(8700) CPT Coding and Related CMS Payment Policy: Trends for Pathology and Laboratory Medicine.

September 18, 2013 1:00-2:50 pm
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AMA-CPT Editorial Panel
Disclosure

In the past 12 months, I have not had a significant financial interest or other relationship with the manufacturer(s) of the product(s) or provider(s) of the service(s) that will be discussed in my presentation.

This presentation will (not) include discussion of pharmaceuticals or devices that have not been approved by the FDA or unapproved or "off-label" uses of pharmaceuticals or devices.
Program Description

This lecture will provide a brief summary of current issues related to Current Procedural Terminology (CPT) coding as it pertains to pathology and clinical laboratory services, as well as current trends in the CPT Editorial Process. Issues related to Medicare payment for new coding systems (e.g., molecular pathology) will also be discussed.
Learning Objectives

1. Understand the significant changes for CPT coding for laboratory and pathology services in 2013.
2. Learn the big issues/trends in Pathology and Laboratory CPT coding in the near future.
3. Understand the issues that CMS are considering related to #1 and #2 and review any announced recently policies related to the same.
4. **BONUS (as time permits)** Coding & Compliance Pearls!
But First!

• Let’s mark sure that we understand how our payment system works!
The World of Lab Income (Medicare Version)

CPT & RUC

Pathologists
- Medical Directorship Services
- Interpretive Services

Clinical Laboratory Analyses (CBC’s, Chem Panels, Microbiology, etc.)
- Hospital Patients
- Non-Hospital Patients ("Non-patients")

Clinical Lab Fee Schedule ("CLFS")
- IEFRA 1984 Designated that this payment is included in the global payment for clinical lab analyses
- Medicare Part B payment amounts formulated through conversion factor, and RB-RVS valuation

Inpatients
- Diagnosis Related Groups ("DRG’s")

Outpatients
- Clinical Laboratory Fee Schedule ("CLFS")
- Outpt Prospective Payment System ("O-PPS") through the ambulatory payment categories ("APC’s") for blood bank and TC of AP services
CPT Coding Basics

- **CPT** is owned and “controlled” by the American Medical Association.
- **Editorial Panel** 16 members-including Internal Medicine, Family Practice, Surgery, CMS, Managed Care, Insurance Industry.
- **Advisory Committee** >90 members from all specialty societies represented in AMA Federation + several other applicable non-physician societies (including CAP, USCAP, ASC, ASCP, ACMG, AACC).
- **Pathology Coding Caucus** Chaired and staffed by the College of American Pathologists, provides the non-physician laboratory community for a voice in laboratory CPT coding.
- **MoPath Advisory Group** Co-chaired by Editorial Panel members to advise on Molecular code CPT proposals.
CPT Coding Basics

- **Category I CPT Code changes** are published annually* with any party being able to request a code addition, deletion, or modification.
- It is a political process!
- It is a slow process!
- AMA-CPT maintains the codes and does **NOT set the relative values/prices**. That is the job of AMA-RUC and CMS
CPT Code Sets

- **Category I** are traditional CPT codes used for billing.
  - 88305  Level IV Surgical Pathology, gross and microscopic examination

- **Category II** are “performance measurement tracking codes (eg, PQRS)
  - 3260F  pT category (primary tumor), pN category (regional lymph nodes), and histologic grade in pathology report (PATH)

- **Category III** are “temporary codes for emerging technology, services, and procedures”
  - 0111T Long-chain (C20-22) omega-3 fatty acids in red blood cell(RBC) membranes

- **MAAA Administrative Code List** are Multianalyte Assays with Algorithmic Analyses (appendix O)
How are CPT Codes Valued?

- Clinical laboratory analyses → Clinical Laboratory Fee Schedule (CLFS)

- “Physician” performed testing → (Non-patient) Resource Based Relative Value System (RB-RVS)

- “Physician” performed testing (TC) → (Hospital outpatient) Ambulatory Patient Categories (APC)
Clinical Lab Fee Schedule (new code assignment)

• Beginning 2001 all new clinical lab tests (new CPT codes) are published annually in the Federal Register and discussed in a public hearing to assign payment in July
  • **Crosswalking:** Finding a procedure that is similar to the new code in cost/methodology and using that payment level for the new code.
  • **Gap Filling:** In the absence of an appropriate crosswalk the code will be temporarily assigned a payment level by the local carrier and then over the next year, data will be collected to arrive at the NLA.
Clinical Lab Fee Schedule

- Includes all clinical lab tests. It does not include anatomic pathology analyses, except for the non-professional component of Pap Tests (and now molecular pathology).
- It is based on traditional and customary charges (Not cost based).
- The Congress/President’s budget set the annual pricing (across the board % increase/decrease).
- The amount set Federally is know as the NLA (National Limitation Amount). Regional Carriers’ Schedules may pay less. In either case they will not pay more than your billed amount.
• Resource Based Relative Value System Update Committee (1991)
• 31 members (including CAP) including three rotating seats, AMA and CPT members (28 voting members)
• Functions:
  – Review inputs on codes potentially over- or undervalued (Continuous process)
  – Value new codes put forth by CPT
SURVEY INPUTS

• PHYSICIAN WORK

• PRACTICE EXPENSE

• PLI
Physician Work

- Data driven (Surveys of Providers)
  - **Time to perform the service!!!**
  - Technical skill and physical effort
  - Required mental effort and judgment
  - Stress due to the potential risk to the patient

- Allocated by RUC
  - Paid via the Conversion Factor
  - Includes Indirect (Practitioner) Practice Expense (software, administrative staff)
RUC Survey Issues

Physician Work = Time x Intensity
Practice Expense/PLI

- Direct inputs (slides, stains, equipment time, personnel)
- Scrupulously overseen by Practice Expense Subcommittee of RUC
- Major driver of cost, increasingly technology driven
- Malpractice Liability is based on formula derived from actuarial data (outdated)
The Physician Payment System (RB-RVS)

• Payment for all CPT coded physician services are calculated by the following equation:

\[ \$ = \text{CF} \times (\text{RVU}_{\text{work}} \times \text{GPCI}_{\text{work}}) + (\text{RVU}_{\text{PE}} \times \text{GPCI}_{\text{PE}}) + (\text{RVU}_{\text{PLI}} \times \text{GPCI}_{\text{PLI}}) \]

CF = Conversion factor, the common single unit that links all physician payments together. Determined by the Sustainable Growth Rate (SGR) computation. 2013 = $34.0376
Ambulatory Payment Classification (APC)

- Created in August 2000 as a part of the Outpatient Prospective Payment System (per BBA of 1997).
- Built to address growing Medicare expenses to hospitals (shifting outpt to inpt post-DRG)
- Includes many hospital-related outpatient services (for the lab it includes only anatomic pathology technical component and blood bank services)
- “All services paid under the new PPS are classified into groups. Services in each APC are similar clinically and in terms of the resources they require.”
Ambulatory Payment Classification (APC)

- A payment rate is established for each APC.
- “The payment rates for most separately payable medical and surgical services are determined by multiplying the prospectively established scaled relative weight for the service’s clinical APC by a conversion factor (CF) to arrive at a national unadjusted payment rate for the APC.”
- “The scaled relative weight for an APC measures the resource requirements of the service and is based on the geometric mean cost of services in that APC.”
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Pathology CPT Changes 2013
areas of changes

- Evocative/Suppression Testing (editorial)
- Molecular Pathology
- Multianalyte Assays with Algorithmic Analyses
- Chemistry
- Immunology
- Tissue Typing
- Microbiology
- Surgical Pathology
Molecular Pathology section (MoPath)

― “Medical lab procedures involving analyses of nucleic acids to detect variants in genes that may be indicative of germline or somatic disease, or to test for histocompatibility antigens”

― “Does not include infectious disease or in situ hybridization analyses” (found in the Microbiology and Anatomic Pathology sections, respectively)
Molecular Pathology changes

• Special 5-page insert (pgs xix-xxiii) within front section of Professional Edition CPT codebook
  – Offers additional information for Tier1/2
  – Explains abbreviations within code descriptors
  – Includes FAQ’s
Molecular Pathology– Deleted Codes/Sections

– “Stacking” codes 83890-83914 – deleted*
– Array-based evaluation codes (88384-88386) – deleted*
– Appendix I (Genetic Testing Modifiers) – deleted*
– Tiers 1 and 2 used in replacement
– Creation of 81479 (Unlisted molecular pathology procedure) to be use for analyses not captured in Tiers 1 and 2

* and all associated cross-references/parentheticals.
Definitions for Molecular Pathology Sections

- Three additional definitions (as these terms were added in modified Tier 2 codes):
  - Inversion
  - Loss of Heterozygosity (LOH, allelic imbalance)
  - Uniparental Disomy
Molecular Pathology section changes (MoPath)

• Tier 1
  – Now contains 105 codes
  – Includes 13 new codes for Molecular Pathology for 2013
  – Used with gene-specific genomic procedures
  – Code selection based on specific gene being analyzed
  – Gene description according to Human Genome Organization (HUGO) naming
Molecular Pathology section changes (MoPath)

• Tier 1
  – Gene name represented by an abbreviation
    • Abbreviation listed first
    • Followed by full gene name italicized in parentheses
  – Examples ("eg.") do not represent all conditions in which testing of the gene may be indicated.
  – Reference MoPath Intro guidelines for details/instructions/definitions
Molecular Pathology section changes (MoPath)

• Tier 1 – New codes:
  – 81201, 81202, and 81203 (sequence, familial variant, & dup/del, respectively)
    • APC (*adenomatous polyposis coli*)
    • For the assessment of familial adenomatosis polyposis (FAP)/attenuated FAP (eg)
Molecular Pathology section changes (MoPath)

• Tier 1 – New codes:
  – 81235 (common variants)
    • Testing for presence of epidermal growth factor receptor (EGFR)
    • Predictive of response to tyrosine-kinase inhibitor therapies in the treatment of malignancies (e.g., non-small cell lung cancer, colorectal carcinoma, etc)
Molecular Pathology section changes (MoPath)

• Tier 1 – New codes:
  – 81252 and 81253 (gene sequence, known variant, respectively)
    • GJB2 (gap junction protein, beta 2, 26kDa, connexin)
  – 81254 (common variants)
    • GJB6 (gap junction protein, beta 6, 30kDa, connexin)
  – Associated with nonsyndromic hearing loss
Molecular Pathology section changes (MoPath)

• Tier 1 – New codes:
  – 81321, 81322, 81323 (sequence, familial variant, & dup/del, respectively)
    • PTEN (*phosphatase and tensin homolog*)
    • For the assessment of Cowden syndrome (eg "Multiple hamartoma syndrome")
Molecular Pathology section changes (MoPath)

• Tier 1 – New codes:
  – 81324, 81325, 81326 (dup/del, sequence, & familial variant, respectively)
    • PMP22 \( (\text{peripheral myelin protein 22}) \)
    • For the assessment of Charcot-Marie-Tooth syndrome (progressive loss of muscle tissue and touch sensation across various parts of the body)
Molecular Pathology section changes (MoPath)

- Tier 2
  - Report procedures not listed in Tier 1 molecular pathology codes (81200-81383)
  - Represent medically useful procedures generally performed in lower volumes than Tier 1 (eg, incidence of disease being tested is rare)
  - Arranged by level of technical resources and interpretative work by physician/qualified health care professional
Molecular Pathology section changes (MoPath)

• Tier 2
  – Utilize Tier 1 coding principles and guidelines
  – Code listing is not all inclusive
  – Parenthetical examples of methodologies presented near beginning of code provide guidelines regarding intended use of that level of code
Molecular Pathology section changes (MoPath)

• Tier 2 – Guideline revision:
  – Note to use level of Tier 2 code that includes specific listed analyte after root code descriptor
  – If analyte tested is not listed in Tier 1 or 2, new instruction specifies use of unlisted pathology code 81479
Molecular Pathology section changes (MoPath)

• Tier 2 – Code revisions (analyte additions to each level):
  – 81400 - 81408

• Editorial revisions to codes listed to include additional analytes determined to fall under Tier 2 reporting
Molecular Pathology section changes (MoPath)

• Tier two analyte additions
  • 81400-  9 additions
  • 81402-  2 additions
  • 81403- 15 additions
  • 81404- 22 additions
  • 81405- 41 additions
  • 81406- 50 additions
  • 81407- 14 additions
  • 81408-  6 additions
Molecular Pathology section changes (MoPath)

• Tier two analyte additions
  • 81400- 9 additions
  • 81402- 2 additions
  • 81403- 15 additions
  • 81404- 22 additions
  • 81405- 41 additions
  • 81406- 50 additions
  • 81407- 14 additions
  • 81408- 6 additions
Molecular Pathology section changes (MoPath)

– Tier 2 – Code revisions (analyte additions to each level):
  
  • 81401
    
    – Analyte FGFR3 revised to include 2 additional common variants (in parenthesis) for:
      
      » 1620C>A
      
      » 1620C>G
Molecular Pathology section changes (MoPath)

– Tier 2 – Code editorial revisions to root analyte “eg, list’ (in light of analyte additions to level):

  • 81402
    – Loss of heterozygosity (LOH)
    – Uniparental disomy (UPD)
Molecular Pathology section changes (MoPath)

– Tier 2 – Code revisions (analyte modification):
  • 81406
    – Analyte descriptor for NOTCH3 editorially revised to note “autosomal dominant” form of cerebral arteriopathy
Molecular Pathology section changes (MoPath)

• Tier 2 – Code revisions (analyte additions to each level):
  – 81403
    • Known familial variant not otherwise specified, for gene listed in Tier 1 or Tier 2, DNA sequence analysis, each variant exon
    • Addition of instructional note to report specific common variant Tier 1/Tier 2 code for known familial variant considered a common variant
    • Analyte description for KRAS edited
      – Changed number of exon in test from “2” to “3”
      – Example provided in parentheses (“eg, carcinoma”)
Path/Lab CPT Changes 2013

Multianalyte Assays with Algorithmic Analyses (MAAA)

Issue was spawn from the Molecular Pathology Workgroup who could not determine a mechanism within the Tier 1 & Tier 2 code set heirarchy to codify for these tests.
Path/Lab CPT Changes 2013

Also referred to as IVDMIA’s (FDA)-- In vitro Diagnostic Multivariant Index Assays.

• Common thread between all of these tests- multiple data points (eg, lab results) combined in an algorithm to provide a result (eg, prognostic index, recurrence score, probably score)

• Typically these are single-source tests.
AMA-CPT IVDMIA Workgroup
Convened in July 2011, with a wide range of attendees from industry, organized medicine, CMS, and insurers present (>100).

And..................
Multianalyte Assays with Algorithmic Analyses (MAAA)

- Category I MAAA code set will function like traditional CPT codes
- An Administrative code list (Appendix O) will also be maintained by CPT that:
  - As a minimum standard it is an analysis that is generally available for patient care.
  - The AMA will not review procedures in the administrative code set for clinical utility.
- Neither proposed MAAA code set will be restricted solely to MoPath (none are for 2013!)
Multianalyte Assays with Algorithmic Analyses (MAAA)

– New Category I Subsection
– Utilize multiple results derived from:
  • MoPath assays
  • Fluorescent in situ hybridization
  • Other non-nucleic acid-based assays (proteins, polypeptides, lipids, carbohydrates)
  • All used as inputs into algorithmic analysis to derive a single result (numeric score/index/probability)
  • Generally available through a single lab/vendor
Multianalyte Assays with Algorithmic Analyses (MAAA)

- New subsection includes:
  - New Heading (Multianalyte Assays with Algorithmic Analysis)
  - Category I Introductory Guidelines
  - Includes an “Unlisted Multianalyte assay with algorithmic analysis code” (81599)
Multianalyte Assays with Algorithmic Analyses (MAAA)

- 81500/3 – Ovarian cancer risk score
- 81506 – Diabetes risk score
- 81508, 81509, 81510, 81511, 81512 – Maternal serum screening for risk of fetal congenital abnormalities.
Multianalyte Assays with Algorithmic Analyses (MAAA)

- Appendix O additions:
  - 3 new Administrative MAAA codes
  - 8 new Cat I MAAA codes (also included in Appendix O table)
    - Introductory guidelines include:
      - Provide specific guidance on how to report/assign codes
      - Specific requirements for inclusion in the Administrative code list/Cat. I
Multianalyte Assays with Algorithmic Analyses (MAAA)

- CPT understands need for rapid accessibility of these codes
- AMA CPT Web site features updates provided in March, June, and November
- These dates correspond to the CPT Editorial Panel actions for March, June, and November
### Appendix O — Multianalyte Assays with Algorithmic Analyses

<table>
<thead>
<tr>
<th>Proprietary Name and Clinical Laboratory or Manufacturer</th>
<th>Alpha-Numeric Code</th>
<th>Code Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCV FibroSURE™, LabCorp</td>
<td>0001M</td>
<td>Infectious disease. HCV, six biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, and haptoglobin) utilizing serum. prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver</td>
</tr>
<tr>
<td>ASH FibroSURE™, LabCorp</td>
<td>0002M</td>
<td>Liver disease, ten biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, haptoglobin, AST, glucose, total cholesterol and triglycerides) utilizing serum. prognostic algorithm reported as quantitative scores for fibrosis, steatosis and alcoholic steatohepatitis (ASH)</td>
</tr>
<tr>
<td>NASH FibroSURE™, LabCorp</td>
<td>0003M</td>
<td>Liver disease, ten biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, haptoglobin, AST, glucose, total cholesterol and triglycerides) utilizing serum. prognostic algorithm reported as quantitative scores for fibrosis, steatosis and nonalcoholic steatohepatitis (NASH)</td>
</tr>
</tbody>
</table>

### Category I Codes for Multianalyte Assays with Algorithmic Analyses (MAAA)

| Risk of Ovarian Malignancy Algorithm (ROMA)™, Fujirebio Diagnostics | 81500 | Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score |
| OVA1™, Vermillion, Inc.                                           | 81503 | Oncology (ovarian), biochemical assays of five proteins (CA-125, apolipoprotein A1, b2-eta-2 microglobulin, transferrin, and pre-albumin), utilizing serum, algorithm reported as a risk score |
| PreDx Diabetes Risk Score™, Tethys Clinical Laboratory            | 81506 | Endocrinology (type 2 diabetes), biochemical assays of seven analytes (glucose, Hba1c, insulin, hs-CRP, adiponectin, ferritin, interleukin 2-receptor alpha), utilizing serum or plasma, algorithm reporting a risk score |

Maternal serum screening procedures are well established procedures and are performed by many labs throughout the country. The concept of prenatal screens has existed and evolved for over ten years and is not exclusive to any one facility.

| Maternal serum screening procedures are well established procedures and are performed by many labs throughout the country. The concept of prenatal screens has existed and evolved for over ten years and is not exclusive to any one facility. | 81509 | Fetal congenital abnormalities, biochemical assays of three proteins (PAPP-A, hCG [any form], DIA), utilizing maternal serum, algorithm reported as a risk score |
| Maternal serum screening procedures are well established procedures and are performed by many labs throughout the country. The concept of prenatal screens has existed and evolved for over ten years and is not exclusive to any one facility. | 81510 | Fetal congenital abnormalities, biochemical assays of three analytes (AFP, uE3, hCG [any form]), utilizing maternal serum, algorithm reported as a risk score |
| Maternal serum screening procedures are well established procedures and are performed by many labs throughout the country. The concept of prenatal screens has existed and evolved for over ten years and is not exclusive to any one facility. | 81511 | Fetal congenital abnormalities, biochemical assays of four analytes (AFP, uE3, hCG [any form], DIA) utilizing maternal serum, algorithm reported as a risk score (may include additional results from previous biochemical testing) |
| Maternal serum screening procedures are well established procedures and are performed by many labs throughout the country. The concept of prenatal screens has existed and evolved for over ten years and is not exclusive to any one facility. | 81512 | Fetal congenital abnormalities, biochemical assays of five analytes (AFP, uE3, total hCG, hyperglycosylated hCG, DIA) utilizing maternal serum, algorithm reported as a risk score |
Chemistry - Revisions to Introduction

Editorial changes noting coding instruction regarding appropriate coding for calculated analyte determinations using values derived from other analyses.

1. Clinical information or mathematically calculated values, which are not specifically requested by the ordering physician and are derived from the results of other ordered or performed laboratory tests, are considered part of the ordered test procedure(s) and therefore are not separately reportable service(s).
2. When the requested analyte result is derived using a calculation that requires values from nonrequested laboratory analyses, only the requested analyte code should be reported. (e.g., TIBC ordered but lab derives from transferrin)

3. When the calculated analyte determination requires values derived from other requested and nonrequested laboratory analyses, the requested analyte codes (including those calculated) should be reported.
4. An exception (to the above) is when an analyte (eg, urinary creatinine) is performed to compensate for variations in urine concentration (eg, microalbumin, thromboxane metabolites) in random urine samples; the appropriate CPT code is reported for both the ordered analyte and the additional required analyte.

5. When the calculated result(s) represent an algorithmically derived numeric score or probability, see the appropriate multianalyte assay with algorithmic analyses (MAAA) code or the MAAA unlisted code (81599).
Path/Lab CPT Changes 2013

• Chemistry –

82000  Acetaldehyde, blood;

p 82009  Acetone or other Ketone body(s) (eg, acetone, acetoacetic acid, beta-hydroxybutyrate) serum; qualitative

p 82010  quantitative

• Specimen source removed
• Parenthetical list of examples (eg acetone, acetoacetic acid) describe ketone bodies within the descriptors
• Used to diabetic ketoacidosis management
Path/Lab CPT Changes 2013

- Chemistry – Code Changes: 82277
  - Added to report Galectin-3 assay
    - Enzyme immunoassay that uses two highly specific monoclonal antibodies for direct measurement of Galectin-3 in human plasma and serum
    - Developed to measure:
      - Galectin-3
      - Related Galectins
    - Used to stratify patient prognoses with heart failure, independent of BNP results.
Immunology – Code Additions – 86152/3 (deletion of commensurate Category III codes 0279T, 0280T)

| 86152 | Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood) |

► (For physician interpretation and report, use 86153. For cell enumeration with interpretation and report, use 86152 and 86153) ◄

| 86153 | physician interpretation and report, when required |
Circulating Tumor Cells

Fluorescent antibody #1

Fluorescent antibody #2
Immunology – Code Addition - 86711

- New code established to report detection of JC (John Cunningham) virus

86710 Antibody; influenza virus
86711 JC (John Cunningham) virus

Purpose of test

- Determine diagnosis in patients with suspected progressive multifocal leukoencephalopathy (PML)
Tissue Typing – New codes for antibody to human leukocyte antigen (HLA) solid phase assays

- Platforms use solid phase assays covering most common HLA class I and II antigens
- Technology uses microspheres, chips, ELISA trays coated with purified/recombinant HLA molecules
- Testing used in the assessment of patients with platelet transfusion refractory thrombocytopenia & in solid organ transplant candidates that may have alloantibodies to HLA antigens.
Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); qualitative assessment of the presence or absence of antibody(ies) to HLA Class I and Class II HLA antigens.

86829 qualitative assessment of the presence or absence of antibody(ies) to HLA Class I or Class II HLA antigens.

▲ (If solid phase testing is performed to assess presence or absence of antibody to both HLA classes, use 86828) ▼

86830 antibody identification by qualitative panel using complete HLA phenotypes, HLA Class I

86831 antibody identification by qualitative panel using complete HLA phenotypes, HLA Class II
Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); **high definition qualitative panel** for identification of antibody specificities (eg, individual antigen per bead methodology), HLA Class I

**86832**

**86833** high definition qualitative panel for identification of antibody specificities (eg, individual antigen per bead methodology),
HLA Antibody

- **86834** Antibody to human leukocyte antigens (HLA), solid phase assays (e.g., microspheres or beads, ELISA, flow cytometry); semi-quantitative panel (e.g., titer), HLA Class I

- **86835** Semi-quantitative panel (e.g., titer), HLA Class II
Path/Lab CPT Changes 2013

• Microbiology – New Codes – Infectious Agent Detection (Respiratory Viruses)
  – Three new codes for Respiratory Viruses (87631, 87632, 87633)
  – New codes accurately define number and potential types of respiratory viral targets simultaneously assessed.
  – Instructional parentheticals added and existing notes revised for further clarification
Respiratory Viral Panels

87470  *Infectious agent detection by nucleic acid (DNA or RNA)*;

- 87631  respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 3-5 targets

- 87632  respiratory virus (eg, adenovirus...), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 6-11 targets

- 87633  respiratory virus (eg, adenovirus ...), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 12-25 targets
Path/Lab CPT Changes 2013

• Microbiology – New Codes – Infectious Agent Genotype Analysis by Nucleic Acid
  – Two new codes added – 87910, 87912 for Infectious Agent Genotype Analysis via Nucleic Acid
  – Help determine drug resistance and treatment options for viral diseases
Path/Lab CPT Changes 2013

- Microbiology – New Codes – Infectious Agent Genotype Analysis by Nucleic Acid
  - 87910
    - Used for detection of cytomegalovirus
  - 87912
    - Used for detection of Hepatitis B Virus
Infectious Agent Genotype Analysis

#l 87910 Infectious agent genotype analysis by nucleic acid (DNA or RNA); cytomegalovirus

p 87901 HIV-1, reverse transcriptase and protease regions

#87906 HIV-1, other region (eg, integrase, fusion)

#l 87912 Hepatitis B virus

87902 Hepatitis C virus
Flow Cytometry

• Confusion regarding use of flow cytometry codes (88184, 88185, 88187-88189)
  – Intended to describe testing performed on patient cells to detect markers (such as antigens on surface of cells for hematologic condition assessment)

► (For assessment of circulating antibodies by flow cytometric techniques, see analyte and method specific codes in the Chemistry section [83516-83520] or Immunology section [86000-86849])
Pathology Changes 2013

• Surgical Pathology – Optical Endomicroscopic Images Interpretation and Report
  – New code to identify interpretation and report for optical endomicroscopic imaging – 88375
  – 43206, 43252 – Identify the “surgical” procedure – Esophagoscopy with optical Endomicroscopy (43206) or EGD with Endomicroscopy (43252)
  – 88375 – Interpretation of the specimens
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Trends in CPT

1. More process transparency
2. Quicker public dissemination of code descriptors/codes
3. More detailed (and longer) code descriptors
4. More detailed introductory information to clarify use.
5. More precise unit of service clarifications
More process transparency

1. CPT Editorial Panel meetings are open to the public (if conflicts of interest/confidentiality agreements are signed).

2. CPT Editorial Panel meeting agendas are publically available prior to the meetings.

3. AMA website provides information on other issues that are currently on the CPT agenda.

4. CPT Workgroups often have public announcements inviting membership and have may have public meetings (eg, in conjunction with the CPT Editorial Panel Meetings).
Quicker public dissemination of code descriptors/codes

• “After each CPT Editorial Panel meeting, a document is prepared showing a summary of the actions that were taken by the Panel on each of the code applications.”*

• “Any category I molecular pathology codes, MAAA codes, vaccine codes, or Category III codes referenced in the Summary of Panel Actions document will be posted to the CPT website on or before July 1st and will be scheduled for implementation January 1st.”*

2014 updates (lab examples)

Accepted establishment of Molecular Pathology Tier 1 code to report DMD (dystrophin) (e.g., Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis.

CASQ that should be added to Tier 2 (level 2, 11 exons): 1405-CASQ2 (calsequestrin, cardiac muscle) (e.g., catecholaminergic polymorphic ventricular tachycardia), full gene sequence.

Accepted establishment of Molecular Pathology Tier 1 code to report DMD (dystrophin) (e.g., Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis.

Accepted editorial revision to codes 1400-81408 to include additional analytes, and addition of a parenthetical note to code 81401 following SMN1/SMN2 instructing users to report 1401 for duplication/deletion analysis of SMN1/SMN2.
2014 updates (lab examples)

PCDH15-Accepted assignment to molecular pathology procedure Tier 2, 81401
ETV6/NTRK3-Accepted assignment to molecular pathology procedure Tier 2, 81401
EWSR1/ATF1-Accepted assignment to molecular pathology procedure Tier 2, 81401
EWSR1/WT1-Revised
FOXO1/PAX3-Revised
FOXO1/PAX7-Revised
FUS/DDIT3-Accepted assignment to molecular pathology procedure Tier 2, 81401
SS18/SSX1-Accepted assignment to molecular pathology procedure Tier 2, 81401
SS18/SSX2-Accepted assignment to molecular pathology procedure Tier 2, 81401
COL1A1/PDGFB-Accepted assignment to molecular pathology procedure Tier 2, 81402
CTNNB1-Accepted assignment to molecular pathology procedure Tier 2, 81403
DNMT3A-Accepted assignment to molecular pathology procedure Tier 2, 81403
CD40LG-Accepted assignment to molecular pathology procedure Tier 2, 81404
ZNF41-Accepted assignment to molecular pathology procedure Tier 2, 81404
FTSJ1-Accepted assignment to molecular pathology procedure Tier 2, 81405
IL2RG-Accepted assignment to molecular pathology procedure Tier 2, 81405
ISPD-Accepted assignment to molecular pathology procedure Tier 2, 81405
MTM1-Accepted assignment to molecular pathology procedure Tier 2, 81405
PDHA1-Accepted assignment to molecular pathology procedure Tier 2, 81405
FTSJ1-Accepted assignment to molecular pathology procedure Tier 2, 81406
IDUA-Accepted assignment to molecular pathology procedure Tier 2, 81406
MTM1-Accepted assignment to molecular pathology procedure Tier 2, 81406
PCDH15-Accepted assignment to molecular pathology procedure Tier 2, 81406
MYH11-Accepted assignment to molecular pathology procedure Tier 2, 81408
**2014 updates (lab examples)**

<table>
<thead>
<tr>
<th>Request</th>
<th>Accepted Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) <strong>Revise code 88342 to:</strong> a) <strong>Include</strong> immunocytochemistry; b) <strong>Define the unit of service;</strong> and c) <strong>Remove reference to</strong> tissue immunoperoxidase;</td>
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</tr>
<tr>
<td>2) <strong>Establish an add-on code to report</strong> each additional separately identifiable antibody; and</td>
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</tr>
<tr>
<td>3) <strong>Add instructional parenthetical notes for these services.</strong></td>
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</tr>
</tbody>
</table>
2015 updates (lab examples)

Name:
In Situ Hybridization

Code #’s:
88365 88367 88368 883X1 883X2 883X3

Description of CPT Editorial Panel Action:
Accepted revision of codes 88365, 88367 88368, and addition of codes 8836X6, 8836XX, 8836X9.
Quicker public dissemination of code descriptors/codes

- Publication of the electronic files and the CPT book are being available earlier.
- When in doubt look at the public website
More detailed (and longer) code descriptors

86152  Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood)

(For physician interpretation and report, use 86153. For cell enumeration with interpretation and report, use 86152 and 86153)

86153  physician interpretation and report, when required
Multianalyte Assays with Algorithmic Analyses

Multianalyte Assays with Algorithmic Analyses (MAAAs) are procedures that utilize multiple results derived from assays of various types, including molecular pathology assays, fluorescent in situ hybridization assays and nonnucleic acid–based assays (eg, proteins, polypeptides, lipids, carbohydrates). Algorithmic analysis using the results of these assays as well as other patient information (if used) is then performed, and reported typically as a numeric score(s) or as a probability. MAAAs are typically unique to a single clinical laboratory or manufacturer. The results of individual component procedure(s) that are inputs to the MAAAs may be provided on the associated laboratory report, however these assays are not reported separately using additional codes.

The format for the code descriptors of MAAAs usually include (in order):

- Disease type (eg, oncology, autoimmune, tissue rejection),
- Material(s) analyzed (eg, DNA, RNA, protein, antibody),
- Number of markers (eg, number of genes, number of proteins),
- Methodology(ies) (eg, microarray, real-time [RT]-PCR, in situ hybridization [ISH], enzyme linked immunosorbent assays [ELISA]),
- Number of functional domains (if indicated),
- Specimen type (eg, blood, fresh tissue, formalin-fixed paraffin embedded),
- Algorithm result type (eg, prognostic, diagnostic),
- Report (eg, probability index, risk score)

MAAAs, including those that do not have a Category I code, may be found in Appendix O. MAAAs that do not have a Category I code are identified in Appendix O by a four-digit number followed by the letter “M.” The Category I MAAA codes that are included in this subsection are also included in Appendix O. All MAAA codes are listed in Appendix O along with the procedure’s proprietary name.

When a specific MAAA procedure is not listed below or in Appendix O, the procedure must be reported using the Category I MAAA unlisted code (81599). These codes encompass all analytical services required (eg, cell lysis, nucleic acid stabilization, extraction, digestion, amplification, hybridization, and detection) in addition to the algorithmic analysis itself. Procedures that are required prior to cell lysis (eg, microdissection, codes 88380 and 88381) should be reported separately.
More precise unit of service clarifications

88172  Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site

(The evaluation episode represents a complete set of cytologic material submitted for evaluation and is independent of the number of needle passes or slides prepared. A separate evaluation episode occurs if the proceduralist provider obtains additional material from the same site, based on the prior immediate adequacy assessment, or a separate lesion is aspirated)

#+ 88177  immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)
Learning Objectives

1. Understand the significant changes for CPT coding for laboratory and pathology services in 2012.
2. Learn the big issues that are being formulated for Pathology and Laboratory CPT coding in the near future.
3. Understand the issues that CMS are considering related to #1 and #2 and review any announced recently policies related to the same.
Molecular Pathology (CMS) Valuation (2012)

- The College of American Pathologists developed recommendations for:
  - physician work RVU
  - practice expense direct inputs for medical supplies, equipment and clinical staff
  - And submitted to the American Medical Association/Specialty Society RVS Update Committee (RUC) for the majority of the new molecular CPT codes

- The RUC made physician work and practice expense recommendations for the 70 Tier 1 and 9 Tier 2 codes which were submitted to the CMS for CY 2012.

- In CMS’ final ruling, CMS stated that these new CPT codes would not be valid for Medicare purposes for CY 2012.
  - “For CY 2012 Medicare will continue to use the current "stacking" codes for the reporting and payment for these services.”
Molecular Analysis: CMS Payment?

– Primary issues:
  • CLFS vs PFS placement (static non-resourced based vs dynamic resource based fee schedule)
  • PhD interpretative services.
– CMS had a meeting in July 2012 on potential CLFS placement
– Coalition of interested parties discussing possibility of a Congressional fix to PhD interpretative piece
• We were left to wait for the Federal Register CMS Final Rule for 2013...
• 2013 Payment per CMS Final Rule- GAP-fill
  – Lose-lose for Pathology and Clinical Lab organizations that we pushing for PFS an CLFS payment respectively
  – Left the intense work of the CAP and RUC not readily available for non-CMS payors.
  – Each MAC created a fee schedule, then submitted to CMS. CMS them posted on May 9th, with a 60 day comment period.
  – Final fee-schedule for 2013 (largely retrospectively) and 2014 is (was) scheduled to be published in September.
Molecular Analysis PC

• Professional Component of MoPath marginalized
  – requires the use of interim HCPCS code
    G0452 (Molecular pathology procedure; physician interpretation and report)

• To use the following must occur:
  – must be requested by the patient’s attending physician,
    “a hospital’s standing policy can be used as a substitute for the individual request by a patient’s attending physician.”
  – must result in a written narrative report included in the patient’s medical record, and
  – requires the exercise of medical judgment by the consultant physician.
Multi-analyte Assays with Algorithmic Analyses (MAAAs)

CMS Preliminary Payment Decision (09/12)

- CMS uses other codes for payment of the underlying clinical laboratory tests on which the MAAA is done and does not recommend separately pricing the MAAAs codes.

Rationale

- “Medicare does not recognize a calculated or algorithmically derived rate or result as a clinical laboratory test since the calculated or algorithmically derived rate or result alone does not indicate the presence or absence of a substance or organism in the body.”
- “Medicare uses other codes for payment of the underlying clinical laboratory tests on which the MAAA is done and we continue to recommend not separately pricing the MAAAs codes.”
Multi-analyte Assays with Algorithmic Analyses (MAAAs)

However....

Were place on the list for discussion at the CLFS discussion agenda in July 2013 for potential 2014 valuation.
Why is this important?

Molecular Pathology/MAAA driving increased laboratory costs!
Other Clinical Lab Fee Schedule issues

• Preliminary Rule 2014
  – CMS is proposing a process that would allow for the systematic examination of payment amounts on the Clinical Laboratory Fee Schedule (CLFS)
    • Identify those CLFS codes that had undergone “technological changes” affecting the price of the test.
    • Review all CLFS codes over a five-year period
    • Make appropriate adjustments to payment rates on the CLFS whenever necessary.
  – CMS is proposing to bundle clinical laboratory payments into the OPPS payments for related services.
    • CMS believes that, in general, clinical laboratory tests essentially support the underlying outpatient encounter.
2014 Proposed Physician Fee Schedule Issues

• CMS proposed to link payment for over 200 services to hospital outpatient APC rates as part of its “misvalued code” initiative.
  – Reduces TC and Global of 39 pathology codes billed for non-hospital patients
  – Responsible for 5% overall cut to pathology Medicare payment

• Impact on individual practices depends on case mix.
  – Medicare PC only billers are not impacted
  – Global and TC billers will see larger impact
PFS-TC to APC Conversion Issues

• Medicare has an established process for reviewing and revaluing codes it believes are misvalued through the AMA-RUC.

• It appears that payment linkage to the hospital outpatient rates fails to take into consideration the technical costs associated with specific individual codes (represent groupings of “like-cost” procedures).

• Data used to calculate APC for pathology AP services could be conceptually flawed.

• Current law requires physician fee schedule values to be resource based. Linking payment to the hospital outpatient grouping system fails to recognize distinct resources.
2014 Proposed Physician Fee Schedule- Other Issues

• Medical Economic Index weights increase PC only rates (CMS policy change).

• f/u from 2013 Final Rule challenge of block # for 88305– TC: values still under review

• RUC/CPT recoding/valuations
  – Immunohistochemistry (PC and TC)
  – Enhanced Cytology (88112) PC and TC
  – In situ hybridization 88365 family (PC and TC)
Remarkable Proposed Code Price Reduction Examples:

• Surgical Pathology
  • 88307 (global) Tissue exam by pathologists -50%
  • 88309 (global) Tissue exam by pathologists -30%

• Special stains
  • 88312 (global) Special stains group 1 -46%
  • 88313 (global) Special stains group 2 -45%
  • 88342 (global Immunohistochemistry) -27%
  • 88367 (global) In situ hybridization (comp assist) -60%
Remarkable Proposed Code Price Reduction Examples:

• Cytopathology
  • 88108 (global) Cytopath concentrate tech -39%
  • 88112 (global) Cytopath cell enhanced tech -22%
  • 88173 (global) Cytopath eval fna report -25%

• Flow Cytometry
  • 88185 (TC) Flow cytometry add-on code -75%
Proposed Code Price Increase Examples:

- Surgical Pathology
  - 88305 (PC) Tissue exam by pathologists 4%
  - 88305 (global) Tissue exam by pathologist 1%
  - 88307 (PC) Tissue exam by pathologist 3%
  - 88309 (PC) Tissue exam by pathologists 3%
  - 88331 (PC) Path consult intraop 1st block 3%
Proposed Code Price Increase Examples:

- **Cytopathology**
  - 88112 (PC) Cytopath cell enhance tech 4%
  - 88173 (PC) Cytopath eval fna report 3%

- **Special Stains**
  - 88312 (PC) Special stains group 1 3%
  - 88313 (PC) Special Stains group 2 5%
  - 88342 (PC) Immunohistochemistry 5%
Published MUE’s for Surgical Pathology

<table>
<thead>
<tr>
<th>HCPCS\CPT Code</th>
<th>Practitioner or DME Supplier MUE</th>
<th>CPT description</th>
</tr>
</thead>
<tbody>
<tr>
<td>88300</td>
<td>2</td>
<td>Surg Path Level 1</td>
</tr>
<tr>
<td>99302</td>
<td>2</td>
<td>Surg Path Level 2</td>
</tr>
<tr>
<td>88309</td>
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<td>Surg Path Level 6</td>
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<tr>
<td>88325</td>
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<td>88329</td>
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<td>Intraop Consult</td>
</tr>
<tr>
<td>88331</td>
<td>11</td>
<td>Frozen Section</td>
</tr>
<tr>
<td>88333</td>
<td>4</td>
<td>Intraop cytology</td>
</tr>
</tbody>
</table>

- Not all are published.
- Previously adjudicated per line of the claim form (modifiers are on a separate line).
- **Now (by dictum of CMS Program Integrity) some may be adjudicated by entire claim.**
Learning Objectives

1. Understand the significant changes for CPT coding for laboratory and pathology services in 2013.
2. Learn the big issues/trends in Pathology and Laboratory CPT coding in the near future.
3. Understand the issues that CMS are considering related to #1 and #2 and review any announced recently policies related to the same.
4. BONUS (as time permits) Coding & Compliance Pearls!
1. Remember units of service definitions for 88300-88309:
   - “The separately identifiable specimen” (not always the separate container), e.g.,
     - Skin biopsies
     - Uterus, tubes and ovaries
     - Twin placentas
2. Remember “other” units of service definitions:
   – Immunohistochemistry: “The unit of service for immunohistochemistry (CPT codes 88342, 88360, 88361) is each antibody(s) stain (procedure) per specimen.”, eg,
     • Sentinel nodes requiring multiple blocks. OK
     • Multiple antibodies using different chromagens on same slide. Yes(CAP), No (NCCI)- but changes will occur in 2014
     • MAK-6 keratin cocktails. Not OK
   – Other special stains: : “Per separately identifiable antibody per block if it is medically reasonable and necessary”
   – In situ hybridization: “Per specimen per separately identifiable probe”;
     • Per different fluorescent marker (anticipate changes in 2015)
   – Consultations: “The outside specimen accession” (CAP)
   – Frozen sections: “Per frozen section block” (per specimen)
3. CPT codes 88302-9 each have a range of work that may overlap with other codes
   – TURP
   – Seborrheic keratoses
4. Specimen type grouping in codes CPT 88302-9 were intentionally crafted to optimize the system
   – TURP
5. If a specimen type is specifically stated in CPT 88302-9 one MUST use that code:
   – Skin excisions for cutaneous tumors are 88305 regardless of specimen size
   – Malignant appendices or gallbladders can not be upcoded.
6. When a specimen type is not specifically stated in CPT 88302-9 one must extrapolate from existing codes with comparable physician work:
   – Uvulectomy
   – Omentectomy
Be wary of mixing non-GYN CPT for the same specimens

- Direct smears and concentrated preparations on a bronchial brushing
- Also applicable for FNA’s
- Not applicable for separate specimens received as a single accession (bronchial brushing and bronchial washing)
- Not applicable for cell blocks.

Remember the unit of service designations for FNA’s

- 88172 and 88177 (FNA rapid interpretation): each evaluation episode
- 88173 Final interpretation: per site
CPT Coding Compliance Pearls for Pathologists

1. Remember who is ultimately responsible for coding:
   • The pathologist whose name is submitted on the claim

2. Develop a personal method for coding
   • “The bathroom mirror test”
   • Assure that your report appropriately justifies your code assignment.

3. Document both what you do, and what you find, in your report
   • Consider the pathology report the definitive billing justification document
     • Special procedure
     • Gray coding areas
4. Have a plan!
   - Develop (and implement) a usable corporate compliance plan
     - See CAP’s “Compliance Guidelines for Pathologists” (1998)

   - Within the plan develop strategies to promote Group coding consistency:
     - Have a rational plan for who codes, who checks the codes and who monitors the codes.
     - Discuss within the group problem areas of coding
     - Promote CME activities for coding (ie, CAP Internet Coding Tutorial)
Questions?