MEDICALLY UNBELIEVABLE EDITS

The Centers of Medicare and Medicaid Services (CMS, formerly known as Health Care Finance Administration, HCFA) has proposed limiting the number of units of service that a pathologist can bill a patient for professional services given to a patient on a single day. An example of a proposed limit is two surgical pathology CPT codes per patient per provider per day. You read that right. This means that if your gastroenterologist submits 6 biopsy specimens from the colon as part of a surveillance protocol in a patient with chronic ulcerative colitis, you will only be allowed to bill CPT 88305 x 2 instead of 88305 x 6. The name given this initiative is Medically Unbelievable Edits (MUE) and it affects both anatomic and clinical pathology codes.

MUE were initially put in place to prevent CMS from being billed for such mistakes as 2 appendectomies on a single patient. This kind of audit, of course, makes perfect sense and is most likely going to capture transcription, or otherwise unintended, errors. And the National Correct Coding Initiative (NCCI) edits were intended to prevent payment for 2 codes when one code subsumed the other. Although NCCI edits were, and remain, controversial, at least there is a basic premise that can be seen as reasonable. For example, one cannot bill an 88300 (gross examination only) and an 88305 for a single breast biopsy since the gross examination is incorporated into the 88305 (gross and microscopic exam).

However, the current MUE initiative is purely a means of financial control over Part B payments and would appear to be aimed primarily at pathologists and laboratories. It essentially limits the number of codes that can be billed on a given day. The maddening irony, of course, is that pathologists, and clinical labs, do not control the number of specimens sent to them. If your urologist likes sextant prostate biopsies as a means to localize the adenocarcinoma for directed therapy, you most certainly are obligated to review all of those slides and give 6 site-specific diagnoses. (This is not to be confused with “unbundling”- where the axillary contents of a mastectomy are submitted separately instead as one specimen with a single billing code of 88309.) The current proposal does not provide any means to override the rules for extenuating circumstances- there are no modifiers.

Now, you might be thinking that certainly this new policy is being announced so that individual pathologists and our professional organizations will be able to comment on the proposed changes and that, as a last resort, there will be an appeals process. Unfortunately, CMS is proceeding without following the standard procedures for comment and review. The College of American Pathologist notes that in February of 2005, CMS issued and then rescinded a notice to establish MUE. The American Medical Association, in December of 2005, circulated to medical societies a proposed MUE list from a CMS contractor with a comment deadline of February 5, 2006. This contractor (CMS routinely contracts out these programs) did not provide the AMA with any specific information concerning the comment period, implementation date, methodology, or the use of modifiers.
SIMPLY UNBELIEVABLE

The specter of the Medically Unbelievable Edits (MUE) may be the harbinger of what CMS has in mind to control part B payments, the Medicare program that pays physicians for their professional services. CMS has always claimed, and physicians have denied, that when payment per unit of service was decreased, physicians compensated by performing more units of service. However, pathologists have a right to be cynical about the MUE to control Medicare spending as we control only a small portion of our “units of service” - limited to such things as the number of immunostains needed to pinpoint the primary tumor or flow cytometry markers needed to diagnosis a specific lymphoma.

Some might even suggest that the emphasis on pathology by the current MUE proposal is really evidence that our clinical colleagues, with the greed that is implicit in direct client billing, the pod histology labs, and the physician office histology labs, killed our goose looking for the golden egg to boost their sagging incomes. Such schemes, in their various disguises, are legal in all states (in New York, our colleagues use the histology POL model with a pathologist placed on the payroll as an employee) and I have it on good authority that the Inspector General and all the power of CMS could find no legal way to shut them completely down. Apparently, the self-evident self-referral conflict of interest that occurs when a gastroenterologist submits 20 specimens per patient to his/her own histology lab is not sufficiently covered by those pesky Stark laws (the POL exception, remember?). Well, if nothing else, the implementation of the MUE as they are currently proposed would close these labs down faster than you can say “kickback”.

And speaking of kickbacks, someone suggested that the proposed MUE might be the ultimate kickback scheme. Currently, you cannot walk into your local urologists’ office and ask that they send your laboratory all of their clinical colleagues, with the greed that is implicit in direct client billing, the pod histology labs, and the physician office histology labs, killed our goose looking for the golden egg to boost their sagging incomes. Such schemes, in their various disguises, are legal in all states (in New York, our colleagues use the histology POL model with a pathologist placed on the payroll as an employee) and I have it on good authority that the Inspector General and all the power of CMS could find no legal way to shut them completely down. Apparently, the self-evident self-referral conflict of interest that occurs when a gastroenterologist submits 20 specimens per patient to his/her own histology lab is not sufficiently covered by those pesky Stark laws (the POL exception, remember?). Well, if nothing else, the implementation of the MUE as they are currently proposed would close these labs down faster than you can say “kickback”.

And speaking of kickbacks, someone suggested that the proposed MUE might be the ultimate kickback scheme. Currently, you cannot walk into your local urologists’ office and ask that they send your laboratory all of their clinical tests, and in exchange you will give them a huge discount on their office biopsies. Well, just think of it. Now you can. You can propose that they send you all the biopsies they want, localized to as many areas as they can image (or imagine) and you will only charge their patients 88305 x 2. A loss leader concept-marketing dream.

with the proposed edits. In the meantime, it appears that CMS has changed contractors. The CAP is attempting to get the new contractor to agree to a comment deadline of late February or early March.

The final insult is that should CMS decide to implement this draconian MUE, there is no appeals process! Therefore, it is the goal of the NYSSPath, other state societies, and the CAP to convince CMS to withdraw the proposal until there has been adequate input from the medical community. The CAP is currently working to develop clinical examples to show how these edits do not reflect the reality of the practice of pathology and are therefore inappropriate and unreasonable. It shouldn’t take long to come up with a list of evidence-based clinical practice protocols that call for multiple specimens.

The CAP has already done some preliminary review of Medicare claims files. As might be expected, the pathology procedure with the highest volume is 88305. A review of the data in terms of the proposed MUE reveals that almost 1% of claims would exceed the code limit of 2 per patient/day. Obviously, some practices more than others would be impacted by this change—reflecting local inpatient versus outpatient referral practices.

It needs to be pointed out that the proposed MUE affect all facets of pathology. Proposed limits include limiting 88313 (special stains, group II) to 2 units, 88342 (immunocytochemistry) to 4 units, and 88331 (pathology consultation during surgery) to 1 unit. The CAP review suggests that cytogenetic and cytopathology claims will be significantly impacted. The proposed MUE also places limits on the clinical pathology codes performed in the outpatient setting (inpatient testing is under the DRG system) and some of the limits are medical nonsense. In fact, the claims limits under the proposed MUE are so ridiculous, Dr. Tom Sodeman, CAP’s president, is hopeful that reason will prevail.

NYSSPATH’S 2006 ANNUAL MEETING

The 2006 Annual Continuing Education Meeting and Schleifstein Lecture will be held at the University Sheraton in Syracuse, NY on Saturday, April 29, 2006.

Robert Riddell, MD, Schleifstein Lecture
Selected Topics in GI Pathology
Geoffrey Gottlieb, MD
Folklore of Melanocytic Neoplasia
Algorithm for the Diagnosis of Melanoma
Marshal Austin, MD
Litigation Related Pap Test Challenges: Endocervical Adenocarcinoma
Adjudication of Litigated Cased by Multiple Slide
Blinded Re-screening
Dierdre Astin, Director of NYS CLEP
Recent Issues from Wadsworth
The AMA Interim meeting was held in Dallas, TX November 3-9, 2005. I attended the Young Physicians Section portion of the meeting as a delegate from MSSNY and also participated in HOD activities, including reference committee hearings. I also served as Chair of the Resident and Young Physician Pathology Caucus at this meeting.

Highlights from the Pathology Caucus included an excellent legislative update from Phillip Bongiorno, who is the Assistant Director of Scientific Affairs from the CAP’s Division of Advocacy. He discussed several topics of concern, including medical technologist licensure, direct billing, waived testing, cytology proficiency testing, and the two big recurring themes at this AMA meeting: the pending Medicare cuts and Pay for Performance (PFP). It appears that the battles over medical technologist licensure and direct billing are still being fought at the state levels, with successful legislation on the former being passed in Illinois, Massachusetts, Michigan, and Missouri and on the latter being passed in Illinois and Montana. However, the issue of direct billing and contractual joint ventures is one that will undoubtedly attract more federal attention in the very near future (and certainly needs to).

The Young Physicians Section Assembly meeting included an informative educational session on lobbying skills, which was presented by Carlyle Gregory, a Washington, and D.C. - based political consultant, and AMA lobbying staff. There were no resolutions of particular concern to pathologists in the YPS. However, there was one interesting resolution that sought to have the AMA work with the National Residency Match Program to permit residency and fellowship applicants to receive multiple offers of employment from as many programs as are interested in hiring them. This would presumably allow applicants to have some leverage with regards to work hours, benefits, and salary. The testimony from the Section was overwhelmingly in opposition to this type of change to the NRMP and the resolution was not adopted.

Within the House of Delegates, there was one resolution of particular concern to pathologists. Resolution 806 "Standardized Laboratory Reporting Forms", from the Florida delegation, asked that the AMA work with laboratories in the US to standardize reporting forms to make the results easier to interpret; and seek legislation to require standardization of laboratory reporting forms. I attended the hearing of the reference committee to which this item was assigned. The testimony was mixed. The pathology caucus to the HOD did not support the resolution in its present form. Several speakers noted that it is often difficult to interpret lab results; however, many did not feel that standardization of reporting forms was an effective solution to the problem. Many speakers felt that improved communication between labs and treating physicians would be a more appropriate way of addressing the problem. There was also concern that utilizing a standard format for reporting lab results would prevent customization of lab reporting that is often used in different circumstances or by different providers facilitating the interpretation of results. Based on the testimony, the reference committee recommended that a substitute resolution entitled "Improvements to Reporting of Clinical Laboratory Results" be adopted in lieu of resolution 806. This substitute resolution asked that the "AMA work with the appropriate specialty societies and laboratories in the United States for continued improvements in the reporting of clinical laboratory results with a report back to the House of Delegates at the 2006 Interim Meeting." The HOD adopted this substitute resolution.

Finally, the two recurring themes I alluded to earlier, Medicare payment cuts and Pay for Performance (PFP), were the topics of reports, resolutions, and a great many discussions in the HOD. As many of you are aware, the Centers for Medicare and Medicaid Services (CMS) in late October issued its final rule calling for a 4.4% reduction in Medicare physician payments beginning January 1, 2006. Over the next six years, Medicare payments will be cut by 26%. These cuts are based on a flawed sustainable growth rate formula. Although the Senate has passed a bill calling for a 1% increase in payments next year in lieu of the cuts, the House of Representatives has yet to pass similar legislation. There are only a few weeks left in which to obtain this legislative relief; otherwise, the cuts will be unavoidable. The impact on patient access to care will be horrendous as 38% of physicians say they will accept fewer new Medicare patients if the first cut is imposed. The AMA set up a "Make the Calls" booth at the meeting and provided each HOD delegate with cards containing their three federal lawmakers’ contact information so that they could call the legislators and urge them to thwart these cuts. More than 560 physicians participated in this effort.

The same day that the CMS issued its final rule on the Medicare payment cuts, it also announced plans to implement a Physician Volunteer Reporting Program (PVRP) on January 1, 2006 as part of PFP. There are many concerns about this program and PFP as a whole. The AMA is working to develop a media campaign and public education materials to teach patients about the potential risks and liabilities of PFP programs.

The frustration caused by these two issues was clear to see. Many physicians were heatedly discussing opting out of Medicare and some were even wondering aloud whether physician strikes might eventually have to occur (something that the AMA is adamantly opposed to in principle). Interestingly, a Board of Trustees report on AMA membership showed that the number of full dues-paying AMA members increased this year for the first time since 1994. The number of AMA members who are young physicians also increased for the first time since 1990. Could this possibly mean that more physicians are beginning to realize the value of working together as a large group to try to correct some of the ills affecting our profession? I would certainly like to think so. My take home message to all of you from this meeting is: 1) Join the AMA (if you are not already a member) and 2) Contact your legislators now regarding the upcoming Medicare cuts. See you again in this column after the 2006 Annual meeting next June!
NEW 2006 SURGICAL PATHOLOGY CODES
Ernest J. Conforti, MS., SCT (ASCP) MT

Did you know you could now get paid for touch preps with frozen sections again?

Beginning January 1, 2006, you should use new codes 88333 (Pathology consultation during surgery; cytologic examination [e.g., touch prep, squash prep], initial site) and code 88334 (cytologic examination [e.g., touch prep, squash prep], each additional site) to report intraoperative pathology consultations that involve touch preps. You should use new codes 88333 and 88334 only for touch preps the pathologist performs during a surgical consultation however; you should continue to use cytology codes for smears that are not part of a surgical consultation. These codes include 88160 (Cytopathology, smears, any other source; screening and interpretation), 88161, and 88162 (...extended study involving over 5 slides and/or multiple stains). CPT includes a note that states, "Do not report 88333 and 88334 for non-intraoperative cytologic examination, see 88160-88162.

In the past, you used to report two (2) codes when a pathologist performed a touch prep during an intraoperative consultation. This included codes 88329 and 88161 for the touch prep, which needed to be reported separately. In 2006, you just need to report one code to report the service, code 88333. Do not report 88329 and 88333 together for an intraoperative consultation that includes a touch prep.

If the pathologist evaluates touch preps from multiple sites during a consultation, you need to use codes 88333 and 88334 respectively. The initial touch prep is coded as 88333 and 88334 for each additional touch prep performed from other sites. This process is very similar when coding for frozen sections in which code 88331 is listed for the first block (Pathology consultation during surgery; first tissue block, and frozen section [s], single specimen) and one unit of 88332 for each additional block from the same specimen (...each additional tissue block with frozen section [s]).

For example: The pathologist is asked to consult with a surgeon on surgical margins from a breast excision. If the pathologist performs touch preps on all four margins individually, you should report the touch preps as 88333 and 88334 x 3.

Don't be confused with FNA cytology evaluation? If the pathologist evaluates a fine needle aspirate (FNA) for immediate cytologic adequacy and interpretation, you should continue to use codes 88172 (Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen [s]) and 88173 (...)interpretation and report). Continue to use these codes if the pathologist evaluates an FNA specimen during surgery. To avoid confusion, CPT added this note: "Do not report 88333 and 88334 for intraprocedural cytologic evaluation of fine needle aspirate, see 88172. However CPT also states, “For percutaneous needle biopsy requiring intraprocedural cytologic examination, use 88333.”

For more information, please refer to the following links:
http://www.empiremedicare.com/
http://www.cap.org
http://codinginstitute.com

New York State Society of Pathologists
P.O. Box 85
Syracuse, NY 13209-0085

April 21 - 22, 2006
American Pathology Foundation
Spring 2006 Meeting
Act Today to Prepare for Tomorrow
Las Vegas, Nevada

April 29, 2006.
NYSSPath's 2006 Annual Continuing Education Meeting and Schleifstein Lecture
University Sheraton in Syracuse, NY