c/v thin layer by md	0.26	0.41	0.01	0.68	33.8872
P3001		Screening pap smear by phys	0.26	0.41	0.01	0.68	33.8872

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88160		Cytopath smear other source	0.50	1.71	0.03	2.24	33.8872
88160	TC	Cytopath smear other source	0.00	1.47	0.02	1.49	33.8872
88160	26	Cytopath smear other source	0.50	0.24	0.01	0.75	33.8872
88161		Cytopath smear other source	0.50	1.76	0.03	2.29	33.8872
88161	TC	Cytopath smear other source	0.00	1.53	0.02	1.55	33.8872
88161	26	Cytopath smear other source	0.50	0.23	0.01	0.74	33.8872
88162		Cytopath smear other source	0.76	2.75	0.03	3.54	33.8872
88162	TC	Cytopath smear other source	0.00	2.38	0.02	2.40	33.8872
88162	26	Cytopath smear other source	0.76	0.37	0.01	1.14	33.8872
88172		Cytp dx eval fna 1st ea site	0.69	0.94	0.02	1.65	33.8872
88172	TC	Cytp dx eval fna 1st ea site	0.00	0.61	0.01	0.62	33.8872
88172	26	Cytp dx eval fna 1st ea site	0.69	0.33	0.01	1.03	33.8872
88173		Cytopath eval fna report	1.39	3.36	0.06	4.81	33.8872
88173	TC	Cytopath eval fna report	0.00	2.74	0.04	2.78	33.8872
88173	26	Cytopath eval fna report	1.39	0.62	0.02	2.03	33.8872
88177		Cytp fna eval ea addl	0.42	0.44	0.01	0.87	33.8872
88177	TC	Cytp fna eval ea addl	0.00	0.24	0.00	0.24	33.8872
88177	26	Cytp fna eval ea addl	0.42	0.20	0.01	0.63	33.8872

ICD Coding – Screening versus Diagnostic Cytopathology

Statutory Medicare Coverage Exclusion

- Sec. 1862. [42 U.S.C. 1395y] (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—
- (1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
  - https://www.ssa.gov/OP_Home/ssact/title18/1862.htm
    - WHAT THIS MEANS IS THAT, BY DEFAULT, THERE WOULD BE NO PAYMENT FOR SCREENING SERVICES

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When can CMS add preventive services as Medicare benefits?

- CMS may add coverage of preventive services through the National Coverage Determination (NCD) process if the service meets all of the following criteria:
  1. Reasonable and necessary for the prevention or early detection of illness or disability
  2. Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF)
  3. Appropriate for individuals entitled to benefits under Part A or enrolled under Part B of the Medicare Program
- CMS may also add preventive services through statutory and regulatory authority.
  - https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html

Screening Pap Tests (NCD 210.2)

- A screening pap smear and related medically necessary services provided to a woman for the early detection of cervical cancer (including collection of the sample of cells and a physician's interpretation of the test results) and pelvic examination (including clinical breast examination) are covered under Medicare Part B when ordered by a physician (or authorized practitioner) under one of the following conditions:
- She has not had such a test during the preceding two years or is a woman of childbearing age (§1861(nn)) of the Social Security Act (the Act).
- There is evidence (on the basis of her medical history or other findings) that she is at high risk of developing cervical cancer and her physician (or authorized practitioner) recommends that she have the test performed more frequently than every two years.

Screening Pap Tests (NCD 210.2)

- High risk factors for cervical and vaginal cancer are:
  - Early onset of sexual activity (under 16 years of age)
  - Multiple sexual partners (five or more in a lifetime)
  - History of sexually transmitted disease (including HIV infection)
  - Fewer than three negative or any pap smears within the previous seven years
  - DES (diethylstilbestrol) exposed - daughters of women who took DES during pregnancy.
- NOTE: Claims for pap smears must indicate the beneficiary's low or high risk status by including the appropriate ICD code on line Item 24E of the Form CMS-1500.
  - Low risk – Z01.411, Z01.419, Z11.51, Z12.4, Z12.72, Z12.79, Z12.89
  - High risk – Z72.51, Z72.52, Z72.53, Z77.29, Z77.9, Z91.89, Z92.89, Z92.850, Z92.858, Z92.86

Screening for Cervical Cancer with Human Papillomavirus (HPV) Tests (NCD 210.2.1)

- CMS has determined that the evidence is sufficient to add Human Papillomavirus (HPV) testing once every five years as an additional preventive service benefit under the Medicare program for asymptomatic beneficiaries aged 30 to 65 years in conjunction with the Pap smear test.
- ICD-10 Codes

  Z11.51, and either Z01.411 or Z01.419

  •Z11.51 Encounter for screening for human papillomavirus (HPV)
  •Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings
  •Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings

Diagnostic Pap Smears NCD 190.2

- Benefit Category Diagnostic Laboratory Tests
- A diagnostic pap smear and related medically necessary services are covered under Medicare Part B when ordered by a physician under one of the following conditions:
- Previous cancer of the cervix, uterus, or vagina that has been or is presently being treated;
- Previous abnormal pap smear;
- Any abnormal findings of the vagina, cervix, uterus, ovaries, or adnexa;
- Any significant complaint by the patient referable to the female reproductive system; or
- Any signs or symptoms that might in the physician's judgment reasonably be related to a gynecologic disorder.

Cervical/Vaginal Cytology Laboratory Services

- Setting (screening / diagnostic)
  - Screening cytopathology
  - Diagnostic cytopathology
- Specimen / reporting system
  - Smears, cervical or vaginal / any reporting system
  - Slides, cervical or vaginal / the Bethesda system
  - Preservative fluid collection, automated thin layer preparation / any reporting system
- Screening / rescreening
  - Manual screening
  - Manual screening and rescreening
  - Manual screening and computer-assisted rescreening
  - Manual screening and computer-assisted rescreening using cell selection
  - Screening by automated system
  - Screening by automated system and manual rescreening

2023 Clinical Diagnostic Laboratory Fee Schedule

The Department of Health and Human Services is planning for the federal Public Health Emergency for COVID-19 (PHE), declared under Section 319 of the Public Health Service Act, to expire

Because of the termination of the PHE, HCPCS codes G2023, G2024, U0003, U0004, and U0005 will no longer be payable for dates of service on or after May 12, 2023, and the HCPCS codes

HCPCS	RATE2023	EXTENDED LONGDESC		
88130	$17.98	Sex chromatin identification	barr bodies	
88140	$7.99	Sex chromatin identification	peripheral blood smear, polymorphonuclear drumsticks	
88155	$14.65	Cytopathology	slides, cervical or vaginal	definitive hormonal evaluation (list in addition to code[s] for other service
88142	$20.26	Cytopathology	collected in preservative fluid, automated thin layer preparation	manual screening
88143	$23.04	Cytopathology	collected in preservative fluid, automated thin layer preparation	manual screening and rescreening
88147	$50.56	Cytopathology	smears, cervical or vaginal	screening by automated system
88148	$17.31	Cytopathology	smears, cervical or vaginal	screening by automated system and manual rescreening
88150	$17.31	Cytopathology	slides, cervical or vaginal	manual screening
88152	$27.64	Cytopathology	slides, cervical or vaginal	manual screening and computer-assisted rescreening
88153	$24.03	Cytopathology	slides, cervical or vaginal	manual screening and rescreening
88164	$17.31	Cytopathology	slides, cervical or vaginal (the bethesda system)	manual screening
88165	$42.22	Cytopathology	slides, cervical or vaginal (the bethesda system)	manual screening and rescreening
88166	$17.31	Cytopathology	slides, cervical or vaginal (the bethesda system)	manual screening and computer-assisted rescreening
88167	$17.31	Cytopathology	slides, cervical or vaginal (the bethesda system)	manual screening and computer-assisted rescreening using cell selection
88174	$25.37	Cytopathology	collected in preservative fluid, automated thin layer preparation	screening by automated system
88175	$26.61	Cytopathology	collected in preservative fluid, automated thin layer preparation	screening by automated system and manual rescreening
G0123	$20.26	Screening cytopathology	collected in preservative fluid, automated thin layer preparation	manual screening
G0143	$27.05	Screening cytopathology	collected in preservative fluid, automated thin layer preparation	manual screening and rescreening
G0144	$43.97	Screening cytopathology	collected in preservative fluid, automated thin layer preparation	screening by automated system
G0145	$26.49	Screening cytopathology	collected in preservative fluid, automated thin layer preparation	screening by automated system and manual rescreening
G0147	$17.31	Screening cytopathology	smears, cervical or vaginal	screening by automated system
G0148	$31.94	Screening cytopathology	smears, cervical or vaginal	screening by automated system and manual rescreening
P3000	$17.31	Screening cytopathology	smears, cervical or vaginal, up to three	manual screening
87623	$35.09	Detection, infections agent	human papillomavirus (hpv), low-risk types (eg, 6, 11, 42, 43, 44)	
87624	$35.09	Detection, infections agent	human papillomavirus (hpv), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)	
87625	$40.55	Detection, infections agent	human papillomavirus (hpv), types 16 and 18 only, includes type 45, if performed	
G0476	$35.09	Screening, infections agent	human papillomavirus (hpv), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68), must be performed in addition to pap test	

National Correct Coding Initiative – Flow Cytometry and Cytopathology Procedure to Procedure Edits

Flow Cytometry and Cytopathology PTP Edits (Procedure To Procedure)

- CMS will implement edits with column 1 [flow cytometry codes] and column 2 [cytopathology codes]. The column 2 cytopathology codes are often misused with [flow cytometry].
- Some providers report one of these [cytopathology] codes when they utilize these techniques to view the cells that are being analyzed by the flow cytometer.
- A provider should never perform tests without confirming the appropriateness of the specimen, and a provider should only perform tests that are reasonable and medically necessary for the specimen being evaluated.
- When a provider evaluates a [cytopathology preparation] to confirm that the correct cells are being gated or to help select the flow cytometry markers, CMS considers such an evaluation to be inherent in the flow cytometry procedure.
- These edits allow use of NCCI associated modifiers if the cytopathology procedures are performed for separate diagnostic purposes unrelated to the flow cytometry.

CMS NCCI Procedure To Procedure Edits

Colum1/Column2 Edits

Column 1	Column 2	*=in existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
88187	88108		20050101	*	1	Standards of medical / surgical practice
88188	88108		20050101	*	1	Standards of medical / surgical practice
88189	88108		20050101	*	1	Standards of medical / surgical practice
88187	88112		20050101	*	1	Standards of medical / surgical practice
88188	88112		20050101	*	1	Standards of medical / surgical practice
88189	88112		20050101	*	1	Standards of medical / surgical practice
88187	88160		20050101	*	1	Standards of medical / surgical practice
88188	88160		20050101	*	1	Standards of medical / surgical practice
88189	88160		20050101	*	1	Standards of medical / surgical practice
88187	88161		20050101	*	1	Standards of medical / surgical practice
88188	88161		20050101	*	1	Standards of medical / surgical practice
88189	88161		20050101	*	1	Standards of medical / surgical practice
88187	88162		20050101	*	1	Standards of medical / surgical practice
88188	88162		20050101	*	1	Standards of medical / surgical practice
88189	88162		20050101	*	1	Standards of medical / surgical practice

MODIFIER 59 ARTICLE

- The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations.
- For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of "0," the codes should never be reported together by the same provider for the same beneficiary on the same date of service.
  - If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied.
- For PTP edits that have a CCMI of "1," the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers.

MODIFIER 59 ARTICLE

- **Distinct Procedural Service:**
- Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.
- Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.
- Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Medically Unlikely Edits – Cytopathology Services and Adjudication Indicators

Medically Unlikely Edits (MUEs) and Adjudication Indicators (MAIs)

- MUEs with MAI of "1"* will be adjudicated as claim line edits.
- MUEs with MAI of "2" are absolute date of service (DOS) edits based on policy.
  - UOS in excess of the MUE value on the same DOS would be contrary to statute, regulation, or subregulatory guidance.
- MUEs with MAI of "3"* are date of service edits based on clinical benchmarks.

* Claim denials based on MAI 1 or 3 edits may be appealed, and MACs may pay UOS in excess of MUE value if there is adequate documentation of medical necessity of correctly reported units.

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HCPCS/CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
10005	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
10021	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
88130	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
88140	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
P3000	1	3 Date of Service Edit: Clinical	Code Descriptor / CPT Instruction
P3001	1	3 Date of Service Edit: Clinical	Code Descriptor / CPT Instruction
88141	1	3 Date of Service Edit: Clinical	Nature of Analyte
88142	1	3 Date of Service Edit: Clinical	Nature of Analyte
88143	1	3 Date of Service Edit: Clinical	Nature of Analyte
88147	1	3 Date of Service Edit: Clinical	Nature of Analyte
88148	1	3 Date of Service Edit: Clinical	Nature of Analyte
88150	1	3 Date of Service Edit: Clinical	Nature of Analyte
88152	1	3 Date of Service Edit: Clinical	Nature of Analyte
88153	1	3 Date of Service Edit: Clinical	Nature of Analyte
88155	1	3 Date of Service Edit: Clinical	Nature of Analyte
88164	1	3 Date of Service Edit: Clinical	Nature of Analyte
88165	1	3 Date of Service Edit: Clinical	Nature of Analyte
88166	1	3 Date of Service Edit: Clinical	Nature of Analyte
88167	1	3 Date of Service Edit: Clinical	Nature of Analyte
88174	1	3 Date of Service Edit: Clinical	Nature of Analyte
88175	1	3 Date of Service Edit: Clinical	Nature of Analyte

HCPCS/CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
G0123	1	3 Date of Service Edit: Clinical	Anatomic Consideration
G0124	1	3 Date of Service Edit: Clinical	Anatomic Consideration
G0141	1	3 Date of Service Edit: Clinical	Anatomic Consideration
G0143	1	3 Date of Service Edit: Clinical	Anatomic Consideration
G0144	1	3 Date of Service Edit: Clinical	Anatomic Consideration
G0145	1	3 Date of Service Edit: Clinical	Anatomic Consideration
G0147	1	3 Date of Service Edit: Clinical	Anatomic Consideration
G0148	1	3 Date of Service Edit: Clinical	Anatomic Consideration
G0476	1	2 Date of Service Edit: Policy	CMS Policy
88125	1	3 Date of Service Edit: Clinical	Clinical: Data
10004	3	3 Date of Service Edit: Clinical	Clinical: Data
10006	3	3 Date of Service Edit: Clinical	Clinical: Data
88162	3	3 Date of Service Edit: Clinical	Clinical: Data
88160	4	3 Date of Service Edit: Clinical	Clinical: Data
88161	4	3 Date of Service Edit: Clinical	Clinical: Data
88104	5	3 Date of Service Edit: Clinical	Clinical: Data
88106	5	3 Date of Service Edit: Clinical	Clinical: Data
88172	5	3 Date of Service Edit: Clinical	Clinical: Data
88173	5	3 Date of Service Edit: Clinical	Clinical: Data
88108	6	3 Date of Service Edit: Clinical	Clinical: Data
88112	6	3 Date of Service Edit: Clinical	Clinical: Data
88177	6	3 Date of Service Edit: Clinical	Clinical: Data

FNA Performance with or without Ultrasound Guidance

Fine Needle Aspiration (FNA) Biopsy 2023 Work RVUs

CPT Code	Long Descriptor	Physician Work RVU
10021	Fine needle aspiration biopsy, without imaging guidance; first lesion	1.03
10004	Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure)	0.80
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	1.46
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)	1.00

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FACILITY

HCPCS	MOD	DESCRIPTION	WORK RVU	PE RVU	MP RVU	TOTAL RVU	CONV FACTOR
10021		Fna bx w/o img gdn 1st les	1.03	0.46	0.14	1.63	33.8872
10004		Fna bx w/o img gdn ea addl	0.80	0.35	0.11	1.26	33.8872
10005		Fna bx w/us gdn 1st les	1.46	0.55	0.17	2.18	33.8872
10006		Fna bx w/us gdn ea addl	1.00	0.38	0.10	1.48	33.8872

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NON-FACILITY

HCPCS	MOD	DESCRIPTION	WORK RVU	PE RVU	MP RVU	TOTAL RVU	CONV FACTOR
10021		Fna bx w/o img gdn 1st les	1.03	1.88	0.14	3.05	33.8872
10004		Fna bx w/o img gdn ea addl	0.80	0.61	0.11	1.52	33.8872
10005		Fna bx w/us gdn 1st les	1.46	2.44	0.17	4.07	33.8872
10006		Fna bx w/us gdn ea addl	1.00	0.69	0.10	1.79	33.8872

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FACILITY

HCPCS	MOD	DESCRIPTION	WORK RVU	PE RVU	MP RVU	TOTAL RVU	CONV FACTOR
10021		Fna bx w/o img gdn 1st les	$34.90	$15.59	$4.74	$55.24	33.8872
10004		Fna bx w/o img gdn ea addl	$27.11	$11.86	$3.73	$42.70	33.8872
10005		Fna bx w/us gdn 1st les	$49.48	$18.64	$5.76	$73.87	33.8872
10006		Fna bx w/us gdn ea addl	$33.89	$12.88	$3.39	$50.15	33.8872

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HCPCS	MOD	DESCRIPTION	WORK RVU	PE RVU	MP RVU	TOTAL RVU	CONV FACTOR
10021		Fna bx w/o img gdn 1st les	$34.90	$63.71	$4.74	$103.36	33.8872
10004		Fna bx w/o img gdn ea addl	$27.11	$20.67	$3.73	$51.51	33.8872
10005		Fna bx w/us gdn 1st les	$49.48	$82.68	$5.76	$137.92	33.8872
10006		Fna bx w/us gdn ea addl	$33.89	$23.38	$3.39	$60.66	33.8872

FNA Performance – Units of Service

FNA Biopsy – Performance – Unit of Service

NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL

CHAP III – CPT codes 10000-19999

Revision Date: 1/1/2023

K. Medically Unlikely Edits (MUEs)

3. The unit of service for fine needle aspiration biopsy (CPT codes 10004-10012 and 10021) is the separately identifiable lesion.

- If a physician performs multiple "passes" into the same lesion to obtain multiple specimens, only one unit of service may be reported.
- However, a separate unit of service may be reported for a separate aspiration biopsy of a distinct separately identifiable lesion.

FNA Immediate Assessment of Adequacy – Units of Service

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FNA Immediate Evaluation for Adequacy – Unit of Service

NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL

CHAP X – CPT codes 80000-89999

Revision Date: 1/1/2023

M. Medically Unlikely Edits (MUEs)

7. The unit of service (UOS) for CPT codes 88172 (cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site) and 88177 (cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site...) is the evaluation episode.

FNA – Immediate Evaluation – the Evaluation Episode

- An evaluation episode consists of examination of a set of cytologic material to determine whether the material is adequate for diagnosis.
- The evaluation episode ends when a pathologist renders an assessment advising the operating physician whether the submitted material is adequate [and t]he operating physician utilizes the cytologic diagnosis to determine whether additional cytologic material should be obtained for examination.
- The evaluation episode is independent of the number of passes of the needle into a lesion and the number of slides examined.

FNA – Immediate Evaluation – the Evaluation Episode

- A second or additional evaluation episode (i.e., CPT code 88177) cannot begin before an assessment is rendered by the pathologist to the operating physician, and the operating physician uses the assessment to determine whether additional needle passes should be performed.
- If the operating physician performs multiple needle passes into a lesion while the pathologist is examining the material from each pass as rapidly as possible, only one evaluation episode may be reported since the operating physician does not wait for the pathologic result to determine whether additional passes are necessary.
  - CPT code 88172 may be reported with one UOS for each separate lesion evaluated.

Service Codes – Evaluation and Management Services

Evaluation and Management Services

- According to CPT, either time or Medical Decision-Making (MDM) may be used to select the appropriate code level for Evaluation and Management services codes. The appropriate amounts of time and level of MDM for each code are defined in the service descriptions.
- The elements comprising each level of MDM are described in CPT 2023
  (https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf)
- For a service to qualify for a level of MDM, at least two of the three elements for that level must be met or exceeded

Outpatient Consultations for a New or Established Patient

- ★▲**99242 –** requires a medically appropriate history and/or examination and **straightforward medical decision making**.
  When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- ★▲**99243 – a** requires a medically appropriate history and/or examination and **low level of medical decision making**.
  When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- ★▲**99244 – a** requires a medically appropriate history and/or examination and **moderate level of medical decision making**.
  When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

Elements for Each Level of Medical Decision Making

TYPE OF DECISION MAKING	NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED	RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Evaluation & Management Services 2023 Work RVUs

CPT Code	Long Descriptor	Physician Work RVU
99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making (20 min)	1.08
99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making (30 min)	1.80
99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making (40 min)	2.69
99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making (55 min)	3.75

Medical Decision-Making Criteria

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	**Minimal** ■ **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
Low	**Low** ■ **2** or more self- limited or minor problems; **or** ■ **1** stable, chronic illness; **or** ■ **1** stable, acute illness; **or** ■ **1** acute, uncomplicated illness or injury; ■ **1** acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 out of 2 categories)* **Category 1: Tests and documents** ■ **Any combination of 2 from the following:** ● Review of prior external note(s) from each unique source*; ● Review of the result(s) of each unique test*; ● Ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**

Questions?