APS Update

PATHOLOGY NEWSLETTER

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New Direct Billing Legislation

Ohio recently joined a long list of states with direct billing provisions for pathologist services. In essence these laws, although they differ in some details, call for pathologists to bill insurance carriers directly for the services they provide. In many cases, referring physicians have contacted pathologists and requested that the pathologists bill them rather than the insurance for services provided to the referring physicians patients. The referring physician usually asks for a discount on those services to reflect the cost that the referring practice will incur to pursue insurance payment and to accept the malpractice risk of being the legal provider of the service.

The growth of this practice, however, came when referring physicians noted that such discounts permitted a reasonable profit on the service and therefore became more than a convenience for their patients but rather a profit center for their practice. The direct billing provisions that have been enacted attempt to remove the profit incentive for the referring practice and return the "profit" of the service to the professional providing the service.

In addition, Ohio also enacted legislation calling for reforms in the physician-insurer relationship to improve the atmosphere for physicians in the state. This legislation has precursors in other states as well. Specifically, the Ohio statute calls for the provision of fee schedules to be used by the insurer in processing claims, the identification of network access agreements which permit insurers to sell access to their networks to other insurance companies (the process used by silent PPOs), improvements in the credentialing process to permit providers to fill out one form that all insurances will use and that any credentialing process would take only 90 days to complete.

Each state has its own regulations in these two areas and knowing and using these to your practice's advantage is crucial to your success in business and insurer relations.

2009 EDUCATION CALENDAR

Hope to see you there!

Feb 7: Columbus, OH
OH Society of Pathologists

Feb 7: Seattle, WA
WA State Society of Pathologists

Feb 13-15: Orlando, FL
FL Society of Pathologists

Mar 9-11: Boston, MA
US & Canadian Academy of Pathology

Mar 12-13: Las Vegas, NV
American Pathology Foundation

Apr 17-18: Harrisburg, PA
PA Association of Pathologists

May 2-5: Tampa, FL
CLMA ThinkLab '09

New "G" Codes For Prostate Saturation Biopsies

Effective January 1, 2009, CMS has implemented four new HCPCS codes. They are "G" codes and are to be used to report Prostate Saturation biopsies when submitted for gross and microscopic evaluation. This type of a procedure can produce from 1-60 biopsies. The four new codes are:

- G0416 - Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1-20 specimens
- G0417 - Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21-40 specimens
- G0418 - Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41-60 specimens
- G0419 - Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens

Only Medicare patients having Prostate Saturation biopsies (Surgical CPT code 55706) submitted will be assigned a "G" code. All other prostate biopsies will be reported with CPT code 88305 (Surgical pathology, gross and microscopic examination; prostate, needle biopsy), such as needle biopsies and TUR (Transurethral resection). Even though prostate saturation biopsies could be differentiated by the number of specimens submitted, the only way to guarantee the coding of prostate biopsies accurately will be by the surgical procedure code.

For additional information on the new HCPCS codes, go to www.apsmedbill.com, click on News/Events, Newsletters, Pathology.

ICD-10 Update

The Department of Health and Human Services (HHS), with the approval from the Office of Management and Budget (OMB), finalized and approved the ruling on the implementation date for ICD-10-CM to October 1, 2013. The proposed date had been October 1, 2011. October 1, 2013 is a firm date. ICD-9-CM codes will not be able to be used to report services after this date. The additional two years is allowing everyone the appropriate time to train coders, physicians and auxiliary personnel as well as update or install new systems. There will be crosswalks, mapping and guidelines made available that will help entities move from ICD-9-CM to ICD-10-CM to avoid from having to maintain the capacity to work with both coding systems on and after this date.

There will be two websites that will provide a mapping program through this process. They are:

Centers for Disease Control Web page:
www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm
CMS Web page:
www.cms.hhs.gov/ICD10/02_ICD-10-PCS.asp

Medical Necessity Denials for IHC Stain

Beginning September, 2008, pathology practices in California and Nevada began receiving Medicare denials on IHC codes for non-cancer diagnoses. All such services were being denied. It was determined that the denials were the result of a local medical review policy decision limiting the number of IHCs done in cases involving cancer. APS immediately began investigating the situation and began requesting explanations of the denials since the written policy did not address non-cancer cases. As a result of such requests, the contractor (Palmetto, which recently began performing MAC functions in the area), has indicated that the policy was incorrectly implemented and that those denials are to be reversed upon resubmission of the claims.

In this time of rapid change in Medicare administrative functions, especially with the addition of MACs in place of carriers and intermediaries, the disruptions caused by the RACs, etc. it becomes even more important to watch denials for inadvertent errors by the administrators of your claims. We have found commercial carriers to be more than capable of errors in processing claims and should not be surprised when it happens with our governmental payers as well. If you have any questions please contact us.

Coding Corner

Is an excisional breast specimen inked for possible malignancy in the gross description, but has a final diagnosis of benign breast tissue, reported with CPT code 88305 or 88307?

Per CPT codes 88305 and 88307 for breast specimens are defined as either with margin evaluation (88307) or without margin evaluation (88305). Margins that are documented as "inked" in the gross description do not always mean that the margins will be evaluated. If they are reviewed and commented in the micro exam or the final diagnosis, report 88307. For cases where margins are not reviewed, report 88305. Final diagnoses, whether benign or malignant, do not affect the code choice.

Are all Ovarian cysts reported with 88305?

Assigning both the procedure and diagnosis code for ovarian cysts is to be 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 or soft tissue tumor (except lipoma), biopsy/simple excision.

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.