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Coding and  
Payment Guide

# Laboratory Services

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reimbursement resource for laboratory  
and pathology services

SAMPLE

**— 2017 ICD-10**

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# Introduction

Coding systems and claim forms are part of the reality of modern health care. This *Coding and Payment Guide* provides a comprehensive look at the coding and reimbursement systems used by laboratory service providers. It is organized topically and numerically, and can be used as a comprehensive coding and reimbursement resource and as a quick lookup resource to solve coding problems.

Coding systems grew out of the need for data collection. By having a standard notation for the procedures performed and for the diseases, injuries, and illnesses diagnosed, statisticians could identify effective treatments as well as broad practice patterns. Before long, these early coding systems emerged as the basis to pay claims. Coding systems and claim forms have evolved to become the basis of reimbursement for health care services. The correct application of codes and knowledge of payer policies correlates directly to payment.

The administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 required the standardization of the several hundred health care claim formats previously in existence, as well as the establishment of standardized code sets for medical data including diagnoses, drugs, procedures, equipment, and supplies. The goal of the national standards is to reduce the administrative encumbrances of the existing system, simplify the way medical claims are paid, reduce costs, and promote the growth of electronic business in the health care industry.

This *Coding and Payment Guide* provides a comprehensive explanation of the coding and reimbursement systems used for laboratory services.

## Coding Systems

Coding systems seek to answer two questions: what was wrong with the patient (i.e., the diagnosis or diagnoses) and what was done to treat the patient (i.e., the procedures or services rendered).

Under the aegis of the federal government, a three-tiered coding system emerged for physician offices and outpatient facilities. Physicians' Current Procedural Terminology (CPT®) codes report procedures and physician services and comprises Level I of the system. A second level, known informally as HCPCS largely report supplies, nonphysician services, and pharmaceuticals. Dovetailing with each of these levels is the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) classification system that reports the diagnosis of illnesses, diseases, and injuries. Further explanations of each of these coding systems follows.

## HCPCS Level I or CPT Codes

The Centers for Medicare and Medicaid Services (CMS), in conjunction with the American Medical Association (AMA), the American Dental Association (ADA), and several other professional groups, developed, adopted, and implemented a coding system describing services rendered to patients. Known as HCPCS Level I, the CPT coding system is the most commonly used system to report medical services and procedures. Copyright of CPT codes and descriptions is held by the AMA. This system reports outpatient and provider services.

The three categories of CPT codes predominantly describe medical services and procedures, and are adapted to provide a common billing language that providers and payers can use for payment purposes. The

codes are required for billing by both private and public insurance carriers, managed care companies, and workers' compensation programs. A requirement of HIPAA is that CPT codes are used for the reporting of physician and other health care services.

The AMA's CPT Editorial Panel reviews the coding system and adds, revises, and deletes codes and descriptions. The panel accepts information and feedback from providers about new codes and revisions to existing codes that could better reflect the services.

The majority of codes are found in Category I of the CPT coding system. These five-digit numeric codes describe procedures and services that are customarily performed in clinical practices.

CPT Category II codes are supplemental tracking codes that are primarily used when participating in the Physician Quality Reporting System (PQRS) established by Medicare and are intended to aid in the collection of data about quality of care. At the present time, participation in this program is optional and physicians should not report these codes if they elect not to participate. Category II codes are alphanumeric, consisting of four digits followed by an F and should never be used in lieu of a Category I CPT code. This series of codes is updated on a biannual basis (January 1 and July 1), with codes that are released becoming effective six months later (e.g., codes released on January 1 become effective July 1). Refer to the AMA CPT website at <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-ii-codes.page>.

Category III of the CPT coding system contains temporary tracking codes for new and emerging technologies that are meant to aid in the collection of data on these new services and procedures. Category III codes are indicated by four numeric digits followed by a T. Like Category II codes, Category III CPT codes are released twice a year (January 1 and July 1) and can be found on the on the AMA CPT website. Relative value units (RVUs) are not assigned for these codes, and payment is made at the discretion of the local payer. Once implemented, a service described by a Category III CPT code may eventually become a Category I code. The most current list of these codes can be found at <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-iii-codes.page>.

## ICD-10-CM Codes

In response to ICD-9-CM's shortcomings, new coding systems were developed and have been implemented in the United States. The World Health Organization (WHO) created and adopted ICD-10 in 1994 and it has been used in much of the world since then. This system is the basis for the new U.S. diagnosis coding system, International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) effective October 1, 2015.

The ICD-10-CM coding system is an alphanumeric system and allows for up to seven digits to be assigned to describe a disease or injury. Generally, the reason the patient seeks treatment should be sequenced first when multiple diagnoses are listed.

Overall, the 10th revision goes into greater clinical detail than ICD-9-CM and addresses information about previously classified diseases, as well

# 81020

**81020** Urinalysis; 2 or 3 glass test

## Explanation

This test may be ordered as a two-glass or three-glass test, a MacConkey-blood agar test, an MC-blood agar test, or any of the previous with a gram-positive plate. This is a culture for bacteria and will typically involve a culture plate of 5 percent sheep's blood agar and a MacConkey plate (a medium containing differentiate for lactose and nonlactose fermenters). A third plate of gram-positive media may offer further discrimination of bacteria cultured. The test is useful in determining the types and prevalence of bacteria in the urine.

## Coding Tips

If a specimen is transported to an outside laboratory, report 99000 for handling or conveyance.

## Documentation Tips

Documentation must show that all tests were ordered by an authorized individual, correctly performed on the correct patient by qualified personnel, and timely reported to the ordering provider. The results of testing must be interpretable and accurate. Documentation must also be maintained to substantiate that test systems are operating correctly.

Many insurers rely on written evidence of the evaluation of the patient, care plan, and goals for improvement to determine and approve medical necessity of care.

## Reimbursement Tips

Medicare reimburses this service under the laboratory fee schedule.

Neither deductible nor coinsurance applies to laboratory tests paid under the fee schedule.

## Terms To Know

**bacteriuria.** Bacteria in the urine. The presence of large amounts may be a sign of infection in the urinary tract.

**specimen.** Tissue cells or sample of fluid taken for analysis, pathologic examination, and diagnosis.

## 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.

## Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
<b>81020</b>	0.0	0.0	N/A	X	1(3)

	Modifiers				Medicare References
<b>81020</b>	N/A	N/A	N/A	N/A	None

\* with documentation

# 81025

**81025** Urine pregnancy test, by visual color comparison methods

## Explanation

This test may be ordered by any of the brand name kits available. The tests typically involve a dipstick impregnated with reagents that chemically react upon contact with urine. A change in color indicates positive or negative for the presence of hormones found in the urine of women in early pregnancy.

## Coding Tips

This test may be performed using a CLIA-waived test system. See appendix 1 for CLIA-waived kits and test systems.

## Documentation Tips

Many insurers rely on written evidence of the evaluation of the patient, care plan, and goals for improvement to determine and approve medical necessity of care.

## Reimbursement Tips

Medicare reimburses this service under the laboratory fee schedule.

Modifier QW would be appended to this laboratory code to report a Clinical Laboratory Improvement Amendments (CLIA)-approved code.

## Terms To Know

**CLIA.** Clinical Laboratory Improvement Amendments. Requirements set in 1988, CLIA imposes varying levels of federal regulations on clinical procedures. Few laboratories, including those in physician offices, are exempt. Adopted by Medicare and Medicaid, CLIA regulations redefine laboratory testing in regard to laboratory certification and accreditation, proficiency testing, quality assurance, personnel standards, and program administration.

**hormone.** Chemical substance produced by the body that has a regulatory effect on the function of its specific target organ(s).

## ICD-10-CM Diagnostic Codes

N91.0	Primary amenorrhea
N91.1	Secondary amenorrhea
N91.2	Amenorrhea, unspecified
Z32.00	Encounter for pregnancy test, result unknown
Z32.01	Encounter for pregnancy test, result positive
Z32.02	Encounter for pregnancy test, result negative

Please note that this list of associated ICD-10-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

## Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
<b>81025</b>	0.0	0.0	N/A	X	1(3)

	Modifiers				Medicare References
<b>81025</b>	N/A	N/A	N/A	N/A	None

\* with documentation

# 84244

**84244** Renin

## Explanation

This test may be ordered as plasma renin activity, or PRA. The specimen is plasma. Certain medications such as beta-blockers, may affect testing outcome. Methodology may include radioimmunoassay.

## Coding Tips

Venipuncture is separately reportable. For collection of venous blood by venipuncture, see code 36415. When venipuncture on a patient 3 years of age or older requires the skill of a physician or other qualified health care provider, see code 36410. For venipuncture on a patient younger than 3 years of age performed by a physician or other qualified health care provider, see codes 36400-36406. If a specimen is transported to an outside laboratory, report code 99000 for handling.

## Documentation Tips

Documentation must show that all tests were ordered by an authorized individual, correctly performed on the correct patient by qualified personnel, and timely reported to the ordering provider. The results of testing must be interpretable and accurate. Documentation must also be maintained to substantiate that test systems are operating correctly.

Many insurers rely on written evidence of the evaluation of the patient, care plan, and goals for improvement to determine and approve medical necessity of care.

## Reimbursement Tips

Medicare reimburses this service under the laboratory fee schedule.

Most third-party payers and state scope of work exclude the use of a code requiring a physician or other qualified health care provider, a phlebotomist, or other unlicensed clinical staff.

## Terms To Know

**glomerulonephritis.** Disease of the kidney with diffuse inflammation of the capillary loops of the glomeruli. It may be a complication of bacterial infection or immune disorders and can lead to renal failure and may be associated with hypertension or diabetes.

## 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.

## Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
<b>84244</b>	0.0	0.0	N/A	X	2(3)

	Modifiers				Medicare References
<b>84244</b>	N/A	N/A	N/A	N/A	None

\* with documentation

# 84255

**84255** Selenium

## Explanation

This test may also be known by the abbreviation Se. The specimen is serum or urine collected over a 24-hour period. Methods may include fluorometry and atomic absorption. The blood and the urine test may be performed simultaneously. This test may be ordered to monitor nutritional therapy and for possible toxic exposure.

## Coding Tips

Venipuncture is separately reportable. For collection of venous blood by venipuncture, see code 36415. When venipuncture on a patient 3 years of age or older requires the skill of a physician or other qualified health care provider, see code 36410. For venipuncture on a patient younger than 3 years of age performed by a physician or other qualified health care provider, see codes 36400-36406. If a specimen is transported to an outside laboratory, report code 99000 for handling.

## Documentation Tips

Documentation must show that all tests were ordered by an authorized individual, correctly performed on the correct patient by qualified personnel, and timely reported to the ordering provider. The results of testing must be interpretable and accurate. Documentation must also be maintained to substantiate that test systems are operating correctly.

Many insurers rely on written evidence of the evaluation of the patient, care plan, and goals for improvement to determine and approve medical necessity of care.

## Reimbursement Tips

Medicare reimburses this service under the laboratory fee schedule.

Most third-party payers and state scope of work exclude the use of a code requiring a physician or other qualified health care provider, a phlebotomist, or other unlicensed clinical staff.

## ICD-10-CM Diagnostic Codes

- E59 Dietary selenium deficiency
- E70.0 Classical phenylketonuria
- I12.0 Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
- I12.9 Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
- I13.11 Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease
- I13.2 Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease
- I42.0 Dilated cardiomyopathy
- I42.1 Obstructive hypertrophic cardiomyopathy
- I42.2 Other hypertrophic cardiomyopathy
- I42.7 Cardiomyopathy due to drug and external agent
- I42.8 Other cardiomyopathies
- I42.9 Cardiomyopathy, unspecified
- N17.0 Acute kidney failure with tubular necrosis
- N17.1 Acute kidney failure with acute cortical necrosis

N17.2	Acute kidney failure with medullary necrosis
N17.8	Other acute kidney failure
N17.9	Acute kidney failure, unspecified
N18.1	Chronic kidney disease, stage 1
N18.2	Chronic kidney disease, stage 2 (mild)
N18.3	Chronic kidney disease, stage 3 (moderate)
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5
N18.6	End stage renal disease
N18.9	Chronic kidney disease, unspecified
N19	Unspecified kidney failure
T56.891A	Toxic effect of other metals, accidental (unintentional), initial encounter
T56.892A	Toxic effect of other metals, intentional self-harm, initial encounter
T56.893A	Toxic effect of other metals, assault, initial encounter
T56.894A	Toxic effect of other metals, undetermined, initial encounter
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.01	Encounter for general adult medical examination with abnormal findings
Z01.812	Encounter for preprocedural laboratory examination

Please note that this list of associated ICD-10-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**Medicare Edits**

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
<b>84255</b>	0.0	0.0	N/A	X	2(3)

	Modifiers				Medicare References
<b>84255</b>	N/A	N/A	N/A	N/A	None

\* with documentation

# 84260

**84260** Serotonin

**Explanation**

This test may also be called 5-HT or 5-Hydroxytryptamine. The specimen is whole blood or serum or spinal fluid. Methods may include fluorometry, radioimmunoassay (RIA), and gas or liquid chromatography spinal puncture to obtain specimen. This test may be performed to diagnose carcinoid syndrome and severe depression.

**Coding Tips**

A separately reportable lumbar puncture is performed to collect cerebrospinal fluid (CSF), see code 62270. Venipuncture is separately reportable. For collection of venous blood by venipuncture, see code 36415. When venipuncture on a patient 3 years of age or older requires the skill of a physician or other qualified health care provider, see code 36410. For venipuncture on a patient younger than 3 years of age performed by a physician or other qualified health care provider, see codes 36400-36406. If a specimen is transported to an outside laboratory, report code 99000 for handling.

**Documentation Tips**

Documentation must show that all tests were ordered by an authorized individual, correctly performed on the correct patient by qualified personnel, and timely reported to the ordering provider. The results of testing must be interpretable and accurate. Documentation must also be maintained to substantiate that test systems are operating correctly.

Many insurers rely on written evidence of the evaluation of the patient, care plan, and goals for improvement to determine and approve medical necessity of care.

**Reimbursement Tips**

Medicare reimburses this service under the laboratory fee schedule.

Most third-party payers and state scope of work exclude the use of a code requiring a physician or other qualified health care provider, a phlebotomist, or other unlicensed clinical staff.

**ICD-10-CM Diagnostic Codes**

- C7A.00 Malignant carcinoid tumor of unspecified site
- C7A.010 Malignant carcinoid tumor of the duodenum
- C7A.011 Malignant carcinoid tumor of the jejunum
- C7A.012 Malignant carcinoid tumor of the ileum
- C7A.019 Malignant carcinoid tumor of the small intestine, unspecified portion
- C7A.020 Malignant carcinoid tumor of the appendix
- C7A.021 Malignant carcinoid tumor of the cecum
- C7A.022 Malignant carcinoid tumor of the ascending colon
- C7A.023 Malignant carcinoid tumor of the transverse colon
- C7A.024 Malignant carcinoid tumor of the descending colon
- C7A.025 Malignant carcinoid tumor of the sigmoid colon
- C7A.026 Malignant carcinoid tumor of the rectum
- C7A.029 Malignant carcinoid tumor of the large intestine, unspecified portion
- C7A.090 Malignant carcinoid tumor of the bronchus and lung
- C7A.091 Malignant carcinoid tumor of the thymus
- C7A.092 Malignant carcinoid tumor of the stomach