

APS Update

PATHOLOGY NEWSLETTER

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Local Coverage Rules for Ohio and Kentucky for CPT Code 88342

By Jan Toczynski, CPC, CCP

The recent change of the Medicare provider from Palmetto to CIGNA Government Services for Ohio and Kentucky in July 2011, brought a change of Local Coverage Determination's (LCD) for various services.

An LCD is a "local coverage determination" which CMS (Centers for Medicare and Medicaid Services) requires fiscal intermediaries and carriers to issue when they have local guidelines regarding when and how to bill for certain services. These LCD's also place limits on the diagnosis codes that justify medical necessity for some services, establishes billing guidelines and includes limits on frequency and patient eligibility.

There is now an LCD (L31873) for code 88342 (Immunohistochemistry, each body) for Ohio and Kentucky for MAC-Part B. This LCD includes an allowed list of diagnosis codes to support medical necessity. The allowed list of ICD-9 codes has many of the neoplastic codes and conditions for all systems. In order to be paid for this service, one of these diagnosis codes must be reported with the appropriate documentation (the pathology report) to support it.

As always, keep in mind the correct use of an ICD-9 code does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must also meet the criteria specified in the LCD.

Per the LCD, it also provides limitations on frequency. It will cover up to 10 immunohistochemical analyses. Utilization beyond this should be supported in the medical record and may be subject to review.

A copy of this LCD can be found at the CMS Medicare website: www.cms.gov/center/coverage.asp and follow the below menus:

- ⇒ Coverage Process
- ⇒ Local Coverage Determination
- ⇒ LCD Indexes
- ⇒ Advanced Search
- ⇒ Document ID - L31873
- ⇒ LCD Effective Date - 06/18/2011

Medicare Provider Enrollment Revalidation

By Nikki Dawson, Credentialing Specialist

The Affordable Care Act established requirements for all enrolled Medicare providers to revalidate their enrollment under new screening criteria. All providers enrolled with Medicare prior to March 25, 2011 will be required to revalidate their enrollment information with their Part B Medicare Carrier. CMS will send out letters between now and March 23, 2013 to each provider when it is time for revalidation. CMS is requesting revalidation applications not be sent in prior to receiving this letter. Once the provider receives the letter there is a 60-day window to submit the revalidation application along with supporting documents (ex: CLIA, NPI confirmation, License, Drivers License, etc). When APS receives the letter for revalidation, a Credentialing specialist will send our client an application to sign and return to APS for processing to their Medicare carrier.

Also beginning March 25, 2011 Medicare will be charging an enrollment fee for Institutional providers and suppliers, which includes Independent Laboratories. The fee for 2011 is \$505 and must be paid thru pay.gov for your revalidation application to be processed.

If you have any questions, please contact your assigned Credentialing Representative at (800) 288-8325.

2011 EDUCATION CALENDAR

Hope to see you there!

Sept 11-12: Grapevine, TX
CAP '11

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

Oct 15: Columbus, OH
OH Society of Pathologists

Oct 15-16: Seattle, WA
Pacific NW Society of Pathologists

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

Nov 19: Holmdel, NJ
NJ Society of Pathologists

Nov 30-Dec 2: San Francisco, CA
CA Society of Pathologists

Dec 3: Plymouth, MI
MI Society of Pathologists

Dec 4: San Francisco, CA
California Tumor Tissue Registry

APS Stays Out Front with ANSI 5010 Implementation

By Matt Ward, Regional Director of Business Development

In our last newsletter we indicated that APS was leading the industry in the preparation for ANSI 5010 implementation, required for January, 2012. As we have continued our efforts to work with payers we have found that many of the commercial carriers are not currently ready for the mandated switch over.

Most Medicare programs are in testing with their business partners, including billing companies and clearinghouses, and for all that are ready, APS has completed testing and has entered actual production status, meaning that we are already sending and receiving ANSI 5010 files for current business. As stated above, the switch over is mandatory for January 1, 2012 but the entities can begin using the new format immediately, if ready.

The record with commercial insurers and clearinghouses is somewhat spottier. As APS has reached out to carriers and intermediaries we have found several who are not ready to test and few that are willing to move into a production status with us. This follows a typical pattern for any mandated change in file format. Commercial plans which must absorb the cost of the change are typically slow in moving into the new format for testing and even slower for adoption. In this case, however, many of our requests to enter testing have been met by the carriers with comments that we are the first claim submitting organization to ask to do so. While heartening from a readiness standpoint, this may point to an industry lack of readiness for the switch over that could cause cash flow shortages for the unprepared come January.

APS is currently able to produce files in both the new and old format and remains as one of the early adopters of the ANSI 5010 format. Regardless of the readiness of an individual carrier we are prepared to submit claims in either fashion and can switch between the two formats quite easily. We do however want to continue to push for the adoption of the ANSI 5010 format as soon as possible. The key is that the new format gives insurers less leeway to have carrier specific denial codes, etc. enabling APS to more efficiently sort such items as denials for swift action in appeals or requests for reconsideration or to submit corrected claims if necessary.

While we expect all such changes to be attempted on time, the late availability of testing on the part of the commercial carriers may indicate that there could be some difficulties in the first quarter of 2012 as they transition their systems to the new format. APS will continue to push for implementation of the format with our carriers and will alert our clients to specific issues which may impact them.

Update: Indiana Direct Billing Legislation

By Matt Zaborski, Regional Account Executive

Passed early this year, Indiana House Bill 1071 enacted Public Law 222, regarding Anatomic Pathology Billing. The law was signed by the Governor on May 13th, 2011 and was effective July 1, 2011. This bill protects Indiana patients against "markup" charges by prohibiting an ordering physician from billing patients for anatomic pathology services performed or supervised by another physician. This is the practice required by Medicare since 1984.

Since the passing of this bill, various Indiana medical organizations have spoken out in opposition to this bill. Most prominently is the Indiana State Medical Association (ISMA) who states in Resolution 11-33 that, "Public Act 222 is not clear and its language is ambiguous and confusing to Indiana physicians." However ISMA also states, "The ISMA does not currently have a position statement on the billing for anatomic pathology services." The Resolution goes on to state, ISMA is "seeking guidance on Public Act 222 from the appropriate state agency" and "in collaboration with all interested parties will request the issue be considered by the Medical Licensing Board of Indiana for rule promulgation in a timely manner."

APS is under the understanding that multiple state agencies are involved in resolving this issue. We expect a more concrete determination of this law and its language within the next month as it is considered an urgent matter. Stay tuned for further updates or call your client representative with any further questions.

Coding Corner

By Jan Toczynski, CPC, CCP

We received a uterus with fibroid (leiomyoma), can we report a separate code for the fibroids?

Even though CPT has leiomyoma as a listed specimen as code 88305 and code 88307 for uterus, with or without ovaries and tubes; non neoplastic, when a uterus with leiomyomas is submitted and examined the only code you should report is 88307. On a rare occasion a surgeon may perform a myomectomy and then expand the procedure to a hysterectomy. When this occurs, two separately identified specimens are submitted for exam and diagnosis. Report the appropriate CPT code for each specimen.

Is code 88104 the correct CPT code for sputum when given to us as a direct smear?

No. Sputum is a non gynecological, non fluid/washing/brushing specimen. The correct code to report for sputum submitted as a direct smear would be code 88160 (smears, any other source). If the sputum was concentrated or prepared as a thin prep then the appropriate code would be 88108 (concentrated) or 88112 (thin prep) for the method of preparation.

Update: Illinois Out of Network Billing (HB 5085)

By Matt Zaborski, Regional Account Executive

As previously discussed, effective June 1, 2011 the Illinois Insurance Code was amended by adding Section 356z.3a. This amendment creates a very important shift in reimbursement rules and will affect all hospital based specialties. Previously, law had required the insurer to reimburse an out-of-network provider in full for services provided when a patient has made a good faith effort to use an in-network provider. As outlined in the new legislation, insurers shall provide non-participating providers with a written EOB that specifies "proposed" reimbursement and the applicable patient responsibility. If the parties fail to agree on a rate, then arbitration may be initiated by either party through the state's Department of Insurance. The costs associated with arbitration are then paid as determined in the decision.

I was recently in communication with Anne Owings Ford from McDonald Hopkins, LLC and was given the following update on the pending lawsuit challenging HB 5085's constitutionality.

"On behalf of Plaintiff Physicians, McDonald Hopkins, LLC, filed a reply brief in support of the motion for preliminary injunction on August 10, 2011. One week later, we filed a motion for hearing on the motion for preliminary injunction, to ensure the opportunity to present oral argument, as well as the legal briefs we already have provided to the Court.

The State Defendants had filed a motion to dismiss on July 26, 2011, and McDonald Hopkins filed a brief in opposition to that motion on Monday, August 22, explaining the legal deficiencies in the State Defendants' motion. The next day, August 23, we appeared before Judge Darrah for the State Defendants' presentment of their motion to dismiss, at which a briefing and hearing schedule was to be set. Since we already had opposed the State Defendants' motion, the Court set September 2, 2011 as the due date for the State Defendants' reply brief. Counsel for the State Defendants declined a hearing on their motion, so it is anticipated that the Court will issue its ruling on the motion to dismiss within the next several weeks. Although it is possible the Court could dismiss some or all of the Physicians' claims, the standard for granting such a motion presents an extremely high hurdle for defendants, as the law and court rules favor allowing plaintiffs' claims to be heard.

We are scheduled to appear before Judge Darrah again on October 26, 2011, at which time the Court expects to set the Physicians' motion for preliminary injunction for hearing."

(cont.)

(IL OON Billing cont.)

Contacts for more information on this matter are Anne Owings Ford and Steven M. Harris of McDonald Hopkins, LLC. They can be reached through the contact information below:

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Molecular Diagnostics Codes are Changing for 2012

By Jan Toczynski, CPC, CCP

The American Medical Association (AMA) is making significant changes to the coding structure of Molecular Diagnostics for January 2012. The codes will affect molecular assays in cancer, genetics, and histocompatibility. This will not impact molecular microbiology tests or most cytogenetic assays.

The current code system is a "stacking" system (83890-83914) based on methodology and a set of identifying disease and mutation modifiers that add specificity to the code set, where as, the new system will have two categories of codes. There will be two specific "Tiers." "Tier" 1 will be for the more frequently performed tests and have analyte-specific CPT codes and "Tier" 2 for the less common tests.

Tier 1 will include codes for breast cancer evaluation, genetic cystic fibrosis tests and will include codes for human leukocyte antigen typing using molecular techniques. Tier 2 will consist of nine level codes. These nine resource level codes will describe specific tests and each level will represent the range of resources required and physician work for that specific test. For both "Tiers" there will be a list of specific tests under each code. It is expected the number of new codes to be added will be high. For a test not in Tier 1 or Tier 2, the current "stacking" codes would apply but with the goal of eliminating them completely in the future.

Updates will be provided as soon as final details are worked out and the new codes are available.

New Pathology Quality Measures for 2012

By Gerrick Gonzales, Regional Director of Business Development

Next year's professional fee schedule (PFS) from CMS includes 3 pathology-related quality measures developed by CAP, thus expanding the number of measures pathologists can report for the agency's Physician Quality Reporting System (PQRS) to five. The 2012 proposed PFS pathology measures include:

- ⇒ **Barrett's Esophagus**
 - * Esophageal biopsies with a diagnosis of Barrett's esophagus that include a statement on dysplasia
- ⇒ **Radical Prostatectomy Pathology Reporting**
 - * Reports include the pT category, the pN category, the Gleason score and a statement about margin status.
- ⇒ **Immunohistochemical (IHC) Evaluation of HER2 for Breast Cancer patients**
 - * Quantitative HER2 evaluation by IHC uses the system recommended by the ASCO/CAP guidelines

In addition, there are also three measures developed by the American Society of Breast Surgeons that may be reportable by surgical pathologists beginning 2012, depending on their final specifications to be announced at a later date. They are (1) preoperative diagnosis of breast cancer; (2) sentinel lymph node biopsy for invasive breast cancer; and (3) biopsy follow-up.

PQRS Incentive. Extends PQRS payment bonuses through 2014. Eligible professionals who successfully report quality data for the quality reporting period will receive a 1.0% bonus in 2011 and dropped a 0.5% bonus in years 2012 through 2014.

PQRS Penalty. Eligible professionals who do not successfully report quality data during the designated quality reporting period will have their Medicare payments reduced by 1.5% in 2015 and by 2.0% in 2016 and each subsequent year. The payment incentives and reductions are based on the Medicare fee schedule amounts (determined after applicable adjustments) for all covered services furnished by the eligible professional. The penalty applies to the applicable year and is not cumulative.

APS keeps abreast about the never-ending changes and challenges affecting the business of pathology. Should you have any questions or are interested in maximizing billing to improve revenue, please contact one of our professional representatives at APS Medical Billing at (800) 288-8325.

Summer Activity on Medicare Payment

By Matt Ward, Regional Director of Business Development

In July, CMS issued its expected changes in the payment levels and structure for physician payment in 2012. As expected, the payment levels incorporate the 29.5% reduction in payments required by the SGR which was left in place by the health reform law passed in 2010. While there will be efforts by many industry organizations to have this year's across the board reductions tabled as has happened year after year, the attention that Congress will be placing on economy wide measures and the difficulty in enacting legislation which will carry a high price tag, such as this make this year's fix somewhat more questionable than in previous years.

In addition to the changes in the general payment levels, CMS is continuing to target the relative value system for revision. Currently in the spotlight are several potentially misvalued codes including E/M codes and the highest non-E/M expenditure codes for each specialty, including pathology. While no specific action was listed in this area other than further study, the intention of the statement is clear that such attention is not geared towards increasing payment rates.

The grandfather provision allowing independent labs to bill for technical services provided to hospital patients if they have been doing so in the previous year is specifically target for a sunset at the end of this year. As in the update factor, this is an issue which has been successfully rolled back year after year, but again its ability to be renewed is dependent on the political process in a busy season for Congress.

Finally, CMS has extended the MPPR (multiple procedure payment reduction) policy to the professional component of radiological exams for 2012 and is considering extending it to other diagnostic areas, including pathology, in future years. In this process additional professional services after the first for a patient are typically paid at a decreasing percentage of the allowable rate to reflect "efficiencies" in the handling and examination of multiple procedures for the same patient. While a specific rule has not been suggested, the cuts for subsequent procedures in the same CPT family can be significant. Understandably, radiologists are fighting this extension of the MPPR to their specialty. Pathology, with a large number of repeated CPTs per claim can seem a likely candidate for such a policy to those looking for areas to reduce payments.

As can be seen, the number of potentially significant areas of concern is increasing, while Congress' window for attention and action to such matters is decreasing. The fall will be an interesting time as providers attempt to gain Congress' attention and understanding of the impact of these issues and the inappropriate nature of some of the proposed reductions. APS will continue to provide updates on these important issues.