APS Update

PATHOLOGY NEWSLETTER

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ICD-9 Coding Update

Choosing the correct ICD-9 code can sometimes be a difficult task. Failing to assign the correct ICD-9 code may sometimes be a reason for denials. Here are some guidelines to follow that may help in choosing the appropriate ICD-9 code to avoid unwanted denials.

1. Code to the highest level of Certainty – This would be reporting the final diagnosis when one is provided. If the physician can't determine a definitive diagnosis or the specimen is "normal," report the patient's signs or symptoms to support medical necessity.
2. Be as specific as possible – The code assigned should be the most precise code for the service. If a fourth or fifth digit is required, this needs to be assigned for a complete diagnosis.
3. Never use "rule out," "suspect," "probable," etc. This is assigning the patient an unconfirmed diagnosis.
4. Assign "V" codes when applicable. This provides additional clinical information to the carrier. Most "V" codes are secondary codes, but on occasion a "V" code is primary. For example, an elective sterilization.

October will be here before you know it, which means it will be time for the annual update for ICD-9-CM codes. For 2011 there are more then 130 proposed new codes along with the revised and deleted diagnosis codes. Changes are expected to be made to transfusion reaction codes with fevers, transfusion-associated hemochromatosis, as well as expanding thrombocytopenia codes. These changes become effective October 1, 2010. Remember, there is no longer a grace period to implement these new and changed ICD-9 codes. If using an incorrect diagnosis code after October 1st it will likely result in a denial.

For those who are beginning to consider the impact of switching to the ICD-10 codes in October, 2013 please realize that the time is rapidly passing by. At APS we have completed the programming necessary to accommodate the new ICD-10 codes. Since previous conversions of billing data and formats have been accompanied by widespread confusion amongst payers about the date to convert and the types of billing supported by their systems, APS has developed the ability to work with either ICD-9 or ICD-10 codes as necessary.

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If we receive ICD-9 codes and the payer requires ICD-10 codes to be submitted we have the crosswalk to convert the 9s into 10s. Similarly, if a practice site has converted to ICD-10 but the payer cannot yet accommodate the new codes we can backstep the process to submit with ICD-9 codes.

While we are ready to ensure that our clients do not incur substantial cash flow difficulties as a result of the ICD-9/10 conversion process we cannot guarantee that all payers will be as diligent about ensuring that their processes can meet the deadlines that are fast approaching.

Refunds to Medicare & Medicaid

As part of the Patient Protection and Affordable Care Act (the health reform legislation which will start being referred to as the PPACA) deadlines for the refunding of overpayments from Medicare and Medicaid were established. The provisions, which were not readily apparent in the legislation, call for refunds to be made to the paying organization (e.g. the state, carrier, government contractor, etc.) within 60 days of "identifying the overpayment."

The legislation is not clear as to what actually encompasses identification of an overpayment. From an operational standpoint it would be difficult to refund any amounts unless the actual overpayment is quantified, which means that each credit balance account would have to be researched and verified as to the amount that is due back to the payer. Since this remains an open issue, regulations defining the initiation of the 60 day period are likely to be issued to clarify the situation.

In the meantime, providers are encouraged to assume that the 60 day time limit became effective as of March 23, 2010 (the effective date of PPACA), investigate all potential refund situations to ensure that any potential liabilities are identified and research any Medicare or Medicaid program payers as to their refund or take back policies to ensure that refunds can be made within the 60 day timeframe. Finally, we will be on the lookout for any clarifying regulations.

PECOS

Those of you who were keeping track noticed that a new claim submission guideline went into place on July 6, 2010. Providers are now required to submit PECOS numbers for referring/ ordering physicians. Originally, PECOS enrollment was required only for ordering DME and related services. As in all such programs, however, the requirement to participate in PECOS (the Provider Enrollment Chain Ownership System, not a Wild West movie) has grown and mutated over time.

The first version of PECOS was only for ordering DME and was to be completed by January 4, 2010. Never fear, a delay until April 5, 2010 was forthcoming and then another delay until January 3, 2011 to accommodate the addition of the referring doctor's PECOS number for all referred/ordered diagnostic tests.

With a great deal of grumbling, most doctors began the process of obtaining their PECOS numbers at that point. This really wouldn't be worth an article except for one small bump in the road. The health reform legislation including a minor adjustment to the effective date of the PECOS number denial process: *July 6, 2010*. This broke all the rules as deadline changes almost always move later not earlier.

As those experienced with such projects expected, the PECOS system could not handle the increased number of applicants and, as a result, the denial of claims due to missing PECOS numbers did not begin in July and is indefinitely delayed (the AMA asked for the old date of January 3, 2011).

In any event, APS has gone out to the PECOS system and obtained referring physician information for all of our client practices to ensure that, once the indefinite hold on denials for missing PECOS information is removed, client invoices will be paid.

"Special" Stain/IHC Reminder

Per Centers for Medicare and Medicaid Services (CMS), Version 15.3 of the National Correct Coding Initiative (NCCI); the unit of service for "special" stains (88312-88313) and immunohistochemistry (88342, 88360 and 88361) is now 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 includes 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. If an IHC stain is performed, document whether quantitative or semi-quantitative and the method, manual vs computer-assisted. As this differs from AMA and CAP's position the CMS coding policy of coding per block is felt to more accurately track the technical costs and physician's time.

Filing Appeals to CMS

CMS has changed the dollar limits for appeals of carrier or MAC decisions requiring an administrative law judge or federal district court review effective for claims filed on or after January 1, 2010. In typical Medicare fashion, this change was included in the Change Request 6894 of May 7, 2010. The administrative law judge dispute limit increases from $120 to $130 and the federal district court dispute limit increases from $1,220 to $1,260. In both cases, the dispute amounts refer only to differences in disputed payment treatment. That means that if you think that payment on a claim should have been $90 and the payment was $60 the dispute is $30. This is very important in determining the size of disputes in bundling cases.

Such changes have become an annual event beginning in 2005 when the limits were to be adjusted to "reflect the percentage increase in the medical care component of the consumer price index for all urban consumers for July 2003 to the July preceding the year involved." Interestingly, payments to physicians have not kept pace with this increase therefore meaning that more and more claims no longer meet the threshold for either review level. One need only compare the typical professional payment for an 88305 with these limits to see that most professional pathology cases will not meet the threshold.

In order to partially meet provider complaints as to the inability to keep pace with the thresholds, claims may be aggregated to meet the dollar thresholds as long as they reflect similar services or similar issues of law and fact.

Recent activity by newly minted MACs (the combined Part A/Part B administrators in different regions of the country) have shown that we can expect more "innovative" activity such as the recent decision by one MAC to consider FISH experimental except in certain breast and bladder cancers or the relegation of IHC to the "medically unnecessary" bucket for all non-cancer diagnoses by another (which was subsequently dropped). In cases such as these, the administrative law judge and court review processes gave providers the opportunity to address capricious Medicare administrator decisions. Since these processes could take 360 to 480 days to complete, the relief was certainly delayed. With the continued increase in the limits, even this relief is less feasible.

2010 EDUCATION CALENDAR

Hope to see you there!

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

Sep 11: Asheville, NC
SC Society of Pathologists

Sep 11-12: Portland, OR
Pacific NW Society of Pathologists

Sep 26-27: Chicago, IL
CAP 2010

Oct 2: Columbus, OH
OH Society of Pathologists

Nov 6: Seattle, WA
WA State Society of Pathologists

Nov 20: Holmdel, NJ
NJ Society of Pathologists

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

Dec 4: Plymouth, MI
MI Society of Pathologists

Billing as a Non-Participating Provider in IL

Pathology, as a hospital based specialty, has often occupied a very odd position within the "participating provider" process. Unlike most specialists who see a patient and have the opportunity to assess their own participation status prior to diagnosing and treating the patient, the pathologist only knows of the patient's service when they are presented with clinical results or tissue to examine. This leads to terrible confusion for the patient who typically does not understand who the pathologist is or what they did with respect to the care they received; and for their insurance company which often doesn't understand how the pathologist came to be involved in the care or why they aren't in network.

That the insurance companies don't understand the pathologist or their role in the care and treatment of patients, is the result of several "educational" sessions that APS has had with insurance companies over the years as a prelude to negotiating participating provider agreements. There is a reason that most insurances provide pathologists with contracts which specifically call for the pathologists' admitting privileges and office hours despite the fact that such items are irrelevant to the practice of pathology in a hospital setting.

After many patient complaints to the government in Illinois there is a movement to regulate the payment of hospital based physician claims for non-participating providers. While still at a relatively early stage and subject to (one hopes) change, the provisions of the current draft shed some light on what may be the kind of processes that we can expect as commercial insurances come into a more regulated environment.

The first suggestion was to limit payment on such claims to some "fair and equitable" level. The level suggested was 125% of Medicare payments. While "fair and equitable" perhaps in some areas, this is well below the rate that is typically accepted for participating agreements in Illinois let alone non-participating service payments. As a response to that, the suggestion was just limit the patient payment to that which they would have paid under a participating agreement and have the insurance company pay the rest of the charge. The insurance companies rightly pointed out that there would be no incentive for any hospital based physician to contract under such a process. They were, of course, correct.

The current draft of the process reads that upon the receipt of an invoice from a non-participating hospital-based physician provider, an insurance company has three options. In all three options the patient payment is to be limited to that which would have been required if the provider were participating. First, the insurance company can pay the claim based on charges. Second, if they do not intend to pay such a claim on charges they can work out an individual claim level agreement with the provider. Finally, if they cannot work out an individual claim level agreement they can file, within the first 30 days of the process, a request for arbitration.

At this stage each party would present their requested level of payment and a justification for their position. Arbitration carries with it a whole host of questions and concerns stemming from the documentation required, the expertise of the arbitrators and the potential abuse of the system.

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This regulation will continue to be debated in the months to come. It will be watched with great interest by those looking for signals as to future trends in reimbursement. Experiments of this type, if successful, are highly likely to be given wider distribution as a result of the health reform legislation currently in implementation.

Coding Corner

If we received four blocks for four skin specimens during a surgery, do we report 88331x1 and 88332x3?

If the four specimens are separately identified specimens submitted for gross and micro exam you would report 88331x4. Code 88331 is reported for the first tissue block from each separately identified specimen submitted. If you had only one skin specimen with four blocks for frozen section then 88331x1 and 88332x3 would be the correct reporting, as code 88332 is to be reported for each additional frozen section block from one specimen. Coding incorrectly for this service could be lost revenue. Ohio Medicare will reimburse $59.97 for CPT 88331-26 and $29.67 for 88332-26.

Uterus, tubes and ovaries are submitted to pathology with clinical information of prolapse. After the gross and micro exam a malignancy is found. What ICD-9 code do we report for the pathology services?

Following The ICD-9-CM Official Guidelines, the principle diagnosis to report for the technical and professional components for pathology services is the pathologists' final diagnosis. So reporting the ICD-9 code for the malignancy would be the correct choice. Also consider that a diagnosis code can affect a pathology procedure code in some situations. As uterus, tubes and ovaries for prolapse, per CPT, is reported with code 88305. When a diagnosis of malignancy is reported, the correct procedure code to report for the specimen would be 88309.

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.