



Your essential illustrated coding guide for pathology & laboratory, including CPT®, HCPCS Level II, tips, CPT® to ICD-10-CM Cross References, NCCI edits, and RVU information

CODERS' SPECIALTY GUIDE

Pathology & Laboratory

Volumes I & II



2026

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Cardiovascular System

36415

Collection of venous blood by venipuncture

Clinical Responsibility

The provider cleanses the venipuncture site, usually on the upper arm or elbow, with an appropriate antiseptic, usually 70% alcohol. He allows the area to dry. The provider wraps an elastic band tightly around the upper arm so that the vein at the arm swells. Next, the provider inserts a needle slowly into the vein, taking care not to puncture the posterior wall of the vein. He draws around 5 mL of blood into a collection tube. Then he removes the needle and applies direct pressure onto the puncture site to stop the bleeding.

Fee Schedule Information

Medicare Fees (National): Conversion Factor \$32.3465, Facility Fee: \$0.00, Non Facility Fee: \$0.00

RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: X, PC/TC Indicator: 9, Endoscopic Base Code: None

Practitioner MUE: 2

Modifier Allowances

33, 52, 53, 59, 76, 77, 79, 99, AQ, AR, CR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 31.0)

36591⁰, 36592⁰, 96523⁰, 99211¹

ICD-10-CM Cross References

ICD-10-CM contains hundreds of matches for this code. Please check individual payer guidelines for specific coverage determinations.

36416

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

Clinical Responsibility

The provider uses a sterile sharp pointed device and pricks the site, most commonly the finger, heel, or ear lobe. He presses the pricking site to collect the blood sample. He then presses the site to stop the bleeding.

Coding Tips

This procedure is also known as a fingerstick or heelstick.

Fee Schedule Information

Medicare Fees (National): Conversion Factor \$32.3465, Facility Fee: \$0.00, Non Facility Fee: \$0.00

RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: B, PC/TC Indicator: 9, Endoscopic Base Code: None

Practitioner MUE: 0

Modifier Allowances

33, 52, 53, 63, 73, 74, 76, 77, 79, 99, AR, CR, ET, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, GA, GC, GJ, GR, GY, GZ, KX, Q5, Q6, QJ

NCCI Alerts (version 31.0)

36591⁰, 36592⁰, 96523⁰

ICD-10-CM Cross References

ICD-10-CM contains hundreds of matches for this code. Please check individual payer guidelines for specific coverage determinations.

36591

Collection of blood specimen from a completely implantable venous access device

Clinical Responsibility

When the patient is appropriately prepped, the provider draws blood from the venous access device that he placed in a prior procedure. The provider applies a liquid antiseptic to the area and then places a needle through the skin into the port or reservoir. He then withdraws a blood sample using this needle and flushes the port with a heparin solution to prevent a clot formation.

Coding Tips

Use 36592 when the provider draws the blood sample using an established central or peripheral catheter.

Fee Schedule Information

Medicare Fees (National): Conversion Factor \$32.3465, Facility Fee: \$26.85, Non Facility Fee: \$26.85

RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.82, Malpractice RVU 0.01, Total RVU 0.83

RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.82, Malpractice RVU 0.01, Total RVU 0.83

MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: T, PC/TC Indicator: 3, Endoscopic Base Code: None

Practitioner MUE: 2

Modifier Allowances

47, 52, 53, 59, 63, 73, 74, 76, 77, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, GY, GZ, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 31.0)

35201⁰, 35206⁰, 35226⁰, 35231⁰, 35236⁰, 35256⁰, 35261⁰, 35266⁰, 35286⁰

ICD-10-CM Cross References

I87.301-I87.309, I87.311-I87.319, I87.321-I87.329, I87.331-I87.339, I87.391-I87.399, I97.410, I97.610, I97.630, I97.640, K64.5, O03.35, O03.85, O04.85, O07.35, O08.7, O22.50-O22.53, O22.8X1-O22.8X9, O87.3, O87.8, Q26.2-Q26.5, R75, T45.611A-T45.611S, T45.612A-T45.612S, T45.613A-T45.613S, T45.614A-T45.614S, T45.615A-T45.615S, T45.616A-T45.616S, T80.211A-T80.211S, T80.212A-T80.212S, T80.218A-T80.218S, T80.219A-T80.219S, T81.505A-T81.505S, T81.506A-T81.506S, T81.507A-T81.507S, T81.515A-T81.515S, T81.516A-T81.516S, T81.517A-T81.517S, T81.525A-T81.525S, T81.526A-T81.526S, T81.527A-T81.527S, T81.535A-T81.535S, T81.536A-T81.536S, T81.537A-T81.537S, T81.595A-T81.595S, T81.596A-T81.596S, T81.597A-T81.597S, T82.41XA-T82.41XS, T82.42XA-T82.42XS, T82.43XA-T82.43XS, T82.49XA-T82.49XS, T82.514A-T82.514S, T82.524A-T82.524S, T82.534A-T82.534S, T82.594A-T82.594S, T82.598A, T82.818A, T82.828A, T82.856A, T82.858A, T82.868A, T82.898A, T82.9XXA, T83.510A-T83.510S, T83.511A-T83.511S, T83.512A-T83.512S, T83.518A-T83.518S, Z01.812, Z45.2, Z46.82, Z49.01, Z49.02, Z86.718

36592

Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified

Clinical Responsibility

When the patient is appropriately prepped, the provider draws blood from an established central or peripheral catheter. The provider applies a liquid antiseptic to the area and then places a core needle through the skin into the catheter. He first aspirates and discards a small amount of blood before drawing the blood sample because the initial blood sample withdraw may include contaminated material from the catheter that might affect the lab test results. He then withdraws the blood sample using this needle and flushes the catheter with heparin solution to prevent a clot formation.

Coding Tips

Use 36591 when the provider draws the blood sample from a completely implantable venous access device.

Fee Schedule Information

Medicare Fees (National): Conversion Factor \$32.3465, Facility Fee: \$28.79, Non Facility Fee: \$28.79

RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.88, Malpractice RVU 0.01, Total RVU 0.89

RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.88, Malpractice RVU 0.01, Total RVU 0.89

MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: T, PC/TC Indicator: 3, Endoscopic Base Code: None

Practitioner MUE: 1

Modifier Allowances

47, 52, 53, 59, 63, 73, 74, 76, 77, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, GY, GZ, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 31.0)

35201⁰, 35206⁰, 35226⁰, 35231⁰, 35236⁰, 35256⁰, 35261⁰, 35266⁰, 35286⁰, 36591⁰, J1642¹, J1644¹

ICD-10-CM Cross References

I27.21, I74.09, I76, I77.3, I87.301-I87.309, I87.311-I87.319, I87.321-I87.329, I87.331-I87.339, I87.391-I87.399, I97.410, I97.610, I97.630, I97.640, K64.5, N52.01, N52.03, O03.35, O03.85, O04.85, O07.35, O08.7, O22.50-O22.53, O22.8X1-O22.8X9, O87.3, O87.8, Q20.0, Q20.3, Q26.2-Q26.5, Q87.82, R75, T45.611A-T45.611S, T45.612A-T45.612S, T45.613A-T45.613S, T45.614A-T45.614S, T45.615A-T45.615S, T45.616A-T45.616S, T80.211A-T80.211S, T80.212A-T80.212S, T80.218A-T80.218S, T80.219A-T80.219S, T81.505A-T81.505S, T81.506A-T81.506S, T81.507A-T81.507S, T81.515A-T81.515S, T81.516A-T81.516S, T81.517A-T81.517S, T81.525A-T81.525S, T81.526A-T81.526S, T81.527A-T81.527S, T81.535A-T81.535S, T81.536A-T81.536S, T81.537A-T81.537S, T81.595A-T81.595S, T81.596A-T81.596S, T81.597A-T81.597S, T82.311A-T82.311S, T82.312A-T82.312S, T82.321A-T82.321S, T82.322A-T82.322S, T82.331A-T82.331S, T82.332A-T82.332S, T82.391A-T82.391S, T82.392A-T82.392S, T82.41XA-T82.41XS, T82.42XA-T82.42XS, T82.43XA-T82.43XS, T82.49XA-T82.49XS, T82.514A-T82.514S, T82.524A-T82.524S, T82.534A-T82.534S, T82.594A-T82.594S,

T82.598A, T82.818A, T82.828A, T82.856A, T82.858A, T82.868A, T82.898A, T82.9XXA, T83.510A-T83.510S, T83.511A-T83.511S, T83.512A-T83.512S, T83.518A-T83.518S, Z01.812, Z45.2, Z46.82, Z49.01, Z49.02, Z86.718

Pathology and Laboratory

80047

Basic metabolic panel (Calcium, ionized)

This panel must include the following:

Calcium, ionized (82330)

Carbon dioxide (bicarbonate) (82374)

Chloride (82435)

Creatinine (82565)

Glucose (82947)

Potassium (84132)

Sodium (84295)

Urea Nitrogen (BUN) (84520)

Clinical Responsibility

The lab analyst performs a test to measure the blood level of eight chemicals including ionized calcium, sodium, potassium, chloride, carbon dioxide, glucose, blood urea nitrogen, and creatinine. Notice in this code, the clinician measures ionized calcium, which is the active, or free form of calcium in the blood that is not attached to proteins. A typical specimen is serum, or blood. The lab analyst may perform collection of the specimen, and if necessary she inserts a needle into the vein of the patient and withdraws a blood sample for analysis. Carefully review the code descriptor to identify the specific tests the panel includes. The code requires performance of all eight components to report. The eight panel tests include: 82330 for ionized calcium; 82374 for carbon dioxide, or bicarbonate; 82435 for chloride; 82565, creatinine; 82947, glucose; 84132 for potassium; 84295 for sodium, and 84520, blood urea nitrogen (BUN). The lab analyst may use a variety of methods to perform each of the tests in the panel.

A provider orders this test to assess a range of different acute and chronic health conditions. It is done often during routine health exams or in the emergency department to check on a person's kidneys, their electrolyte and acid to base balance, as well as their blood glucose and calcium levels.

Coding Tips

Some payers may pay separately for collecting the specimen using a code such

as 36415, Collection of venous blood by venipuncture.

To report the code for the panel, the analyst must perform every test the code definition lists. If the lab analyst performs fewer tests than the panel lists, you should report each test individually instead of using the panel code. If the lab analyst performs more tests than the panel lists, you should list the panel code plus the individual codes for the additional tests.

Fee Schedule Information

Medicare Fees (National): Conversion Factor \$32.3465, Facility Fee: \$0.00, Non Facility Fee: \$0.00

RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: X, PC/TC Indicator: 9, Endoscopic Base Code: None

Practitioner MUE: 2

Modifier Allowances

59, 79, 90, 91, 99, AY, CR, ET, GA, GC, GR, GY, GZ, KX, Q5, Q6, QJ, QP, QW, XE, XP, XS, XU

NCCI Alerts (version 31.0)

80048⁰, 80051¹, 82330¹, 82374¹, 82435¹, 82565¹, 82947¹, 84132¹, 84295¹, 84520¹, 96523⁰

ICD-10-CM Cross References

D61.03, E20.810-E20.819, E20.89, E74.89, E79.89, E86.0, E87.20-E87.29, E88.810-E88.819, G90.81, G90.89, P74.421, P74.422, P74.49, R82.994, R82.998, T40.711S, T40.712S, T40.713S, T40.714S, T40.715S, T40.721S, T40.722S, T40.723S, T40.724S, T40.725S, Z00.00, Z00.01, Z01.812

80048

Basic metabolic panel (Calcium, total)

This panel must include the following:

Calcium, total (82310)

Carbon dioxide (bicarbonate) (82374)

Chloride (82435)

Creatinine (82565)

Glucose (82947)

Potassium (84132)

Sodium (84295)

Urea nitrogen (BUN) (84520)

Clinical Responsibility

The lab analyst performs a test to measure the blood level of eight chemicals including a total calcium, sodium, potassium, chloride, carbon dioxide, glucose, blood urea nitrogen, and creatinine. Notice in this code, the clinician measures total calcium, or both the active (or free) form of calcium in the blood that is not attached to proteins and the calcium bound to a protein such as albumin. A typical specimen is serum, or blood. The lab analyst may perform collection of the specimen, and if necessary she inserts a needle into the vein of the patient and withdraws the blood sample for analysis. Carefully review the code descriptor to identify the specific tests the panel includes. The code requires the performance of all eight components to report. The eight panel tests include: 82310 for total calcium; 82374 for carbon dioxide, or bicarbonate; 82435 for chloride; 82565, creatinine; 82947, glucose; 84132 for potassium; 84295 for sodium, and 84520, blood urea nitrogen (BUN). The lab analyst may use a variety of methods to perform each of the panel tests.

The clinician orders these tests to assess the range of different acute and chronic health conditions. The panel may be done during routine health checks or in the emergency department to check on the patient's kidneys, electrolyte and fluid balance, as well as the glucose and calcium levels in the blood.

Coding Tips

Some payers may pay separately for collecting the specimen using a code such as 36415, Collection of venous blood by venipuncture.

To report the code for the panel, the analyst must perform every test the code definition lists. If the lab analyst performs fewer tests than the panel lists, you should report each test individually instead of using the panel code. If the lab analyst performs more tests than the panel lists, you should list the panel code plus the individual codes for the additional tests.

Fee Schedule Information

Medicare Fees (National): Conversion Factor \$32.3465, Facility Fee: \$0.00, Non Facility Fee: \$0.00

RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: X, PC/TC Indicator: 9, Endoscopic Base Code: None

Practitioner MUE: 2

Modifier Allowances

79, 90, 91, 99, AR, AY, CR, ET, GA, GC, GR, GY, GZ, KX, Q5, Q6, QJ, QP, QW

NCCI Alerts (version 31.0)

80051¹, 82310¹, 82374¹, 82435¹, 82565¹, 82947¹, 84132¹, 84295¹, 84520¹, 96523⁰

ICD-10-CM Cross References

D61.03, E20.810-E20.819, E20.89, E74.89, E79.89, E86.0, E87.20-E87.29, E88.810-E88.819, G90.81, G90.89, O14.04, O14.05, O14.14, O14.15, O14.94, O14.95, P74.421, P74.422, P74.49, R82.994, R82.998, T40.711S, T40.712S, T40.713S, T40.714S, T40.715S, T40.721S, T40.722S, T40.723S, T40.724S, T40.725S, Z00.00, Z00.01, Z01.812

80050

General health panel

This panel must include the following:

Comprehensive metabolic panel (80053)

Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004)

OR

Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009)

Thyroid stimulating hormone (TSH) (84443)

Clinical Responsibility

The lab analyst performs the technical steps to complete each of the tests the general health panel requires. The analyst may perform collection of the specimens, typically whole blood and serum, needed for this group of tests. Carefully review the code descriptor to identify the specific tests the panel includes. The code requires three components. The first two are 80053, Comprehensive metabolic panel, and 84443, Thyroid stimulating hormone, TSH. The third component is a blood count with manual or automated differential. Various tests qualify for this third component. One possibility is 85025, Blood count; complete, CBC, automated, Hgb, Hct, RBC, WBC and platelet count, and automated differential WBC count. Another possibility is a combination of 85027, Blood count; complete, CBC, automated, Hgb, Hct, RBC, WBC and platelet count, along with 85004, Blood count; automated differential WBC count. You may also see a combination of 85027 for automated complete blood count along with 85007, Blood count; blood smear, microscopic examination with manual differential WBC count. A final option for this third component is 85027 for automated complete blood count along with 85009, Blood count; manual differential WBC count, buffy coat.

The lab analyst must perform each of these three components to report the general health panel. A single component may require multiple tests. The lab analyst may use a variety of methods to perform each of the required panel tests.

Clinicians may order this panel for a comprehensive general health screening review, as results provide information related to the patient's metabolic processes, state of the blood, and state of the thyroid.

Coding Tips

Some payers may pay separately for collecting the specimen using a code such as 36415, Collection of venous blood by venipuncture.

Clinicians rarely order the general health panel, as over the years most payers of lab tests, including Medicare, have denied

payment of this panel. One reason is that its name has the connotation of being for a health screen, for which almost all payers deny payment. Consequently, when the clinician orders the three component tests as diagnostic tests, you should report the codes for the individual laboratory tests rather than the screening panel code.

To report the code for the panel, the analyst must perform every test the code definition lists. If the lab analyst performs fewer tests than the panel lists, you should report each test individually instead of using the panel code. If the lab analyst performs more tests than the panel lists, you should list the panel code plus the individual codes for the additional tests.

Fee Schedule Information

Medicare Fees (National): Conversion Factor \$32.3465, Facility Fee: \$0.00, Non Facility Fee: \$0.00

RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: N, PC/TC Indicator: 9, Endoscopic Base Code: None

Practitioner MUE: 0

Modifier Allowances

79, 90, 91, 99, AR, CR, ET, GA, GC, GR, GY, GZ, KX, Q5, Q6, QJ, QP

NCCI Alerts (version 31.0)

96523⁰

ICD-10-CM Cross References

ICD-10-CM contains hundreds of matches for this code. Please check individual payer guidelines for specific coverage determinations.

80051

Electrolyte panel

This panel must include the following:

Carbon dioxide (bicarbonate) (82374)

Chloride (82435)

81222

CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants

Clinical Responsibility

The lab analyst performs all technical steps, from extracting the nucleic acids by methods such as cell lysis and digestion, to increasing and stabilizing the quantity of nucleic acid for analysis by amplification, to detecting the target genes by methods such as nucleic acid probes, to analyzing the CFTR gene for the number of copies of a specific gene sequence, which is called dosage. Normal dosage is two copies of the gene sequence, so testing dosage helps establish if the sequence shows a deletion, meaning one or zero copies, or a duplication, meaning three or more copies.

Clinicians may order this test as a secondary test for patients with suspected cystic fibrosis when frequent CFTR mutations evaluated with 81220 are not found. The frequency of deletion/duplication mutations in CFTR are less common, and they may be undetected by methods used in the initial CFTR screening.

Coding Tips

You may separately report prep work that precedes cell lysis, when documented, such as tissue selection from archived specimens, which you can report using 88363; or microdissection, which you can report using 88380; or special macroscopic dissection, which you can report using 88387 or +88388.

If the ordering clinician separately requests physician interpretation of 81222 and the pathologist renders an interpretation and writes a report, you can additionally report G0452 with modifier 26 to Medicare and perhaps other payers. An MD or DO physician must perform the interpretation, not a PhD laboratory scientist, according to CMS.

Make sure to distinguish 81222 for CFTR duplication deletion variants from 81220 for CFTR common variants, 81221 for CFTR known familial variants, 81223 for CFTR full gene sequence, and 81224 for CFTR intron 8 poly-T analysis.

Fee Schedule Information

Medicare Fees (National): Conversion Factor \$32.3465, Facility Fee: \$0.00, Non Facility Fee: \$0.00

RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: X, PC/TC Indicator: 9, Endoscopic Base Code: None

Practitioner MUE: 1

Modifier Allowances

59, 90, 91, 99, GX, GY, GZ, KX, Q0, Q6, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0009U¹, 0068U¹, 0086U¹, 0112U¹, 0115U¹, 0140U¹, 0141U¹, 0142U¹, 0202U¹, 0321U¹, 0330U¹, 0429U¹, 80503¹, 80504¹, 80505¹, 80506¹, 81513¹, 84311¹, 87140¹, 87143¹, 87147¹, 87149¹, 87150¹, 87152¹, 87153¹, 87154¹, 87158¹, 87468¹, 87469¹, 87471¹, 87472¹, 87475¹, 87476¹, 87478¹, 87480¹, 87481¹, 87482¹, 87483¹, 87484¹, 87485¹, 87486¹, 87487¹, 87490¹, 87491¹, 87492¹, 87493¹, 87495¹, 87496¹, 87497¹, 87498¹, 87500¹, 87501¹, 87502¹, 87503¹, 87505¹, 87506¹, 87507¹, 87510¹, 87511¹, 87512¹, 87516¹, 87517¹, 87520¹, 87521¹, 87522¹, 87525¹, 87526¹, 87527¹, 87528¹, 87529¹, 87530¹, 87531¹, 87532¹, 87533¹, 87534¹, 87535¹, 87536¹, 87537¹, 87538¹, 87539¹, 87540¹, 87541¹, 87542¹, 87550¹, 87551¹, 87552¹, 87555¹, 87556¹, 87557¹, 87560¹, 87561¹, 87562¹, 87580¹, 87581¹, 87582¹, 87590¹, 87591¹, 87592¹, 87623¹, 87624¹, 87625¹, 87631¹, 87632¹, 87633¹, 87636¹, 87637¹, 87640¹, 87641¹, 87650¹, 87651¹, 87652¹, 87653¹, 87660¹, 87661¹, 87797¹, 87798¹, 87799¹, 87800¹, 87801¹, 88271¹, 88272¹, 88273¹, 88274¹, 88275¹, 88291¹, 88364¹, 88365¹, 88366¹, 88367¹, 88368¹, 88369¹, 88373¹, 88374¹, 88377¹, 96523⁰, G0452¹, G0476¹

ICD-10-CM Cross References

E84.0-E84.9, E84.11, E84.19, Z13.71, Z13.79, Z14.1, Z31.430, Z31.440, Z31.5, Z36.0-Z36.5, Z36.81-Z36.8A, Z36.9

81223

CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence

Clinical Responsibility

The lab analyst performs all technical steps, from extracting the nucleic acids by methods such as cell lysis and digestion, to increasing and stabilizing the quantity of nucleic acid for analysis by amplification, to detecting the target genes by methods such as nucleic acid probes. Code 81223 involves analyzing the full gene sequence for CFTR, not just common variations in the gene.

Clinicians seldom order CFTR gene sequencing to screen for CF carrier status. Rather, they more commonly order analyzing the entire gene sequence for patients who are already diagnosed with CF, for those with a family history of CF, or for symptomatic individuals with negative screening results. Clinicians may also order the full gene sequence for males with a congenital abnormality associated with CFTR mutations involving absence of the vas deferens.

Coding Tips

You may separately report prep work that precedes cell lysis, when documented, such as tissue selection from archived specimens, which you can report using 88363; or microdissection, which you can report using 88380; or special macroscopic dissection, which you can report using 88387 or +88388.

If the ordering clinician separately requests physician interpretation of 81223 and the pathologist renders an interpretation and writes a report, you can additionally report G0452 with modifier 26 to Medicare and perhaps other payers. An MD or DO physician must perform the interpretation, not a PhD laboratory scientist, according to CMS.

Make sure to distinguish 81223 for CFTR full gene sequence analysis from 81220 for CFTR common variants, 81221 for CFTR known familial variants, 81222 for CFTR duplication deletion variants, and 81224 for CFTR intron 8 poly-T analysis.

Fee Schedule Information

Medicare Fees (National): Conversion Factor \$32.3465, Facility Fee: \$0.00, Non Facility Fee: \$0.00

RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: X, PC/TC Indicator: 9, Endoscopic Base Code: None

Practitioner MUE: 1

Modifier Allowances

59, 90, 91, 99, GX, GY, GZ, KX, Q0, Q6, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0009U¹, 0068U¹, 0086U¹, 0112U¹, 0115U¹, 0140U¹, 0141U¹, 0142U¹, 0202U¹, 0321U¹, 0330U¹, 0429U¹, 80503¹, 80504¹, 80505¹, 80506¹, 81220⁰, 81221⁰, 81222¹, 81513¹, 84311¹, 87140¹, 87143¹, 87147¹, 87149¹, 87150¹, 87152¹, 87153¹, 87154¹, 87158¹, 87468¹, 87469¹, 87471¹, 87472¹, 87475¹, 87476¹, 87478¹, 87480¹, 87481¹, 87482¹, 87483¹, 87484¹, 87485¹, 87486¹, 87487¹, 87490¹, 87491¹, 87492¹, 87493¹, 87495¹, 87496¹, 87497¹, 87498¹, 87500¹, 87501¹, 87502¹, 87503¹, 87505¹, 87506¹, 87507¹, 87510¹, 87511¹, 87512¹, 87516¹, 87517¹, 87520¹, 87521¹, 87522¹, 87525¹, 87526¹, 87527¹, 87528¹, 87529¹, 87530¹, 87531¹, 87532¹, 87533¹, 87534¹, 87535¹, 87536¹, 87537¹, 87538¹, 87539¹, 87540¹, 87541¹, 87542¹, 87550¹, 87551¹, 87552¹, 87555¹, 87556¹, 87557¹, 87560¹, 87561¹, 87562¹, 87580¹, 87581¹, 87582¹, 87590¹, 87591¹, 87592¹, 87623¹, 87624¹, 87625¹, 87631¹, 87632¹, 87633¹, 87636¹, 87637¹, 87640¹, 87641¹, 87650¹, 87651¹, 87652¹, 87653¹, 87660¹, 87661¹, 87797¹, 87798¹, 87799¹, 87800¹, 87801¹, 88271¹, 88272¹, 88273¹, 88274¹, 88275¹, 88291¹, 88364¹, 88365¹, 88366¹, 88367¹, 88368¹, 88369¹, 88373¹, 88374¹, 88377¹, 96523⁰, G0452¹, G0476¹

ICD-10-CM Cross References

E84.0-E84.9, E84.11, E84.19, Z13.71, Z13.79, Z14.1, Z31.430, Z31.440, Z31.5, Z36.0-Z36.5, Z36.81-Z36.8A, Z36.9

81224

CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)

Clinical Responsibility

The lab analyst performs all technical steps, from extracting the nucleic acids by methods such as cell lysis and digestion, to increasing and stabilizing the quantity of nucleic acid for analysis by amplification, to detecting the target genes by methods such as nucleic acid probes. Code 81224 involves testing for the intron 8 poly-T mutation.

Following a CF screening for the 23 common CFTR mutations, including R117H, clinicians may reflexively order intron 8 poly-T testing for R117H positive patients. This screening assists in evaluating couples at risk for having offspring with CF.

Clinicians may also order intron 8 poly-T testing for patients with certain diagnoses such as male patients with a congenital abnormality associated with CFTR mutations involving absence of the vas deferens.

Coding Tips

You may separately report prep work that precedes cell lysis, when documented, such as tissue selection from archived specimens, which you can report using 88363; or microdissection, which you can report using 88380; or special macroscopic dissection, which you can report using 88387 or +88388.

If the ordering clinician separately requests physician interpretation of 81224 and the pathologist renders an interpretation and writes a report, you can additionally report G0452 with modifier 26 to Medicare and perhaps other payers. An MD or DO physician must perform the interpretation, not a PhD laboratory scientist, according to CMS.

Make sure to distinguish 81224 for CFTR intron 8 poly-T analysis from 81220 for CFTR common variants, 81221 for CFTR known familial variants, 81222 for CFTR duplication deletion variants, and 81223 for CFTR full gene sequence analysis.

If the clinician orders intron 8 poly-T analysis as an additional test based on R117H positive findings while performing 81220, you should not separately report 81224 for the additional test.

Fee Schedule Information

Medicare Fees (National): Conversion Factor \$32.3465, Facility Fee: \$0.00, Non Facility Fee: \$0.00

RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: X, PC/TC Indicator: 9, Endoscopic Base Code: None

Practitioner MUE: 1

Modifier Allowances

59, 90, 91, 99, GX, GY, GZ, KX, Q0, Q6, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0009U¹, 0068U¹, 0086U¹, 0112U¹, 0115U¹, 0140U¹, 0141U¹, 0142U¹, 0202U¹, 0321U¹, 0330U¹, 0429U¹, 80503¹, 80504¹, 80505¹, 80506¹, 81513¹, 84311¹, 87140¹, 87143¹, 87147¹, 87149¹, 87150¹, 87152¹, 87153¹, 87154¹, 87158¹, 87468¹, 87469¹, 87471¹, 87472¹, 87475¹, 87476¹, 87478¹, 87480¹, 87481¹, 87482¹, 87483¹, 87484¹, 87485¹, 87486¹, 87487¹, 87490¹, 87491¹, 87492¹, 87493¹, 87495¹, 87496¹, 87497¹, 87498¹, 87500¹, 87501¹, 87502¹, 87503¹, 87505¹, 87506¹, 87507¹, 87510¹, 87511¹, 87512¹, 87516¹, 87517¹, 87520¹, 87521¹, 87522¹, 87525¹, 87526¹, 87527¹, 87528¹, 87529¹, 87530¹, 87531¹, 87532¹, 87533¹, 87534¹, 87535¹, 87536¹, 87537¹, 87538¹, 87539¹, 87540¹, 87541¹, 87542¹, 87550¹, 87551¹, 87552¹, 87555¹, 87556¹, 87557¹, 87560¹, 87561¹, 87562¹, 87580¹, 87581¹, 87582¹, 87590¹, 87591¹, 87592¹, 87623¹, 87624¹, 87625¹, 87631¹, 87632¹, 87633¹, 87636¹, 87637¹, 87640¹, 87641¹, 87650¹, 87651¹, 87652¹, 87653¹, 87660¹, 87661¹, 87797¹, 87798¹, 87799¹, 87800¹, 87801¹, 88271¹, 88272¹, 88273¹, 88274¹, 88275¹, 88291¹, 88364¹, 88365¹, 88366¹, 88367¹, 88368¹, 88369¹, 88373¹, 88374¹, 88377¹, 96523⁰, G0452¹, G0476¹

ICD-10-CM Cross References

E84.0-E84.9, E84.11, E84.19, Q55.4, Z13.71, Z13.79, Z14.1, Z31.430, Z31.440, Z31.5, Z36.0-Z36.5, Z36.81-Z36.8A, Z36.9

89257

Sperm identification from aspiration (other than seminal fluid)

Clinical Responsibility

The lab analyst performs the technical lab steps to identify sperm from specimens other than seminal fluid or semen that a clinician aspirated from the vas deferens or epididymis. The test may use specimens obtained by aspiration methods such as MESA, PESA, and TESA, and then uses microscopy to identify that sperm are present in the specimen before performing further evaluation using separately reportable tests.

Clinicians may typically order this test in a facility that specializes in reproductive medicine and infertility treatments.

Fee Schedule Information

Medicare Fees (National): Conversion Factor \$32.3465, Facility Fee: \$0.00, Non Facility Fee: \$0.00

RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: X, PC/TC Indicator: 9, Endoscopic Base Code: None

Practitioner MUE: 1

Modifier Allowances

59, 79, 90, 91, 99, CR, ET, GA, GC, GJ, GR, GY, GZ, KX, Q0, Q5, Q6, QJ, QP, XE, XP, XS, XU

NCCI Alerts (version 31.0)

80503¹, 80504¹, 80505¹, 80506¹, 96523⁰

ICD-10-CM Cross References

N46.01, N46.021-N46.029, N46.11, N46.121-N46.129, N46.8, N46.9, Z31.41

89258

Cryopreservation; embryo(s)

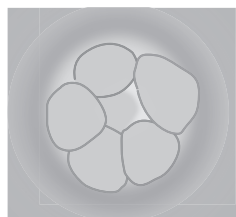
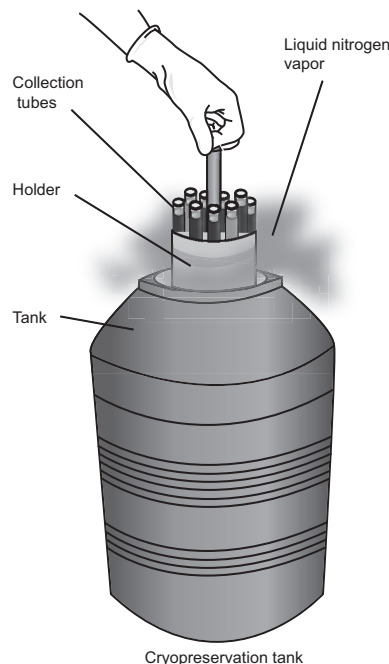
Clinical Responsibility

The lab analyst performs the technical lab steps to preserve one or more embryos from a female patient using cryopreservation during an in vitro fertilization, or IVF, cycle. Cryopreservation uses a cold protective solution to freeze and store extra embryos, harvested during an IVF cycle, at a sub-zero temperature for use at a later time to accomplish conception and pregnancy.

Clinicians may typically order this service in a facility that specializes in reproductive medicine and infertility treatments.

Coding Tips

You may use 89258 on more than one day during an IVF cycle to capture the work of preserving embryos at different stages of the cycle, which may last up to a week.

Illustration

Frozen embryo cells

89258

Fee Schedule Information

Medicare Fees (National): Conversion Factor \$32.3465, Facility Fee: \$0.00, Non Facility Fee: \$0.00

RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: X, PC/TC Indicator: 9, Endoscopic Base Code: None

Practitioner MUE: 1

Modifier Allowances

79, 90, 91, 99, CR, ET, GA, GC, GJ, GR, GY, GZ, KX, Q0, Q5, Q6, QJ, QP

NCCI Alerts (version 31.0)

96523⁰

ICD-10-CM Cross References

N97.0-N97.9, N98.2, N98.3, O09.00-O09.03, Q50.4, Q50.5, Q51.6, R97.0, Z31.81

89259

Cryopreservation; sperm

Clinical Responsibility

The lab analyst performs the technical lab steps to preserve sperm from a male patient using cryopreservation. Cryopreservation uses a cold protective solution to freeze and store sperm from a male patient at a sub-zero temperature for use at a later time to accomplish conception and pregnancy in a female patient.

Clinicians may typically order this service in a facility that specializes in reproductive medicine and infertility treatments. Another term for the service is sperm banking, often used for male patients who need cancer therapy or infertility surgery, or who are having a vasectomy.

Fee Schedule Information

Medicare Fees (National): Conversion Factor \$32.3465, Facility Fee: \$0.00, Non Facility Fee: \$0.00

RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: X, PC/TC Indicator: 9, Endoscopic Base Code: None

Practitioner MUE: 1

Modifier Allowances

79, 90, 91, 99, CR, ET, GA, GC, GJ, GR, GY, GZ, KX, Q0, Q5, Q6, QJ, QP

NCCI Alerts (version 31.0)

96523⁰

ICD-10-CM Cross References

N46.01, N46.021-N46.029, N46.11, N46.121-N46.129, N49.1, R36.1

89260

Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis

Clinical Responsibility

The lab analyst performs the technical lab steps to isolate sperm during a semen analysis using a simple preparation such as sperm wash and swim-up to prepare sperm for insemination during an in vitro fertilization, or IVF, cycle, or for diagnostic purposes to identify sperm abnormalities. The test may use methods such as washing the sperm to remove excess fluid and debris, and adding a special enrichment medium that creates an optimal environment for healthy sperm that can swim normally.

Clinicians may typically order this service in a facility that specializes in reproductive medicine and infertility treatments.

Coding Tips

This service includes the work of semen analysis, such as count and motility, so you

should not report codes such as 89300 and 89310 with 89260.

See 89261 for complex prep.

Fee Schedule Information

Medicare Fees (National): Conversion Factor \$32.3465, Facility Fee: \$0.00, Non Facility Fee: \$0.00

RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: X, PC/TC Indicator: 9, Endoscopic Base Code: None

Practitioner MUE: 1

Modifier Allowances

79, 90, 91, 99, CR, ET, GA, GC, GJ, GR, GY, GZ, KX, Q0, Q5, Q6, QJ, QP

NCCI Alerts (version 31.0)

80503¹, 80504¹, 80505¹, 80506¹, 89300⁰, 89310⁰, 89320⁰, 89321¹, 96523⁰, G0027⁰

ICD-10-CM Cross References

N46.01, N46.021-N46.029, N46.11, N46.121-N46.129, N46.8, N46.9, Z31.41

89261

Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis

Clinical Responsibility

The lab analyst performs all technical steps to isolate sperm during a semen analysis using a complex prep, such as Percoll gradient or albumin gradient, for insemination during an in vitro fertilization cycle or for diagnostic purposes to identify sperm abnormalities. Collected semen contains materials other than just sperm, and the analyst needs to separate out these other materials to isolate the sperm. The patient may collect the specimen himself or a clinician may perform the collection by inserting a fine needle into the testicle to obtain the sample in a separately reported service. The analyst

analyzes the sperm, usually under a microscope, to ensure there are enough sperm present and to note the shape, size, and motility. Using complex services such as one of the gradient tests mentioned above, the analyst mixes the semen with a medium and then places the mixture in a centrifuge. After the material runs through the centrifuge, which spins the material at high speed, all the sperm will be at the bottom of the tube. Discarding the liquid at the top leaves a purer sperm sample. Sometimes the analyst may repeat the centrifuge step for better purification.

Although not limited to testing for a specific condition, providers may order this service for a patient involved in vitro fertilization or for a male patient suspected of having a spermatid disorder requiring a diagnosis.

Coding Tips

This service includes the work of semen analysis, such as count and motility, so you should not report semen analysis codes such as 89300 and 89310 with 89261.

See 89260 for simple prep.

Because infertility treatment often involves both a man and a woman, coders aren't always sure whose insurance they should bill. In the absence of specific payer guidance, you should bill whichever patient is most directly connected with a given service. The exception with artificial insemination is when a sperm donor is involved. In this case, you would bill the sperm wash and the insemination code to the female because the female accepts financial responsibility.

Generally, physician offices use 58323, Sperm washing for artificial insemination. A high complexity lab is most likely to use the complex prep represented by 89261.

Percoll gradient and albumin gradient and other gradient preparations use a specific medium that is less dense at the top of the tube and denser at the bottom so that as the specimen is centrifuged the denser items in the sample will be able to reach the bottom of the tube.

Fee Schedule Information

Medicare Fees (National): Conversion Factor \$32.3465, Facility Fee: \$0.00, Non Facility Fee: \$0.00

HCPCS Level II Codes

Enteral and Parenteral Therapy

B4187

Omegaven, 10 grams lipids

Clinical Responsibility

Omegaven® fish oil triglycerides emulsion is administered intravenously as a source of calories and fatty acids to pediatric patients with parenteral nutrition-associated cholestasis. The recommended dosage depends on the patient's age, activity level, clinical status, weight, tolerance, ability to metabolize, and other energy sources given to the patient; however, the standard recommended daily dose (and the maximum dose) for pediatric patients is 1 g/kg/day.

Omegaven® fish oil triglycerides is supplied as an injectable emulsion in single-dose bottles of 5 g/50 mL and 10 g/100 mL (0.1 g/mL).

Report this code for each 10 g of lipids in the form of Omegaven®.

Coding Tips

Report this code only for the brand Omegaven®; for 10 g of lipids not otherwise specified, see B4185.

See B4164 to B5200 for other forms of parenteral solutions and supplies.

This code represents the supply of Omegaven®. Check coding and individual payer guidelines to determine whether you can also report the administration of the product.

If the dose administered is only part of a bottle and the remainder has to be discarded, you may be able to report modifier JW, Drug amount discarded/not administered to any patient.

BETOS

01C: Enteral and parenteral

Outpatient PPS

C7501

Percutaneous breast biopsies using stereotactic guidance, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, all lesions unilateral and bilateral (for single lesion biopsy, use appropriate code)

Clinical Responsibility

When the patient is appropriately prepped, the provider uses stereotactic guidance, which is technology that combines imaging from different angles, to determine the exact location of the breast lesion. After administering anesthetic, the provider makes a small incision to access the lesion and uses a minimally invasive percutaneous approach to remove the target breast tissue for biopsy. This code applies to all lesions whether in one breast or both. The provider also may place one or more localization devices to assist with finding the site during a future procedure, and the provider may image the specimen. The provider closes incision sites and completes the procedure.

BETOS

P1A: Major procedure - breast

C7502

Percutaneous breast biopsies using magnetic resonance guidance, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, all lesions unilateral or bilateral (for single lesion biopsy, use appropriate code)

Clinical Responsibility

When the patient is appropriately prepped, the provider uses magnetic resonance (MR) guidance to determine the exact location of the breast lesion. The patient may be face-down on a special exam table with the breast compressed between two plates for MR imaging so the provider can calculate the position and depth of the needle placement for biopsy. The provider makes a small incision to access

the lesion and uses a minimally invasive percutaneous approach to remove the target breast tissue for biopsy. This code applies to all lesions whether in one breast or both. The provider also may place one or more localization devices to assist with finding the site during a future procedure, and the provider may image the specimen. The provider closes incision sites and completes the procedure.

BETOS

P1A: Major procedure - breast

C7503

Open biopsy or excision of deep cervical node(s) with intraoperative identification (eg, mapping) of sentinel lymph node(s) including injection of non-radioactive dye when performed

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider incises the skin of the neck and dissects the tissue overlying the target node or nodes, taking care to preserve critical nerves and other structures in the area. The provider then excises or takes biopsy specimens from the lymph node or nodes. The provider may use a method of identifying lymph nodes for excision by injecting a nonradioactive dye into a known area of disease and allowing the dye to drain into the lymphatic system. The node that picks up the most dye is the first (sentinel) node to filter fluids from the diseased area. If the results show no disease, then the provider excises no further lymph nodes. If, however, the lymph node shows the presence of disease, the provider may remove additional nodes as necessary. The provider then completes the procedure, including closing surgical wounds as appropriate.

BETOS

P5E: Ambulatory procedures - other

Procedures/Professional Services

G0103

Prostate cancer screening; prostate specific antigen test (PSA)

Clinical Responsibility

The provider performs a prostate cancer screening in which he detects the prostate specific antigen, or PSA level in the patient's blood. PSA is a protein that increases in the blood of a patient with conditions like prostate cancer. This protein is considered as an indicator for prostate cancer. The provider collects the blood sample through a venipuncture. This test helps to detect prostate cancer in its early stages. A normal level of PSA in blood of men below 50 years of age is less than 2.5, for age 50 to 60 it is less than 3.5, for age 60 to 70 it is less than 4.5 and for age above 70 it is 6.6.

Coding Tips

The Healthcare Common Procedure Coding System, or HCPCS Level II, codes that begin with a G identify professional health care procedures and services that would otherwise be coded in CPT® but for which there are no CPT® codes.

Medicare provides coverage for an annual prostate cancer screening, or PSA, test for men at the age of 50.

When the provider performs a prostate specific antigen test to screen for prostate cancer, use G0103, Prostate cancer screening; prostate specific antigen test, PSA. When the provider performs a diagnostic PSA for a patient with symptoms of a prostate abnormality, use 84153, Prostate specific antigen, or PSA; total.

BETOS

T1H: Lab tests - other (Non-Medicare fee schedule)

G0123

Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision

Clinical Responsibility

Screening of cytopathology smears of the cervix or vagina diagnose cervical cancer. Specimens are collected from scrapings taken from a patient's cervix, endocervical canal, or vagina, or by aspiration of fluids and cells from the vagina and submitted in a preservative fluid. The specimens are prepared by the method of automated thin layer preparation. A cytotechnologist, a specialized laboratory professional, screens the specimen using computer analysis of digital images to identify abnormal cells, under the supervision of a physician provider.

Coding Tips

Use G codes for professional healthcare procedures and services that would otherwise be coded in CPT® but for which there are no CPT® codes.

If a physician provider interprets the results, report G0124, Screening cytopathology, cervical or vaginal, any reporting system, collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician.

For related cytopathology services, see G0141 to G0147 and 88104 to 88199, Cytopathology procedures.

BETOS

T1H: Lab tests - other (Non-Medicare fee schedule)

G0124

Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician

Clinical Responsibility

Screening of cytopathology smears of the cervix or vagina diagnose cervical cancer. Specimens are collected from scrapings taken from a patient's cervix, endocervical canal, or vagina, or by aspiration of fluids and cells from the vagina and submitted in a preservative fluid. The specimens are prepared by the method of automated thin layer preparation. A physician provider interprets the findings.

Coding Tips

Use G codes for professional healthcare procedures and services that would otherwise be coded in CPT® but for which there are no CPT® codes.

For related cytopathology services, see G0141 to G0147, G0123, and 88104 to 88199, Cytopathology procedures.

BETOS

T1H: Lab tests - other (Non-Medicare fee schedule)

G0141

Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician

Clinical Responsibility

Screening of cytopathology smears of the cervix or vagina diagnose cervical cancer. A specimen is collected from scrapings taken from a patient's cervix, endocervical canal, or vagina, or by aspiration of fluids and cells from the vagina. An automated screening uses computer analysis of digital images for identifying cells. The cells are then rescreened by manual examination under a microscope to detect abnormal changes in cell structure to confirm the results of the automated screening. A physician provider must interpret the results.

Medicare provides coverage to their beneficiaries annually for this service.

Coding Tips

Use G codes to identify professional health care procedures and services that would otherwise be coded in CPT® but for which there are no CPT® codes.

For related codes, see cytopathology screening codes G0141 to G0148 and CPT® codes 88141 to 88143, Cytopathology Procedures.

BETOS

T1H: Lab tests - other (Non-Medicare fee schedule)

G0143

Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreeing by cytotechnologist under physician supervision

Clinical Responsibility

Screening of cytopathology smears of the cervix or vagina diagnose cervical cancer. A specimen collected from scrapings taken from a patient's cervix, endocervical canal, or vagina, or by aspiration of fluids and cells from the vagina and submitted in a preservative fluid is prepared by automated thin layer preparation. A cytotechnologist examines the cells under a microscope to detect any abnormal changes in the cell structure indicating cancer. If there are any changes in the cell structure, the cytotechnologist repeats the test for confirmation of the diagnosis.

Medicare provides coverage to their beneficiaries annually for this service.

Coding Tips

Use G codes to identify professional health care procedures and services that would otherwise be coded in CPT® but for which there are no CPT® codes.

For related codes, see cytopathology screening codes G0141 to G0148 and CPT® codes 88141 to 88143, Cytopathology Procedures.

BETOS

T1H: Lab tests - other (Non-Medicare fee schedule)

G0144

Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision

Clinical Responsibility

Screening of cytopathology smears of the cervix or vagina diagnose cervical cancer. Specimens are collected from scrapings taken from a patient's cervix, endocervical canal, or vagina, or by aspiration of fluids and cells from the vagina and submitted in a preservative fluid. The specimens are prepared by the method of automated thin

layer preparation. Automated screening along with computer analysis of digital images takes place to identify abnormal cells, under the supervision of a physician provider.

Medicare provides coverage to their beneficiaries annually for this service.

Coding Tips

Use G codes to identify professional health care procedures and services that would otherwise be coded in CPT® but for which there are no CPT® codes.

For related codes, see cytopathology screening codes G0141 to G0148 and CPT® codes 88141 to 88143, Cytopathology Procedures.

BETOS

T1H: Lab tests - other (Non-Medicare fee schedule)

G0145

Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreeing under physician supervision

Clinical Responsibility

Screening of cytopathology smears of the cervix or vagina diagnose cervical cancer. Specimens are collected from scrapings taken from a patient's cervix, endocervical canal, or vagina, or by aspiration of fluids and cells from the vagina and submitted in a preservative fluid. The specimens are prepared by the automated thin layer preparation method. Automated screening along with computer analysis of digital images takes place to identify abnormal cells. The cells are then manually rescreened for confirmation of the diagnosis under the supervision of a physician provider.

Medicare provides coverage to their beneficiaries annually for this service.

Coding Tips

Use G codes to identify professional health care procedures and services that would otherwise be coded in CPT® but for which there are no CPT® codes.

For related codes, see cytopathology screening codes G0141 to G0148 and CPT®

codes 88141 to 88143, Cytopathology Procedures.

BETOS

T1H: Lab tests - other (Non-Medicare fee schedule)

G0147

Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision

Clinical Responsibility

Screening of cytopathology smears of the cervix or vagina diagnose cervical cancer. Specimens are collected from scrapings taken from a patient's cervix, endocervical canal, or vagina, or by aspiration of fluids and cells from the vagina. Automated screening along with computer analysis of digital images takes place to identify abnormal cells, under the supervision of a physician provider.

Medicare provides coverage to their beneficiaries annually for this service.

Coding Tips

Use G codes to identify professional health care procedures and services that would otherwise be coded in CPT® but for which there are no CPT® codes.

For related codes, see cytopathology screening codes G0141 to G0148 and CPT® codes 88141 to 88143, Cytopathology Procedures.

BETOS

T1H: Lab tests - other (Non-Medicare fee schedule)

G0148

Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreeing

Clinical Responsibility

Screening of cytopathology smears of the cervix or vagina diagnose cervical cancer. A specimen collected from scrapings taken from a patient's cervix, endocervical canal, or vagina, or by aspiration of fluids and cells from the vagina. An automated screening uses computer analysis of digital images for identifying cells. The cells are then rescreened by manual

ICD-10-CM Cross Reference Details

A00.0	Cholera due to <i>Vibrio cholerae</i> 01, biovar cholerae	A07.4	Cyclosporiasis
A00.1	Cholera due to <i>Vibrio cholerae</i> 01, biovar eltor	A07.8	Other specified protozoal intestinal diseases
A00.9	Cholera, unspecified	A07.9	Protozoal intestinal disease, unspecified
A01.00	Typhoid fever, unspecified	A08.0	Rotaviral enteritis
A01.01	Typhoid meningitis	A08.11	Acute gastroenteropathy due to Norwalk agent
A01.02	Typhoid fever with heart involvement	A08.19	Acute gastroenteropathy due to other small round viruses
A01.03	Typhoid pneumonia	A08.2	Adenoviral enteritis
A01.04	Typhoid arthritis	A08.31	Calicivirus enteritis
A01.05	Typhoid osteomyelitis	A08.32	Astrovirus enteritis
A01.09	Typhoid fever with other complications	A08.39	Other viral enteritis
A01.1	Paratyphoid fever A	A08.4	Viral intestinal infection, unspecified
A01.2	Paratyphoid fever B	A08.8	Other specified intestinal infections
A01.3	Paratyphoid fever C	A09	Infectious gastroenteritis and colitis, unspecified
A01.4	Paratyphoid fever, unspecified	A15.0	Tuberculosis of lung
A02.0	Salmonella enteritis	A15.4	Tuberculosis of intrathoracic lymph nodes
A02.1	Salmonella sepsis	A15.5	Tuberculosis of larynx, trachea and bronchus
A02.20	Localized salmonella infection, unspecified	A15.6	Tuberculous pleurisy
A02.21	Salmonella meningitis	A15.7	Primary respiratory tuberculosis
A02.22	Salmonella pneumonia	A15.8	Other respiratory tuberculosis
A02.23	Salmonella arthritis	A15.9	Respiratory tuberculosis unspecified
A02.24	Salmonella osteomyelitis	A17.0	Tuberculous meningitis
A02.25	Salmonella pyelonephritis	A17.1	Meningeal tuberculoma
A02.29	Salmonella with other localized infection	A17.81	Tuberculoma of brain and spinal cord
A02.8	Other specified salmonella infections	A17.82	Tuberculous meningoencephalitis
A02.9	Salmonella infection, unspecified	A17.83	Tuberculous neuritis
A03.0	Shigellosis due to <i>Shigella dysenteriae</i>	A17.89	Other tuberculosis of nervous system
A03.1	Shigellosis due to <i>Shigella flexneri</i>	A17.9	Tuberculosis of nervous system, unspecified
A03.2	Shigellosis due to <i>Shigella boydii</i>	A18.01	Tuberculosis of spine
A03.3	Shigellosis due to <i>Shigella sonnei</i>	A18.02	Tuberculous arthritis of other joints
A03.8	Other shigellosis	A18.03	Tuberculosis of other bones
A03.9	Shigellosis, unspecified	A18.09	Other musculoskeletal tuberculosis
A04.0	Enteropathogenic <i>Escherichia coli</i> infection	A18.10	Tuberculosis of genitourinary system, unspecified
A04.1	Enterotoxigenic <i>Escherichia coli</i> infection	A18.11	Tuberculosis of kidney and ureter
A04.2	Enteroinvasive <i>Escherichia coli</i> infection	A18.12	Tuberculosis of bladder
A04.3	Enterohemorrhagic <i>Escherichia coli</i> infection	A18.13	Tuberculosis of other urinary organs
A04.4	Other intestinal <i>Escherichia coli</i> infections	A18.14	Tuberculosis of prostate
A04.5	<i>Campylobacter</i> enteritis	A18.15	Tuberculosis of other male genital organs
A04.6	Enteritis due to <i>Yersinia enterocolitica</i>	A18.16	Tuberculosis of cervix
A04.71	Enterocolitis due to <i>Clostridium difficile</i> , recurrent	A18.17	Tuberculous female pelvic inflammatory disease
A04.72	Enterocolitis due to <i>Clostridium difficile</i> , not specified as recurrent	A18.18	Tuberculosis of other female genital organs
A04.8	Other specified bacterial intestinal infections	A18.2	Tuberculous peripheral lymphadenopathy
A04.9	Bacterial intestinal infection, unspecified	A18.31	Tuberculous peritonitis
A05.0	Foodborne staphylococcal intoxication	A18.32	Tuberculous enteritis
A05.1	Botulism food poisoning	A18.39	Retroperitoneal tuberculosis
A05.2	Foodborne <i>Clostridium perfringens</i> [<i>Clostridium welchii</i>] intoxication	A18.4	Tuberculosis of skin and subcutaneous tissue
A05.3	Foodborne <i>Vibrio parahaemolyticus</i> intoxication	A18.50	Tuberculosis of eye, unspecified
A05.4	Foodborne <i>Bacillus cereus</i> intoxication	A18.51	Tuberculous episcleritis
A05.5	Foodborne <i>Vibrio vulnificus</i> intoxication	A18.52	Tuberculous keratitis
A05.8	Other specified bacterial foodborne intoxications	A18.53	Tuberculous chorioretinitis
A05.9	Bacterial foodborne intoxication, unspecified	A18.54	Tuberculous iridocyclitis
A06.0	Acute amebic dysentery	A18.59	Other tuberculosis of eye
A06.1	Chronic intestinal amebiasis	A18.6	Tuberculosis of (inner) (middle) ear
A06.2	Amebic nondysenteric colitis	A18.7	Tuberculosis of adrenal glands
A06.3	Ameboma of intestine	A18.81	Tuberculosis of thyroid gland
A06.4	Amebic liver abscess	A18.82	Tuberculosis of other endocrine glands
A06.5	Amebic lung abscess	A18.83	Tuberculosis of digestive tract organs, not elsewhere classified
A06.6	Amebic brain abscess	A18.84	Tuberculosis of heart
A06.7	Cutaneous amebiasis	A18.85	Tuberculosis of spleen
A06.81	Amebic cystitis	A18.89	Tuberculosis of other sites
A06.82	Other amebic genitourinary infections	A19.0	Acute miliary tuberculosis of a single specified site
A06.89	Other amebic infections	A19.1	Acute miliary tuberculosis of multiple sites
A06.9	Amebiasis, unspecified	A19.2	Acute miliary tuberculosis, unspecified
A07.0	Balantidiasis	A19.8	Other miliary tuberculosis
A07.1	Giardiasis [lamblia]s]	A19.9	Miliary tuberculosis, unspecified
A07.2	Cryptosporidiosis	A20.0	Bubonic plague
A07.3	Isosporiasis	A20.1	Cellulocutaneous plague
		A20.2	Pneumonic plague
		A20.3	Plague meningitis

A20.7	Septicemic plague	A36.3	Cutaneous diphtheria
A20.8	Other forms of plague	A36.81	Diphtheritic cardiomyopathy
A20.9	Plague, unspecified	A36.82	Diphtheritic radiculomyelitis
A21.0	Ulceroglandular tularemia	A36.83	Diphtheritic polyneuritis
A21.1	Oculoglandular tularemia	A36.84	Diphtheritic tubulo-interstitial nephropathy
A21.2	Pulmonary tularemia	A36.85	Diphtheritic cystitis
A21.3	Gastrointestinal tularemia	A36.86	Diphtheritic conjunctivitis
A21.7	Generalized tularemia	A36.89	Other diphtheritic complications
A21.8	Other forms of tularemia	A36.9	Diphtheria, unspecified
A21.9	Tularemia, unspecified	A37.00	Whooping cough due to <i>Bordetella pertussis</i> without pneumonia
A22.0	Cutaneous anthrax	A37.01	Whooping cough due to <i>Bordetella pertussis</i> with pneumonia
A22.1	Pulmonary anthrax	A37.10	Whooping cough due to <i>Bordetella parapertussis</i> without pneumonia
A22.2	Gastrointestinal anthrax	A37.11	Whooping cough due to <i>Bordetella parapertussis</i> with pneumonia
A22.7	Anthrax sepsis	A37.80	Whooping cough due to other <i>Bordetella</i> species without pneumonia
A22.8	Other forms of anthrax	A37.81	Whooping cough due to other <i>Bordetella</i> species with pneumonia
A22.9	Anthrax, unspecified	A37.90	Whooping cough, unspecified species without pneumonia
A23.0	Brucellosis due to <i>Brucella melitensis</i>	A37.91	Whooping cough, unspecified species with pneumonia
A23.1	Brucellosis due to <i>Brucella abortus</i>	A38.0	Scarlet fever with otitis media
A23.2	Brucellosis due to <i>Brucella suis</i>	A38.1	Scarlet fever with myocarditis
A23.3	Brucellosis due to <i>Brucella canis</i>	A38.8	Scarlet fever with other complications
A23.8	Other brucellosis	A38.9	Scarlet fever, uncomplicated
A23.9	Brucellosis, unspecified	A39.0	Meningococcal meningitis
A24.0	Glanders	A39.1	Waterhouse-Friderichsen syndrome
A24.1	Acute and fulminating melioidosis	A39.2	Acute meningococcemia
A24.2	Subacute and chronic melioidosis	A39.3	Chronic meningococcemia
A24.3	Other melioidosis	A39.4	Meningococcemia, unspecified
A24.9	Melioidosis, unspecified	A39.50	Meningococcal carditis, unspecified
A25.0	Spirillosis	A39.51	Meningococcal endocarditis
A25.1	Streptobacillosis	A39.52	Meningococcal myocarditis
A25.9	Rat-bite fever, unspecified	A39.53	Meningococcal pericarditis
A26.0	Cutaneous erysipeloid	A39.81	Meningococcal encephalitis
A26.7	Erysipelothrix sepsis	A39.82	Meningococcal retrobulbar neuritis
A26.8	Other forms of erysipeloid	A39.83	Meningococcal arthritis
A26.9	Erysipeloid, unspecified	A39.84	Postmeningococcal arthritis
A27.0	Leptospirosis icterohemorrhagica	A39.89	Other meningococcal infections
A27.81	Aseptic meningitis in leptospirosis	A39.9	Meningococcal infection, unspecified
A27.89	Other forms of leptospirosis	A40.0	Sepsis due to streptococcus, group A
A27.9	Leptospirosis, unspecified	A40.1	Sepsis due to streptococcus, group B
A28.0	Pasteurellosis	A40.3	Sepsis due to <i>Streptococcus pneumoniae</i>
A28.1	Cat-scratch disease	A40.8	Other streptococcal sepsis
A28.2	Extraintestinal yersiniosis	A40.9	Streptococcal sepsis, unspecified
A28.8	Other specified zoonotic bacterial diseases, not elsewhere classified	A41.01	Sepsis due to Methicillin susceptible <i>Staphylococcus aureus</i>
A28.9	Zoonotic bacterial disease, unspecified	A41.02	Sepsis due to Methicillin resistant <i>Staphylococcus aureus</i>
A30.0	Indeterminate leprosy	A41.1	Sepsis due to other specified staphylococcus
A30.1	Tuberculoid leprosy	A41.2	Sepsis due to unspecified staphylococcus
A30.2	Borderline tuberculoid leprosy	A41.3	Sepsis due to <i>Hemophilus influenzae</i>
A30.3	Borderline leprosy	A41.4	Sepsis due to anaerobes
A30.4	Borderline lepromatous leprosy	A41.50	Gram-negative sepsis, unspecified
A30.5	Lepromatous leprosy	A41.51	Sepsis due to <i>Escherichia coli</i> [E. coli]
A30.8	Other forms of leprosy	A41.52	Sepsis due to <i>Pseudomonas</i>
A30.9	Leprosy, unspecified	A41.53	Sepsis due to <i>Serratia</i>
A31.0	Pulmonary mycobacterial infection	A41.54	Sepsis due to <i>Acinetobacter baumannii</i>
A31.1	Cutaneous mycobacterial infection	A41.59	Other Gram-negative sepsis
A31.2	Disseminated mycobacterium avium-intracellulare complex (DMAC)	A41.81	Sepsis due to <i>Enterococcus</i>
A31.8	Other mycobacterial infections	A41.89	Other specified sepsis
A31.9	Mycobacterial infection, unspecified	A41.9	Sepsis, unspecified organism
A32.0	Cutaneous listeriosis	A42.0	Pulmonary actinomycosis
A32.11	Listerial meningitis	A42.1	Abdominal actinomycosis
A32.12	Listerial meningoencephalitis	A42.2	Cervicofacial actinomycosis
A32.7	Listerial sepsis	A42.7	Actinomycotic sepsis
A32.81	Oculoglandular listeriosis	A42.81	Actinomycotic meningitis
A32.82	Listerial endocarditis	A42.82	Actinomycotic encephalitis
A32.89	Other forms of listeriosis	A42.89	Other forms of actinomycosis
A32.9	Listeriosis, unspecified	A42.9	Actinomycosis, unspecified
A33	Tetanus neonatorum	A43.0	Pulmonary nocardiosis
A34	Obstetrical tetanus	A43.1	Cutaneous nocardiosis
A35	Other tetanus	A43.8	Other forms of nocardiosis
A36.0	Pharyngeal diphtheria		
A36.1	Nasopharyngeal diphtheria		
A36.2	Laryngeal diphtheria		

Modifier Descriptors

Modifier	Description
CPT® Modifiers	
22	Increased Procedural Services
23	Unusual Anesthesia
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
26	Professional Component
27	Multiple Outpatient Hospital E/M Encounters on the Same Date
32	Mandated Services
33	Preventive Services
47	Anesthesia by Surgeon
50	Bilateral Procedure
51	Multiple Procedures
52	Reduced Services
53	Discontinued Procedure
54	Surgical Care Only
55	Postoperative Management Only
56	Preoperative Management Only
57	Decision for Surgery
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
59	Distinct Procedural Service
62	Two Surgeons
63	Procedure Performed on Infants less than 4 kg
66	Surgical Team
73	Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia
74	Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional

Modifier	Description
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available)
90	Reference (Outside) Laboratory
91	Repeat Clinical Diagnostic Laboratory Test
92	Alternative Laboratory Platform Testing
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
96	Habilitative Services
97	Rehabilitative Services
99	Multiple Modifiers
CPT® Category II Modifiers	
1P	Performance Measure Exclusion Modifier due to Medical Reasons
2P	Performance Measure Exclusion Modifier due to Patient Reasons
3P	Performance Measure Exclusion Modifier due to System Reasons
8P	Performance Measure Reporting Modifier - Action Not Performed, Reason Not Otherwise Specified
HCPCS Level II Modifiers	
A1	Dressing for one wound
A2	Dressing for two wounds
A3	Dressing for three wounds
A4	Dressing for four wounds
A5	Dressing for five wounds
A6	Dressing for six wounds
A7	Dressing for seven wounds
A8	Dressing for eight wounds
A9	Dressing for nine or more wounds
AA	Anesthesia services performed personally by anesthesiologist

Modifier	Description
AB	Audiology service furnished personally by an audiologist without a physician/npp order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures
AE	Registered dietitian
AF	Specialty physician
AG	Primary physician
AH	Clinical psychologist
AI	Principal physician of record
AJ	Clinical social worker
AK	Non participating physician
AM	Physician, team member service
AO	Alternate payment method declined by provider of service
AP	Determination of refractive state was not performed in the course of diagnostic ophthalmological examination
AQ	Physician providing a service in an unlisted health professional shortage area (HPSA)
AR	Physician provider services in a physician scarcity area
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
AT	Acute treatment (this modifier should be used when reporting service 98940, 98941, 98942)
AU	Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
AV	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic
AW	Item furnished in conjunction with a surgical dressing
AX	Item furnished in conjunction with dialysis services
AY	Item or service furnished to an ESRD patient that is not for the treatment of ESRD
AZ	Physician providing a service in a dental health professional shortage area for the purpose of an electronic health record incentive payment
BA	Item furnished in conjunction with parenteral enteral nutrition (PEN) services
BL	Special acquisition of blood and blood products
BO	Orally administered nutrition, not by feeding tube
BP	The beneficiary has been informed of the purchase and rental options and has elected to purchase the item
BR	The beneficiary has been informed of the purchase and rental options and has elected to rent the item

Modifier	Description
BU	The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision
CA	Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission
CB	Service ordered by a renal dialysis facility (RDF) physician as part of the ESRD beneficiary's dialysis benefit, is not part of the composite rate, and is separately reimbursable
CC	Procedure code change (use 'CC' when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed)
CD	AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable
CE	AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity
CF	AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable
CG	Policy criteria applied
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
CR	Catastrophe/disaster related
CS	Cost-sharing waived for specified COVID-19 testing-related services that result in and order for or administration of a COVID-19 test and/or used for cost-sharing waived preventive services furnished via telehealth in rural health clinics and federally qualified health centers during the COVID-19 public health emergency

Terminology

Terminology	Explanation
11 deoxycortisol	A precursor of cortisol; a steroid hormone, also known as Compound S.
Abscess	A collection of pus in a walled off sac or pocket, the result of infection.
ACE-inhibitors	A class of drugs known as antihypertensives, which are taken to aid in the reduction of hypertension or blood pressure.
Acetic anhydride	Colorless liquid with pungent smell that pharmaceuticals companies use in the manufacture of aspirin.
Acid fast bacilli	Also called AFB, these bacteria resist loss of stain color when treated with a dilute acid, and are part of the taxonomic class bacillus that are typically rod shaped bacteria.
Acid-base balance	The condition of the balance between the acid ions and the base or alkaline ions, a delicate mechanism, which controls the pH or acidity-alkalinity in the body.
Acidosis	Increased acidity in the blood due to increased hydrogen ions, causing a decrease in pH below 7.35; this affects all body functions especially metabolism and respiration.
Aciduria	The presence of acid in urine, particularly in abnormal amounts.
Acute	A medical condition or injury of sudden onset, sometimes severe in nature, and typically last a short period of time; opposite of chronic.
Acute circulatory failure	A sudden drop in cardiac output.
Acute coronary syndrome	Conditions caused by sudden loss of blood supply to the heart because of a blockage; these include but are not limited to unstable angina and heart attack.
Acute lymphoblastic anemia	A sudden abnormal rise in production by the body of a kind of white blood cell called a lymphoblast; usually found in the bone marrow, a large number of these immature cells replace the normal healthy cells, thereby causing life threatening symptoms.
Acute tubular necrosis	A condition involving the death of cells that form the tubules of the kidneys; this condition commonly leads to acute kidney injury.
Addison's disease	A serious chronic condition caused by a reduction of hormones produced by the adrenal cortex, located on the upper pole of each kidney.
Adenoma	A benign tumor with glandular structure or origin that may secrete hormones or affect hormone production.
Adenosine triphosphate, or ATP	A molecular unit that consists of adenosine and three phosphate groups that provides the main source of energy within cells for metabolism
Adenovirus	DNA viruses; different types of which cause respiratory infections, conjunctivitis, and gastroenteritis.
Adrenal cortex	The gland located on the upper portion of each kidney, with the cortex being the outer portion of that gland.
Adrenal gland	A small gland located on the upper pole of each kidney that secretes hormones directly into the blood.
Adrenal hormones	The adrenal glands produce hormones that are responsible for functions such as heart rate control and blood pressure; they also produce the stress hormone, commonly known as the flight or fight hormone, in addition to many more.
Adrenocortical	Pertaining to hormones produced by the outer portion, or cortex, of the adrenal gland, located on the upper pole of each kidney.
Adrenocorticotrophic hormone, or ACTH	A hormone secreted by the pituitary gland in the brain that acts to regulate the cortex, or outer region, of the adrenal gland.
Adrenogenital hyperplasia	A congenital disorder caused by the lack of the enzyme 21 hydroxylase, which involves the adrenal glands and affects cortisol production, a necessary hormone for growth, blood pressure, and other vital functions.
Aerobic	Indicating the presence of air or oxygen; in microbiology, referring to growth in the presence of air or oxygen.
Affinity	Attraction; what makes one element or substance in a compound combine with another element or substance.
Affinity separation	A biochemical method of dividing substances by binding their specific antigens to specific antibodies.
Agar	A gelatinous material derived from algae that labs often mix with nutrients and other desired substances for use as a solid substrate on which to culture or grow microorganisms or other cells.
Agglutination	Clumping.

Terminology	Explanation
AIDS	Acquired immune deficiency syndrome, is a disease caused by human immunodeficiency virus, HIV, that affects the immune system, causing the patient to be susceptible to infections, tumors, and other conditions that eventually can cause death; transmitted primarily through sexual contact but can be transmitted through blood transfusions and sharing of needles for drug use.
Albumin	A liver protein that tells a provider about a patient's liver function and nutritional status by measuring the level of the protein in the blood.
Albumin dialysis	A process to remove albumin-bound toxins (waste products harmful to the body) from patients in liver failure or impending liver failure; albumin is the most abundant protein in blood plasma and helps maintain the water concentration of blood.
Algorithm	A specific set of step-by-step calculations using defined inputs at each step to produce a useful output.
Aliquot	A portion of the whole; a sample.
Alkalinize	To change the pH by the addition of an alkaline or base; the opposite of making something more acidic.
Alkaloids	A term used to identify a group of nitrogenous substances found in plants; a common pharmaceutical prescribed by practitioners for many conditions; common alkaloids include the analgesics, codeine, and morphine, which are medicines that give relief from pain.
Alkalosis	Decreased acidity in the blood due to decrease in hydrogen ions, causing an alkaline state of a pH greater than 7.45; this affects all body functions especially metabolism and respiration.
Allele	Specific variant version of a gene at a specific locus.
Allergen	Substance, such as pollen, dust, dander, venom, etc., which triggers an allergic response.
Allergic purpura	An allergic reaction of an unknown origin that causes red patches on the skin along with other symptoms.
Allogeneic	A tissue graft harvested from one person for another; donors include cadavers and living individuals related or unrelated to the recipient; also known as allograft and homograft.
Alpha-2 antiplasmin	A fibrinolysis inhibitor that halts plasmin activity, thereby slowing the process of fibrinolysis.
Alzheimer's disease	A continuous decline in the mental functions, most commonly prevalent in middle or old age, due to degeneration of brain tissues.
Amenorrhea	Irregular or absent menstrual periods.
Amniocentesis	Obtaining a sample of amniotic fluid by inserting a needle in the uterus to examine any abnormality in the fetus.
Amniotic fluid	The fluid in the liquid filled sac that the fetus is encased in, inside the pregnant uterus.
Amniotic sac	A bag of fluid inside the uterus where the fetus develops and grows; it is sometimes called the membranes because the sac is made of two membranes called the amnion and the chorion.
Amoeba	A tiny single cell organism that lives in fresh water.
Amoebiasis	Also spelled amebiasis; infection with <i>Entamoeba histolytica</i> in the intestines causing severe diarrhea.
Amphetamines	A central nervous system stimulant drug that a provider uses to treat certain psychiatric disorders.
Amplification	Making more copies of a desired gene for study by processes such as polymerase chain reaction, called PCR, or transcription of DNA to RNA and reverse transcription from RNA to make an additional copy of the DNA.
Anaerobic	Condition where oxygen is not present or utilized during the activity.
Analgesic	Medicines that give relief from pain.
Analyte	The substance the analyst is measuring during a test.
Anaphylaxis	Widespread allergic systemic reaction causing severe symptoms leading to vascular collapse, shock, respiratory distress, and death.
Androgen	A hormone or compound, usually a steroid, that stimulates or controls male or female hormonal activity or production.
Androgenic receptor modulator	A hormone regulator that acts or modulates many different steroids.
Anemia	A condition where the amount of red blood cells or hemoglobin is below normal, resulting in a feeling of weakness or tiredness, and also evidence of pallor.
Anemia of chronic disease	An anemia of inflammatory response, a natural protective mechanism whereby the body is able to sequester or isolate a portion of the iron to prevent it from being available to nourish pathogens.
Aneuploidy	Chromosome mutation involving an abnormal chromosome number, such as one or three chromosome copies in the nucleus of cells that have a normal chromosome number of two.

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