

# APS Update

## PATHOLOGY NEWSLETTER

Volume 8 June 2011 Issue 2

### Coding for Bone Specimens

By Jan Toczynski, CPC, CCP

In the gross and microscopic section (CPT codes 88304-88309) of the CPT 2011 text, there are eight bone specimens listed. The listed specimens are:

- 88304 - Bone fragment(s), other than pathologic fracture
- 88304 - Femoral head, other than fracture
- 88305 - Bone exostosis
- 88305 - Femoral head, fracture
- 88305 - Joint, resection
- 88307 - Bone-biopsy/curettings
- 88307 - Bone fragment(s), pathologic fracture
- 88309 - Bone resection

Bone fragments have two choices. There are fragments submitted for fracture due to weakening of bone due to disease, such as neoplasm or osteomyelitis which is reported with code 88307. If they are bone fragments submitted due to trauma or shavings for repair, report 88304. Typically, soft tissue and cartilage may be attached or included and cannot be separately reported. Check the clinical information and specimen submitted to be sure you have chosen the most accurate code. For example, if the bone fragments are from a knee and include soft tissue and synovium, it could describe a joint resection and be more accurately reported as 88305.

Femoral head also has two specific choices, code 88304 and 88305. Both codes are specifically for the femoral head and only that, and secondly either for fracture or other than for fracture. So if the acetabulum is included with a femoral head without fracture, the specimen could equate to a joint resection code 88305. If a significant portion of the neck of the femur is included with the femoral head it could be reported as 88309, bone resection. The code choice will not change if the femoral head is submitted in fragments or pieces. This will also apply to a knee joint resection.

Bone biopsy should be straightforward. They are reported with CPT code 88307. Keywords such as biopsy and/or curettings in the final diagnosis should be used to prevent coding errors. Bone exostosis is a listed specimen in CPT and reported with code 88305. As osteochondroma is considered a type of exostosis, it would also be reported with 88305. A bone resection whether submitted in fragments and/or pieces or intact is reported with code 88309 if the intent of the surgery was a resection.

(cont.)

(Bone Specimens continued)

Most bone specimens will require decalcification. Report the appropriate documentation and report code 88311. Code 88311 is reported once per specimen. If additional studies are performed, document and report for each add-on service that's medically necessary.

### Commercial Carriers Continue to Pay Claims Incorrectly

By Matt Zaborski, Regional Account Executive

History has shown that insurance companies make mistakes when processing claims. These errors almost always result in underpayments to physician practices. In fact, the AMA recently completed a study of carrier payment patterns (The National Health Insurer Report Card, 2010) and found that accuracy in claims processing only reaches an average of 84% for commercial plans. This means that 1 in every 6 line items on a claim is paid incorrectly. Even Medicare, with fee schedules that do not vary from provider to provider, still underpays 1 in 25 line items. This study is further proof that practices who fail to verify that every account is paid at contracted rates are certainly leaving money on the table.

APS continues to verify that every account is paid correctly for each client in real time, thanks to our proprietary contract management system. All incorrect payments are flagged, a specialist is notified and underpayments are collected. Please contact your account representative with any questions.

### 2011 EDUCATION CALENDAR Hope to see you there!

June 5: Costa Mesa, CA  
CA Tumor Tissue Registry

June 18: Versailles, KY  
KY Society of Pathologists

July 8-10: Key Biscayne, FL  
FL Society of Pathologists

July 15-17: Vail, CO  
CO Society of Clinical Pathologists

Sept 11-12: Grapevine, TX  
CAP '11

Sept 16-18: Asheville, NC  
SC Society of Pathologists

Oct 19-22: Las Vegas, NV  
American Society for Clinical Pathology

Dec 3: Plymouth, MI  
MI Society of Pathologists

## State of Indiana Legislation Update

By Tim Mousseau, Director of Revenue

HB 1071 is now a part of the Indiana State Code effective July 1, 2011. The act was signed by the governor on May 13, 2011. This bill requires direct billing for pathology services.

Direct billing legislation (HB 1071) protects Indiana patients against "markup" charges by prohibiting an ordering physician from billing patients for anatomic pathology services (e.g. Pap test and biopsies) performed or supervised by another physician.

Since 1984, Medicare has required direct billing for Pathology services, as does Indiana Medicaid.

HB 1071 is consistent with the American Medical Association's (AMA) billing and coding guidance and ethics policy that states: "When services are provided by more than one physician, each physician should submit his or her own bill to the patient and be compensated separately, if possible. A physician should not charge a markup, commission or profit on the services rendered by others." To read the bill in its entirety; please visit the following link:

<http://www.in.gov/legislative/bills/2011/IN/IN1071.1.html>

## APS Reporting Update

By Tim Mousseau, Director of Revenue

As APS continues to meet the demand for paperless, 24/7 reporting access for our clients; we urge you to visit our online reporting web site at <https://onlinereports.apsmmedbill.com> to see our latest reporting enhancements. Not signed up yet? Please contact your assigned Account Representative or Account Manager to get the latest paperless, 24/7 reporting access.

Just think of the ability to view your practice's monthly financials anytime and anywhere that you have internet access; all the while saving paper in the process . . . GO GREEN!

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# Coding Corner

By Jan Toczynski, CPC, CCP

**If we are consulting on slides from an outside facility and prepare additional H&E slides plus "special" stains, can we report for them?**

When you consult on slides from an outside facility they may include slides that involve routine, "special" or IHC stains. If the referring lab prepared the slides, do not report the stain code in addition to the consultation code. But if you prepared H&E and stained slides, report code 88323 (consultation and report on referred material requiring preparation of slides) for the consultation plus the appropriate stain code.

**There are many times when we receive an FNA specimen we receive anywhere from 15-20 slides. Can we report 88162?**

Code 88162 (cytopathology smears any other source; extended study involving over 5 slides and/or multiple stains) cannot be reported when your specimen source is an FNA. "Any other source" is defined as specimens that are not cervical or vaginal, not fluids, washings or brushings or FNA's. A cytology code is chosen based on the specimen source and the method of preparation for the source. As this is an FNA specimen, code 88173 would be the appropriate code to report. Code 88173 includes interpretation and report and all slides reviewed.

## **Looming Deadline for ANSI 5010 Causes Concerns APS First in Nation to Pass Anthem Testing**

*By Matt Ward, Regional Director of Business Development*

As of this coming January, all providers who submit electronic claims will have to conform to the version 5010 electronic administrative standard transaction format. There are several changes, none of which seem dramatic (e.g. the place of service cannot be a PO Box) but the effect on your cash flow of an inadequately planned transition can be tremendous. Take the example mentioned above; if you have changed the place of service to correctly identify the street address of the place of service and maintain your PO Box as the remittance address, but have not communicated the change to payers, your claims may not be honored as many use the place of service address as a confirming data element to identify your claims. In essence, in complying with ANSI 5010 requirements, you have changed your address and that requires a whole set of credentialing activity as well.

In recent meetings questions have been posed to providers as to whether they are ready for this change. Roughly 2% have indicated that they are ready with only 7 months before the mandated deadline. The January 1, 2012 deadline is merely the last day for the switch, many carriers and all Medicare carriers/MACs are ready to accept ANSI 5010 transaction format claims now.

As in any such change, many carriers may not be completely ready or may require additional activities, such as the credentialing mentioned above, on the part of providers to ensure that claims are able to be received and processed. APS has been actively addressing this transition for our clients and has completed all the necessary internal programming necessary. We have also been actively working with payers to ensure that our clients' claims can be submitted and will be honored to avoid any delays in payment due to programming issues on the payer side. As part of that effort we were pleased to hear from Anthem Blue Cross and Blue Shield that APS was the first organization to successfully test an ANSI 5010 claims submission with them.

This is just part of APS' determination to ensure that regulatory changes in the business of health care do not go unaddressed. With only 2% of providers actively addressing this change it is clear that there will be many who are unready for the change and experiencing cash flow shortages. Our clients will be ready. If you have questions about the ANSI 5010 transition please feel free to call your practice manager or client representative. If you are not an APS client and have concerns about this transition, please feel free to contact Tom Scheanwald at (800) 288-8325.

## **Update on CPT 88363 Clarification on Coding for this Service**

*By Holly Wolford, CPC*

To use this code, the pathologist must identify and select "appropriate tumor tissue from a previous surgical specimen," according to CPT Changes 2011- An Insider's View.

- ⇒ The identification and selection is critical for the success of the subsequent molecular analysis studies.
- ⇒ The pathologist must exercise medical judgment in selecting the archived tissue for the analysis studies in order to charge 88363.
- ⇒ The pathologist may also review the initial report and initiate any necessary block or slide preparation of this chosen tissue to forward for molecular testing.
- ⇒ 88363 can be used whether an in-house lab or outside reference lab is going to perform the molecular study.

88363 can be used when the pathologist selects archive tissue for "molecular analysis" which includes a wide range of codes.

- ⇒ KRAS is listed in parenthesis in CPT which indicates that KRAS is only an example.
- ⇒ Any molecular test that is described by codes in the 83890 -83914 range (Molecular diagnostics) would qualify for 88363.
- ⇒ Although the pathologist may be able to use 88363 for archive specimens that have been selected for tests such as molecular cytogenetics (88271-88275) & In situ hybridization (such as 88365), CPT does not provide specific direction on this matter.

Use 88363 for 'Signed Out' cases.

- ⇒ The number of days between the original case & the 88363 service is not the key factor in determining if it's appropriate to use 88363. Don't confuse CPT's use of the term "archival tissue(s)" with Medicare's definition of "archived specimen."
- ⇒ The case is "archival" when the pathologist has released the case report and sent the slides/tissues to be stored. That means 88363 should not be used when the pathologist or treating physician decides to prep tissue for molecular test (such as KRAS), before the pathologist completes the primary case and signs it out.

88363 should not be reported with TC or 26 modifiers.

- ⇒ The Medicare physician fee schedule doesn't allow modifiers TC & 26, but will provide a higher payment rate for non-facility (non-hospital patients) vs. facility (hospital patient). The payment difference represents the tech component of the service, such as sectioning the blocks. Medicare's OPPS APC fee schedule lists a payment rate for 88363, which accounts for the tech work the hospital provides for the service for an outpatient.
- ⇒ When an independent lab supports the pathologist's work & reports 88363 with place of service 11 or 81 on the CMS-1500 form, the lab will receive the higher non-facility payment.
- ⇒ A hospital that's due payment for the technical support of the pathologist's 88363 work will be paid by the OPPS APC fee schedule upon filing with its Part A contractor.