

APS Update

PATHOLOGY NEWSLETTER

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Remember to Document Additional Services

So, you've coded the gross and microscopic codes for the specimen(s) submitted. There are many additional services that are performed in addition to the primary exam to assist in rendering a diagnosis. Such as decalcification, frozen sections, touch preps, staining for organisms or other cellular abnormalities, IHC stains, in situ hybridization, flow cytometry, etc. With the recent CPT change for 2010 for codes 88312 and 88313 which revised the definition and removed the add-on status so they can be reported separately from surgical pathology, there are only a few select codes that are considered true add-on codes. All others are not considered add-on codes by AMA definition but you would rarely see one reported without a gross and microscopic code (88302-88309).

Proper and complete documentation in the medical report for any additional service is essential. It is important for two reasons: 1) from an auditing standpoint and 2) for accurate coding. In reviewing or coding a report for additional services, documentation should state: 1) was a separate service performed, 2) which specific service was performed, 3) which specimen(s) does the service(s) relate to, and 4) how many times was the service performed with each specimen. This information enables the auditor/coder to report the most accurate CPT code for the service and how many units to report. Additional tips which may be helpful are:

- ⇒ For special stains, document which stain was used and it's results. This will help determine the purpose of the stain to choose the correct code. It cannot be assumed, for example that iron stores mean the specimen was examined by an iron stain.
- ⇒ If multiple specimens and/or blocks stained, document which specimens and/or blocks the stains were performed on and the results
- ⇒ If a special stain did not yield a diagnosis, do not use words like "normal" or "noncontributory." This tends to mean that the service was not medically necessary. Rather "GMS stain negative for H. pylori" or "Iron stores confirmed by Iron stain."

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- ⇒ Be sure to specify the technique or approach used to obtain a diagnostic result. Is it an immuno stain, in situ hybridization studies, etc. Was the approach qualitative, quantitative or semi-quantitative and if it was manual or computer-assisted.
- ⇒ Don't assume when a bone specimen is submitted a decalcification is reported. Document decalcification in the report. Report code 88311 once per specimen.
- ⇒ Clearly document for intraoperative consultations. If the finding was due to a gross only exam (88329) or if a microscopic diagnosis is given. If a microscopic diagnosis is given is it based on a frozen section (88331), touch prep (88333) or both (88331/88334). If both clearly document the specific site each was taken.

Relief – Sort of

Congress acted on the current year physician pay issue by delaying the 20% reduction in payment called for by the SGR formula change. The difference is that, with health care reform being pushed by Congress with potential solutions to the SGR formula issues, the delay is only until March 1st. At the time that decision was made, the primary issue was that the House and Senate reform legislation differ as to the approach to fixing the SGR. The House bill calls for a permanent fix to the formula by eliminating the past cuts and adding an update mechanism based on the GDP growth. The Senate bill opts for the familiar one year delaying of the cut without addressing the root problem.

Of real concern now, since the Senate election in Massachusetts, is whether there will be any reform legislation passed in time to avoid the now looming deadline of February 28, 2010. Health Reform legislation is no longer considered a foregone conclusion and the "fixes" in the two bills may not be relevant, if not passed. Add to that the fact that the carriers will need time to reset their systems even if there is an extension of the relief and we may be looking at an extended period of disruption in Medicare cash flow. At this time, it appears as though a legislative remedy will be passed by the end of the month, but the disruption is quite likely.

Grandfathered Labs on Shaky Ground

Congress avoided action on the grandfather clause for independent labs pending the final resolution of the Health Reform legislation being considered in Congress. As a result, independent labs which had been able to bill for the full global fee for Medicare hospital patients under the grandfather clause were instructed to submit claims for the professional component of their services only for dates of service beginning January 1, 2010, until such time as the legislation was passed. As both the House and Senate bills contained extensions of the grandfathering provision (the Senate for one year and the House for two years) it was felt that grandfathered labs could wait for the final legislation to be passed and then submit their bills for the technical portion.

Given the difficulties that the legislation may now have, and the results of the Senatorial election in Massachusetts, it is possible that this period may extend beyond the one or two months originally expected and that the final legislation may not resemble the bills that have already passed through the House and Senate. Under these circumstances it is probable that cash flow will be impacted for such labs. It is also conceivable that no fix will be passed although there are movements to attach one year relief to a current bill. It may be prudent for such labs to begin conversations with their client hospitals to determine compensation for the technical portion of the laboratory services as a contingency if congressional action is not forthcoming.

Date of Service Changes Rescinded

The Healthcare Billing and Management Association has released a notification to its members that CMS has rescinded the changes proposed for the interpretation of the date of service for diagnostic testing. As a result, no change in the 2009 definition of date of service, is in place and the 2009 definition will continue to be used until further notice. It is expected that this CMS action is the result of extensive feedback from providers indicating how the proposed change would make accurate reporting of claims very difficult.

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Coding Corner

On occasion we review a Tzanck smear. Is 87207 the correct code for this service?

That all depends on the exam. Code 87207 from the microbiology section of the CPT book is for the examination for the presence of absence of inclusion bodies. If you are examining the smear and providing a written report then 87207-26 would be the correct code to report. But if you are examining the smear to determine the etiology for the inclusion bodies, then you would report CPT code 88160 or CPT code 88161 if the staining is done outside the lab.

With the recent changes to the FNA immediate evaluation code (88172) for Medicare, can you clarify the unit of service for procedure codes 10021 and 10022 for the actual procedure of aspirating the fluid?

Per CPT, codes 10021 (Fine Needle Aspirate; without imaging guidance) and 10022 (Fine Needle Aspirate; with imaging guidance) are reported **once** for "each lesion or different site biopsied." A lesion can be separate nodules or mass and separate site could be right and left lobes of the thyroid.

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.

2010 EDUCATION CALENDAR Hope to see you there!

Mar 3-5: Las Vegas, NV
American Pathology Foundation

Mar 22-24: Washington, DC
US & Canadian Academy of Pathology

Apr 16: Chapel Hill, NC
NC Society of Pathologists

Apr 23-24: Harrisburg, PA
PA Association of Pathologists

Apr 24: Carmel, IN
IN Association of Pathologists

May 1-2: Seattle, WA
Pacific NW Society of Pathologists
WA State Society of Pathologists

May 4-5: Las Vegas, NV
CLMA ThinkLab '10

May 8: Plymouth, MI
MI Society of Pathologists