APS Update

PATHOLOGY NEWSLETTER

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CPT CODES: 88387 and 88388

New codes 88387 and 88388 for 2010 were established to report the sterile macroscopic dissection performed prior to ancillary diagnostic testing applicable to molecular studies.

88387-Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (e.g., nucleic acid-based molecular studies); each tissue preparation (e.g., a single lymph node)
> (Do not report 88387 for tissue preparation for microbiologic cultures or flow cytometric studies) <
> (**Do not** report 88387 in conjunction with 88388, 88329-88334) <
+88388-...........in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (e.g., a single lymph node). (List separately in addition to code for primary procedure)
> (**Use** 88388 in conjunction with 88329-88334) <
> (Do not report 88387 or 88388 for tissue preparation for microbiologic cultures or flow cytometric studies) <

The medical report must have documentation to support the pre-analytic work performed. It should have its own separate area on the report and should include:

- The pre-analytic work that was performed
- Description of the examination
- Dissection that was performed
- The precautions taken to avoid contamination
- The molecular analysis anticipated
- Example: "A sentinel node is received for complex macro exam and dissection. At a sterile workstation and with sterile equipment to avoid contamination a 2.5 node is identified in the fatty tissue and dissected. Thin sections are cut to submit for XXX testing, labeled and packed for shipping to XXX Lab. The remaining is frozen and submitted in one block. Frozen section is examined and findings are provided to the surgeon in the OR."

Codes 88387 and 88388 are reported once for "each tissue preparation." If two separately identified sentinel nodes are submitted and a separate prep performed on each for molecular testing report 88387 or 88388 times two.

RAC Refund Demands Have Begun

As readers of this newsletter know, the Recovery Audit Contractor program of Medicare has become a nationwide process as a result of the success of the program in finding incorrect payments by CMS for patient services. Contracts were issued to four companies in specific geographic regions to audit claims throughout the country to find and reverse overpayments by Medicare. We have obtained and reviewed each company's workplan and understand their specific target case types. Although each of these companies may focus on different types of providers and conditions we expect to see refund demands from all of them. Their range includes claims for dates of service extending from October, 2007 through current dates of service.

The RAC program has presumptive authority, meaning that a refund must be made if demanded even if, upon appeal, the demand is found to be incorrect. APS has established a process whereby such demands are honored and the cases reviewed immediately to determine if they are appeal-able. Appeals and the documentation supporting them must be submitted within strict and demanding timelines in order to meet the criteria for acceptance. Such appeals are very important since one aspect of the RAC program is the ability of the RAC to extrapolate the results of their initial audits to a provider's entire business based on the results of the initial sampling.

As a result, our staff may need to contact you for additional information concerning services provided for patients which have been challenged through this program. Given the potential substantial nature of the impact of an unappealed refund demand we are asking for prompt attention to such requests.

2010 EDUCATION CALENDAR

Hope to see you there!

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

ICD-9 UPDATE

ICD-9 is updated annually with new, revised and deleted diagnosis codes. For 2011 there again will be new, revised and deleted codes. These changes became effective October 1, 2010. Remember, in keeping with HIPAA regulations, there is no longer a grace period to implement these new and changed ICD-9 codes.

Per CMS going forward for 2012, the ICD-9-CM Coordination and Maintenance Committee has put a freeze on new ICD-9 and ICD-10 codes except for updates for new technology or diseases. For 2013 there will be no updates to ICD-9 as ICD-9 will no longer be used for reporting purposes and for ICD-10 again only limited updates for new technology and diseases. October 1, 2014 regular updates will begin for ICD-10.

The Election and Prospects for a Physician Pay Fix

Have you factored in the potential reduction in physician payments from Medicare beginning on 12/1/2010? As things now stand, the delay in the SGR mechanism that would reduce payments for physicians by 23% ends on November 30. If Congress does not act to delay or repeal the SGR this cut will go into place as well as a separate cut of 6% on January 1st.

Given the large gains by Republicans in the House of Representatives it is unlikely that a fix of this type would come without a way to pay for the higher payments required. Some GOP staffers have suggested that they can get the savings by restructuring or repealing the reform package but that will have to pass by a Democratic Senate and President in order to happen. It is not likely that such a scenario will work. There will be a lot of groups working to make a delay possible but it is hard to see how the results of the election will make it any easier to get the SGR fix that doctors have been looking for over the past several years.

United Healthcare Out of Network Class Action Suit

As many of our clients are aware, a settlement was reached with United Healthcare in a class action suit over their misuse of the Ingenix database to "set" payment rates for non-participating providers between 1994 and 2009. In essence, United used the database in an inappropriate way to lower the payments made to out of network providers for covered services and then covered over its use of the data in its communications with providers and patients.

A fund of $350 million has been established to permit payment of claims in this matter. The total fund includes sufficient monies to pay between 50 and 90% of the amounts that payments were reduced. The suit calls for claims to be filed in specific phases. APS has filed information on behalf of all of our qualifying clients for the first phase of the claim. This phase of the process is used to qualify providers for reimbursement under the class. In the second phase, claim data will be provided to validate and quantify the claim against the settlement fund.

For those clients who have been with APS throughout this period we will handle all of the filings necessary. If your practice used another biller during this period it may be necessary to get information from the previous biller to ensure that all of the potential reimbursement against the claim is obtained. We will be in contact with you to see if this information can be obtained.

IHC "COCKTAILS"

What is an IHC "antibody cocktail?" An "antibody cocktail" is a single stain that contains multiple histochemical antibodies. Some examples of different cocktails would be "racemase" (p63/ AMCAR), melanoma cocktail, AE1/AE3, ADH and Prostate Triple Stain (PIN-4).

The CPT code to report for an IHC stain is code 88342 (Immunohistochemistry [including tissue immunoperoxidase], each antibody). It is reported once for each "antibody." Per CAP Today (June, 2004) "when a specimen is stained with a "cocktail" each antibody is reported separately only if each one can be differentiated microscopically."

As the racemase uses two distinct antibodies that can be separately visualized and interpreted, report 88342x2. Where as the AE1/AE3 which is also two histochemical antibodies but because the individual components cannot be separately evaluated is reported as 88342x1. A common "cocktail" used on prostate specimens is the PIN-4 (p63, high molecular weight cytokeratin, AMCAR [P504S]). Each of the three antibodies provides unique diagnostic information and would be reported as 88342x3.

Documentation needs to support reporting multiple IHC stains. Document the diagnostic result of each antibody in the report, as this will clarify that each antibody was individual to the diagnosis.

Example:
Brown nuclear stain represents p63 in basal cells, while brown cytoplasmic stain represents HMW-keratin on mature epithelial cells; red cytoplasmic stain represents P504S in prostate cancer cells.

As in Medicare's NCCI (National Correct Coding Initiative) Policy Manual version 15.3 if it is medically reasonable and necessary to examine IHC stains on more then one specimen or block report for each specimen or block.

Coding Corner

We received conjunctiva for biopsy. Would the correct code be 88305?

Whether you receive conjunctiva for biopsy or pterygium you will report CPT code 88304. This is the only "biopsy" specimen in CPT reported as 88304. It is not a common specimen, so beware when you see it and not automatically assign an incorrect code. Size, severity of condition, complexity, etc. will not change the code.

Can a cell block be reported with a Fine Needle Aspirate?

Yes, when a cell block is prepared and examined report 88305. Per the AMA, a cell block can be reported for each primary specimen submitted. For a Fine Needle Aspirate case the primary specimen would be the aspiration specimen. Additional "add-on" codes that may apply to an FNA case would be "special stains" (88312 and 88313) and IHC stains (88342).

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 a tscheanwald@ucbinc.com and I will provide answers and/or feedback.

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