Session #7006 – CPT Coding & Medicare Payments: Preparing for 2015 & Beyond

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Speaker 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.
Agenda

- *CPT-2015* updates
- 2015 PQRS measures
- Hospital packaged services
- ICD-10-CM status
- Future of Medicare CLFS
- Clinical utility: The next hurdle
CPT-2015 Updates

• Drug testing
  – Revised drug screening codes
  – Many new, revised and deleted single drug test codes

• Blood typing 86900-86906 now specifies “serologic”

• New HPV testing codes (delete 87620-87622)
  – 87623 Human Papillomavirus, low-risk types (eg, 6, 11, 42, 43, 44)
  – 87624 Human Papillomavirus, high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)
  – 87625 Human Papillomavirus, types 16 and 18 only, includes type 45, if performed
CPT-2015 Updates

• Molecular Tier 1 & Tier 2 code updates

• New ‘next generation’ sequencing molecular codes
  – Aortic dysfunction or dilation (81410, 81411)
  – Nonsyndromic hearing loss (81430, 81431)
  – X-linked intellectual disability (81470, 81471)
  – Fetal chromosomal aneuploidy (81420)
  – Hereditary colon cancer syndromes (81435, 81436)
  – Whole mitochondrial genome (81460, 81465)
  – Targeted solid organ and/or hematolymphoid neoplasm (81445, 81450, 81455)
**CPT-2015 Updates**

- Specific next generation sequencing codes will alleviate several existing dilemmas
  - Single code or 81479 versus ‘stacking’ approach
    - Expected new instruction: “Use individual Tier 1 or Tier 2 code when all components are not performed”
  - Clinical objective: Screening versus diagnostic
  - Referring physician informed consent
  - Issues reminiscent of old SMAC billing compliance debates and lawsuits
CPT-2015 Updates

- In situ hybridization (e.g., FISH) code changes
  - **88365** In situ hybridization (eg, FISH), each probe per specimen; initial single probe stain procedure
  - **88364** ... each additional single probe stain procedure (List separately in addition to code for primary procedure)
  - **88366** ... each multiplex probe stain procedure
  - Codes 88365, 88364 and 88366 are for *qualitative* ISH testing
CPT-2015 Updates

• In situ hybridization (e.g., FISH) code changes (cont.)
  – **88367** Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe, using computer-assisted technology, per specimen; using computer-assisted technology initial single probe stain procedure
  – **88373** … each additional single probe stain procedure (List separately in addition to code for primary procedure)
  – **88374** … each multiplex probe stain procedure
CPT-2015 Updates

• In situ hybridization (e.g., FISH) code changes (cont.)
  – 88368 Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe, manual, per specimen; manual initial single probe stain procedure
  – 88369 ... each additional single probe stain procedure (List separately in addition to code for primary procedure)
  – 88377 ... each multiplex probe stain procedure
CPT-2015 Updates

• In situ hybridization (e.g., FISH) code changes (cont.)
  – Note change from ‘probe’ to ‘probe stain procedure’ *per specimen* (not block) as the unit of service
  – ‘Probe stain procedure’ presumably refers to each specific ISH test (e.g., Her-2/neu) regardless of probe count
  – ‘Single’ presumably refers to an ISH test consisting of one probe (e.g., CEP-8 or -12 for chromosome enumeration)
  – ‘Multiplex’ presumably refers to an ISH test consisting of two or more probes (e.g., Her-2/neu, ALK, CLL, EGR1), including dual and triple color probe sets
CPT-2015 Updates

• Immunohistochemistry code changes
  – **88342** Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear specimen; first separately identifiable initial single antibody per slide stain procedure
  – **88341** ... each additional single antibody stain procedure (List separately in addition to code for primary procedure)
  – **88343** ... each additional separately identifiable antibody per slide (List separately in addition to code for primary procedure)
  – **88344** ... each multiplex antibody stain procedure
CPT-2015 Updates

• Immunohistochemistry code changes (cont.)
  – 88360 Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semi-quantitative, per specimen, each single antibody stain procedure; manual
  – 88361 ... using computer-assisted technology
  – DLP Note: The 2015 pre-production CPT code file from the AMA does not list a ‘multiplex’ antibody stain procedure companion code for either 88360 or 88361.
CPT-2015 Updates

• Immunohistochemistry code changes (cont.)
  – Note change from *block* to *specimen* as the anchor unit for IHC charges, consistent with Medicare
  – ‘Single antibody stain procedure’ presumably refers to one antibody per vial (e.g., S100, HMB-45, CD20), usually equivalent to one antibody per slide
  – ‘Multiplex antibody stain procedure’ presumably refers to two or more antibodies per slide (e.g., PIN-4)
  – What about something like CK-5/6 or AE1/AE3? Padget advises treatment as ‘single antibody stain procedure’.
CPT-2015 Updates

• Will CMS adopt the new IHC and ISH codes for 2015, deleting G0461 and G0462?
• Ask the magic 8 ball: Yes or No or Maybe
2015 PQRS Measures

- Three new measures for pathologists in 2015
  - **Melanoma Reporting**: Reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness and ulceration, and for pT1, mitotic rate
  - **Lung Cancer Reporting (Resection Specimen)**: Reports based on resection specimens with a diagnosis of primary lung carcinoma that include the pT category, pN category, and, for non-small cell lung cancer, histologic type
  - **Lung Cancer Reporting (Biopsy/Cytology Specimens)**: Reports based on biopsy and/or cytology specimens with a diagnosis of non-small cell lung cancer classified into specific histologic type or as NSCLC-NOS with an explanation included in the report
2015 PQRS Measures

• Five measures carried forward from 2014
  – **Breast Cancer Resection (#99):** Reports based on resection specimens with a diagnosis of primary breast carcinoma that include the pT category, pN category, and histologic grade
  – **Immunohistochemistry Evaluation of Her-2/neu for Breast Cancer Patients (#251):** Reports based on quantitative evaluation of Her-2/neu by IHC using the ASCO/CAP reporting guidelines
  – **Colorectal Cancer Resection (#100):** Reports based on resection specimens with a diagnosis of primary colorectal carcinoma that include the pT category, pN category, and histologic grade
2015 PQRS Measures

• Five measures carried forward from 2014 (cont.)
  – **Barrett’s Esophagus (#249):** Reports based on esophageal biopsy that document the presence of Barrett’s mucosa and that also include a statement about dysplasia
  – **Radical Prostatectomy (#250):** Reports based on radical prostatectomy specimens that include the pT category, pN category, Gleason score, and statement about the margin status

• Pathologists ineligible for 2015 PQRS reporting
  – Professional services billed by independent laboratory (specialty 69)
  – Certain subspecialists: Neuropathology; renal pathology; clinical pathology; and hematopathology
2015 PQRS Measures

• Other 2015 PQRS rules and considerations
  – Reporting options: Claims basis or registry
  – Penalty in 2017 for failure to report or meet threshold
  – Successful reporting requirements
    • Number of measures to be reported
    • Percentage threshold
  – Other considerations
    • Internal failsafe mechanisms
    • You control your own destiny
Hospital Packaged Services

- Clinical lab tests, excluding molecular, starting 2014
- Pathology add-on codes starting 2014
  - 88311, 88314
  - 88177, 88185, 88332, 88334, G0462
- Histology and cytology technical services
  - Withdrawn for 2014, but reintroduced for 2015
  - Packaged with “primary service” (i.e., surgical procedure)
  - Examples: 88112, 88172-88173, 88184, 88304-88307, 88312-88313, 88331, G0461, 88360-88361, 88365-88368
ICD-10-CM Status

• CMS “drop dead” date for adopting ICD-10-CM is October 1, 2015

• How realistic is that date?
  – ICD-11 will go live May 2017 per WHO
  – Republicans may control House & Senate in Jan. 2015
  – Transition to ACA still rocky (e.g., pending premium jumps)

• Advice: Keep moving forward internally, but don’t “pull trigger” until March 2015
Future of Medicare CLFS

• Medicare clinical lab fee schedule (CLFS) initially published in mid-1984

• Enabling legislation prior to April 1, 2014 did not accommodate periodic rebasing
  – New, revised and deleted test codes per AMA CPT updates and CMS HCPCS-II updates
  – New and revised codes priced mainly by gap-fill, with limited use of “inherently unreasonable” authority
  – CPI-type updates authorized by Congress
Future of Medicare CLFS

- CMS gave itself authority to rebase the CLFS via the 2014 MPFS final rule
- Protecting Access to Medicare Act of 2014 (P.L. 113-093), signed by President Obama April 1, 2014
  - Avoided 24% SGR reduction in physician allowed charges by Medicare in 2014
  - Postponed ICD-10-CM implementation to no earlier than October 1, 2015
Future of Medicare CLFS

• PAMA (§216) and Medicare CLFS
  – “Improving Policies for Clinical Diagnostic Laboratory Tests”
  – Adds new part to §1834 of SSA
  – Substantially changes methodology for setting CLFS payment rates starting January 1, 2017
    • Weighted median of payments to labs by private health insurers and group health plans, Medicare Advantage plans, and Medicaid managed care plans
    • Payment data must take into account “all discounts, rebates, coupons, and other price concessions” given by reporting labs
Future of Medicare CLFS

• PAMA (§216) and Medicare CLFS (cont.)
  – Secretary of DHHS to issue regulations to implement §216 no later than June 30, 2015
    • Initial data collection period (e.g., a previous 12-month period)
    • Lab reporting exemption criteria (e.g., very few Medicare patients)
    • Payment data reporting format to be used by lab providers
    • Reporting deadline
    • Other rules and instructions deemed relevant by Secretary
  – Secretary may formulate alternate methodology for pricing “advanced lab tests” (e.g., molecular)
Future of Medicare CLFS

• PAMA (§216) and Medicare CLFS (cont.)
  – Anticipated reporting requirements by labs
    • Amount received per each different test from each different private insurer or other specified payer, together with payment volume data
    • If insurer paid different amounts for a given test during the period, report each different payment rate and volume for that test
    • PAMA doesn’t mention payments by non-insurers (e.g., physician office clients), but the Secretary may include those by regulation
  – Sanctions, including civil monetary penalty, provided for labs that fail to report or that misrepresent data
Future of Medicare CLFS

• PAMA (§216) and Medicare CLFS (cont.)
  – Secretary of DHHS authorized to consolidate coverage policy and/or claim processing for CLFS payments
    • Coverage policy presumably would include frequency limits, clinical utility, and the like
    • Coordination with National Correct Coding Initiative and Medically Unlikely Edit authority not yet addressed
    • Secretary may consolidate authority under just one Medicare Administrative Contractor
      – Coverage policy
      – Claim processing
Future of Medicare CLFS

• Will you be able to furnish the requisite data?
  – Payments posted at claim level vs. line-item (test)
  – Await guidance on deductibles, coinsurance, secondary payments, etc.

• What will Medicare CLFS rates look like 01/01/2017?
Clinical Utility: The Next Hurdle

• Prediction: Government and private insurers will require definitive evidence of medical necessity for pathology procedures (e.g., special stains, IHC) with increasing frequency in next three years.

• Support for prediction
  – Longstanding NCCI policy for proof of medical necessity for both IHC and flow on same bone marrow case
  – May 2014 Palmetto GBA policy on medical necessity of special stain or IHC for H. pylori on gastric biopsies
Clinical Utility: The Next Hurdle

- Palmetto GBA policy re: special stain or IHC for H. pylori on gastric biopsies
  - Issued in May 2014, but withdrawn in August
  - Automatic special stain or IHC for H. pylori not medically indicated (20% or fewer biopsies require more than H&E)
  - Policy supported by professional literature
  - Palmetto mistakes that led to withdrawal of policy
    - Failed to follow CMS prescribed LCD release guideline
    - Insufficient recognition of circumstances that support greater than 20% utilization ratio
Clinical Utility: The Next Hurdle

• Movement afoot (within next three years): Ultimate transparency for pathology special procedures
  – “Z-code” approach (unique HCPCS-II code per each specific procedure)
    • Special stains (PAS, PAS-d, giemsa instead of 88312-313)
    • IHC (ER, PR, CD45, CD138 instead of 88342)
    • FISH (each probe has its own code)
  – Powerful clinical utility monitoring tool when combined with ICD diagnosis codes
Clinical Utility: The Next Hurdle

• What should you do today?
  – **Definition:** A *medically necessary* service is one that a prudent pathologist would provide to a patient for the purpose of diagnosing an illness, disease, condition or symptom. Prudence means the service is clinically appropriate considering the patient’s history, the current clinical circumstances, and generally accepted standards of medical practice. It’s imprudent to conduct a service primarily for the convenience of the patient, the ordering physician or the examining pathologist.
Clinical Utility: The Next Hurdle

• What should you do today (cont.)?
  – **Suggestion #1:** Limit automatic ordering of special stains, immunohistochemistry, immunofluorescence, and other special procedures to clinical situations of unquestioned prudence vis-à-vis generally accepted medical practice standards; examples of unquestioned prudence include, but aren’t necessarily limited to, (1) a limited, defined battery of histologic and immunofluorescence stains with renal biopsies; and (2) a limited, defined battery of enzyme histochemistry stains with muscle biopsies.
Clinical Utility: The Next Hurdle

• What should you do today (cont.)?
  – **Suggestion #2:** Except as provided via the immediately preceding principle, base your decision to order a special stain, immunohistochemistry stain, immunofluorescent stain, or other procedure on your findings from the microscopic examination of the routine tissue sections or smears and/or on the patient’s pertinent medical history; for example, the referring physician may state “rule out H. pylori” on the requisition.
Clinical Utility: The Next Hurdle

• What should you do today (cont.)?
  – **Suggestion #3:** Document in your medical report the reason each special procedure was ordered as well as the medical conclusion you reached based on the special procedure; for example...

  **Final Diagnosis:** Gastric biopsy showing chronic gastritis with mild atrophy and intestinal metaplasia, suggestive of autoimmune gastritis (see comment)

  **Comment:** Gastrin immunohistochemical stain confirms the presence of antral and body-type mucosa. Within the body-type mucosa, synaptophysin IHC stain highlights linear and nodular neuroendocrine hyperplasia, supporting the above diagnosis.
Thank you for your attention...

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