Laboratory Services
An essential coding, billing and reimbursement resource for laboratory and pathology services
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Getting Started with Coding and Payment Guide

The Coding and Payment Guide for Laboratory Services is designed to be a guide to the specialty procedures classified in the CPT® books. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

For ease of use, Coding and Payment Guide for Laboratory Services lists the CPT and HCPCS level II codes in ascending numeric order. Included in the code set are all surgery and medicine codes pertinent to the specialty. Each CPT code is followed by its official code description.

Resequencing of CPT Codes
The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed nor had only minimal changes, the AMA has assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence. Codes within the Optum360 Coding and Payment Guide series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM
Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

Detailed Code Information
One or more columns are dedicated to each procedure or service to a series of similar procedures/services. Following the specific HCPCS Level II and CPT code and its narrative, is a combination of features. A sample is shown on page 2. The black boxes with numbers in them correspond to the information on the page following the example.

Appendix Codes and Descriptions
Some procedure codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official code description and associated relative value units, with the exception of the Category II and III CPT Codes. Because no values have been established by CMS for the Category II and Category III codes no clinical laboratory fee schedule limits or Medicare physician fee schedule relative value units and Medicare edits can be identified.

CCI Edit Updates
The Coding and Payment Guide series includes the list of codes from the official Centers for Medicare and Medicaid Services’ National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 23.3, the most current version available at press time. The CCI edits are now located in a section at the back of the book. Optum360 maintains a website to accompany the Coding and Payment Guide series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is https://www.optum360coding.com/ProductUpdates/. The 2018 edition password is: SPECIALTY18. Please note that you should log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

Index
A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

<table>
<thead>
<tr>
<th>Skin</th>
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<tbody>
<tr>
<td>Tests</td>
</tr>
<tr>
<td>Candida, 86485</td>
</tr>
<tr>
<td>Coccidioidomycosis, 86490</td>
</tr>
<tr>
<td>Histoplasmosis, 86510</td>
</tr>
<tr>
<td>Other Antigen, 86356</td>
</tr>
<tr>
<td>Tuberculosis, 86580</td>
</tr>
</tbody>
</table>

General Guidelines

Providers
The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group. Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies
Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component
Some pathology codes have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key
On the following pages are a sample page from the book displaying the format of Coding and Payment Guide with each element identified and explained on the opposite page.
**36415-36416**

- **36415** Collection of venous blood by venipuncture
- **36416** Collection of capillary blood specimen (eg, finger, heel, ear stick)

### Explanation

A needle is inserted into the skin over a vein to puncture the blood vessel and withdraw blood for venous collection in 36415. In 36416, a prick is made into the finger, heel, or ear and capillary blood that pools at the puncture site is collected in a pipette. In either case, the blood is used for diagnostic study and no catheter is placed.

### Coding Tips

These procedures do not include laboratory analysis. For handling or conveyance of a specimen transported to an outside laboratory, see 99000. Do not report 36415 if provided with critical care, see 99466–99467, 99468–99467, and 99486.

### Reimbursement Tips

The frequency limit for reporting code 36415 is once per day. Code 36415 is paid under the laboratory fee schedule. No deductible or coinsurance applies. The collection of capillary blood specimen, CPT code 36416, is not reportable paid under the laboratory fee schedule. No deductible or coinsurance apply.

### ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

**AMA:** 36415 2017, Jan, 8; 2016, Jan, 13; 2015, Jan, 16; 2014, May, 4; 2014, Jan, 11; 2012, Jan, 15-42; 2011, Jan, 11

### Relative Value Units/Medicare Edits

<table>
<thead>
<tr>
<th>Non-Facility RVU</th>
<th>Work</th>
<th>PE</th>
<th>MP</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
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<tr>
<td>36416</td>
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<table>
<thead>
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<tr>
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<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

### Terms To Know

capillary. Tiny, minute blood vessel that connects the arterioles (smallest arteries) and the venules (smallest veins) and acts as a semipermeable membrane between the blood and the tissue fluid.

diagnostic code links here. Refer to your ICD-10-CM book.

### 36420-36425

- **36420** Venipuncture, cutdown; younger than age 1 year
- **36425** age 1 or over

### Explanation

The physician makes an incision in the skin directly over the vessel and dissects the area surrounding the vein. A needle is passed into the vein for the withdrawal of blood or for the infusion of intravenous medication of a patient under 12 months of age (in 36420) or over 12 months of age (in 36425). A catheter may be left behind. Once the procedure is complete, the incision is repaired with a layered closure.

### Coding Tips

Local anesthesia is included in these services. For handling or conveyance of a specimen transported to an outside laboratory, see 99000. For venipuncture on a patient younger than 3 years of age, see 36400–36406. For venipuncture requiring physician skill on a patient under 3 years of age or older, see code 36410. Do not report code 36420 if provided with critical care; see codes 99468–99480. Code 36425 should not be reported with endovascular ablation (36475–36479).

### Reimbursement Tips

These codes are excluded from the laboratory fee schedule limitations and are paid under the Medicare physician fee schedule (MPFS) or the OPPS as applicable.

### ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

**AMA:** 36420 2017, Jan, 8; 2016, Jan, 13; 2015, Jan, 16; 2014, Oct, 6

### Relative Value Units/Medicare Edits

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<td>36425</td>
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<td>0.3</td>
<td>0.1</td>
<td>1.16</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility RVU</th>
<th>Work</th>
<th>PE</th>
<th>MP</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>36420</td>
<td>1.01</td>
<td>0.18</td>
<td>0.16</td>
<td>1.35</td>
</tr>
<tr>
<td>36425</td>
<td>0.76</td>
<td>0.3</td>
<td>0.1</td>
<td>1.16</td>
</tr>
</tbody>
</table>

### Terms To Know

critical care. Treatment of critically ill patients in a variety of medical emergencies that requires the constant attendance of the physician (e.g., cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, critically ill neonate).

cutdown. Small, incised opening in the skin to expose a blood vessel, especially over a vein (venous cutdown) to allow venipuncture and permit a needle or cannula to be inserted for the withdrawal of blood or administration of fluids.

venipuncture. Piercing a vein through the skin by a needle and syringe or sharp-ended cannula or catheter to draw blood, start an intravenous infusion, instill medication, or inject another substance such as radiopaque dye.
**81252-81254**

**81252**  
GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence

**81253**  
GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants

**81254**  
GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis; common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])

**Explanation**

This test may be requested as GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) or nonsyndromic hearing loss gene analysis. Specimen is whole blood. Methodology is bidirectional sequence analysis and/or PCR amplification. This test screens for a genetic mutation of GJB2, which is accountable for a high frequency of nonsyndromic autosomal recessive deafness (DFNA3). Report 81252 for the analysis of the full gene sequence. Report 81253 if only the known familial variants are analyzed. Code 81254 may be requested as GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) or nonsyndromic hearing loss gene analysis. Specimen is whole blood. Methodology is bidirectional sequence analysis and/or PCR amplification. This test screens for a genetic mutation of GJB6, which is accountable for a high frequency of recessively inherited deafness (DFNB1).

**Coding Tips**

These are Tier 1 molecular pathology codes. These codes include all analytical services that are required to perform the assay, including cell lysis, nucleic acid stabilization, extraction, digestion, amplification, and detection. When only the interpretation is performed, append modifier 26. For physician interpretation and reporting of molecular pathology procedures performed on Medicare patients, see HCPCS Level II code G0452.

**ICD-10-CM Diagnostic Codes**

- **H90.0**  
  Conductive hearing loss, bilateral

- **H90.11**  
  Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side

- **H90.12**  
  Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side

- **H90.2**  
  Conductive hearing loss, unspecified

- **H90.3**  
  Sensorineural hearing loss, bilateral

- **H90.41**  
  Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side

- **H90.42**  
  Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side

- **H90.5**  
  Unspecified sensorineural hearing loss

- **H90.6**  
  Mixed conductive and sensorineural hearing loss, bilateral

- **H90.71**  
  Mixed conductive and sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side

- **H90.72**  
  Mixed conductive and sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side

- **H90.8**  
  Mixed conductive and sensorineural hearing loss, unspecified

- **H91.8X1**  
  Other specified hearing loss, right ear

- **H91.8X2**  
  Other specified hearing loss, left ear

- **H91.8X3**  
  Other specified hearing loss, bilateral

- **H91.8X9**  
  Other specified hearing loss, unspecified ear

- **Z13.71**  
  Encounter for nonprocreative screening for genetic disease carrier status

**Z13.79**  
Encounter for other screening for genetic and chromosomal anomalies

**Z14.8**  
Genetic carrier of other disease

**Z15.89**  
Genetic susceptibility to other disease

**Z31.430**  
Enounter of female for testing for genetic disease carrier status for procreative management

**Z31.440**  
Encounter of male for testing for genetic disease carrier status for procreative management

**Z31.5**  
Encounter for procreative genetic counseling

**Z71.83**  
Encounter for nonprocreative genetic counseling

**Z82.2**  
Family history of deafness and hearing loss

**AMA: 81252**  
2017, Jan, 8; 2016, Jan, 13; 2016, Aug, 9; 2015, Jan, 16; 2014, Jan, 16; 2013, Sep, 3-12

**81253**  
2017, Jan, 8; 2016, Jan, 13; 2016, Aug, 9; 2015, Jan, 16; 2014, Jan, 11; 2013, Sep, 3-12

**81254**  
2017, Jan, 8; 2016, Jan, 13; 2016, Aug, 9; 2015, Jan, 16; 2014, Jan, 11; 2013, Sep, 3-12

**CMS Fee Schedule/Medicare Edits**

<table>
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<td>35.00</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**IOM Reference**

None

**Terms To Know**

**Assay.** Test of purity or the amount of any particular constituent of a mixture.

**Conductive hearing loss.** Reduction in ability to hear due to loss of conduction between the outer and middle ear.

**Mutation.** Alteration in gene function that results in changes to a gene or chromosome. Can cause deficits or disease that can be inherited, can have beneficial effects, or result in no noticeable change.

**Methodology** is bidirectional sequence analysis and/or PCR amplification. This test screens for a genetic mutation of GJB2, which is accountable for a high frequency of nonsyndromic hearing loss (DFNA3). Report 81252 for the analysis of the full gene sequence. Report 81253 if only the known familial variants are analyzed. Code 81254 may be requested as GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) or nonsyndromic hearing loss gene analysis. Specimen is whole blood. Methodology is bidirectional sequence analysis and/or PCR amplification. This test screens for a genetic mutation of GJB6, which is accountable for a high frequency of recessively inherited deafness (DFNB1).