

**CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.**

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## Pathology: Cytopathology

This section contains information to assist providers in billing for pathology procedures related to cytopathology services.

### Pap Smear Tests

Taking a Papanicolaou (Pap) smear sample is considered part of a pelvic examination and is not separately reimbursable. The Pap smear test is reimbursable only to the provider who performs and reads the Pap smear and issues the written report. These tests include up to three smears for Pap tests for cancer screening and/or a qualitative report on the patient's level of estrogen.

### Modifiers TC and 26

Providers may use modifier TC to bill cervical or vaginal Pap smear results. When a smear is billed with modifier 26, it is reimbursable only to a hospital pathologist whose service is not covered by the hospital.

Submitting a claim on one line without a modifier indicates that both the professional and technical components of the service were provided.

### Clinical or Hospital Laboratory

Pap smears examined in a clinical or hospital laboratory can be reimbursed without a modifier only if both the professional and technical components are performed in the laboratory.

### Billing Restrictions

CPT-4 code 88120 will not be reimbursed if billed in conjunction with codes 88121 or 88365; CPT-4 code 88121 will not be reimbursed if billed in conjunction with codes 88120 or 88365.

CPT-4 codes 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166 or 88167, 88174 or 88175 may be used to bill cervical or vaginal Pap smear tests and to report physician interpretation services. Reimbursement is limited to one Pap smear in 30 days when billed by any provider, for the same recipient.

Claims billing CPT-4 code 88141 may be reimbursed when billed with ICD-9-CM diagnosis codes 795.00 – 795.09, documenting that the patient has recently had an abnormal Pap smear. Failure to document one of these diagnosis codes will result in denial of the claim.

Physicians, hospital outpatient departments and clinical laboratories may bill using codes 88147 and 88148.

**Note:** Clinical laboratories must use technical component modifier TC when billing for these services.

CPT-4 code 88141 (cytopathology, cervical or vaginal [any reporting system]; requiring interpretation by physician) is used to report smears that require separate interpretation by a physician. This code is not split-billed and must not be billed with modifier 26, TC or 99. Split-billed claims will be denied. This code is not to be used to bill routine quality control measures used in the supervision of technicians.

**Note:** Same day billing is allowed for code 88141 and a Pap smear code (88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166 or 88167, 88174 and 88175) when a smear requiring separate physician interpretation is detected and documented on the claim. Same day billing for these codes is not allowed for the routine quality control re-examination of slides made by a technical supervisor or pathologist. Medical justification must be documented in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on an attachment.

#### Age Restriction

The following cervical screening codes are restricted to women ages 21 through 65 regardless of sexual history.

Reimbursement may be made for services provided to women younger than 21 years or over the age of 65 who have, or do not have, a cervix. However, the ordering provider must document on the laboratory order, and the laboratory provider must document in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim (or attached to the claim) that the woman meets one or more of the following:

- Received a diagnosis of a high-grade precancerous cervical lesion (cervical intraepithelial neoplasia [CIN] 2, CIN 3, or adenocarcinoma in situ [AIS]) within the past 20 years and requires screening after the initial post-treatment surveillance per current American College of Obstetricians and Gynecologists (ACOG), American Cancer Society (ACS), American Society for Colposcopy and Cervical Pathology (ASCCP) and American Society for Clinical Pathology (ASCP) guidelines, or any prior diagnosis of cervical cancer.
- In utero exposure to diethylstilbestrol (DES).

- Immunocompromised status (such as HIV positive or immune suppressed such as a transplant patient using steroids).
- Requires repeat cervical cytology to reevaluate prior atypical squamous cells of undetermined significance (ASC-US), low-grade squamous intraepithelial lesion (LSIL), or CIN 1 test result.
- Over the age of 65 who did not have adequate negative prior screening. Adequate negative prior screening is defined as three consecutive negative cytology results or two consecutive negative co-tests within the ten years before cessation of screening, with the most recent test occurring within the past five years.

Cervical Screening Codes

<u>CPT-4 Code</u>	<u>Description</u>
<u>88142</u>	<u>Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision</u>
<u>88143</u>	<u>with manual screening and rescreening under physician supervision</u>
<u>88147</u>	<u>Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision</u>
<u>88148</u>	<u>screening by automated system with manual rescreening under physician supervision</u>
<u>88150</u>	<u>Cytopathology, slides, cervical or vaginal; manual screening under physician supervision</u>
<u>88152</u>	<u>with manual screening and computer-assisted rescreening under physician supervision</u>
<u>88153</u>	<u>with manual screening and rescreening under physician supervision</u>
<u>88154</u>	<u>with manual screening and computer-assisted rescreening using cell selection and review under physician supervision</u>

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88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88165	with manual screening and rescreening under physician supervision
88166	with manual screening and computer-assisted rescreening under physician supervision
88167	with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision
88175	with screening by automated system and manual rescreening or review under physician supervision

Optical Imaging Evaluations

CPT-4 code 88152 (cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision) describes an improved technology using optical imaging equipment to routinely evaluate negative smears. This code is not to be used to bill routine quality control measures used in the supervision of technicians.

Hormonal Evaluation

CPT-4 code 88155 is reimbursable for Pap smears performed for a definitive hormonal evaluation, and may be billed in conjunction with codes 88141 – 88143, 88147, 88148, 88150, 88152 – 88154 or 88164 – 88167, 88174 and 88175. Medical justification must be documented in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on an attachment.

**Fine Needle Aspirates**

CPT-4 codes 88172 and 88173 are used for billing the cytopathology evaluations of fine needle aspirates. Code 88177 is billable for more than one unit if accompanied by documentation supporting the need for more units in order to determine tissue type. Code 88199 or other “By Report” codes for this procedure will be denied. Providers must use the appropriate modifier when billing these procedures.