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1.0 Description of the Procedure, Product, or Service

Cytogenetics is the study of a cell's chromosomal composition by light microscopy. Cytogenetic testing involves the determination of chromosome number and structure including deletions and duplications; variations in either can produce numerous abnormalities.

Fluorescent in situ hybridization (FISH) is the application of fluorescently labeled DNA molecules to metaphase chromosomes and interphase nuclei for the detection of chromosomal abnormalities and alterations. It is a rapid, reliable, and direct approach for diagnosis, prognosis, and management of hematological malignancies. FISH is also a component of testing for some non-cancerous genetic conditions (for example, DiGeorge syndrome, William's syndrome, or Angelman syndrome) and is also used for preliminary diagnosis, prognosis, and management of pregnancies with indications for testing.

1.1 Constitutional Chromosomal Abnormalities

Constitutional chromosomal abnormalities are chromosomal abnormalities that are present at birth.

1.2 Neoplastic (Cancerous) Chromosomal Abnormalities

Cancerous chromosomal abnormalities are chromosomal abnormalities that have been acquired by a cancerous population of cells.

1.3 Genetic Counselor

Genetic counselors are health professionals with specialized education, training, and experience in medical genetics and counseling. They help people understand and adapt to the implications of genetic contributions to disease.

1.4 Genetic Counseling

Genetic counseling is a process of communication that allows recipients and their families to make informed medical decisions. These services may include obtaining a structured family medical and genetic history, constructing a multiple-generation genetic pedigree, performing an analysis of available medical information for genetic risk assessment, and counseling the recipient and family. This counseling includes natural history of disease, recurrence risk to family members, and availability of testing, screening and monitoring options.

2.0 Eligible Recipients

2.1 General Provisions

NC Medicaid (Medicaid) recipients must be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

NC Health Choice (NCHC) recipients, ages 6 through 18 years of age, must be enrolled on the date of service to be eligible, and must meet policy coverage criteria, unless otherwise specified.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT and Prior Approval Requirements

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid and NC Health Choice Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid and NC Health Choice Billing Guide:

<http://www.ncdhhs.gov/dma/basicmed/>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

2.3 Health Choice Special Provision: Exceptions to Policy Limitations for Health Choice Recipients ages 6 through 18 years of age

EPSDT does not apply to NCHC recipients. If a NCHC recipient does not meet the clinical coverage criteria within **Section 3.0** of the clinical coverage policy, the NCHC recipient will be denied services. Only services included under the Health Choice State Plan and the DMA clinical coverage policies, service definitions, or billing codes will be covered for NCHC recipients.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.

3.1 General Criteria

Procedures, products, and services related to this policy are covered when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Medicaid and NCHC cover cytogenetic studies when the following criteria are met:

- a. a comprehensive history and physical examination (H&P) reveals a constellation of signs and symptoms that suggests recognizable patterns of human malformation, **or** a prenatal ultrasound reveals a structural malformation suggesting a genetic abnormality, **and**

Note: See exclusions for NCHC in Subsection 4.3)

- b. the results of the studies will directly affect clinical decision making or clinical outcome for the recipient.

3.3 Constitutional Cytogenetics

Medicaid covers cytogenetic studies for constitutional chromosomal abnormalities for the diagnosis and treatment, including the following conditions:

- a. Genetic disorders (such as Down syndrome);
- b. Failure of sexual development;
- c. Developmental delay;
- d. Advanced maternal age; (**For NCHC refer to Subsection 4.3**)
- e. Multiple malformations; and
- f. Mental retardation.

3.4 Neoplastic (Cancer) Cytogenetics

The usefulness of testing for acquired chromosomal abnormalities has been demonstrated for the diagnosis and treatment of an increasing number of cancers. Medicaid therefore covers cytogenetic studies in suspected cases of these cancers, including the following:

- a. Chronic myelogenous leukemia
- b. Acute leukemia
- c. Myelodysplasia
- d. Lymphomas
- e. Multiple myeloma

3.5 Genetic Counseling

Medicaid covers appropriate genetic counseling when it is provided in conjunction with performance or consideration of medically necessary genetic studies that meet the criteria listed throughout **Section 3.0**. This includes follow-up genetic counseling to discuss the results of these tests. Three 30-minute units (for a total of 90 minutes) are allowed per day.

All recipients undergoing genetic testing for any reason shall have both pre-and post-test genetic counseling with a licensed or certified genetic counselor or qualified physician. Refer to **Subsection 1.4**.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Non-Covered Criteria

Medicaid and NCHC do not cover cytogenetic studies for general population screening when:

- a. there is no symptomatic evidence, **or**
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**.

Note: Cytogenetic studies performed primarily for family planning purposes are not covered.

4.3 NCHC Non-Covered Criteria

Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Health Choice program shall be equivalent to coverage provided for dependents under the NC Medicaid Program except for the following:

- a. no services for long-term care;
- b. no non-emergency medical transportation;
- c. **no EPSDT**; and
- d. dental services shall be provided on a restricted basis.

NCHC exclusions include obstetrics, gynecology, complications of pregnancy, childbirth and the puerperium. The following are not covered under NCHC:

- a. a prenatal ultrasound reveals a structural malformation suggesting a genetic abnormality (**as listed in Subsection 3.2**)
- b. advanced maternal age (**as listed in Subsection 3.3**)
- c. see Attachment A for Diagnosis and Billing Code(s) excluded from coverage

4.4 Medicaid Non-Covered Criteria

No additional non-covered criteria.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.

5.1 Prior Approval

Prior approval is not required for Medicaid and NCHC recipients.

5.2 Provision of Service

Conventional cytogenetic testing, for routine clinical purposes, using either non-neoplastic tissue (constitutional cytogenetics) or neoplastic tissue (cancer cytogenetics), includes the following:

- a. Tissue culture of the specimen
- b. Metaphase arrest of dividing cells with chemicals that inhibit the mitotic spindle
- c. Exposure to hypotonic solution to swell the cells and thus release the chromosomes
- d. Slide preparation and staining, which permits the microscopic analysis of each chromosome in a metaphase preparation, to enable the observation of any aberrations
- e. Preparation of images called karyotypes, either on paper or electronically, which display all the chromosomes of a metaphase
- f. Interpretation of the results (normal or abnormal) within the context of the recipient's indication for the study and clinical presentation
- g. Generation of a report that conveys the patient results in cytogenetic nomenclature

5.3 Testing Limitations

See **Attachment A** Section G Reimbursement for Testing limitations for CPT codes covered in this policy.

5.4 Documentation Requirements

Cytogenetic testing beyond the limitations stated in **Subsection 5.3** requires documentation supporting the need for additional test(s). Documents may include the reason for the test(s); previous lab results; and how the test results will be utilized, how the test results will contribute to improved health outcomes, and how the test results will alter the recipient's treatment and management.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid or NCHC qualifications for participation;
- b. be currently Medicaid - enrolled; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Genetic counseling is provided incident to the services of a physician. Genetic counseling may be provided by a genetic counselor that is certified by the American Board of Genetic Counseling or has an Active Candidate Status. A genetic counselor shall be employed by or under contract to hospitals or other entities that employ licensed physicians who are also Medicaid-enrolled providers. Licensed physicians shall be responsible for providing on-site clinical supervision and must be directly involved in the care of NC Medicaid recipients for whom the counseling service is billed.

Clinical laboratory services may be rendered only by medical care entities that are issued certifications that are in compliance with the Clinical Laboratories Improvement Amendment (CLIA) [Public Law 100-578, amended §353 of the Public Health Service Act (PHSA)].

7.0 Additional Requirements

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: November 1, 1987

Revision Information:

Date	Section Revised	Change
10/1/2008	Throughout	Initial promulgation of current coverage
7/1/2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”
8/1/2011	Sections 1.0, 3.0, 4.0, 5.0, 6.0, 7.0	Updated standard DMA template language
8/1/2011	Section 3.0	Revised wording to clarify criteria
8/1/2011	Subsection 3.5	Added, “All recipients undergoing genetic testing for any reason shall have both pre-and post-test genetic counseling with a licensed or certified genetic counselor or qualified physician. Refer to Subsection 1.4. ”
8/1/2011	Subsection 5.3	Deleted 88264 from list in 5.3 e. Added 5.3.i CPT code 88264 is limited to 2 units per day. Deleted 88273 from list in 5.3h. Added 5.3.j CPT code 88273 is limited to 3 units per day.
8/1/2011	Subsection 7.2	Deleted “Laboratories may not bill N.C. Medicaid for a test performed while a patient is in hospital inpatient status. Payment arrangements must be made between the laboratory and the hospital. Medicaid”
8/1/2011	Subsection 7.3	Removed Records Retention :As a condition of participation, providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N. C. Medicaid program [Social Security Act 1902(a) and 42 CFR 431.107]. Records must be retained for a period of at least five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements (10A NCAC 22F.0107). Copies of records must be furnished upon request. The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the release of records to Medicaid (45 CFR 164.502).
8/1/2011	Attachment A (E)	Changed 1½ hours to 90 minutes
8/1/2011	Attachment A (B)	Deleted wording that “covered ICD-9 CM diagnosis codes are listed below:” Added wording that “the provider shall ensure that the

Date	Section Revised	Change
		recipient meets the criteria in section 3.0 of this policy. The ICD-9 CM codes include:” Added the following codes to the diagnosis code table: 279.2, 287.31, 287.32, 287.33, 348.30, 348.31, 348.39 and 630.1. Deleted inactive diagnosis codes 655.22, 655.24 and 743.60. Added Note: Providers are to use diagnoses code 631 through September 30, 2011 and use ICD-9 diagnosis code 631.0 effective October 1, 2011.
8/1/2011	Attachment A (D)	Deleted “(CPT 2008 codebook)”
8/1/2011	Attachment A (G)	Added Cytogenetic Studies to co-payments
2/1/2012	Attachment A: C	Added statement about Revenue Codes billing
2/1/2012	Section 6.0	Deleted “Genetic counseling is provided incident to the services of a physician. Genetic counseling may be provided by board-certified or board-eligible genetic counselors employed by or under contract to hospitals or other entities that employ board-certified or board-eligible genetic or prenatal diagnostic specialists (MDs or DOs) who are also enrolled with N.C. Medicaid. The specialist shall be responsible for providing on-site clinical supervision and must be directly involved in the care of recipients for whom the counseling service is billed.”Added to 6.0 “Genetic counseling is provided incident to the services of a physician. Genetic counseling may be provided by a genetic counselor that is certified by the American Board of Genetic Counseling or has an Active Candidate Status. A genetic counselor shall be employed by or under contract to hospitals or other entities that employ licensed physicians who are also Medicaid-enrolled providers. Licensed physicians shall be responsible for providing on-site clinical supervision and must be directly involved in the care of NC Medicaid recipients for whom the counseling service is billed.”
3/12/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid or NCHC guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid and NCHC managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers shall bill the ICD-9-CM diagnosis code(s) to the highest level of specificity that supports medical necessity. The provider shall ensure that the recipient meets the criteria in **Section 3.0** of this policy. The ICD-9 CM codes include:

158.0	171.5	191.0	191.1	191.2	191.3	191.4	191.5
191.6	191.7	191.8	191.9	200.20	200.21	200.22	200.23
200.24	200.25	200.26	200.27	200.28	201.90	201.91	201.92
201.93	201.94	201.95	201.96	201.97	201.98	202.00	202.01
202.02	202.03	202.04	202.05	202.06	202.07	202.08	202.8
202.80	202.81	202.82	202.83	202.84	202.85	202.86	202.87
202.88	203.00	203.01	203.02	203.80	203.81	204.00	204.01
204.02	204.10	204.11	204.12	204.90	204.91	204.92	205.00
205.01	205.02	205.10	205.11	205.12	205.20	205.21	205.22
205.30	205.31	205.80	205.81	205.82	205.90	205.91	205.92
206.00	206.01	206.02	206.10	206.11	206.20	206.21	206.80
206.81	206.90	206.91	208.00	208.01	208.02	208.10	208.11
208.20	208.21	208.80	208.81	208.90	208.91	208.92	228.1
237.71	237.72	238.71	238.72	238.73	238.74	238.75	238.76
238.79	253.0	256.31	257.2	257.8	257.9	259.0	273.1
273.3	276.2	279.11	279.2	282.1	284.01	284.09	284.1
284.2	284.89	284.9	285.22	285.9	286.0	286.1	287.30
287.31	287.32	287.33	287.5	288.00	288.01	288.02	288.03
288.04	288.09	288.1	288.2	288.3	288.4	288.50	288.51
288.59	288.60	288.61	288.62	288.63	288.64	288.65	299.00
299.01	299.10	299.11	299.80	299.81	299.90	299.91	312.00
312.01	312.02	312.03	312.10	312.11	312.12	312.13	312.20
312.21	312.22	312.23	312.30	312.34	312.35	312.39	312.4
312.81	312.82	312.89	312.9	314.00	314.01	314.1	314.2
314.8	314.9	315.00	315.01	315.02	315.09	315.1	315.2
315.31	315.32	315.39	315.4	315.5	315.8	315.9	317
318.0	318.1	318.2	319	330.0	330.8	330.9	331.4
331.83	333.4	333.99	334.8	334.9	337.9	343.9	348.3
348.30	348.31	348.39	359.0	359.1	359.81	359.89	359.9
377.43	389.9	441.9	524.0	611.1	626.0	629.81	629.89
629.9	630		631.0	632	634.90	634.91	634.92

Codes continue on next page

Covered ICD-9-CM diagnosis codes, continued

646.33	646.83	653.70	653.71	653.73	655.03	655.10	655.11
655.13	655.21	655.23	655.33	655.43	655.53	655.83	
655.93	656.40	656.41	656.43	656.50	656.51	656.53	656.60
656.61	656.63	657.03	658.03	659.43	659.53	659.63	659.73
663.83	709.00	709.09	728.3	737.30	740.0	740.1	740.2
741.00	741.01	741.02	741.03	741.90	741.91	741.92	741.93
742.0	742.1	742.2	742.3	742.4	742.51	742.53	742.59
742.8	742.9	743.00	743.03	743.06	743.10	743.11	743.12
743.20	743.21	743.22	743.30	743.31	743.32	743.33	743.34
743.35	743.36	743.37	743.39	743.41	743.42	743.43	743.44
743.45	743.46	743.47	743.48	743.49	743.51	743.52	743.53
743.54	743.55	743.56	743.57	743.58	743.59	743.61	
743.62	743.63	743.64	743.65	743.66	743.69	743.8	743.9
744.00	744.01	744.02	744.03	744.04	744.05	744.09	744.1
744.21	744.22	744.23	744.24	744.29	744.3	744.41	744.42
744.43	744.46	744.47	744.49	744.5	744.81	744.82	744.83
744.84	744.89	744.9	745.0	745.10	745.11	745.12	745.19
745.2	745.3	745.4	745.5	745.60	745.61	745.69	745.7
745.8	745.9	746.00	746.01	746.02	746.09	746.1	746.2
746.3	746.4	746.5	746.6	746.7	746.81	746.82	746.83
746.84	746.85	746.86	746.87	746.89	746.9	747.0	747.10
747.11	747.20	747.21	747.22	747.29	747.3	747.40	747.41
747.42	747.49	747.5	747.60	747.61	747.62	747.63	747.64
747.69	747.81	747.82	747.83	747.89	747.9	748.0	748.1
748.2	748.3	748.4	748.5	748.60	748.61	748.69	748.8
748.9	749.00	749.01	749.02	749.03	749.04	749.10	749.11
749.12	749.13	749.14	749.20	749.21	749.22	749.23	749.24
749.25	750.0	750.10	750.11	750.12	750.13	750.15	750.16
750.19	750.21	750.22	750.23	750.24	750.25	750.26	750.27
750.29	750.3	750.4	750.5	750.6	750.7	750.8	750.9
751.0	751.1	751.2	751.3	751.4	751.5	751.60	751.61
751.62	751.69	751.7	751.8	751.9	752.0	752.10	752.11
752.19	752.2	752.3	752.40	752.41	752.42	752.49	752.51
752.52	752.61	752.62	752.63	752.64	752.65	752.69	752.7
752.81	752.89	752.9	753.0	753.10	753.11	753.12	753.13
753.14	753.15	753.16	753.17	753.19	753.20	753.21	753.22
753.23	753.29	753.3	753.4	753.5	753.6	753.7	753.8
753.9	754.0	754.1	754.2	754.30	754.31	754.32	754.33
754.35	754.40	754.41	754.42	754.43	754.44	754.50	754.51
754.52	754.53	754.59	754.60	754.61	754.62	754.69	754.70
754.71	754.79	754.81	754.82	754.89	755.00	755.01	755.02
755.10	755.11	755.12	755.13	755.14	755.20	755.21	755.22
755.23	755.24	755.25	755.26	755.27	755.28	755.29	755.30
755.31	755.32	755.33	755.34	755.35	755.36	755.37	755.38
755.39	755.4	755.50	755.51	755.52	755.53	755.54	755.55

Codes continue on next page

Covered ICD-9-CM diagnosis codes, continued

755.56	755.57	755.58	755.59	755.60	755.61	755.62	755.63
755.64	755.65	755.66	755.67	755.69	755.8	755.9	756.0
756.10	756.11	756.12	756.13	756.14	756.15	756.16	756.17
756.19	756.2	756.3	756.4	756.50	756.51	756.52	756.53
756.54	756.55	756.56	756.59	756.6	756.70	756.71	756.79
756.81	756.82	756.89	756.9	757.0	757.1	757.2	757.31
757.32	757.33	757.39	757.4	757.5	757.6	757.8	757.9
758.0	758.1	758.2	758.3	758.31	758.32	758.33	758.39
758.4	758.5	758.6	758.7	758.81	758.89	758.9	759.0
759.1	759.2	759.3	759.4	759.5	759.6	759.7	759.81
759.82	759.83	759.89	759.9	760.71	778.0	779.8	779.9
780.39	783.1	783.40	783.41	783.42	783.43	796.4	796.5
796.6	996.85	996.89	V16.0	V16.3	V16.41	V42.81	V42.82

Note: NCHC exclusions include obstetrics, gynecology, complications of pregnancy, childbirth and the puerperium. The following diagnosis codes are not covered under NCHC:

256.31	630	632	634.90	634.91	634.92	646.33	646.83
653.70	653.71	653.73	655.03	655.10	655.11	655.13	655.21
655.23	655.33	655.43	655.53	655.83	655.93	656.40	656.41
656.43	656.50	656.51	656.53	656.60	656.61	656.63	657.03
658.03	659.43	659.53	659.63	659.73	778.0	779.8	779.9
796.5	796.6						

C. Billing Code(s)

Providers are required to select the most specific billing code that accurately describes the service(s) provided.

CPT Code	Description
88230	Tissue culture for non-neoplastic disorders; lymphocyte
88233	Tissue culture for non-neoplastic disorders; skin or other solid tissue biopsy
88235	Tissue culture for non-neoplastic disorders; amniotic fluid or chorionic villus cells
88237	Tissue culture for neoplastic disorders; bone marrow, blood cells
88239	Tissue culture for non-neoplastic disorders; solid tumor
88245	Chromosome analysis for breakage syndromes; baseline Sister Chromatid Exchange (SCE), 20–25 cells
88248	Chromosome analysis for breakage syndromes; baseline breakage, score 50–100 cells, count 20 cells, 2 karyotypes (eg, for ataxia telangiectasia, Fanconi anemia, fragile X)
88261	Chromosome analysis; count 5 cells, 1 karyotype, with banding
88262	Chromosome analysis; count 15–20 cells, 2 karyotypes with banding
88263	Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes with banding
88264	Chromosome analysis; analyze 20–25 cells

CPT Code	Description
88267	Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotype, with banding
88269	Chromosome analysis, in situ for amniotic fluid cells, count cells from 6–12 colonies, 1 karyotype, with banding
88271	Molecular cytogenetics; DNA probe, each (eg, FISH)
88272	Molecular cytogenetics; chromosomal in situ hybridization, analyze 3–5 cells (eg, for derivatives and markers)
88273	Molecular cytogenetics; chromosomal in situ hybridization, analyze 10–30 cells (eg, for microdeletions)
88274	Molecular cytogenetics; interphase in situ hybridization, analyze 25–99 cells
88275	Molecular cytogenetics; interphase in situ hybridization, analyze 100–300 cells
88280	Chromosome analysis; additional karyotypes, each study
88283	Chromosome analysis; additional specialized banding technique (eg, NOR, C-banding)
88285	Chromosome analysis; additional cells counted, each study
88289	Chromosome analysis; additional high resolution study
88291	Cytogenetics and molecular cytogenetics, interpretation and report
96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family

Note: NCHC exclusions include obstetrics, gynecology, complications of pregnancy, childbirth and the puerperium. CPT code 88235 is not covered under NCHC:

Providers shall bill the CPT code with the appropriate Revenue Codes as listed below

Revenue Code	Description
300	Laboratory; General classification
301	Laboratory; Chemistry
302	Laboratory; Immunology
304	Laboratory; Non-routine dialysis
305	Laboratory; Hematology
306	Laboratory; Bacteriology and microbiology
307	Laboratory; Urology
309	Laboratory; Other laboratory
310	Laboratory Pathology; General classification
311	Laboratory Pathology; Cytology
312	Laboratory Pathology; Histology
314	Laboratory Pathology; Biopsy
319	Laboratory Pathology; Other laboratory pathology

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Inpatient, Outpatient, Office.

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and over-the-counter drugs and services for NCHC.

Cytogenetic Studies (Laboratory services) are not subject to co-payments for Medicaid.

H. Reimbursement

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>

Testing Limitations

- a. CPT codes, 88245, 88248, 88261, 88262, 88263, 88267, 88269, 88283, 88289, and 88291 are limited to 1 unit each per day.
- b. CPT codes 88230, 88233, and 88239 are limited to 2 units each per day.
- c. CPT code 88271 is limited to 42 units per day.
- d. CPT code 88280 is limited to 5 units per day.
- e. CPT codes 88237 and 88285 are limited to 4 units each per day.
- f. CPT code 88235 is limited to 3 units per conception. (NCHC exclusion see **Attachment A Billing Code (s)**).
- g. CPT code 96040 is limited to 3 units (1 unit = 30 minutes) per day.
- h. CPT codes 88272, 88274 and 88275 are limited to 25 units per day.
- i. CPT code 88264 is limited to 2 units per day.
- j. CPT code 88273 is limited to 3 units per day.