Pathology/Lab Coding Alert

Your practical adviser for ethically optimizing coding, payment, and efficiency in pathology practices and clinical laboratories

December 2011, Vol. 12, No. 12 (Pages 81-88)

CPT 2012

88312-88319: Revamp Your Special Stain Coding for Accurate Claims

3 groups clarify parallel services.

Prepare for a CPT® special-stain overhaul starting Jan. 1, 2012, but don’t expect big changes to how you code your work.

Although revisions impact every special stain code in the range 88312-88319, they’re more minor repair than major revamp. See the changes for yourself with the chart on page 82.

‘Interpretation and Report’ is Primary

Most, but not all, of the CPT® 2011 special stain codes include the phrase “including interpretation and report” somewhere in the code definition.

CPT® 2012 moves the phrase to a position preceding the semicolon and includes it in every special stain code definition.

Identify code family: CPT® 2012 creates a true code family of the code range 88312-88319, because each subsequent code indents under 88312 (Special stain including interpretation and report; Group I for microorganisms [e.g., acid fast, methenamine silver]).

Welcome Group III

Notice that starting Jan. 1, 88319 (… Group III for enzyme constituents) will designate enzyme constituents as “Group III” stains. The change shouldn’t alter how you use the code — 88319 has always described stains for enzyme constituents.

“Prior to this change, CPT® classified special stains only as ‘Group I’ or Group II,”’ says R.M. Stainton Jr., MD, president of Doctors’ Anatomic Pathology Services in Jonesboro, Ark.

Starting Jan. 1, Group III stains join Group I stains that identify microorganisms, and Group II stains that identify all “other.”

Accommodate Group III: Notice that CPT® 2012 provides a change to 88319 (… Group II, all other (e.g., iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry) to clarify that “other” now represents non-Group I and non-Group III stains, as well as non-immunostains (88342, Immunohistochemistry (including tissue immunoperoxidase), each antibody).

Adding the “Group III” terminology and eliminating method-specific descriptors (Determinative histochemistry or cytochemistry) are the primary changes to 88319.

Stain example: “We occasionally perform dual esterase stain, which we report with 88319,” says Peggy Slagle, CPC, billing compliance coordinator at the University of Nebraska Medical Center in Omaha. Labs may use an esterase stain for muscle biopsies, for instance. The code selection should not change under CPT® 2012.
Beware Unit of Service

Special stain code revisions remove the word “each” from the definitions. Does that mean you should no longer separately code each special stain?

No. The 2011 definitions stated “special stains ... each,” but the new definitions state, “special stain” — singular. The effect is the same in how you should use these codes — one unit per special stain per specimen.

Caveat: CMS’ Version 15.3 of the NCCI Policy Manual, effective Oct. 1, 2009, introduced instruction allowing you to bill Medicare payers using 88312 and 88313 per block, rather than per specimen. Your lab compliance officer should work with

ICD-10

C22.- Broadens Liver Cancer Options

Prepare for new liver biopsy diagnosis options.

When you start using ICD-10 on Oct. 1, 2013, you’ll need to leave your 155.0 comfort zone and start using more specific codes for primary liver neoplasms that your pathologist diagnoses.

ICD-9 Gives One Choice

A number of diagnoses fall under the ICD-9 code you currently use, as follows:

» 155.0, Malignant neoplasm of liver primary

Carcinoma:

liver, specified as primary hepatocellular liver cell Hepatoblastoma

Find Many Choices in ICD-10

The new code set does not provide a one-to-one corresponding code. Instead, you’ll need to choose from a number of possibilities for liver biopsy results:

» C22.0, Liver cell carcinoma

Hepatocellular carcinoma

Hepatoma

» C22.2, Hepatoblastoma

» C22.3, Angiosarcoma of liver

Kupffer cell sarcoma

» C22.4, Other sarcomas of liver

» C22.7, Other specified carcinomas of liver

» C22.8, Malignant neoplasm of liver, unspecified as to type.

Documentation: If your pathologist’s current documentation format doesn’t distinguish between hepatoma rather than hepatoblastoma or angiosarcoma, add the C22.- diagnoses to your provider education and clinical documentation improvement strategy in preparation for the transition to ICD-10.

Coder tip: For the C22.- codes, ICD-10 instructs you to use an additional code to identify:

» Alcohol abuse and dependence (F10.-)

» Hepatitis B (B16.-, B18.0-B18.1)

» Hepatitis C (B17.1., B18.2).

Remember: When ICD-10 goes into effect on Oct. 1, 2013, you should apply the code set and official guidelines in effect for the date of service reported. Learn more at www.cms.gov/ICD10/ and www.cdc.gov/nchs/icd/icd10cm.htm#10update. □
Chart Your New Course for Special Stain Coding 2012

Clarify groups and units.

Use the following table to look ahead to CPT® 2012 special stain coding for your lab. Be ready to use these codes on Jan. 1.

“When you look at the description of many of these codes, the words are similar — they’re just moved around a little,” says Peggy Slagle, CPC, billing compliance coordinator at the University of Nebraska Medical Center in Omaha. The changes appear to be primarily “housecleaning” to clarify proper code usage, she says.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>2011 Descriptor</th>
<th>2012 Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>88312</td>
<td>Special stains; Group I for microorganisms (e.g., Gridley, acid fast, methenamine silver), including interpretation and report, each</td>
<td>Special stain including interpretation and report; Group I for microorganisms (e.g., acid fast, methenamine silver)</td>
</tr>
<tr>
<td>88313</td>
<td>… Group II, all other (e.g., iron, trichrome), except immunocytochemistry and immunoperoxidase stains, including interpretation and report, each</td>
<td>… Group II, all other (e.g., iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry</td>
</tr>
<tr>
<td>+88314</td>
<td>… histochemical staining with frozen section(s), including interpretation and report (List separately in addition to code for primary procedure)</td>
<td>… histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>88318</td>
<td>Determinative histochemistry to identify chemical components (e.g., copper, zinc)</td>
<td>Deleted</td>
</tr>
<tr>
<td>88319</td>
<td>Determinative histochemistry or cytochemistry to identify enzyme constituents, each</td>
<td>… Group III for enzyme constituents</td>
</tr>
<tr>
<td>88342</td>
<td>Immunohistochemistry (including tissue immunoperoxidase), each antibody</td>
<td>Unchanged</td>
</tr>
</tbody>
</table>

Payers to establish the accepted unit of service for special stain billing: per stain for each block, or per stain for each specimen.

Watch +88314 change: CPT® changes the +88314 descriptor from “histochemical staining with frozen section(s),” in 2011 to “histochemical stain on frozen tissue block” in 2012. The new definition should not change the unit of service.

Rather, the updated code definition better describes the 88314 procedure — staining slides from frozen tissue blocks rather than from standard paraffin blocks. Labs sometimes use this procedure for specimens such as muscle, because fixatives in standard paraffin imbedding may interfere with certain cellular features critical to diagnosis.

CCI Edits

87493 C. Difficile Test Catches More Restrictions Under CCI 17.3


Already restricted by CPT® instruction and prior Correct Coding Initiative (CCI) edits, you’ll find even more limitations for reporting amplified-probe Clostridium difficile testing, thanks to new edit pairs in the third quarter CCI update.

CCI version 17.3, effective Oct. 1, offers 1,380 new edit pairs and 835 terminated bundles, according to an analysis by Frank Cohen, MPA, MBB, principal and senior analyst with The Frank Cohen Group, LLC. Let us help you peer through the numbers to learn the CCI changes that will impact your laboratory.

(Continued on next page)
'Complete' Amplified Probe Code Stands Alone

Earlier CCI versions bundled 87493 (*Clostridium difficile, toxin gene[s], amplified probe technique*) with several molecular diagnostics codes in the range 83890-83913 (*Molecular diagnostics …*).

Now CCI 17.3 also lists 87493 as the column one code with the following six codes in that range:

» 83891 — Molecular diagnostics; isolation or extraction of highly purified nucleic acid, each nucleic acid type (i.e., DNA or RNA)
» 83898 — … amplification, target, each nucleic acid sequence
» +83901 — … amplification, target, multiplex, each additional nucleic acid sequence beyond 2 (List separately in addition to code for primary procedure)
» 83902 — … reverse transcription
» 83909 — … separation and identification by high resolution technique (e.g., capillary electrophoresis), each nucleic acid preparation
» 83912 — … interpretation and report.

That’s because 87493 is an infectious-agent specific code that represents a complete procedure.

“Code 87493 includes any molecular diagnostics methods used to perform the test,” says William Dettwyler, MTAMT, president of Codus Medicus, a laboratory coding consulting firm in Salem, Ore.

**Either/or:** CCI 17.3 also bundles 87493 with 87324 (*Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Clostridium difficile toxin[s]*) as mutually exclusive procedures.

“You should choose the single *C. diff* code that best describes the lab methods used to identify the organism,” Dettwyler says.

Don’t Double Dip Blood Processing Services

When you bill for a unit of blood or blood product using a HCPCS Level II “P” code, you shouldn’t additionally code work that went into preparing the unit. CCI 17.3 adds over 30 edit pairs to help you make that distinction.

**For instance:** If you’re billing for fresh frozen plasma using one of the following codes, you shouldn’t additionally report 86927 (*Fresh frozen plasma, thawing, each unit*), according to CCI 17.3:

» P9017 — Fresh frozen plasma (single donor), frozen within 8 hours of collection, each unit
» P9023 — Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit
» P9059 — Fresh frozen plasma between 8-24 hours of collection, each unit
» P9060 — Fresh frozen plasma, donor retested, each unit.

The latest CCI edits also bundle the following blood processing codes with multiple blood-product “P” codes:

» 86930 — Frozen blood, each unit; freezing (includes preparation)
» 86931 — … thawing
» 86945 — Irradiation of blood product, each unit.

For more on CCI edits and to find which ones impact your lab, visit the CMS Web site at www.cms.gov/nationalcorrectcodinited/ncciep/list.asp.

**Drug Screens 2012**

G0434 Payment Won’t Change, CMS Says

Agency denies reconsideration request.

Your lab will continue to get the same pay for a dipstick or chemistry analyzer screening for multiple drug classes in a single patient encounter.

That’s according to the agency’s preliminary payment determination, in which CMS denied industry commentators’ requests at the annual laboratory public meeting to distinguish the services.

**Keep With Current Practice**

When your lab performs a drug screen for a Medicare beneficiary, you should code the work as one unit of G0434 (*Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter*) when the lab uses any of the following methods:

» CLIA waived or non-instrumented moderate complexity test systems read by direct optical observation (such as dipsticks, cups, or cards)
» Moderate complexity instrumented test systems intended for repeated use, not read by direct optical observation (such as spectrophotometers, multi-channel chemistry analyzers, and fluorometers).

**Don’t Expect Additional Code**

Several commentators at the Clinical Laboratory Fee Schedule (CLFS) annual public meeting suggested changing G0434 to include only CLIA waived and non-instrumented moderate complexity tests, while introducing a new code for moderate complexity instrumented tests with pricing at four times G0434.
The current grouping under G0434 penalizes clinical labs that perform these tests using instrumented moderate complexity systems, according to Paul Radensky, representing McDermott Will & Emery LLP at the CMS public meeting. The moderate complexity instruments provide some clinical advantages, such as higher specificity, that commentators said should not be discouraged by coding and reimbursement.

CMS says no: The agency’s preliminary crosswalk decision is to “retain the same descriptor and payment” and not create an additional G code. CMS’ rationale for the decision made the following points:

» cost data did not justify higher payment for instrumented moderate complexity systems
» moderate complexity instruments are used to perform other tests, such as cardiac disease testing
» some commentators supported the reasonableness of current reimbursement.

To read more about the decision, visit cms.gov/ClinicalLabFeeSched/Downloads/CY2012_Preliminary_Rationale-Web-Posting-Document.pdf

Get it Right When DOS Spans ICD-9/ICD-10 Implementation Date

Distinguish “from” and “through” dates.

You know you’ll need to start using ICD-10 diagnosis codes for services provided on or after Oct. 1, 2013 — but what about claims for services that begin prior to Oct. 1 and end on or after that date?

Example: The lab begins a 24-hour urine creatinine test, beginning collection at 10 a.m. on Sept. 30, 2013 and completing the procedures at 10 a.m. on Oct. 1, 2013. That means the date of service (DOS) spans the ICD-10 implementation date. Should the lab report ICD-9 codes, ICD-10 codes, or both for the ordering diagnosis for the test?

In an “ICD-10 National Provider Teleconference,” CMS’ Sarah Shirey-Losso stated that “Some claims will continue to use the discharge date, some will use the ‘from’ date, and some may be required to be split,” but indicated that specific instruction would be forthcoming.

Follow Transmittal 950 Guidance

Providers recently received the promised guidance for different provider types when CMS issued Transmittal 950, which breaks down how each facility and provider should report claims that span the ICD-10 implementation date. Following you’ll find some examples of how various entities will report these claims:

Inpatient hospitals: Use the “through” date — if the hospital’s discharge and/or through date occurs on or after Oct. 1, 2013, then you should bill the entire claim with ICD-10 codes.

Providers, Part B hospital services, outpatient hospitals, hospices, and outpatient home health: You’ll split the claim, (Continued on next page)

You Be the Coder

TC/26 Split Goes All the Way

Question:
If our rural hospital lab receives a biopsy specimen and performs accessioning, gross dictation, and tissue processing to send the specimen to another lab for diagnosis, which code describes our service?

Answer: See page 87. Arkansas Subscriber

Are You Prepared for Upcoming Coding Changes?

Join Audio Conferences by Industry Experts on 2012 Coding Updates!

There will be 278 new, 139 revised, 98 deleted and 22 resequenced CPT® codes in 2012. Make plans to attend our audio conferences provided by our panel of coding veterans and experts this December, in order to keep up with these changes.

Here’s what you’ll learn:
• Which updates and guidelines affect your coding and reimbursement in 2012
• Examples of how to apply CPT® changes affecting your specialty
• What documentation payers expect you to provide for full reimbursement

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so all ICD-9 codes remain on one claim and all ICD-10 codes remain on the other claim.

Expect return, not denial: If you submit a claim with DOS or dates of discharge/through dates on or after Oct. 1, 2013 using ICD-9 codes, your Medicare contractor should return to provider (RTP) rather than deny the claim. To identify and correct the problem, expect to see the following message:

“For dates of service on or after October 1, 2013, claims may not contain ICD-9 codes. Please re-submit claim with the appropriate ICD-10 code”.

To read Transmittal 950, which includes the full list of potential provider types, visit www.cms.gov/transmittals/downloads/R950OTN.pdf.

Reader Questions

Keep 'V' Code for Screening

Question:
When a physician orders a screening FOBT test due to blood in the stool, is the appropriate diagnosis code 569.3 or 578.1?
Arkansas Subscriber

Answer:
Neither diagnosis code you listed is appropriate for a screening fecal occult blood test (FOBT). Both of the codes indicate a sign or symptom that would warrant a diagnostic test, not a cancer screening:

» 578.1 — Blood in stool
» 569.3 — Hemorrhage of rectum and anus.

The physician might assign one of these codes based on clinical findings. For instance, the patient may report black, tarry stool indicating blood that originates somewhere in the upper gastrointestinal tract (578.1), or bright red blood on the stool surface indicating bleeding in the rectum or anus (569.3).

If the patient presents with no symptoms and the physician orders an FOBT test to screen for colorectal cancer (such as 82270, Blood, occult, by peroxidase activity [e.g., guaiac], qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening [i.e., patient was provided 3 cards or single triple card for consecutive collection]), the physician should order the test with ICD-9 code V76.51 (Special screening for malignant neoplasms; colon).

Prepare for New ABN Form

Question:
Can we continue to use our 2008 version ABN forms after the first of the year since the wording on the 2011 form is the same?
South Carolina Subscriber

Answer:
No, you should not continue to use old forms. Beginning Jan. 1, 2012 you must use the new 2011 version of the Advance Beneficiary Notice (ABN) (form CMS-R-131).

Here’s why: “ABNs issued after Sun. Jan. 1 that are prepared using the 2008 version of the notice will be considered invalid by Medicare contractors,” CMS warns.

CMS originally set the implementation date for the new ABN form for Sept. 1, but the agency extended the deadline to Jan. 1, 2012 “to permit providers and suppliers with pre-printed stockpiles of ABNs time to exhaust their supplies,” the agency says in a message to providers.

No change: You are correct that the forms are virtually unchanged. “The 2008 and 2011 ABN notices are identical except that the release date of ‘3/11’ is printed in the lower left hand corner of the new version,” CMS points out.

Repeated services are different: What if you have a long-term notification in effect for situations such as repeat prothrombin time test for Coumadin management (85610, Prothrombin time)?

“2008 versions of the ABN that were issued prior to Sun. Jan 1 as long-term notification for repetitive services delivered for up to one year will remain effective for the length of time specified on the notice,” CMS says.

A copy of the 2011 version of the ABN (form CMS-R-131) is online at www.cms.gov/BNI/, under the “FFS Revised ABN” link.

238.3 Requires Specific Diagnosis

Question:
The pathologist examines an FNA from a “breast mass” and is unable to provide a definitive diagnosis. Would the appropriate diagnosis be “breast neoplasm of uncertain behavior”?
Texas Subscriber

Answer:
You should not use an uncertain behavior code, such as 238.3 (Neoplasm of uncertain behavior of breast) if the pathologist does not provide a definitive diagnosis.

In the scenario you describe, a code such as 611.72 (Lump or mass in breast) would be more appropriate.

Here’s why: Uncertain behavior codes are appropriate when the pathologist identifies a neoplasm that exhibits characteristics indicating that it might become malignant. The cells may be undergoing a transformation to malignancy, but the pathologist cannot make a clear distinction between benign and malignant.

If the tumor has an unpredictable behavior, it then fits in the neoplasm of uncertain behavior category. ICD-9 describes these tumors as “histomorphologically well-defined neoplasms, the subsequent behavior of which cannot be predicted from the present appearance.”

In other words, 238.3 means that the tumor is uncertain, not the pathologist. You don’t want to assign a neoplasm code if the pathologist does not clearly indicate the condition.
88104: Avoid Cytology Preparation Trap

**Question:**
Can we bill 88104 and 88108 together for the same non-gyn cytology specimen if the lab prepares and the pathologist diagnoses both direct and concentrated smears?

**Answer:**
The answer to your question depends on the payer.

Long-standing AMA instruction allows you to report each cytology preparation as a distinct service. In other words, if the pathologist needs to examine both a direct smear (88104, Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation) and a concentrated smear (88108 Cytopathology, concentration technique, smears and interpretation [e.g., Saccomanno technique]) to reach a diagnosis, you can bill separately for each preparation.

**Beware Medicare:** CMS has established different criteria for billing these codes, which you’ll need to follow for Medicare or any payers that use the same rules. The Correct Coding Initiative (CCI) edits bundle codes within the 88104-88112 group, meaning that you cannot bill different preparations together for the same specimen.

The CCI *Policy Manual* instructions state that Medicare considers different cytology preparations a “duplicate” service. If the pathologist uses two preparations, you should bill only for the more comprehensive procedure.

That means you should bill your example to Medicare as 88108. You should not additionally report 88104. Even though using modifier 59 (Distinct procedural service) would override the edit pair, you should not use 59 when you’re billing for one specimen. Reserve modifier 59 for cases when the pathologist examines a direct smear and a concentrated smear from two different specimens on the same day.

**Distinguish ‘NOS’ From ‘NEC’ to Pinpoint ICD-9 Choice**

**Question:**
Our pathologist diagnosed a malignant renal neoplasm involving the kidney and ureter, and I’m having trouble with the ICD-9 code selection because of the terms “other specified” and “unspecified.” Which is correct for this case?

**Answer:**
You should code a malignant renal neoplasm of the kidney and ureter as 189.8 (Malignant neoplasm of kidney and other specified sites of urinary organs). Choosing the “unspecified” code (189.9, Malignant neoplasm of urinary organ, site unspecified) would be incorrect.

The text note following 189.8 states that the code represents “malignant neoplasm of contiguous or overlapping sites of kidney and other urinary organs…,” which describes your pathologist’s diagnosis.

**Primer:** To help evaluate code choices like this, you need to keep in mind the following ICD-9 terminology:

» When the medical record provides specific information, but an ICD-9 code doesn’t exist that specifically incorporates that information, you should select a code that uses the terminology “other,” “other specified,” or “not elsewhere classifiable (NEC).” In other words, the deficiency in these cases lies with ICD-9 not providing enough specificity.

» When the opposite situation occurs — the medical record does not provide enough specific information to select a very specific ICD-9 code — you should select a code that uses the terminology “unspecified,” or “not otherwise specified (NOS).” In these cases, the deficiency lies with the medical record not providing enough specificity.

**Coder tip:** Often, but not always, NEC codes end with a final digit of “8,” while NOS codes end with a final digit of “9.”

**Reader Questions and You Be the Coder** were prepared with the assistance of R.M. Stainton Jr., MD, president of Doctors’ Anatomic Pathology Services in Jonesboro, Ark.
Pathology/Lab Coding Alert

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to Pathology/Lab coding and reimbursement to the Editor indicated below.

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