The Correct Coding Game:
Name That Code
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Objectives

• Describe correct coding for common and specific testing scenarios encountered in the clinical microbiology laboratory
• Discuss specific areas of current controversy in microbiology test coding
• Discuss current issues in coverage and reimbursement for specific microbiology testing scenarios
• PACE # 362-020-09

Still confused? Join the Club!
I'm not alone!

- Number of sites: 163
- Number of senders: 26
- Number of locations: 23
- Number of states: 16
- Number of questions: 78

Reminder: Key concepts

- All culture based assays have the potential to reflex to identification and susceptibility procedures
- All culture based assays have the potential for composite testing strategies
- Culture based testing and direct specimen testing use different codes
- Replicates of the same code on the same date of service are common and are dealt with in different ways based on the CPT descriptor
- You have to know about modifiers
- The National Correct Coding Initiative provides guidance for correct coding
- The Office of the Inspector General Compliance Guidance for Clinical Laboratories defines steps to take when designing a testing strategy employing reflex, composite, or replicate testing

Reminder: Sources of coding guidance

- CPT 2009, Professional Edition
- CPT 2009 Changes, An Insider’s View
- CPT Assistant
- CPT Coding Helpline
- Other AMA Coding Guidance books and documents (www.ama-assn.org)
- National Correct Coding Initiative (www.cms.hhs.gov/NationalCorrectCodInitEd)
- Other CMS resources (NCDs, LCDs, contractor newsletters)
Other sources

• CodeMap (www.codemap.com)
• Coding and Compliance newletters
• Coding and Compliance consultants
• Commercial manufacturer regulatory affairs
• ASM and other listserves
• People like me who actually like this stuff and review as many guidance issuances as possible

Caution!

• In all decisions, “official issuances” (AMA, CMS) trump anything else
• In the case of “opinions”, try to obtain an “official” guidance if concerned
• Take everything through your Compliance Committee
• If nothing says you can’t, then you can if medically necessary and appropriate

General Categories of Questions

• Baseline culture codes
• Identification coding
• Susceptibility coding
• Virology coding
• Direct specimen testing
• MDRO screening
• Compliance
### How do you code a urine culture?

<table>
<thead>
<tr>
<th>Frequency is one/day! Therefore a modifier must be used for pre and post massage urines</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 87086 Culture, bacterial; quantitative colony count, urine</td>
</tr>
<tr>
<td>• 87088 (Culture, bacterial); with isolation and presumptive identification of each isolate, urine (2007)</td>
</tr>
<tr>
<td>• Baseline culture including inoculation for colony count and preliminary visual assessments</td>
</tr>
<tr>
<td>• Used for presumptive bacterial identifications performed from the colony count plate (rule in/rule out a uropathogen)</td>
</tr>
</tbody>
</table>

Code 87088 does not include the colony count quantification. Code 87088 is used in addition to 87086.

www.cap.org/apps/docs/cpt_coding/articles/cpt801.html

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### Examples of other base codes

- **87040** Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture if appropriate)

  **Note:** Gram stain on positive blood culture is “presumptive”

- **87070** (Culture, bacterial); any other source except urine, blood, or stool, aerobic, with isolation and presumptive identification of isolates

- **87101** Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail (See 87103, blood; 87102, other)

- **87116** Culture, tubercle or other acid-fast bacilli (e.g. TB, AFB, mycobacteria) any source, with isolation and presumptive identification of isolates

- **87252** (Virus isolation); tissue culture inoculation, observation, and presumptive identification by cytopathic effect

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### What constitutes a presumptive versus a definitive identification?

- “Presumptive identification is defined as identification by colony morphology, growth on (primary) selective media, Gram stains (on colonies), or up to three tests, e.g. catalase, oxidase, indole, urea” (any combination)

  - If > 3 tests OR other specified procedures are performed in the evaluation of a single isolate, then definitive identification codes may be used

  - Presumptive identification of “each isolate” from bacterial urine cultures has a unique code (87088)

  - For all other culture types, the primary code includes “isolation and presumptive identification of isolates”

  - Therefore, if CLSI M35-A2 proposes >3 tests, it is “definitive” for coding/billing purposes
Definitive identification

- "Definitive identification is defined as identification to the genus or species level that requires additional tests, e.g. biochemical panels, slide cultures"
- **Definitive identification services may be coded even if the suspected agent turns out to be a non-pathogen**
- In general:
  - Do not code for a “presumptive” and “definitive” identification on the same isolate for urine (one should code only for the “most definitive procedure”)
  - Do not code for a second procedure of the same type on the same isolate (eg two biochemical methods)

www.cap.org/apps/docs/cpt_coding/articles/ct0601.html

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“Presumptive” vs “Definitive”

<table>
<thead>
<tr>
<th>Group</th>
<th>Presumptive</th>
<th>Definitive (including typing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staphylococcus</td>
<td>Coagulate: tube/slide</td>
<td>Agglutination</td>
</tr>
<tr>
<td>Beta strep</td>
<td>Bacitracin</td>
<td>Agglutination</td>
</tr>
<tr>
<td>Enterococcus</td>
<td>PYR</td>
<td>Biochemicals</td>
</tr>
<tr>
<td>S. pneumo./ pseudopneumoniae</td>
<td>Optochin or Bile solubility</td>
<td>Probe</td>
</tr>
<tr>
<td>GNB</td>
<td>Abbreviated.&lt;3 tests</td>
<td>Biochemicals</td>
</tr>
<tr>
<td>Yeasts</td>
<td>Germ tube</td>
<td>Biochemicals</td>
</tr>
<tr>
<td>Molds</td>
<td>Tease mount</td>
<td>Slide/sub culture</td>
</tr>
<tr>
<td>Viruses</td>
<td>CPE</td>
<td>DNA/molecular</td>
</tr>
</tbody>
</table>

Based on ASM Professional Affairs Committee Consensus. Note that there is controversy and difference of opinion

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What are definitive identifications?

**Note:** Used for “each” isolate/organism

<table>
<thead>
<tr>
<th>Group</th>
<th>Procedures</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staphylococci</td>
<td>Biochemical panel</td>
<td>87077</td>
</tr>
<tr>
<td>Streptococci</td>
<td>Biochemical panel</td>
<td>87077</td>
</tr>
<tr>
<td>Nonfastidious GNB</td>
<td>Biochemical panel</td>
<td>87077</td>
</tr>
<tr>
<td>Fastidious GNB</td>
<td>ID panel, &gt;3 tests (eg Campy, set-up, Quadplate)</td>
<td>87077</td>
</tr>
<tr>
<td>Anaerobes</td>
<td>Biochemical panel</td>
<td>87076</td>
</tr>
<tr>
<td>AFB</td>
<td>Biochemical panel</td>
<td>87118</td>
</tr>
<tr>
<td>Yeasts</td>
<td>Biochemical panel</td>
<td>87106</td>
</tr>
<tr>
<td>Molds</td>
<td>Slide culture or tease mounts on subcultures</td>
<td>87107</td>
</tr>
<tr>
<td>Viruses</td>
<td>Hemadsorption, neutralization, immunofluorescence</td>
<td>87253</td>
</tr>
</tbody>
</table>
Culture typing

- “If additional studies involve molecular probes, chromatography, or immunologic techniques, these should be coded in addition to definitive codes”
- Use if a culture typing is required in addition to the definitive (conventional) identification and it provides additional “useable” information
- If a presumptive method provides the “definitive result”, it is appropriate to use typing codes
- May be used as “stand alone” codes for identification

Use of culture “isolate” typing codes

Note: Use “per” antiserum/probe/procedure

<table>
<thead>
<tr>
<th>Method</th>
<th>Code</th>
<th>Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immuno-fluorescent</td>
<td>87140</td>
<td>FA (bacteria, viral typing)</td>
</tr>
<tr>
<td>GLC or HPLC</td>
<td>87143</td>
<td>Anaerobes</td>
</tr>
<tr>
<td>Other immunologic</td>
<td>87147</td>
<td>Agglutinations (Staph, Strep, Enterics)</td>
</tr>
<tr>
<td>Nucleic acid probe</td>
<td>87149</td>
<td>Accuprobe™ (Note no distinction between direct and amplified)</td>
</tr>
<tr>
<td>PFGE</td>
<td>87152</td>
<td>Bacteria</td>
</tr>
<tr>
<td>Other</td>
<td>87158</td>
<td>eg Sequencing</td>
</tr>
</tbody>
</table>

How do you code susceptibility studies?

Note: Codes are based on method and isolate

<table>
<thead>
<tr>
<th>Method</th>
<th>Code</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agar dilution (e.g. gradient strip)</td>
<td>87181</td>
<td>Per agent</td>
</tr>
<tr>
<td>Disk method</td>
<td>87184</td>
<td>Per plate, ≤ 12 abx</td>
</tr>
<tr>
<td>Enzyme detection</td>
<td>87185</td>
<td>Per enzyme</td>
</tr>
<tr>
<td>Microdilution or agar dilution MIC or breakpoint</td>
<td>87186</td>
<td>Each multi-antimicrobial plate</td>
</tr>
<tr>
<td>MLC</td>
<td>+ 87187</td>
<td>Each plate</td>
</tr>
<tr>
<td>Macrrobroth dilution</td>
<td>87188</td>
<td>Each agent</td>
</tr>
<tr>
<td>Mycobacteria; prop. method</td>
<td>87190</td>
<td>Each agent</td>
</tr>
</tbody>
</table>
Issues with “AST studies”

- There are many CCI Mutually Exclusive edits for codes in this group
- All edit pairs are subject to a -59 override if appropriate
- So when is it appropriate to use more than one susceptibility study code per isolate?
  - When the initial test does not provide valid results
  - When the second test is a unique service and provides additional clinically relevant actionable information
  - Not when the service is performed because the first procedure failed to provide results or provides the same information as the initial result

Virology culture coding

- Not based on number of tubes but “each isolate”
- Typing code an anomaly of “crosswalking”
How does one code specific non-culture dependent infectious agent assays from primary source?

<table>
<thead>
<tr>
<th>Category</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antigen detection</td>
<td>Immunofluorescent Enzyme immunoassay</td>
</tr>
<tr>
<td></td>
<td>Optical immunoassay (Latex agglutination)</td>
</tr>
<tr>
<td>Nucleic acid detection</td>
<td>Direct probe Amplified probe Quantification</td>
</tr>
</tbody>
</table>

“For similar studies on culture material, refer to codes 87140-87158” (“culture typing”)

NEW ISSUE: What about analyte specific tests on broths?

Coding is Per Analyte

“Infectious agents by antigen detection, immunofluorescence microscopy, or nucleic acid probe techniques should be reported as precisely as possible. The most specific code possible should be reported…When separate results are reported for different species or strain of organisms, each result should be coded separately. Use modifier -59 when separate results are reported for different species or strains that are described by the same code”

There codes for IF, EIA, and nucleic acid methods that apply to “multiple organisms” not otherwise specifically identified.

Issues in non-culture dependent coding for primary source ONLY

- Both analyte and method specific
  - If >1 analyte within a code, use modifier
  - If analyte not specified, use NOS code
- EIA (multiple step) vs. EIA single step vs. OIA not clearly defined
  - EIA: Tube or microwell with instrumented readout as an option
  - OIA: Solid phase with visual readout
- Nucleic acid code methods mutually exclusive
- CCI edits for >1 non-culture method per analyte
CCI concepts

• Multiple tests to identify the same analyte, marker, or infectious agent should not be reported separately.
  ➢ For example, it would not be appropriate to report both direct probe and amplified probe tests for the same infectious analyte
• CMS does not pay twice for the same laboratory test result even if performed by two different methods unless the two methods are medically reasonable and necessary (in a coverage, not clinical sense)

Mutually exclusive edits for non-culture dependent tests (No override)

Respiratory viruses
- 87275 (B IF)
- 87276 (A IF)
- 87280 (RSV)

Group A Streptococcus
- 87430 (EIA)
- 87880
- 874001 (EIA A/B), 878040 (OIA)
- 874201 (EIA), 878071 (OIA)
- 876500, 876510, 876520 (Probes)

How do you code multiple services with the same code on the same date of service?

<table>
<thead>
<tr>
<th>Approach</th>
<th>Explanation</th>
<th>Used for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Units&quot;</td>
<td>Multiple uses of &quot;each&quot; codes</td>
<td>Presumptive urine ID; Definitive ID; Culture</td>
</tr>
<tr>
<td>(no modifier)</td>
<td></td>
<td>typing; AST; Additional stool pathogens</td>
</tr>
<tr>
<td>Modifier -99</td>
<td>Distinct procedural service</td>
<td>Blood cultures; &gt;1 non-blood urine-stool site</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(as specified by physician)</td>
</tr>
<tr>
<td>Modifier -91</td>
<td>Repeat clinical diagnostic laboratory</td>
<td>Same lab service, same date of service (few</td>
</tr>
<tr>
<td></td>
<td>service</td>
<td>indications in micro)</td>
</tr>
</tbody>
</table>
Coding for MDRO tests

- Culture: 87081→ID and AST as appropriate
  Culture, presumptive, pathogenic organisms, screening only (eg VRE, MRSA, CRE)
- Molecular, primary source: 87500/87640/87641/(87798 NOS)
  Infectious agent detection by nucleic acid; vancomycin resistance (eg enterococcus species vanA, van B), amplified probe technique
  ; Staphylococcus aureus, amplified probe technique
  ; Staphylococcus aureus, methicillin resistant, amplified probe technique

But can these tests be billed?

- In some select states, legislation has been enacted or is pending requiring testing and state reimbursement
- Under Medicare Part B, the current thinking is that this is “screening” and therefore not covered
- Under Medicare Part A, this is part of the DRG (including the “72 hour payment window”) and not separately reimbursable
- Applies to culture based or direct molecular methods

Compliance issues

- Stains and cultures are appropriate “composites” if delineated as such by an accreditation agency or guideline
- If a stain (or any test!) is not performed for technical or clerical reasons, or upon physician request, it MUST NOT be billed (“sink testing”)
- RUO tests should NOT be used clinically or billed; IUO tests may be billed under certain circumstances; ASR tests may be billed and reimbursed according to payer guidelines
Finding your way in correct coding is not easy..

BUT...I'm hoping I've given you some useful directions

Because getting to the right place the right way is critically important!