2013 Coding and Reimbursement Update

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Presented by
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Topics
- Coding changes for 2013
- CCI changes
- MUEs
- Coverage policies and determinations
- Reimbursement
- Molecular codes for 2013
- Future trends
New CPT Codes for 2013

- **82777** Galectin-3
  - Protein with demonstrated involvement in cancer, inflammation and fibrosis, heart disease, and stroke
  - Elevated levels of galectin-3 found to be significantly associated with higher risk of death in both acute heart failure and chronic heart failure
  - FDA approved test exists

Galectin 3, Cont.

- EIA and two monoclonal antibodies in test
- Without sufficient documentation to support two of the codes or unlisted code, CMS has crosswalked to CPT 83520
  - $18.34

New CPT Codes for 2013

- **#86152** Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood)
- Replace Category III code:
  - 0279T Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);
New CPT Codes for 2013
• #86153 Cell enumeration using immunologic selection and identification in fluid specimen (e.g., circulating tumor cells in blood); physician interpretation and report, when required
• Replace Category III code:
  ▪ 0280T Cell enumeration using immunologic selection and identification in fluid specimen (e.g., circulating tumor cells in blood); interpretation and report

CTC, Cont.
• CMS compared to flow cytometry, MPFS & CLFS
• CMS has indicated a gapfill
• History for coverage issues
  ▪ CPT 86152 = $??..?? Gapfilled
  ▪ CPT 86153-26 = $24-28
  ▪ TC/PC
  ▪ FDA approval

New CPT Codes for 2013
• 86711 JC (John Cunningham) virus
  • The virus is very common in the general population, infecting 70 to 90 percent of humans
    ▪ Most people acquire JCV in childhood or adolescence
    ▪ Found in high concentrations in urban sewage worldwide, leading some researchers to suspect contaminated water as a typical route of infection
    ▪ Minor genetic variations are found consistently in different geographic areas
    ▪ Genetic analysis of JC virus samples has been useful in tracing the history of human migration
JC Virus, Cont.

- In U.S., test will be used to determine disease prognosis and treatment of patients with Progressive Multifocal Leukoencephalopathy (PML)
- ELISA procedure to detect antibodies
- CMS believes the code range of 86710 - 86793 justifies crosswalk to 86789
  - $20.39

New HLA Codes

- 8 new codes
  - Newer platforms for solid phase assays
    - Microspheres, chips, ELISA coated trays, flow cytometry
  - Detect common Class I and II antigens
- Still have serologic codes
- Also have new molecular codes

New CPT Codes for 2013

- 86828 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
  - Based on presence or absence of antibodies
  - $56.05
New CPT Codes for 2013

- **86829** 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 or Class II HLA antigens
  - CMS has crosswalked to CPT 86808 based on:
    - Presenter recommendation
    - Similarity in methodology
    - $42.02

New CPT Codes for 2013

- **86830** Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); antibody identification by qualitative panel using complete HLA phenotypes, HLA Class I
  - CMS has crosswalked to CPT 83516x7 based on:
    - ELISA code matches new codes
    - Lymphocytoxicity method currently used but not method for new codes
    - $114.38

New CPT Codes for 2013

- **86831** Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); antibody identification by qualitative panel using complete HLA phenotypes, HLA Class II
  - CMS has crosswalked to CPT 83516x6 based on:
    - ELISA code matches new codes
    - Lymphocytoxicity method currently used but not method for new codes
    - $98.04
New CPT Codes for 2013

• 86832  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

HLA, Cont.

• CMS has crosswalked to CPT 83516x11 based on:
  ▫ ELISA code matches new codes
  ▫ Lymphocytotoxicity method currently used but not method for new codes
  ▫ $179.74

New CPT Codes for 2013

• 86833  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 II
HLA, Cont.

- CMS has crosswalked to CPT 83516x10 based on:
  - ELISA code matches new codes
  - Lymphocytotoxicity method currently used but not method for new codes
  - $163.40

HLA Parenthetical Comment

- Follows CPT 86833
- (If solid phase testing is performed to test for HLA Class I or II antibody after treatment [eg, to remove IgM antibodies or other interfering substances], report 86828-86833 once for each panel with the untreated serum and once for each panel with the treated serum)

New CPT Codes for 2013

- 86834  Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); semi-quantitative panel (eg, titer), HLA Class I
- CMS has crosswalked to CPT 83516x31 based on:
  - ELISA code matches new codes
  - Lymphocytotoxicity method currently used but not method for new codes
  - $506.54
New CPT Codes for 2013

• **86835** Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); semi-quantitative panel (eg, titer), HLA Class II

• CMS has crosswalked to CPT 83516 based on:
  - ELISA code matches new codes
  - Lymphocytotoxicity method currently used but not method for new codes
  - $457.52

Respiratory Virus Coding

• 3 new codes for panel testing dependent on number of viruses tested

• Identify nucleic acid testing

• Parenthetical comments added

New CPT Codes for 2013

• **87631** Infectious agent detection by nucleic acid (DNA or RNA); 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
Respiratory Virus, Cont.

- CMS has crosswalked to CPT 87502 plus 87503x2 as agreed that pricing for 4 targets was appropriate
  - $179.36

New CPT Codes for 2013

- 87632 Infectious agent detection by nucleic acid (DNA or RNA); 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, 6-11 targets

Respiratory Virus, Cont.

- CMS has crosswalked to CPT 87502 plus 87503x6 as agreed that pricing for 8 targets was appropriate
  - $297.04
New CPT Codes for 2013

• 87633 Infectious agent detection by nucleic acid (DNA or RNA); 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, 12-25 targets

Respiratory Virus, Cont.

• CMS has crosswalked to CPT 87502 plus 87503x16 as agreed that pricing for 18 targets was appropriate
  ▫ $591.24

New CPT Codes for 2013

• #87910 Infectious agent genotype analysis by nucleic acid (DNA or RNA); cytomegalovirus
  • CMS has crosswalked to CPT 87902 as agreed that pricing the same for either code
  ▫ $364.64
New CPT Codes for 2013

- #87912  Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis B virus
  - CMS has crosswalked to CPT 87902 as agreed that pricing the same for either code
    - $364.64

Reconsideration Request

- 86386  Nuclear Matrix Protein 22 (NMP22), qualitative
  - Tumor marker for bladder cancer
  - New code in 2012
    - Previously crosswalked to 82487 (Paper chromatog, qual., NOS - $22.61)
    - Request xwalk to CPT 86294 (IA tumor ag, qual or semiquant - $27.79)

Reconsideration Request, Cont.

- CMS retain 82487 xwalk:
  - Immunochromatography performed similar to 1-dimensional flow chromatography for 82487
  - Chemical reaction considered = to immune reaction
Surgical Pathology

- **88375**: Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session
  - Includes all images provided during the endoscopic exam
  - Provided by a separate practitioner such as a pathologist

Optical Endomicroscopic Image(s), Cont.

- Use restricted in conjunction with CPT 43206 and 43252 surgical codes
  - Esophagoscopy - 43206 (new code)
  - Upper GI to include esophagus, stomach, & either duodenum and/or jejunum as appropriate for diagnostic purposes with or without washing or brushing specimens which are separate procedures - 43252 (new code)
  - $?? Not on MPFS

CTC Local Coverage Determination

- Cahaba Active Policy - Example
  - Updated with New codes
  - Only cover CellSearch Platform
  - All Others Methods Non-covered
  - Investigational
  - Limited ICD-9 Codes
    - 153.0-153.9, 154.0-154.8, 174.0-174.9, 185
    - Breast, Colorectal, Prostate
CTCs Cahaba LCD, Continued

- Frequency
  - Once prior to Chemotherapy
  - Once during Chemotherapy
  - Once after Chemotherapy
  - Once annually
- Trailblazer Health Enterprises
  - Duplicates Cahaba

Other CTC LCDs

- CGS
  - Not updated - still indicates CPT 86849
  - Additional ICD-9 Codes for secondary neoplasms
    - 196.0, 198.3, 198.5
- First Coast
  - Updated
  - Added ICDs
- NGS
  - No ICDs
  - No platform detected

Other CTC LCDs

- NHIC
  - No policy detected
- Noridian
  - Non-covered
  - Includes Cell Search
- Palmetto
  - Updated
  - CellSearch only
- WPS
  - Updated
  - CellSearch only
MPFS Final Rule

- Published on November 1, 2012
  - Sets rates for 2013 (CF)
  - Implement findings of RUC review of RVUs for AP codes
  - Last review in about 2000 and thus, due for TC review
  - PC review performed in 2010

Review of CPT 88305

- Biggest shock - TC cut by 51.7%
- Practice expense assigned for an average of 2 blocks (RVUs)
  - CMS asking for input
- PC increased nearly 2%
- Global decrease is about 33%

Review of Other Path Codes

| Code       | Impact  
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Clinical Laboratory Fee Schedule (CLFS) Status

- In 2010, the ACA created a new formula CMS must use to calculate the CLFS annual update
  - CPI impacted by productivity adjustment in 2011
  - Economy wide factor to reflect savings from gains in productivity
- Less a productivity adjustment
  - The result of this calculation cannot go below zero

Clinical Laboratory Fee Schedule (CLFS) Status

- Congress passed the Budget Control Act of 2011, which calls for sequestration of an additional 2 percent
  - This Act was compromise legislation that ended the debt-ceiling crises in 2011
  - Possibility that the sequestration could be eliminated or reduced from the current 2 percent to lessen the burden on providers
- The Middle Class Tax Relief and Job Creation Act of 2012 will result in an additional 2 percent cut
  - Added to offset the cost of canceling the high level cuts to the Medicare Physician Fee Schedule

Clinical Laboratory Fee Schedule (CLFS) Status

- Summation:
  - Consumer Price Index: 1.7
  - Less Productivity Adjustment: -0.9
  - Less Additional PPACA Cut: -1.75
  - 2013 Update (according to PPACA only) = -0.95 percent
  - Additional cut due to Budget Control Act of 2011: -2.0 percent
  - Additional cut due to temporary fix to Physician Fee Schedule: -2.0 percent
- Total decrease: 4.95% (3/1/13)
Clinical Laboratory Fee Schedule (CLFS) Status
• American Taxpayer Relief Act of 2012
  ▫ Signed by President on January 2, 2013
  ▫ Delays 2% sequestration cut until March 1, 2013

Medicare Physician Fee Schedule (MPFS) Status
• Domino effect of continuous overrides by Congress of the multiyear negative impact of the sustainable growth rate (SGR)
• If the temporary increases expire, the physician fee schedule’s conversion factor must decrease by 26.5 percent. The result of this reduction and the 2013 update would be the SGR formula’s update—specific to 2013—of 0.7 percent. (CMS calculation)

MPFS Status, Cont.
• This increase would be applied to the conversion factor after it had been reduced by 26.5 percent
• From 2007 through 2012, the temporary increases totaled a cumulative increase in payment rates of 3.8 percent.
• So, for 2013, projected increase adjusted for budget neutrality
MPFS Status, Cont.

- Meanwhile, the accumulated updates—called for by the formula but legislatively overridden—totaled -24.7 percent. The result is a projected 26.5 percent reduction in payment rates required when the temporary increases expire.
- 2012 CF = $34.0376
- 2013 CF = $25.0008 - Unless Congress overrides again

MPFS Status, Cont.

- American Taxpayer Relief Act of 2012
  - Signed by President on January 2, 2013
  - Prevents cuts by SGR throughout 2013
  - No change in payment
    - Zero % update to MPFS
  - 2013 Conversion Factor = $34.0230
  - Annual Participation Enrollment Program
    - Extended through February 15, 2013

Molecular changes and Update
Background for Molecular CPT Changes

- The initial set of these codes were published in the CPT® 2012 codebook
- MPCW continues to construct codes for less common analytes and more complex analyses
- The current “stacking code” method of reporting molecular pathology services would be deleted upon conclusion of the workgroup’s activities

Background for Molecular CPT Changes

- Tier 1
  - Most commonly performed tests
  - Assigned an analyte specific code
  - Category I code - CPT
- Tier 2
  - Less commonly performed tests
  - Assigned to 1 of 9 resource level codes
  - Level of resources required
  - Level of interpretation
  - Also Category I codes - CPT

2012 Molecular Changes

- Procedures required prior to cell lysis may be reported separately
  - Ex. Microdissection
- Analyses are qualitative unless noted otherwise
Codes Deleted for 2013

- Molecular Diagnostics stacking codes
  - CPT 83890 - 83914
- Array codes
  - CPT 88384 - 88386
- Genetic Modifiers - Appendix I

New Tier 1 Molecular Pathology CPT Codes

- 81201  APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence
- 81202  known familial variants
- 81203  duplication/deletion variants

New Tier 1 Molecular Pathology CPT Codes

- 81235  EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)
New Tier 1 Molecular Pathology CPT Codes

- **81252** GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence
- **81253** known familial variants
- **81254** GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])

New Tier 1 Molecular Pathology CPT Codes

- **81321** PTEN (phosphatase and tensin homolog) eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis
- **81322** known familial variant
- **81323** duplication/deletion variant

New Tier 1 Molecular Pathology CPT Codes

- **81324** PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; duplication/deletion analysis
- **81325** full sequence analysis
- **81326** known familial variant
New Tier 1 Molecular Pathology CPT Codes

- 81161  DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed
- Last minute submission
- Not recognized until January 1, 2014

New Tier 2 Molecular Pathology CPT Analytes (188)

- Level I - 9 new analytes
- Level II - 31 new analytes
- Level III - 2 new analytes
- Level IV - 16 new analytes
- Level V - 23 new analytes
- Level VI - 39 new analytes
- Level VII - 48 new analytes
- Level VIII - 14 new analytes
- Level IX - 6 new analytes

NOS Procedures

- Parenthetical Comment:
  - (Molecular pathology procedures that are not specified in 81200 - 81383 should be reported using either the appropriate Tier 2 code (81400 - 81408) or the unlisted molecular pathology procedure code, 81479)
- Unlisted molecular pathology procedure
- Reports services previously associated with CPT 83890 - 83914 and 88384 - 88386
2013 Tier 2 Comments

- Used to report procedures not listed in the Tier 1
- Represent medically useful procedures that are generally performed in lower volumes than Tier 1 procedures (e.g., the incidence of the disease being tested is rare)
- Arranged by level of technical resources and interpretive work by the physician or other qualified health care professional.

2013 Tier 2 Instructions

- Use the appropriate molecular pathology procedure level code that includes the specific analyte listed after the code descriptor. If the analyte tested is not listed under one of the Tier 2 codes or is not represented by a Tier 1 code, use the unlisted molecular pathology procedure code, 81479.

Multianalyte Assays with Algorithmic Analyses (MAAA)

- Includes 81500 - 81512 & 0001M - 0003M
- Also referred to as IVDMIs
- CMS does not recommend pricing for these codes as other codes are used for “payment of underlying tests on which the MAAA is done”
  - No allowable for algorithms
  - Bill component codes
  - Other payers?
(MAAA) CMS, Cont.

• “A MAAA is a numeric score(s) or a probability (i.e., “p-score”) based on the results of laboratory tests and, in some cases, patient information. 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.”

(MAAA) CMS, Cont.

• “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.”

Multianalyte Assays with Algorithmic Analyses (MAAA)

• 81599 Unlisted multianalyte assay with algorithmic analysis

AMA parenthetical:
▫ (Do not use 81599 for multianalyte assays with algorithmic analyses listed in Appendix O)
▫ Depending on publisher, may be Appendix N
MAAAAMA Comments
- 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).

AMA Interpretations/Instructions
- The results of the procedure may require interpretation by a physician or other qualified health care professional.
- When only the interpretation and report are performed, modifier 26 may be appended to the specific molecular pathology code.

CMS Interpretations
MPFS Final Rule
- “While we do not believe the molecular pathology tests are ordinarily performed by physicians, we do believe that, in some cases, a physician interpretation of a molecular pathology test may be medically necessary to provide a clinically meaningful, beneficiary-specific result.”
CMS Interpretations
MPFS Final Rule

• “In order to make PFS payment for that physician interpretation, on an interim basis for CY 2013, we have created HCPCS G-code G0452 ……to describe medically necessary interpretation and written report of a molecular pathology test, above and beyond the report of laboratory results.”

CMS Interpretations
MPFS Final Rule

• G0452  Molecular pathology procedure; physician interpretation and report
• Professional component only HCPCS G-code will be considered a “clinical laboratory interpretation service,”
  ▫ MPFS indicates -26 modifier
  ▫ Approximately $19-20
  ▫ No APC allowable
• Medical necessity key

CMS Interpretation Requirements

• Subject to same requirements as other interpretations:
  ▫ Must be requested by the 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
  ▫ Note that a hospital’s standing order policy can be used as a substitute for the individual request by a patient’s attending physician.
CMS Interpretations

- Will reassess whether this HCPCS code is necessary, and if so, in conjunction with which molecular pathology tests.
- We do not believe it is appropriate to establish a HCPCS G-code on the CLFS for the interpretation and report of a molecular pathology test by a doctoral-level scientist or other appropriately trained nonphysician health care professional.

CMS Interpretations

- The new molecular pathology CPT codes consolidate the services previously reported using the CLFS stacking codes, including the CLFS stacking code for laboratory interpretation and report of a molecular pathology test (CPT code 83912). As such, we believe that payment for the interpretation and report service would be considered part of the overall CLFS payment for the molecular pathology CPT codes.

CMS Interpretations

- In addition, geneticists and other nonphysician laboratory personnel do not have a Medicare benefit category that allows them to bill and be paid for their interpretation services; therefore, they cannot bill or receive PFS payment for HCPCS code G0452.
CMS Interpretations

- Will monitor the utilization of this service and collect data on billing patterns to ensure that G0452 is only being used when interpretation and report by a physician is medically necessary and is not duplicative of laboratory reporting paid under the CLFS.
- Stacking codes deleted & CMS felt that providers did not supply specific crosswalks from stacked to new codes

Reimbursement of New 2013 Codes - Tier 1 & 2

- Industry mostly recommended crosswalking to previously reported stacked codes
- CMS decision to place on CLFS and gapfill
  - Only for procedures paid under CLFS but includes all Tier 1 and 2 codes (81200 - 81408, includes 2012 codes)

Reimbursement of New 2013 Codes - Tier 1 & 2

- CMS Decision Continued:
  - Variability on stacked codes reported
  - Unlisted codes reported for certain tests
  - Certain codes recommended for the MPFS are not clinical diagnostic laboratory tests for CLFS payment
  - Reportedly 80% of interpretations are rendered by non-physicians
### Example of Billing - BCR/ABL

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- 82106 (major breakpoint) $108.37 and/or
- 82107 (minor breakpoint) $90.31 and/or
- 82108 (other breakpoint) $150.17
- G0452 $19.00

### Example of Billing - BRAF

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- 81210 $57.51
- G0452 $19.00
- **Total** $76.51
- Medical necessity for interpretation

### Palmetto vs. Cahaba

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<td>81350 (UGT1A1)</td>
<td>58.84*</td>
<td>123.00</td>
</tr>
<tr>
<td>81355 (VKORC1)</td>
<td>83.19</td>
<td>90.00</td>
</tr>
</tbody>
</table>

* Not covered
MUEs 2013

- Code Tier 1 MUE
  - 81200-81216 1
  - 81217 2
  - 81220-81267 1
  - 81268 0
  - 81279-81372 1
  - 81373 2
  - 81374 3
  - 81375 1

MUEs 2013

- Code Tier 1 MUE
  - 81376 0
  - 81377 3
  - 81378-81379 1
  - 81380 2
  - 81381-81382 0
  - 81383 3
  - MUEs for Tier 2 0
  - MAAAs (except 81599) 1

CCI Edits

- Most edits prevent billing the cytogenetic codes:
  - 88271-88275 (Chromosome Analysis)
  - 88365-88368 (FISH)
- Most edits have a modifier indicator of “1”
- Exceptions:
  - 81201 cannot be billed with 81202
  - 81202 cannot be billed with 81203
  - APC testing
  - Above two edits have modifier indicator of “0”
CCI Edits for BRCA Analysis - “0” Indicator

- 81211 cannot be billed with 81214 (bill BRCA1x2)
- 81211 cannot be billed with 81216 (bill BRCA2x2)
- 81212 cannot be billed with 81214 (bill BRCA1x2)
- 81212 cannot be billed with 81216 (bill BRCA2x2)
- 81213 cannot be billed with 81214
- 81213 cannot be billed with 81216
- 81214 cannot be billed with 81215
- 81214 cannot be billed with 81216
- 81215 cannot be billed with 81216
- 81216 cannot be billed with 81217

CCI Edits for Other Tier 1 “0” Indicators

- 81221 cannot be billed with 81222 (CF)
- 81223 cannot be billed with 81220 (CF)
- 81223 cannot be billed with 81221 (CF)
- 81228 cannot be billed with 81229 (CGH)
- 81252 cannot be billed with 81253 (GJB2)
- 81302 cannot be billed with 81303 (MECP2)
- 81315 cannot be billed with 81316 (PML)
- 81321 cannot be billed with 81322 (PTEN)
- 81322 cannot be billed with 81323 (PTEN)
- 81324 cannot be billed with 81326 (PMP22)
- 81340 cannot be billed with 81341 (TRB)
- 81370 cannot be billed with 81371-81375 or 86812-86817 (HLA)
- 81371 cannot be billed with 81372-81375 or 86812-86817 (HLA)
- 81372 cannot be billed with 8773-81374 or 86812-86816 (HLA)
- 81373 cannot be billed with 86812-86816 (HLA)
- 81374 cannot be billed with 86812-86813 (HLA)
CCI Edits for Other Tier 1 “0” Indicators
• 81375 cannot be billed with 86812, 86816, 86817 (HLA)
• 81376 cannot be billed with 86816-86817 (HLA)
• 81377 cannot be billed with 86816-86817 (HLA)
• 81378 cannot be billed with 81373, 81374, 81377, 81379, 81380, 81381, 86812-86817 (HLA)
• 81379 cannot be billed with 81370, 81371, 81373, 81374, 81380, 81381, 86812, 86813 (HLA)
• 81380 cannot be billed with 81370-81372, 81381, 86813 (HLA)

CCI Edits for Other Tier 1 “0” Indicators
• 81381 cannot be billed with 81370-81373 or 86813 (HLA)
• 81382 cannot be billed with 81370, 81383 or 86812-86817 (HLA)
• 81383 cannot be billed with 81370-81371 or 86812-86817 (HLA)
• Additional edits are linked to the modifier indicator “1”

Other CCI Edits
• Tier 2 edits also include cytogenetics and serology
  ▫ Generally associated with “1” indicator
• MAAA edits identify component assays
  ▫ Associated with “0” indicator
Coverage Article - Novitas Solutions

- The Tier 1 MOLECULAR pathology codes (81200-81383) are applicable to specific biomarkers. However, Tier 2 MOLECULAR pathology codes (81400-81408) are used to identify groups of biomarkers that require the similar levels of technical and interpretive resources required to complete the testing.
- Because there are multiple biomarkers represented by each of the Tier 2 codes, when billing for these codes, it will be necessary to report the specific biomarker in the claim narrative/remarks. Please report information in the narrative/remarks that provides ample information to uniquely identify the specific biomarker.

Coverage Article - Novitas Solutions

- If the specific biomarker tested is not represented by a Tier 1 code and is not listed under one of the Tier 2 codes, then the testing should be reported using “unlisted” MOLECULAR pathology code 81479. A description of the testing performed is required in the narrative/remarks when using this code.
- Providing the descriptive information for the Tier 2 and the unlisted MOLECULAR pathology code will assist in timely processing of your claims. Failure to provide the information may result in delayed processing or claim denials.

Local Coverage Determinations
Novitas Solutions

- Biomarkers Overview
  - Germline
  - Pharmacogenetics
- Biomarkers for Oncology
  - Colorectal
  - Melanoma
  - Leukemias & Lymphomas
  - NSCLC
  - Urinary Tract
  - Ovarian
Molecular Diagnostic Tests (MDT) Palmetto LCD

- This policy confirms ‘non-coverage’ for all molecular diagnostic tests (MDT) that are not explicitly covered by a National Coverage Determination (NCD), a Local Coverage Determination (LCD), a coverage article published by Palmetto GBA and excluded per MolDx Exempt Tests published on the Palmetto GBA website.

Place of Service Issues

Place of Service (POS) Changes

- Background
  - Medicare Claims Processing Manual
  - Chapter 12, 20.4.2 - Site of Service Payment Differential
  - (Rev. 1604, Issued: 09-26-08, Effective: 01-08-09, Implementation: 01-05-09)
  - Under the physician fee schedule, some procedures have a separate Medicare fee schedule for a physician’s professional services when provided in a facility versus a nonfacility
  - Professional fees, when the services are provided in a facility, are applicable to procedures furnished in the facilities.
Section 20.4.2 Site of Service Payment Differential, Cont

- Place of service code (POS) is used to identify where the procedure is furnished. The list of facilities where a physician’s professional services are paid at the facility rate include:
  - Hospitals (POS code 21-23);
  - Skilled nursing facilities (SNF) for a Part A resident (POS code 31);
  - Medicare-approved ASC for a procedure not on the ASC list of approved procedures with dates of service on or after January 1, 2008. (POS code 24) (partial listing)

Place of Service (POS) Changes

- Medicare Claims Processing Manual
  - Chapter 26, 10.5 - Place of Service Codes (POS) and Definitions
    - (Rev 1869; Issued: 12-11-10; Effective/Implementation Date: 03-10-11)
- Examples:
  - Office (11)
  - Urgent Care Facility (20)
  - Inpatient Hospital (21)
  - Outpatient Hospital (22)
  - Emergency Room-Hospital (23)
  - Independent Laboratory (81)

Place of Service Codes

- Our Research 2010:
  - Facility vs. non-facility payment is driven by the place-of-service (POS) code reported on the CMS-1500 claim
  - Pathologist reports POS 21 for a hospital inpatient, POS 22 for an outpatient (including nonpatient), and POS 23 for an ED patient
  - Reporting POS 11 (office) or 81 (independent laboratory) would inflate reimbursement for a hospital based physician
  - This issue is on the current OIG workplan
POS 2010, Cont.

- CMS has presented two transmittals regarding POS and DOS for the PC and TC of services. Both have been rescinded due to issues with the DOS sections. Example language from the transmittals includes:
  - “The POS codes designate the actual place where the service was provided.”
  - “Physicians who perform services in a hospital outpatient department shall use POS 22 unless the physician maintains a separate office space in the hospital or on hospital property and that physician office space is not considered a provider-based department of the hospital.”

Place of Service Codes

- Our Research 2011:
- Section 10.6, Chapter 26 of the Medicare Claims Processing Manual. This section indicates:
  - If the physician bills for lab services performed in his/her office, the code for “Office” is shown (11).
  - If the physician bills for a lab test furnished by another physician, who maintains a lab in his/her office, the code for “Other” is shown (99).
  - If the physician bills for a lab service furnished by an independent lab, the code for “Independent Laboratory” is used (81).

POS 2011, Cont.

- Section 10.6, Chapter 26, Cont.
  - If an independent lab bills, the place where the sample was taken is shown.
  - An independent laboratory taking a sample in its laboratory shows “81” as place of service.
  - If an independent laboratory bills for a test on a sample drawn on a hospital inpatient, it uses the code for “Hospital Inpatient”.
- Not all Medicare contractors enforced these changes
Place of Service 2012

- Revised and Clarified Place of Service (POS)
- Coding Instructions
  - Transmittal 2407  Date: February 3, 2012
  - Effective Date: April 1, 2012
  - Implementation Date: April 2, 2012
- CMS has delayed effective date to October 1, 2012 (Transmittal 2435)
- Continue to use POS codes currently used
  - Alleviate issues related to “grandfather” claims

POS Update - October 2012

- Transmittal 2561 rescinds 2435
- New implementation date: April 1, 2013
- Discussion primarily impacts MPFS services reported globally or by modified component
  - TC/PC
  - Radiology Section 150 added
  - Pathology to be addressed in follow-up transmittal
  - Jurisdictional payments

Transmittal 2407, Cont.

- All services (two (2) exceptions) paid under the MPFS:
  - “POS code to be used by the physician and other supplier shall be assigned as the same setting in which the beneficiary received the face-to-face service.”
  - “In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the professional component (PC)/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician/practitioner shall be the setting in which the beneficiary received the technical component (TC) service.”
  - TC/PC Splits
Transmittal 2407, Cont.

- Two (2) exceptions to this face-to-face provision/rule regardless of where the face-to-face service:
  - Inpatients
  - Outpatients
- The correct POS code assignment shall be for that setting in which the beneficiary is receiving inpatient or outpatient care from a hospital including
  - Inpatient hospital (POS code 21) or
  - Outpatient hospital (POS code 22).
- Pub. 100-04, Medicare Claims Processing Manual, chapter 26, already requires this for physician services (and for certain independent laboratory services) provided to beneficiaries in the inpatient hospital and this CR clarifies this exception and extends it to beneficiaries of the outpatient hospital, as well

Transmittal 2407, Cont.

- Independent laboratory providers:
  - The respective POS code for the inpatient hospital (POS code 21) or outpatient hospital (POS code 22) code is always used, irrespective of where the face-to-face encounter occurs.
  - There is no POS code for an interpretation that is provided under arrangement to a hospital for global services in which the test and interpretation are not separately billable (global service).
  - In general, the POS code reflects the actual place where the beneficiary receives the face-to-face service and determines whether the facility or nonfacility payment rate is paid.

Transmittal 2407, Cont.

- For professional component (PC) of diagnostic tests, the facility and nonfacility payment rates are the same - irrespective of the POS code on the claim.
Discussion

Thank you for your courtesy!

Diana