Priority Health	BILLING POLICY No. 166
MDS FISH Billing Policy	
Date of origin: October 2025	**Review dates: NA**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

This policy outlines billing and payment requirements associated with fluorescent in situ hybridization (FISH) probes for those whose bone marrow examination is suggestive of myelodysplasia (MDS) and who have an inadequate cytogenetic assessment by conventional karyotyping. In general, conventional karyotype analysis is sufficient for confirmation for the diagnosis of MDS.
The myelodysplastic syndromes (MDS) represent a spectrum of clonal bone marrow diseases with heterogeneous presentations.

MEDICAL POLICY

Genetics: Counseling, Testing, and Screening - 91540

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

Billing details

FISH testing is indicated in the evaluation of patients whose bone marrow examination are suggestive of MDS and who have had a failed or inadequate cytogenetic assessment (conventional karyotype).

Limitations

- If results of conventional cytogenetics are adequate, FISH testing is considered not medically necessary
- In cases of inadequate karyotyping, Medicare limits initial FISH testing to 4 probes (studies) as specified above in this policy;
- Reflex FISH testing may be warranted when the initial 4 probes are negative;
- Molecular next-generation sequencing (NGS) testing alone (for myeloid mutations) or in combination with FISH testing is not reasonable and necessary for the diagnosis of MDS and is considered medically unnecessary
- When a patient has a bone marrow suggestive of another disorder (e.g., a plasma cell disorder), MDS-FISH is not indicated;
- Diagnostic delays do not justify exceeding the initial four FISH studies or bypassing the stepwise reflex testing approach.
- Repeating FISH testing on the same specimen at a different laboratory is not considered medically unnecessary.

Coding specifics

There are 2 distinct sets of CPT codes that are used to report in situ hybridization (ISH). While the laboratory methods are similar, the appropriate code set depends on the context in which ISH is performed.

- CPT codes 88271-88291 should be used when the laboratory performs ISH as an ancillary analysis to cytogenetic studies for oncologic or inherited disorders.
- CPT codes 88365–88377 are designated for ISH performed by a pathologist as part of a surgical pathology or cytopathology case. These codes differentiate between qualitative and quantitative methods, including manual versus computer-assisted analysis.

Pathologists must not use codes 88365–88377 when ISH is performed in conjunction with cytogenetic studies.

CPT/HCPS Codes

Code	Description
88271	MOLECULAR CYTOGENETICS; DNA PROBE, EACH (EG, FISH)
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

88291	CYTOGENETICS AND MOLECULAR CYTOGENETICS, INTERPRETATION AND REPORT

ICD-10-CM Codes that Support Medical Necessity

Code	Description
C94.6	Myelodysplastic disease, not elsewhere classified
D46.0	Refractory anemia without ring sideroblasts, so stated
D46.1	Refractory anemia with ring sideroblasts
D46.20	Refractory anemia with excess of blasts, unspecified
D46.21	Refractory anemia with excess of blasts 1
D46.22	Refractory anemia with excess of blasts 2
D46.A	Refractory cytopenia with multilineage dysplasia
D46.B	Refractory cytopenia with multilineage dysplasia and ring sideroblasts
D46.C	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality
D46.Z	Other myelodysplastic syndromes

Documentation requirements
Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

- The diagnostic report should clearly convey:
  - The diagnostic and prognostic relevance of the FISH findings.
  - Whether the results are normal or abnormal, as well as the percentage of abnormal and normal cells.
  - Whether the results are from metaphase or interphase cells or from both.
  - Specific naming of the probes used to obtain results, including the name of the manufacturer, must be included in the written report.
  - Any specific limitations of the assay, some of which may be described in the probe manufacturer's package insert, should be included in the patient report.

Modifiers
Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

Place of Service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

REFERENCES

Billing and Coding: MDS FISH Article A57576

MDS FISH LCD L37772

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim

payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
October 2025	Policy created