

APS Update

PATHOLOGY NEWSLETTER

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Changes for Reporting CPT Codes 88172 & 88342

As of October 1, 2009 changes were made for the billing of CPT code 88172 (Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen [s]). For non-government carriers no changes were made. The unit of service will continue to be "each" pass evaluated immediately per specimen. A specimen is defined as site, mass or lesion.

What has changed is the unit of service for a Medicare beneficiary. Per the Centers for Medicare and Medicaid Services (CMS), Version 15.3 of the National Correct Coding Initiative (NCCI); the unit of service for CPT code 88172 will now be each separately identified lesion. All "passes" from a single site, mass or lesion will be included in a single unit of service of 88172. This coding and billing policy applies to only Medicare beneficiaries.

Also, per CMS' Correct Coding Initiative; the unit of service for "special" stains (88312-88313) and immunohistochemistry (88342, 88360 and 88361) will be per block. When it is medically necessary and reasonable to perform the same stain on more than one specimen or more than one block of tissue from the same specimen, additional units of service may be reported.

To clarify; a single block will include all multiple levels cut from the same block of tissue stained with the same stain. Documentation will need to support each block. Acceptable documentation would be the name of each different stain used per block/per specimen and results. When IHC stains are performed, document whether the stains are quantitative or semi-quantitative and whether the method is manual vs. computer-assisted. This coding and billing policy applies to all patients, all financial class cases.

Panic, but Calmly

Regardless of your opinion of the direction of the health care system in the United States, the one thing that is certain after last week's passage of the health care reform legislation (and the immediate amendments) is that whether you are ecstatic or massively depressed you are probably overreacting.

As has been discussed in many different venues, the benefits that will be available to the population will be phased in over an extended timeframe, some not occurring until 2018. As a result, the full impact of the bill will not be felt until after the current Congress and administration have had the opportunity to turn over at least once. What is clear is that each of the items in the bill (and in some cases referencing back to the Recovery Act) can have a significant impact on health care diagnosis and treatment, and financing.

Some of the significant changes over the next year which may affect your practice are:

- ◆ Coverage of adult children, through age 26. Many of the "uninsured" are young adults who are trying to go without insurance in order to save money. By providing them with the ability to retain coverage through their parents' policies there will almost certainly be a large number of self pay patients who will suddenly become insured. This is good news for providers and really bad news for insurance companies, and possibly holders of family plan coverage. Simply put, self pay patients will suddenly become insured. Unfortunately for the insurance company, most such insured will come through families that already purchase family coverage and the extension of benefits will be accomplished without additional premiums. Expect some moderate push on family coverage premium levels in order to accommodate this expansion. Luckily for everyone on the insurance front, health care usage levels are nearly the lowest of any age group for the 21-26 crowd.
- ◆ No lifetime dollar limits. Most insurance plans limit the total paid benefits during a lifetime. This change will affect only a few patients since such levels are generally quite high (e.g. \$1,000,000) but for those patients this will be a godsend. These are often the patients who receive total charity care. Expect some reduction in charity write-offs as a result.

2010 EDUCATION CALENDAR Hope to see you there!

May 1-2: Seattle, WA
Pacific NW Society of
Pathologists
WA State Society of Pathologists

May 4-5: Las Vegas, NV
CLMA ThinkLab '10

May 8: Plymouth, MI
MI Society of Pathologists

June 25-27: Key Biscane, FL
FL Society of Pathologists

July 16-18: Vail, CO
CO Society of Clinical
Pathologists

Sep 11: Asheville, NC
SC Society of Pathologists

Sep 26-27: Chicago, IL
CAP 2010

Oct 2: Columbus, OH
OH Society of Pathologists

Dec 1-4: San Francisco, CA
CA Society of Pathologists

Dec 4: Plymouth, MI
MI Society of Pathologists

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- ◆ Several changes are aimed at re-regulating the self funded health care spending (e.g. Flexible spending accounts, MSAs), none of which are expected to have a direct impact on providers.
- ◆ The Medicare doughnut hole will be shrunk, ultimately to zero. This will help seniors afford their prescriptions and may lead to better compliance with drug regimens.
- ◆ Insurance companies will not be able to disenroll the newly ill and will be unable to bar children from insurance due to preexisting conditions. These steps should also help to reduce the rolls of the medically indigent, reducing self pay bad debt and increasing payments for services rendered. Again, these patients tend to be high service users resulting in a disproportionate impact on practice finances.
- ◆ A federal insurance program will be established to help adults with preexisting conditions. Its impact will be similar to that noted above.

So for providers, the outlook is relatively positive. Possibly more patients, definitely more ability for existing patients to move from self pay, bad debt and charity into insured status. Costs to collect accounts should decrease while revenue per account should increase.

If you are an insurance company, this is pretty bad. You have to cover a lot more people for a lot more services and have to do so with a limited ability to raise your premiums. Some of the plans got ahead of the legislation and increased premiums recently, watch for more such press releases. This is very expensive legislation for the insurance companies. Looming in the background are the promised \$500 billion in Medicare payment cuts which are to be used to finance some of these benefits, and the expansion of Medicaid coverage which includes a large unfunded State liability (the federal government provides only partial coverage for Medicaid expenditures).

Any bets about the long term impact of this legislation are probably very premature. The fact is that there are probably very few individuals who have taken the time to read and understand the interrelationships between the many facets of this bill and the actual financing and provision of health care in the United States. After passing the Senate Bill, two separate amendments have been passed and signed by the President. We should expect other amendments to wind their way through the legislative process as the consequences, intended and otherwise, of the reform bill become clear.

Even the Recovery Act will come into play as the comparative effectiveness research, authorized and funded by the Recovery Act will be used in the design of minimum plan coverage standards to be issued by the federal government.

The passage of this legislation is certainly a groundbreaking step, what we don't know as yet is whether this will be the foundation for a great new building, or just a gigantic hole in the ground. The one thing that is certain is that the effect will be small and at the edges for the next year. We will be watching your accounts for the tell tale traces of its impact.

Coding Corner

An appendix labeled “incidental” appendix was submitted along with a hysterectomy specimen. A gross and micro is performed on both specimens. A diagnosis of obliteration of the appendix is given. Would I still be coding the appendix 88302?

When the appendix is submitted alone, typically there is no question whether it is incidental or not. Most often it is of diagnostic interest and CPT code 88304 is reported. Other factors to consider would be the intent of the surgeon, operative procedure or clinical information. The bottom line: if the surgeon “intends” a gross and micro to be performed and it is not part of a primary specimen, report 88304. For an appendix submitted as “incidental” but diagnosed with pathology CPT code 88304 would also apply. As per CPT, code 88302 is only to be assigned to a specimen “when a gross and microscopic exam is performed to confirm identification and the absence of disease.” Therefore, it is not always how the surgeon labels the specimen that determines your code but by the diagnosis rendered.

Are all ovarian cysts reported with 88305?

Assigning both the procedure and diagnosis code for ovarian cysts is based on the pathology report. The examination will fall under one of two CPT codes, 88305 or 88307. Code 88305 is used to describe the work involved in examining a cystic ovary from an oophorectomy (ovary with or without tube, non-neoplastic) or an ovarian cyst from a cystectomy (ovary, biopsy/wedge resection). Code 88307 is for reporting the examination of a neoplastic oophorectomy specimen.

When an ovarian cyst is submitted, determine if it is non-neoplastic or neoplastic cyst. A non-neoplastic cyst such as follicular, corpus luteum or serous cysts is not listed in the CPT book but it is understood to be equivalent to a cervical polyp or an ovarian biopsy and reported with code 88305. A neoplastic cyst such as a serous cystadenoma, dermoid or teratoma is also not listed in the CPT book but it is understood for this specimen to be equivalent to soft tissue tumor (except lipoma), biopsy/simple excision or ovary with or without tube, neoplastic, both are listed specimens and reported with CPT code 88307.

Do you have a coding question or maybe a specimen that you just want clarification on or a comment or coding concern? E-mail it to me at tscheanwald@ucbinc.com and I will provide answers and/or feedback.

PQRI UPDATES

CMS developed the PQRI program in July 2007. It was developed to encourage improved quality of services by physicians. A bonus rate was assigned at that time which has increased to 2% of total Medicare allowed charges for 2010. At this time PQRI is considered a pay-for-reporting system with the intent to go to a pay-for-performance system after 2010. There were changes made to the PQRI for 2010. Some of the key changes are:

- ◆ Introduction of an electronic health record (EHR)-based reporting mechanism.
- ◆ Addition of 30 new individual quality measures.
- ◆ Addition of six new PQRI measures groups;
 - ◆ Coronary Artery Disease;
 - ◆ Heart Failure;
 - ◆ Ischemic Vascular Disease;
 - ◆ Hepatitis C;
 - ◆ Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS);
 - ◆ Community-Acquired Pneumonia
- ◆ Addition of a six-month reporting period for claims-based reporting of individual measures. Starting Jan. 1, 2010, CMS is offering physicians the option of participating for the entire calendar year or for only the last half of the year (July 1 – Dec. 31). If you elect to participate for only half of the year, you must start filing quality codes on July 1, 2010. Your bonus in that instance will be based on your allowed charges captured for the last half of the calendar year, but you must still meet the 80% minimum reporting standard to earn the bonus.
- ◆ Addition of a Group Practice Reporting Option (GPRO).

Pathology became eligible to participate in the PQRI program in January 1, 2008 on two quality indicators. Key guidelines were established to the PQRI codes at that time and these guidelines have not changed.

Some of these are:

- ◆ PQRI will **only** apply to **Breast and Colorectal** cancer cases
- ◆ The allowed CPT codes are:
 - ◆ Breast - **88309 and 88307**
 - ◆ Colorectal - **88309**
- ◆ The allowed ICD-9 codes are:
 - ◆ Breast - 174.0-174.9 and 175.0-175.9
 - ◆ Colorectal - 153.0-153.9, 154.0-154.1 or 154.8
- ◆ The qualifying ICD-9 code must be in the first position on the claim.
- ◆ These cases must have reporting for the pT category, pN category and histologic grade.

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- ◆ The PQRI codes must be submitted at the time the case is submitted.
- ◆ The qualifying PQRI codes are:
 - a) If the pT category (primary tumor), pN category (regional lymph nodes) and histologic grade are documented in the final pathology report, report PQRI code ... **3260F-no modifier**
 - b) If the pT category (primary tumor), pN category (regional lymph nodes) and/or histologic grade are *not* documented in the final pathology report due to a bona fide medical reason (eg, no residual tumor identified), report PQRI code ... **3260F-1P**
 - c) If the pT category (primary tumor), pN category (regional lymph nodes) and histologic grade are *not* documented in the final pathology report and no reason for the omission is evident in the patient record, report PQRI code ... **3260F-8P**
- ◆ Add PQRI to all **breast or colorectal** cases that apply. All carriers.
- ◆ Please be aware there may be instances when the PQRI code may be removed prior to billing if:
 - ◆ The specimen submitted is not a breast or colorectal specimen.
 - ◆ Not an allowed CPT code for specimen submitted.
 - ◆ Not an allowed ICD-9 code.
 - ◆ Staging information is not documented on the report.

Reduction in Michigan Medicaid Reimbursement

The eight percent reduction in Michigan Medicaid reimbursement rates to providers who serve approximately 1.7 million Michigan citizens was approved in the FY 2010 budget – effective 10/1/2009.

The Michigan Department of Community Health (MDCH) had implemented this reduction rate into their CHAMPS system in mid-December. Therefore, claims received by MDCH between October 1st and December 16th must be adjusted by MDCH to pay providers at the reduced rate.

Claim adjustments will be completed by MDCH staff, so physicians and their staff do not have to take any action on claims paid for dates of service on or after October 1, 2009. Adjustments will be reflected as a new paid claim with the new rate and an accompanying negative claim to recover the original rate. The difference between the two will be recovered in future payments.

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