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## General CPT Coding Rules for Laboratory Procedures

When reporting CPT codes for individual clinical laboratory procedures, the following rules apply:

1. Select the code that most accurately identifies the service being performed. The listing of a procedure under a particular specialty in the CPT does not restrict its use to a specific specialty.
2. When a procedure for a specific analyte is not listed, use the method code that most accurately identifies the procedure used. As a last resort use an unlisted service code (those ending in 99) plus appropriate description of the procedure.
3. The same code may be used multiple times when separate and distinct procedures are used to obtain and report separate and distinct results.
4. Unless otherwise specified, laboratory procedures are assumed to be quantitative.
5. The material examined may be from any source unless otherwise specified in the code descriptor.
6. Any method of analysis may be employed unless otherwise specified in the code descriptor.
7. Clinical information derived from test results by mathematical calculation is considered a part of the test procedure and is not coded or reimbursed separately.

### CPT and HCPCS Code Modifiers

CPT and HCPCS code modifiers are two digit codes added to the basic five-digit CPT code. The following modifiers are used to describe unusual circumstances or provide additional information regarding electrophoresis procedures. HCPCS Code Modifiers are created by CMS (rather than the AMA) to describe situations not covered in the CPT.

**-59 Distinct Procedural Service:** This CPT code modifier is used to indicate a test or service which, even though the CPT code is the same, is a distinct and different test or procedure.

**Example 1:** Apolipoprotein A and B1 are determined on the same date of service.

The same CPT code (82172, Apolipoprotein, each) is used to report both assays. To avoid a denial of the second code as a “duplicated service”, it should be reported using the –59 modifier. The two codes submitted for payment would be 82172, for Apolipoprotein A, and 82172-59 for Apolipoprotein B1.

**Example 2:** For a Multiple Myeloma patient with an Ig G Kappa band on the Immunofixation and determined to be taking the drug daratumumab, in this case, the -59 is applicable for the second Immunofixation (86334) which will be a distinct and different test (Hydrashift 2/4 daratumumab Immunofixation).

**-26 Professional Component:** This CPT code modifier is used to identify a physician component of a test (such as interpretation) when it is reported separately. Similarly in the example 2 above, the -26

modifier (interpretation of the second, Hydrashift Immunofixation) would be applicable when interpretation is performed.

**-90 Reference (Outside) Laboratory:** This CPT code modifier is only used by hospital or reference laboratories to identify tests sent to other laboratories.

**-GA Advanced Beneficiary Notice (ABN) on File:** This HCPCS code modifier is used to indicate that the provider has notified a Medicare patient that the test performed may not be reimbursed by Medicare and may be billed to the patient. ABN's must be obtained by a provider and signed by the patient if the patient is to be billed for tests or other services not covered by Medicare.

## **CPT Codes Associated with Electrophoretic Procedures**

### ***Protein Electrophoresis:***

84165 Protein, electrophoretic fractionation and quantification, serum

84166 Protein, electrophoretic fractionation and quantification, other fluids with concentration (eg, urine, CSF)

83916 Oligoclonal immune, (oligoclonal bands)

84181 Protein, Western blot, with interpretation and report

84182 Protein, Western blot, with immunological probe for band identification, each

### ***Total Protein Determinations:***

84155 Total protein, except refractometric

84160 Total protein, refractometric

### ***Immunofixation Assays***

86334 Immunofixation electrophoresis, serum

86335 Immunofixation electrophoresis, other fluids with concentration

CPT code 86334 is used for any specimen not requiring concentration, 86335 is used for any specimen (including serum) that requires concentration.

### ***Hemoglobin Assays***

83020 Hemoglobin fractionation and quantitation, electrophoresis

83036 Hemoglobin, glycosylated, A1c

### ***Isoenzyme Assays***

82552 CK isoenzymes

83625 LDH isoenzymes, separation and quantitation

84080 Alkaline phosphatase isoenzymes

### ***Lipoprotein Assays***

83715 Lipoprotein, blood, electrophoretic separation and quantitation

83716 Lipoprotein, blood, high resolution fractionation and quantitation of lipoprotein  
cholesterols (eg, electrophoresis, nuclear magnetic resonance, ultracentrifugation)

83718 Lipoprotein, direct measurement, HDL cholesterol

83719 Lipoprotein, direct measurement, VLDL cholesterol

83721 Lipoprotein, direct measurement, LDL cholesterol

82172 Apolipoprotein, each

### **Specimen Collection Codes**

Medicare and most other payers allow a separate specimen collection charge for drawing or collecting specimens by venipuncture or catheterization whether or not the specimen is processed on site or referred to another laboratory for analysis. Only one collection fee is allowed for each patient encounter, even though multiple specimens may be collected.

The following CPT codes are used to report the routine collection of blood.

36415 Collection of venous blood by venipuncture

36416 Collection of capillary blood specimen (eg, finger, heel, ear stick)

CPT code 36415 code is used to report routine venipunctures (and for Medicare only, the collection of urine by catheter) Medicare pays a flat rate of \$3.00 for HCPCS code 36415 and does not cover CPT capillary blood collection (CPT code 36416).

24-hour urine specimen collection is reported using CPT code 81050 (Volume measurement for timed collection, each)

### **Diagnosis (ICD-9) Codes**

Diagnosis Codes, otherwise known as ICD-9-CM Codes (International Classification of Disease, 9th Revision, Clinical Modification), are used to identify why a test or service was provided as opposed to CPT codes which identify which specific test or service was provided.

Medicare only pays for services that are medically necessary and indicated. Diagnosis codes provide a means for Medicare carriers to determine if the tests submitted for payment match the patient diagnosis. Diagnosis codes are required on every Part B claim submitted by a physician including those for in-office laboratory tests.

### **ICD-9 Coding Rules**

1. Use codes that describe symptoms and signs, as opposed to a diagnosis, when a diagnosis has not been established.

2. Code to the greatest specificity. Use three-digit codes only if not further subdivided, 4th or 5th digit sub-classifications must be used if listed.

3. Diagnoses documented as: probable, suspected, questionable, rule-out, or working diagnosis should not be coded as though they exist. Rather, code to the highest degree of certainty for a given encounter using codes for signs, symptoms, abnormal test results, exposure to disease, etc.

### **ICD-9 Coding for Undiagnosed Conditions**

When a patient presents with an undiagnosed illness, the ICD-9 code is determined by the "signs and symptoms" present. Symptoms are defined as what the patient tells the physician. Signs are what the physician observes as part of his examination of the patient.