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Outpatient Facility Coding Alert

Procedure Coding: Pinpoint 3 Things for Complete Fine Needle Aspiration Claims

Hint: Confirm units and check for biopsy.

When coding fine needle aspirations with 10022 (Fine needle aspiration; with imaging guidance), knowing how many units to report and how to code any biopsy work are your keys to reimbursement.

Get started with this fine needle aspiration example. The physician performed a fine needle aspiration (FNA) of the right thyroid and separate FNA of a nodule of the right thyroid isthmus. The pathology report shows that "Both specimens were inadequate for diagnosis." Following this, you learn that the physician immediately performed a right thyroid core biopsy and a core biopsy of the right isthmic nodule.

In this case, you encounter two prime challenges: (1) Can you report biopsy with FNA, and (2) how many units of FNA and biopsy can you report? Review the advice that follows on these two fundamental issues.

Watch for 'Inadequate' Notations

You're allowed to report both the FNA and core biopsies to Medicare. All you have to do is make sure documentation states that the FNA samples were inadequate. Append modifier 59 (Distinct procedural service) to 10022 to override the Correct Coding Initiative (CCI) edit pair for 10022 and the biopsy code.

In the example above, you may report 10022-59 and 60100 (Biopsy thyroid, percutaneous core needle). Modifier 59 is necessary to indicate that your physician performed the biopsies on separate and distinct anatomic areas.

Support you can use: The CCI manual states, "Fine needle aspiration (FNA) (CPT® codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (e.g., needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier," (Chapter 3, Section L.11, in the current manual, available at www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html).

Starting point: Check individual payer policies. Those who do not use the CCI edit guidance may have a policy that you should report only the procedure that results in a diagnostically viable specimen.

Check Units for Fine Needle Aspiration

A review of the CCI manual's instruction on counting FNA service units should help guide your reporting. Chapter 3, Section K.3, of the CCI manual states, "The unit of service for fine needle aspiration, CPT® codes 10021 (Fine needle aspiration; without imaging guidance) and 10022, is the separately identifiable lesion. If a physician performs multiple 'passes' into the same lesion to obtain multiple specimens, only one unit of service may be reported. However, a separate unit of service may be reported for separate aspiration(s) of a distinct separately identifiable lesion."

Count the number of lesions being aspirated. "You can report 10022 x 2 when aspiration is done on two separate lesions," says **R.M. Stainton Jr., MD**, president of Doctors' Anatomic Pathology Services in Jonesboro, Ark.

Each separate lesion should be reportable for core biopsy (60100) as well, depending on payer policy. For example, some payers require documentation to support reporting more than one biopsy.

In the example of thyroid FNA above, you report 2 units of 10022 and 2 units of 60100. Payer rules may vary. So you should check with your payer; otherwise 2 units each for 10022 and 60100 should be acceptable in most circumstances.

Don't Forget the Imaging

When reporting 10022, you imply that your physician is using imaging guidance since the descriptor of the code specifies "with imaging guidance." The CCI manual, Chapter IX, Section G.3, includes specific guidelines for the ultrasound guidance:

"CPT® codes 76942 (Ultrasonic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device], imaging supervision and interpretation), 77002 (Fluoroscopic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device]), 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures [epidural or subarachnoid]), 77012 (Computed tomography guidance for needle placement [e.g., biopsy, aspiration, injection, localization device], radiological supervision and interpretation), and 77021 (Magnetic resonance guidance for needle placement [e.g., for biopsy, needle aspiration, injection, or placement of localization device] radiological supervision and interpretation) describe radiologic guidance for needle placement by different modalities.

"CMS payment policy allows one unit of service for any of the above codes at a single patient encounter regardless of the number of needle placements performed. The unit of service for these codes is the patient encounter, not number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations."

On the other hand: CPT® Assistant® (April 2005) takes a different stance, stating, "From a CPT® coding perspective, code 76942 should be reported per distinct lesion that requires separate needle placement."

Bottom line: So, again, see what your payer allows before filing the claim.

In the example of thyroid FNA above, you may report the ultrasound guidance code 76942 depending upon payer policy. Medicare has in place a medically unlikely edit (MUE) unit of 1 for 76942. Other payers may allow you to report 76942 once for each separate nodule biopsied.