APS Update

PATHOLOGY NEWSLETTER

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Physician Quality Reporting Initiative

PQRI (Physician Quality Reporting Initiative) is the "pay-for -reporting" voluntary program implemented by CMS to collect information about treatment of certain conditions. For 2008 this includes specific breast and colorectal pathology services. For participating providers, when appropriate codes are submitted in 80% of the eligible cases, a lump sum payment of 1.5% of the total Medicare allowed amounts for services will be given. PQRI criteria follow:

Breast tissue specimens following resection
⇒CPT codes - 88307 or 88309
⇒ICD-9 codes -174.0-174.9, 175.0 or 175.9
⇒pT category and pN category with histologic grade

Colorectal tissue specimens following resection
⇒CPT code - 88309
⇒ICD-9 codes -153.0-153.9, 154.0, 154.1, 154.8
⇒pT category and pN category with histologic grade

If all requirements are met, the three qualifying codes and applicable modifiers are:

a) If the pT category (primary tumor), pN category (regional lymph nodes) and/or 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.**

Comprehensive information and educational materials are available from CMS on the PQRI web page: www.cms.hhs.gov/pqri.

If you are interested in participating in this program please contact your client representative or call (419) 866-1804 or (800) 288-8325 for further information.

Modifier Change in 2008

Modifier 59 (Distinct Procedural Service) is commonly used in reporting pathology services to over-ride the bundling edits of the Correct Coding Initiative (CCI) by stating that an additional service was provided and, therefore, eligible for billing. Examples of this would include a separate session, distinct anatomic site or a separate lesion. Medicare and other carriers feel that this modifier has been overused by providers to bypass bundling edits inappropriately. In response, CPT has revised modifier 59's descriptor effective January 1, 2008 to specifically require that the multiple procedures involve a separate session or distinct service: "Documentation *must* support when the service provided is a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual."

2008 EDUCATION CALENDAR

Hope to see you there!

Feb 2: Columbus, OH
OH Society of Pathologists

Feb 15-17: Orlando, FL
FL Society of Pathologists

Mar 3-5: Denver, CO
US & Canadian Academy of Pathology

Mar 13-14: Scottsdale, AZ
American Pathology Foundation

Mar 30-Apr 1: Atlanta, GA
CLMA ThinkLab '08

Apr 19: Gettysburg, PA
PA Association of Pathologists

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

Jun 28: Chicago, IL
CAP Pathology Practice Management

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

Medicare Fix Short Term

The pending 10% reduction in physician payments that was scheduled for January 1st, 2008 has been 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 (see article on Page 1) 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.

Stark Changes Deferred, Anti-Markup Enacted

The Centers for Medicare & Medicaid Services (CMS) have initiated changes in the structure of payments for organizations which purchase diagnostic services. In essence, all technical and professional services provided through an "outside supplier" (a non-employee without a reassignment of benefits) have payment limited to the cost to the billing party.

In addition, the regulations alter the definition of "in office" to mean within the medical office space used by the group to furnish "substantially the full range of patient care services that the physician organization provides generally." Services provided outside that area, even though owned by the group, etc., are to be considered provided by an "outside provider" and payment limited to the net cost of the service which may not include overhead.

As can be seen, the effect of these items is to eliminate the ability of most physician practices, without appropriate excess office space, to take advantage of the in office ancillary exclusion. There are indications that CMS may revise some of these provisions to permit some more latitude for the practice to perform its own ancillary services, but there is no date indicated for such clarifications to be issued.

Coding Corner

Q. With Gastric Bypass becoming more popular today, sometimes we receive a small section of intestinal tissue from that surgery. How do we code for that specimen, with CPT code 88305 or 88307?

A. Gastric Bypass tissue is not a specifically-listed specimen per CPT. But technically it is not an unlisted specimen either; it is a segment of small intestine. Per the AMA's CPT's Informational Service, "There is not a problem using code 88307 to account for small intestinal resections for gastric bypass" but it did recommend that a short segment (3-4 centimeters) would most likely only warrant reporting code 88305 based on the work. Therefore, coding appropriately for this type of specimen will likely have to be done on an individual case basis, depending on the specimen size, number of blocks and any other factors. Remember to document appropriately to support the charge.

Q. If the total Prostate gland is submitted in two or so large pieces, can CPT code 88309 be reported?

A. No. To report code 88309 (Prostate, radical resection), it must include the prostate gland, capsule, seminal vesicles and the bladder neck margin. If it does not, CPT code 88307 (Prostate, except radical resection) would be coded. Lymph nodes are not part of a subtotal prostatectomy. Thus, each lymph node biopsy and/or regional resection that is separately identified and diagnosed can be coded separately.

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