CODEX

CODING DECODED

Pathology Coding

Panels, Drug Assays, Molecular Pathology & Vaccine Administration

CODING DECODED

1. Organ or Disease-Oriented Panels

- The tests listed with each panel identify the defined components of that panel.
- If additional tests are performed that are not a component of the specific panel, report those tests separately, in addition to the panel code.
- If a group of tests overlaps two or more panels, report the panel code that incorporates the greater number of tests, and report the remaining tests using individual test codes.

2. Drug Assay

Drug Assay — a test to determine the components of a substance (its presence and the amount present).

Drug testing procedures are divided into three subsections:

- Therapeutic drug assay
- Drug assay
- Chemistry

Code selection depends on the purpose of testing and the type of results obtained. The two major categories for drug testing in the Drug Assay subsection are:

- Presumptive drug class
- Definitive drug class

Presumptive vs. Definitive Drug Class

Presumptive Drug Class	Definitive Drug Class
Procedures used to identify possible use or non-use of a drug or drug class. A presumptive test may be followed by a definitive test to specifically identify the drug(s).	Qualitative or quantitative procedures used to identify specific drugs and associated metabolites. A presumptive drug test is not required prior to a definitive drug test.

- **A.** Specimen for the drug class procedure may be any type unless otherwise specified in the code description (e.g., urine, blood, oral fluid, meconium, hair).
- **B.** The procedure may be qualitative (e.g., positive/negative or present/absent), semi-quantitative, or quantitative (measured), depending on the purpose of testing.

Presumptive Screening Method

- Immunoassays
- Enzymatic
- Chromatographic method without mass spectrometry, or mass spectrometry without adequate drug resolution by chromatography

All drug class immunoassays are considered presumptive. Methods that cannot distinguish between structural isomers are also considered presumptive.

Definitive Drug Identification Method

Able to identify individual drugs and distinguish between structural isomers, but not necessarily stereoisomers.

- Gas chromatography with mass spectrometry
- Liquid chromatography with mass spectrometry

Note — Chromatography: each combination of stationary and mobile phase is considered as one.

3. Presumptive Drug Class Screening

A drug or class of drug may be assayed first by a presumptive screening method, followed by a definitive drug identification method. Each code includes a sample validation procedure performed.

CPT	Description
80305	Results read by the naked eye (dipsticks, cups, cards, and cartridges).
80306	Results read by instrument (dipsticks, cups, cards, and cartridges inserted into the instrument).
80307	Instrumented chemistry analyzers.

Note: Report CPT 80305, 80306, or 80307 once, irrespective of the number of drug class procedures or results on any date of service.

4. Definitive Drug Testing (80320–80377)

Definitive drug testing may be:

- Qualitative
- Quantitative
- A combination of qualitative and quantitative for the same patient on the same date of service

The **definitive drug class listing table** provides the drug class, associated CPT codes, and the drugs included.

- Each drug class category, including metabolite(s) if performed (except stereoisomers), is reported once per date of service.
- Metabolites not listed in the table may be reported using the code for the parent drug.
- A drug class may contain one or more codes based on the number of analytes.

How to Code — Examples

- **Example 1:** Amphetamine and methamphetamine, any number of definitive procedures — 80324 once per date of service.
- **Example 2:** Codeine, hydrocodone, hydromorphone, morphine, any number of definitive procedures — 80361 once per date of service.
- **Example 3:** Codeine, hydrocodone, hydromorphone, morphine, oxycodone, oxymorphone, naloxone, naltrexone, any number of definitive procedures — 80361 × 1, 80362 × 1, and 80365 × 1, once per date of service.
- **Example 4:** Benzoylecgonine, cocaine, carboxy-THC, meperidine, normeperidine, any number of definitive procedures — 80349 × 1, 80353 × 1, 80362 × 1 per facility per day.

Definitive drug procedures not listed in CPT 80320–80373 should be reported using the unlisted definitive procedure codes (**80375, 80376, 80377**), unless the specific analyte is listed in Therapeutic Drug Assays (80150–80203) or Chemistry (82009–84830).

5. Therapeutic Drug Assay & Evocative/Suppression Testing

Therapeutic Drug Assay (TDA)

Performed to monitor clinical response to known, prescribed medications. TDA procedures are typically quantitative tests, and the specimen type is whole blood, serum, plasma, or cerebrospinal fluid.

If the same procedure is performed on more than one specimen type (e.g., blood and urine), report the appropriate code separately for each specimen type and append **modifier 59**.

Drugs or classes of drugs may commonly be assayed first by a presumptive screening method, followed by a definitive drug identification method.

Evocative / Suppression Testing

- These panels involve administering evocative or suppressive agents, then measuring baseline and subsequent effects on chemical constituents.
- These codes report the laboratory component of the overall testing protocol.
- In the code descriptor, a reference to a particular analyte (e.g., Cortisol — 82533 × 2) means the **× 2** refers to the number of times the test for that analyte is performed.

6. Clinical Pathology Consultations

A clinical pathology consultation is a service, including a written report, rendered by the pathologist in response to a request from a physician requiring additional medical interpretive judgment.

If there is no medical interpretive judgment involved in the test results, it is not considered a clinical pathology consultation.

7. Molecular Pathology

Tier 1

Molecular pathology procedures are medical laboratory procedures involving the analysis of nucleic acid (DNA, RNA) to detect variants in genes that may be indicative of:

- Germline (e.g., constitutional disorders), or
- Somatic (e.g., neoplasia) conditions, or
- Histocompatibility antigens (e.g., HLA)

Code selection is based on the specific gene(s) being analyzed.

- If only the interpretation and report are performed, append **modifier 26** to the molecular pathology code.
- Molecular pathology procedures not specified in 81161, 81200–81383 should be reported using either the appropriate Tier 2 code (81400–81408), or the unlisted molecular pathology procedure code (**81479**).

Tier 2 (81400–81479)

- Used to report procedures not listed in Tier 1 (81161, 81200–81383).
- Tier 2 procedures are generally performed in lower volume than Tier 1.
- Codes are arranged by level of technical resources and physician interpretive work.
- Use the appropriate level code that includes the specific analyte listed after the code descriptor.
- If the analyte tested is not listed under Tier 2, or not represented by a Tier 1 code, use **unlisted (81479)**.

Genomic Sequencing Procedures (GSPs)

- CPT codes range from 81410–81471.
- DNA/RNA sequence analysis methods that simultaneously assay multiple genes relevant to a clinical situation.
- The technology is referred to as NGS (next generation sequencing) or MPS (massively parallel sequencing).
- GSPs are performed on nucleic acids from germline or neoplastic samples.

- If genes are listed in more than one code descriptor, report the most specific test for the primary disorder rather than reporting multiple codes for the same genes.
- If all components of the descriptor are not performed, use Tier 1, Tier 2, or unlisted (81479).

8. Chemistry & Immunology

Chemistry

- Materials for examination may be from any source unless otherwise specified in the code descriptor.

If an analyte is measured in multiple specimens from a different source, or a specimen obtained at different times, it should be reported separately for each source and for each specimen.

Immunology

- CPT codes 86602–86804 are qualitative or semiquantitative immunoassays performed by multiple-step methods for detecting antibodies to infectious agents.
- For immunoassays performed by single-step methods (e.g., reagent strips), use code 86318.
- If multiple tests are performed to detect antibodies to organisms classified more precisely than the specificity allowed by available codes, code each as a separate service.
- **Example:** Enterovirus (86658). Coxsackie has no codes for individual species — if assays are performed for antibodies to Coxsackie A and B species, each assay should be coded separately.
- If multiple assays are performed for antibodies of different immunoglobulin classes, each assay should be coded separately.
- If a coding option exists for reporting IgM-specific antibodies (86632), the corresponding nonspecific code (86631) may be reported for an antibody analysis not specific to a particular immunoglobulin class, or for an IgG analysis.

9. Microbiology

- Presumptive identification of a microorganism is identification by colony morphology, growth on selective media, Gram stains, or up to three tests (e.g., catalase, oxidase, indole, urease).
- Definitive identification of a microorganism is identification to the genus or species level, requiring additional tests (e.g., biochemical panels, slide cultures).
- If additional studies involve molecular probes, nucleic acid sequencing, chromatography, or immunologic techniques, code using 87140–87158 in addition to the definitive identification codes.
- The molecular pathology codes (81161, 81200–81408) are not to be used in combination with or instead of the procedures represented by 87140–87158.
- Multiple specimens/sites — use **modifier 59**.
- Repeat laboratory tests on the same day — use **modifier 91**.

10. Surgical Pathology

- Services 88300–88309 include accession, examination, and reporting.
- These codes do not include the services designated in codes 88311–88365 and 88399 (code in addition, if performed).
- The unit of service for codes 88300–88309 is the specimen.
- A specimen is defined as tissue submitted for individual examination and pathologic diagnosis.
- Two or more specimens from the same patient (separate lesions) are each assigned an individual code reflecting its proper level of service.

CPT	Description
88300	Any specimen examined without a microscope.
88302	Gross and microscopic examination performed on a specimen to confirm identification and the absence of

CPT	Description
	disease.
88304 – 88309	Gross, microscopic examination, and additional ascending levels of physician work.

Any unlisted specimen should be assigned to the code that most closely reflects the physician work involved.

11. Proprietary Laboratory Analyses (PLA)

Tests with PLA codes must be performed on human specimens and must be requested by the clinical laboratory or the manufacturer that offers the test.

12. Vaccine Administration Coding

Components of Vaccines with Administration Codes

CPT	Vaccine	Administration Codes
90636	HepA-HepB	90460 & 90461
90644	Hib-MenCY-TT	90460 & 90461 × 3
90696	DTaP-IPV	90460 & 90461 × 3
90698	DTaP-Hib-IPV	90460 & 90461 × 4
90700	DTaP	90460 & 90461 × 2
90701	DTP	90460 & 90461 × 2
90702	DT	90460 & 90461
90707	MMR	90460 & 90461 × 2
90708	Measles and Rubella	90460 & 90461
90710	MMRV	90460 & 90461 × 3
90714	Td (preservative free)	90460 & 90461
90715	Tdap	90460 & 90461 × 2
90718	Td	90460 & 90461
90720	DTP-Hib	90460 & 90461 × 3
90721	DTaP-Hib	90460 & 90461 × 3
90723	DTaP-HepB-IPV	90460 & 90461 × 4
90748	HepB-Hib	90460 & 90461

Vaccination Overview

Vaccination is the administration of a vaccine — a biological preparation that provides active acquired immunity to a particular disease — to stimulate the immune system to protect the body from the pathogen.

In 2011, two new CPT codes (90460 and 90461) were introduced to replace CPT 90465–90468 for vaccine administration.

- CPT **90460–90461** include physician counseling and are billed based on the number of components, not the number of vaccinations.
- CPT **90471–90474** is used when a physician does not counsel the patient on the vaccines administered.

Vaccine Administration CPT Codes

CPT	Description

CPT	Description
90460	Immunization administration through 18 years of age via any route, with counseling by physician or other qualified healthcare professional; first / only component of each vaccine or toxoid administered.
+90461	Each additional vaccine or toxoid component administered (list separately in addition to code for primary procedure).
90471	Immunization administration (percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid).
+90472	Each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure).
90473	Immunization administration by the intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid).
+90474	Each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure).

Selecting the Appropriate Administration Code

To select the appropriate administration code, consider:

- How many vaccinations were administered, and what vaccines were given.
- What the route of administration was.
- How many components were in each vaccine.
- Whether counseling was provided by the physician.

When two or more vaccines are administered, bill each additional vaccine administration with an add-on code. Only **one initial administration code** can be used at a given encounter.

Examples — Without Counseling

- **3 intramuscular injections:** CPT 90471, CPT 90472 × 2.
- **1 intramuscular + 1 oral:** CPT 90471 (intramuscular), CPT 90474 (oral).
- **2 intramuscular + 1 oral:** CPT 90471 (first intramuscular), CPT 90472 (second intramuscular), CPT 90474 (oral).
- **1 nasal + 1 oral:** CPT 90473, CPT 90474.

Vaccine With Counseling (90460 / 90461)

It is the coder's responsibility to determine how many vaccines were administered, as well as how many components are contained in each vaccine.

- **CPT 90460** is for the first component; **CPT 90461** is for each additional component.

A **component** is an antigen that makes up the vaccine for a specific disease. All vaccines include a minimum of one component.

- **Example:** Varicella virus vaccine (90716) is a single-component vaccine. If 2 vaccines are administered with counseling, CPT 90460 is billed twice.
- **Example:** MMR (90707) has three components (measles, mumps, and rubella virus vaccine).

Example — Varicella and MMR: CPT 90460 × 2 (first components of both vaccines) + CPT 90461 × 2 (second and third components of MMR).

Example — Hepatitis A, MMR, and DTaP: CPT 90460 × 3 (first components of all three vaccines) + CPT 90461 × 4 (2nd/3rd components of MMR and DTaP).

Note: CPT 90460 and 90461 are used only when the physician gives counseling to the patient/family during vaccine administration. If counseling is not provided, use CPT 90471–90474.