APS Update

PATHOLOGY NEWSLETTER

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Documentation Requirements For Add-On Services

Per the 2008 CPT text, the guidelines for an "add-on code" are:

- The service is carried out in addition to the primary procedure performed
- The services are designated as add-on codes by the symbol +
- Add-on codes can be readily identified by specific descriptor nomenclature such as "each additional" or "(List separately in addition to primary procedure)"
- Only applies to procedures or services performed by the same physician
- Cannot be reported as a stand-alone code

Four codes listed in the Surgical Pathology section of CPT are designated as true add-on codes. They are code 88311 for decalcification and special stain codes 88312, 88313 and 88314. These codes can never be reported by themselves on a claim without one of the gross and micro codes, 88302-88309. Codes 88311-88319 and 88329-88372 can also be considered all add-on codes. It would be very rare if one of these would be reported without a gross and micro code. Complete documentation is essential when reporting these additional services as to which CPT code accurately describes the service and helps determine how many units to charge. Here are some tips that may help when reporting additional services:

- For special stains, document which stain was used and its results. This will help determine the purpose of the stain to choose the correct code. It cannot be assumed, for example that iron stores mean the specimen was examined by an iron stain. If multiple specimens are stained, document which specimens the stains were performed on.
- If a special stain did not yield a diagnosis, do not use words like "normal" or "noncontributory." This tends to mean that the service was not medically necessary. Rather "GMS stain negative for H. pylori" or "Iron stores confirmed by Iron stain."
- When reporting immuno stains and in situ hybridization studies, be sure to document whether the approach used was qualitative, quantitative or semi-quantitative and if it was manual or computer-assisted.
- Don't assume when a bone specimen is submitted a decalcification is reported. Document decal in the report. Report code 88311 once per specimen.
- Clearly document for intraoperative consults if the finding was due to a gross only exam (88329). If a microscopic diagnosis is given document if it is based on a frozen section (88331), touch prep (88333) or both (88331/88334).

Proper documentation of add-on services will demonstrate that the service was performed and used to evaluate the specimen or case.

Medicare Fix Short Term

The pending 10% reduction in physician payments that was scheduled for January 1st, 2008 was delayed until July 1, 2008 and replaced with a 0.5% increase. The prospects for an extension of that through the rest of 2008 and, indeed, the prospects of a more lasting reform of the physician payment system took a huge blow with the release of a CMS report indicating that total Medicare expenditures rose by 19% in 2006, largely as a result of the prescription drug benefit.

While the increase was not specifically related to physician payments, it creates an environment in which improvements in payment to any health care provider are highly unlikely. Incentive programs such as PQRI must be considered as other avenues to increase payment, as long as they exist. Even those programs must be considered as potential areas for savings (i.e. elimination of the program) under the Federal Government PAYGO approach.

2008 EDUCATION CALENDAR

Hope to see you there!

Apr 19: Gettysburg, PA
PA Association of Pathologists

May 2-3: Chicago, IL
IL Society of Pathologists

May 3: Plymouth, MI
MI Society of Pathologists

May 3: Columbus, OH
OH Society of Pathologists

May 3: Carmel, IN
IN Association of Pathologists

Jun 28: Chicago, IL
CAP Pathology Practice Management

Sept 25-28: San Diego, CA
CAP '08

Medicare Physician Fee Schedule Fix

As noted previously, the "fix" for physician payment under Medicare enacted in the waning days of 2007 will expire on July 1, 2008 at which time payment will drop by 10.1% across the board. As of this writing, the Senate is working on a bill to match a House bill passed last year to revise the physician payment system by dropping the SGR (sustainable growth rate) formula which calls for drastic reductions in physician payments. The House version breaks physicians into six separate groups based on specialties, with growth targets for each group. Proponents of the revision say this permits a focusing of funding to promote better results. Skeptics note that this breaks a large lobbying group (the AMA) into splinter groups permitting easier passage of reductions in the future.

On a separate track, the Administration has suggested that there be a trigger provision to reduce Medicare payments. The trigger provision calls for payment cuts to all provider types whenever less than 55% of the Medicare outlays are funded by the Medicare payroll taxes (meaning that the general fund revenues necessary to fund the program were higher than desired). The reductions would grow each year until the target was reached. Congress has not seen the trigger provision positively but will take it up for consideration.

Finally, the Administration has reintroduced the adoption of the ICD-10. This would replace the current diagnosis coding system (ICD-9) in use today. There will be a significant cost for providers and carriers to achieve this switch as all claims management systems are designed to work with the ICD-9. The use of ICD-10 outside the United States is now routine resulting in a higher likelihood that the ICD-10 will be required in the future.

APS Medical Billing
5700 Southwyck Blvd.
Toledo, OH 43614
419-866-1804 / 800-288-8325
www.apsmedbill.com

PQRI Lightly Used in 2007

In 2007 only 16% of eligible providers submitted information to the PQRI program. While pathologists were not eligible for the program in 2007 they are able to participate during this year. Industry experts are calling for an increase in the bonuses paid under the program which currently provide for an increase in all Medicare payments to the participating provider of 1.5%. In addition, many of the eligible providers in 2007 cited the fact that the measures were not sufficiently tied to quality in their practices to engender a response. CMS, however, is sticking with the program and looking to encourage greater participation. In terms of pathology it is felt that the current reporting process will be used as a baseline which will ultimately be used to fine tune the program.

Importantly, the continued commitment to the program by CMS is seen as a signal within payer circles that performance measures of some sort will continue to be used and will be expanded in the future.

Coding Corner

In a partial or total nephrectomy can the adrenal gland reported separately?

Whether the kidney submitted is partial or total, neoplastic or non-neoplastic, the correct CPT code to report is 88307. The CPT descriptor states "total" so the kidney would be the only organ reported with code 88307. Some secondary specimens that are chargeable may be the adrenal gland or lymph nodes. Provided there is a distinct pathologic diagnosis, code 88307 can be reported for the adrenal gland.

Is a "LEEP" specimen coded the same as a CONE?

A LEEP can be coded with either code 88305 or 88307 depending if it is a "LEEP" biopsy or a "LEEP" conization. The guidance should come from the surgeon. When billing the surgeon's service, the CPT code would be 57560 (Colposcopy with LEEP biopsy) which would then be a "LEEP" biopsy and reported with 88305. If the CPT code for the procedure is 57461 (Colposcopy with LEEP conization) the pathology service would be reported with code 88307. If two or three separate specimens are submitted be sure to document them appropriately so the correct CPT code can be assigned.