APS
MEDICAL BILLING
PROFESSIONAL CONSULTING

Outside Slide Consultations CPT 88321-88325

Code 88321 *Consultation and report on referred slides prepared elsewhere.*

- Code 88321 includes review of special stain, IHC, immunofluorescence, and other special procedure slides and test data prepared and initially interpreted at the referring facility. Special procedures can be separately charged if they are prepared or repeated by the lab at which the consultant practices.
- A slide made solely as the basis for a special stain, IHC, etc. ordered by the consultant doesn't count as a routine preparation.{*CAP Today*, Oct. 2001}
- The number of slides received and examined with an outside consultation case nor their type is taken into account when deciding that 88321 is the proper code to report for a case.
- The number of individual specimens represented by the case will not change the code.
- Clinical history, pathologic diagnosis, and complexity will not justify a code higher than 88321.

Code 88323 *Consultation and report on referred material requiring preparation of slides.*

- If additional routine preparations are needed, for example the ones it came with are not sufficient and re-cuts or deeper sections are required or piece of the original specimen; in other words, the consultant needs his or her lab to prepare additional routine preparations (e.g., H&E slides), because those that came with the case aren't sufficient for some reason. {AMA CPT-IS, KB #1429, Nov. 1, 2007}
- A separate charge for the added routine-stained slides cannot be billed.
- The added slide(s) must be used as an integral part of the evaluation.
- The added slide(s) can't have been made principally as the foundation for a special stain, IHC, immunofluorescence, or some other special study that's been ordered by the consultant. {*CAP Today*, Oct. 2001}
- The number of slides received and examined with an outside consultation case nor their type (e.g., H&E vs. special stain vs. IHC vs. EM micrographs) is taken into account when deciding that 88323 is the proper code to report for a case.
- The number of individual specimens represented by the case doesn't influence the code.
- Clinical history, pathologic diagnosis, and complexity in general don't in and of themselves justify code 88323 or a code higher or lower than 88323.

Code 88325 *Consultation, comprehensive, with review of records and specimens, with report on referred material.*

- It's used when patient records beyond the outside pathology report and associated slides/material are considered by the consultant to make the diagnosis.
- The College says 88325 is "used with review of the patient's chart, laboratory results, oncologist's consultations, etc.," but it's not appropriate for posting "when review of the record is limited to pathology reports." {"Cracking the code…,"*CAP Today*, July 1999}

- Bundled within base code 88325 is review of special stain, IHC, immunofluorescence, and other special procedure slides and test data prepared and initially examined at the referring facility.
- Special procedures are separately chargeable with consult cases only if they're prepared or repeated by the lab at which the consultant practices
- The number of slides, number of original specimens, existence and extent of special study slides and data, and general complexity are irrelevant to the determination that a particular case warrants classification as a "comprehensive" consult.
- The sole criterion is the presence of patient records *beyond* the outside pathologist's report.
- Per the AMA CPT-IS (Information Services) {AMA CPT-IS, KB #1407,Oct. 29, 2007} Code 88325 includes a comprehensive review of the patient's records. CPT neither defines nor states the minimum number or type of additional data sources qualifying the use of 88325. The requirement to review additional records can be considered as a surrogate for a higher level of work because additional patient information, beyond the referred anatomic pathology material and report, may be required to clarify the patient's diagnostic issue. The descriptor nomenclature of 88325 indicates that the consultation involves additional material (more than just a cursory review); and that the consultation process is one that objectively integrates the information to arrive at a diagnosis in conjunction with the pathology specimens received. To substantiate the appropriateness of 88325, it is recommended that the report document that the outside material was incorporated into the process of arriving at a diagnosis, beyond just having received one or two reports or slides.

REPORTING GUIDELINES

- Unit of service for codes 88321-88325 is considered the surgical pathology case or cytopathology case, which can include multiple specimens for review." {*CPT Assistant*, Dec. 2002}
- The unit of service for outside consult codes 88321-88325 isn't the *specimen* as it is for primary surgical pathology codes 88300-88309; instead, it's the *case*. By "case," the AMA's not referring to the totality of the slides and material that'll be covered by your one medical report; rather, it's talking about the individual cases that came in for consultation.
- One *internal* accession number is assigned to slides/material that originally may have had several different *outside* accession numbers—it's the *outside* accession number (or "case") you bill for when the service is reportable with an 88321-88325 code.
- It is required by CMS to bundle all outside preparations—whether routine or special—in the applicable primary consultation code, be that 88321, 88323 or 88325. For example, a case that comes to you for consultation as several H&E slides, a few special stain slides and some IHC slides. All has to be reported within the 88321, 88323 or 88325 code billed for the case, assuming all slides were from just one outside case. Add-on codes like 88312-88319, 88342, 88346 and 88348 can't be separately reported when the underlying preparations were developed at an outside facility.
- For special studies ordered by the consultant from the lab where they practice, separately report the applicable add-on procedure code (88312, 88342, etc.) just as it is done when working on a case from a patient who's registered at the hospital.

- A formal consultative medical report must be prepared and issued by the pathology consultant to warrant a fee being billed to a patient, a payer or insurer, or an outside physician or facility.
- The slides/material is/are identified and briefly described, and the final diagnosis identifies and gives a conclusion for each individual specimen that's represented in the package of slides received for consultation.
- Document any information beyond the outside pathologist's report regarding the patient's medical history and latest evaluation with a brief description of the information should be included in your consultation report.
- Clearly explain in your report what was done with a tissue block(s) from the outside facility. Especially highlight when additional routine preparations (H&E slides for example) are made in your lab for diagnostic evaluation, not mere "record" purposes or as the foundation for a special study. .
- Any special stains or other add-on procedures that are ordered from your lab are separately chargeable with a consultation case, be sure and document (a) what it is that was ordered from your lab; (b) why that item is medically indicated for the case; and (c) what you found from the add-on procedure. Consultation reports often talk about impressions from special stains, IHC, flow cytometry, and the like, and it's extremely important that coders and auditors be able to readily tell with certainty whether the preparation you're talking about was developed at the outside facility or in your lab.
- The date of service assigned to your consultation on the insurance claim should be the date the request and outside slides/material are received. It's important that the consult request letter or form be date/time-stamped, or in lieu of that, a handwritten notation made of the date it was received. You need to coordinate this date assignment policy with the medical reporting process so that there's no conflict in dates between the medical and billing systems.