Focus on 7 New Drug Test ‘G’ Codes for Medicare

See how the change impacts your bottom line.

Labs had to wait in suspense almost to the end of 2015 before CMS released the “final” (with 60 day comment period) codes and pricing for drug testing in 2016.

Now you need to know which HCPCS Level II codes Medicare deletes — and adds — as well as which CPT® codes Medicare won’t recognize.

Let our experts point the way to make sure you correctly code your drug screening and confirmation testing to Medicare in 2016.

Delete These Codes

In 2016, you won’t be using the following, since CMS deletes these three codes:

» G0431 — Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter
» G0434 — Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter
» G6058 — Drug confirmation, each procedure

You should also stop using the codes that Medicare instituted in 2015 to capture definitive drug testing for specific drugs and drug classes (G6030-G6058).

Removing G6030-G6058 should come as a huge relief to labs. Recall that these codes reflected CPT® 2014 codes, many of which had been deleted or modified in 2015. That meant last year’s CMS solution was “not that simple to implement,” recalls Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, CCC, COBC, CPC-I, internal audit manager at PeaceHealth in Vancouver, Wash.

Ignore These Codes

After a year of experience with about 100 new CPT® 2015 codes for drug test reporting, Medicare still says “no” to these codes. The agency had initially indicated its intention to consider these codes for 2016, once they’d had time to evaluate the payment impact.

Avoid: For Medicare beneficiaries, you should not use the following codes in 2016, just as you didn’t in 2015:
For 2016, CMS puts in place the following codes to report presumptive drug testing:

- **G0477** — Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g. immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), including sample validation when performed, per date of service
- **G0478** — ... any number of devices or procedures (e.g. Immunooassay) read by instrument-assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), including sample validation when performed, per date of service
- **G0479** — ... any number of devices or procedures by instrumented chemistry analyzers (e.g. immunoassay, enzyme assay, TOV, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service

**Recall:** Presumptive drug tests, also called screening, check for the presence of drug classes, but don’t identify/distinguish specific drugs.

“

“You should bill just one presumptive code per day for a single patient,” Dettwyler says. “Even if you perform the drug screen tests on a chemistry analyzer, no matter the number, or the CLIA complexity, you should not report more than one unit of G0479 per date of service.”

**Pricing:** Here’s what you can expect for payment for these tests in 2016, relative to what your lab got paid in 2015

- G0477 crosswalk to 0.75 times G0434 ($14.86 national limit amount)
- G0478 crosswalk to G0434 ($19.81 NLA)
- G0479 crosswalk to 4 times G0434 ($79.25 NLA)

For definitive drug testing in 2016, Medicare institutes the following codes:
Unlike some other specialties, things are looking up for pathology and independent laboratories in this year’s Medicare Physician Fee Schedule (MPFS) final rule.

**Good news:** With the Sustainable Growth Rate (SGR) annual adjustment gone, you’re not facing across-the-board double-digit pay cuts as you have in past years.

**More good news:** You can expect Medicare’s allowed charges to increase by 8 percent for pathology practices, and 9 percent for independent labs, according to CMS’s estimations set forth in the final rule.

Read on to learn more about what’s in store for your 2016 pathology and laboratory MPFS pay.

**Expect Conversion Factor Reduction**

In the Protecting Access to Medicare Act of 2014 (PAMA), Congress set a target for adjustments to misvalued codes in the fee schedule for calendar years 2017 through 2020, with a target amount of 0.5 percent of the estimated expenditures under the MPFS for each of those four years. Subsequently, the Achieving a Better Life Experience Act of 2014 (ABLE) accelerated the application of the target by specifying it would apply for calendar years 2016 through 2018, and increasing the target to 1 percent for 2016.

If the net reductions in misvalued codes in 2016 are not equal to or greater than 1 percent of the estimated expenditures under the fee schedule, a reduction equal to the percentage difference between 1 percent and the estimated net reduction in expenditures resulting from misvalued code reductions must be made to all PFS services.

**Impact:** CMS didn’t meet the 2016 one percent goal for misvalued-code payment reductions ordered by Congress. In fact, CMS estimated the CY 2016 net reduction in expenditures resulting from adjustments to relative values of identified misvalued codes to be 0.23 percent. To make up the difference, CMS will reduce the conversion factor by 0.77 percent.

**Tip:** The conversion factor (CF) is the multiplier that payers apply to relative value units (RVUs) to come up with the dollar payment amount for services. A change to the CF will therefore impact payments across the board for all services, whether or not the fee schedule alters the RVUs for a particular procedure.

**That’s not all:** CMS also has a mandate for a 0.5 percent scheduled annual increase as part of the Medicare Access and CHIP Reauthorization Act (MACRA), and a 0.02 percent reduction required by budget neutrality. Combine

(Continued on next page)
those with the -0.77 update, and that “leads to a net decrease of 0.3 percent to the 2016 Medicare conversion factor, with the Final Rule publishing a 2016 CF of $35.8279,” says Michael A. Granovsky, MD, FACEP, CPC, President of LogixHealth, a national coding and billing company based in Bedford, MA. That’s compared to the 2015 CF of 35.9335.

Cheer These RVU Increases

You can attribute the positive 8 to 9 percent final rule update for pathologists and independent labs almost exclusively to increases in Relative Value Units (RVUs) for certain immunohistochemistry (IHC) and in situ hybridization (ISH) services, with much of the increase stemming from the technical component of these procedures.

Not all: Although pay for certain qualitative IHC services increase by as much as 48 percent (88344, Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure), pay for many of the quantitative IHC services actually decrease in 2016, such as 88361 (Morphometric analysis, tumor immunohistochemistry [e.g., Her-2/neu, estrogen receptor/progesterone receptor], quantitative or semiquantitative, per specimen, each single antibody stain procedure; using computer-assisted technology), which decreases by 12.3 percent.

Resource: See Table 1 for a glance at MPFS pricing for select lab and pathology services that change significantly in 2016.

Absorb This Prostate Biopsy Loss

Despite increasing the RVUs for prostate biopsy code G0416 (Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method), payment for the service will decrease in 2016.

Here’s why: CMS now prices the code based on the assumption that the typical number of specimens for a prostate biopsy case ranges from eight to ten. Pricing for G0416 was initially valued based on the assumption that the typical case might involve examination of up to 20 specimens.

That means payment for G0416 declines by 18 percent this year, changing from $649.32 in 2015 to $533.84 in on the 2016 PFS.

Compare: If you charged for each prostate biopsy specimen using 88305 (Level IV - Surgical pathology, gross and microscopic examination ... Prostate, needle biopsy ...), as you do for most non-Medicare payers, just seven prostate biopsies would earn you almost the full G0416 pay. That’s because 88305 pays $74.16 in 2016, so seven biopsies would garner $519.12.

Table 1: Select Pathology MPFS Pay Changes

<table>
<thead>
<tr>
<th>CPT® Code (Global)</th>
<th>Short description</th>
<th>2015 Non Facility</th>
<th>2016 Non Facility</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>88342</td>
<td>Qualitative IHC first single stain</td>
<td>$90.91</td>
<td>$107.48</td>
<td>18.2</td>
</tr>
<tr>
<td>+88341</td>
<td>Qualitative IHC each add’l single stain</td>
<td>$67.91</td>
<td>$90.64</td>
<td>33.5</td>
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<tr>
<td>88344</td>
<td>Qualitative IHC multiplex stain</td>
<td>$117.50</td>
<td>$173.77</td>
<td>47.9</td>
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<tr>
<td>88360</td>
<td>Quantitative IHC manual</td>
<td>$136.55</td>
<td>$121.81</td>
<td>-10.8</td>
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<tr>
<td>88361</td>
<td>Quantitative IHC computer assisted</td>
<td>$170.32</td>
<td>$149.40</td>
<td>-12.3</td>
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<tr>
<td>88365</td>
<td>Quantitative ISH first single stain</td>
<td>$157.39</td>
<td>$178.42</td>
<td>13.4</td>
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<tr>
<td>+88364</td>
<td>Quantitative ISH each add’l single stain</td>
<td>$97.74</td>
<td>$135.07</td>
<td>38.2</td>
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<td>88366</td>
<td>Quantitative ISH multiplex stain</td>
<td>$234.65</td>
<td>$262.62</td>
<td>11.9</td>
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<tr>
<td>88367</td>
<td>Quantitative ISH computer assisted first single stain</td>
<td>$107.80</td>
<td>$107.48</td>
<td>-0.3</td>
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<tr>
<td>88373</td>
<td>Quantitative ISH computer assisted each add’l single stain</td>
<td>$60.73</td>
<td>$75.24</td>
<td>23.9</td>
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<tr>
<td>88374</td>
<td>Quantitative ISH computer assisted multiplex stain</td>
<td>$205.54</td>
<td>$346.10</td>
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<td>Quantitative ISH manual first single stain</td>
<td>$109.24</td>
<td>$115.01</td>
<td>5.3</td>
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<td>+88369</td>
<td>Quantitative ISH manual each add’l single stain</td>
<td>$74.02</td>
<td>$108.56</td>
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<tr>
<td>88377</td>
<td>Quantitative ISH manual multiplex stain</td>
<td>$214.88</td>
<td>$412.02</td>
<td>91.7</td>
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<tr>
<td>G0416</td>
<td>Prostate biopsies</td>
<td>$649.32</td>
<td>$533.84</td>
<td>-21.6</td>
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</tbody>
</table>
Beware: Your Breach Report May Backfire

Best defense is good compliance plan.

If you experience a reportable privacy breach, you could be in big trouble if your underlying HIPAA compliance plan is weak.

In fact, some organizations have been hit with million-dollar fines when the HHA Office for Civil Rights (OCR) investigated a breach notification — and kept looking.

Read on to learn what happened, and how you can avoid the same fate for your lab or pathology practice.

OCR Searches for ‘Widespread Noncompliance’

The OCR recently instituted a “robust” Corrective Action Plan (CAP) and a whopping $3.5-million payout from Triple-S Management Corporation, formerly American Health Medicare Inc.

Interestingly, this settlement was “the outgrowth of privacy breaches that [Triple-S] had reported to OCR, which, in turn, triggered further investigations by the agency,” noted partner attorney Laurie Cohen in a recent blog posting for Nixon Peabody LLP. “The OCR investigation uncovered ‘widespread noncompliance’ with the HIPAA Rules.”

The alleged HIPAA violations the OCR uncovered included:

» Failure to implement appropriate administrative, physical, and technical safeguards to protect its beneficiaries’ PHI;
» Impermissible disclosure of its beneficiaries’ PHI to an outside vendor with which it did not have an appropriate business associate agreement (BAA);
» Use or disclosure of more PHI than was necessary to carry out mailings;
» Failure to conduct an accurate and thorough risk analysis that incorporates all IT equipment, applications, and data systems utilizing ePHI; and
» Failure to implement security measures sufficient to reduce the risks and vulnerabilities to its ePHI to a reasonable and appropriate level.

In addition to the hefty $3.5-million payout, the settlement also involves a CAP that requires Triple-S to establish a comprehensive HIPAA compliance program, which includes:

» A risk analysis and a risk management plan;
» A process to evaluate and address any environmental or operational changes that affect the security of the ePHI it holds;
» Policies and procedures to facilitate compliance with the HIPAA Rules’ requirements; and
» A training program covering the HIPAA Privacy, Security, and Breach Notification Rules’ requirements, intended for all workforce members and business associates providing services on Triple-S premises.

Takeaway: This case and other recent settlement agreements are “a reminder that when investigating a breach, OCR may look beyond the particular incident and review the covered entity’s or business associate’s overall compliance with HIPAA,” warned attorneys Elizabeth Hodge and Thomas Range of Akerman LLP in an analysis of the case. And the next round of HIPAA audits will begin in early 2016, which will only increase the scrutiny of covered entities’ and business associates’ compliance efforts.

Best bet: Make sure your lab or pathology practice has a strong HIPAA compliance plan in place now — both to minimize the risk of having a reportable breach, and to maximize the chance that you can withstand OCR scrutiny if an investigation occurs.

Link: The OCR’s Resolution Agreement and CAP with Triple-S is available at www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/TRIPLES.html.

You Be the Coder

Zero In on ICD-10 Flu Diagnosis

Question:
How can we report the diagnosis of swine flu influenza in ICD-10-CM?

Ohio Subscriber

Answer: See page 15.
Watch ‘Glucose’ Charge for Tolerance Test

Question:
I’ve found conflicting answers about how to bill for a Glucose 2 hour test. Patient had a fasting glucose done first and then a post glucose done at 2 hours. Would there be two lab codes for the fasting and post, or is there one that would cover them both? Does it make a difference if the physician orders the test as a GTT Post Prandial Blood Sugar, but wants only two specimens?

South Carolina Subscriber

Answer:
CPT® code 82950 (Glucose; post glucose dose [includes glucose]) represents a one-specimen glucose tolerance test, whether done at one hour or two hours after ingesting the glucose.

The test described by code 82950 does not include the fasting glucose test that you mentioned the patient received first. You should separately bill the fasting glucose as 82947 (Glucose; quantitative, blood [except reagent strip]).

The code for the three-specimen glucose tolerance test that you mentioned does include the fasting glucose, followed by two more blood samplings to test the glucose levels after giving the glucose to drink (82951, Glucose; tolerance test [GTT], 3 specimens [includes glucose]). Don’t use this code if the lab doesn’t test three specimens pulled at three different times.

Includes glucose: Don’t let the phrase “includes glucose” confuse you. This doesn’t mean that the code includes a glucose test, it means that the code includes the glucose dose given to the patient to consume.

Identify Factors Leading to Lab Test with ‘Z’ Codes

Question:
What diagnosis code would I use if the patient is requesting lab tests to fulfill a work requirement, not for medical reasons?

Virginia Subscriber

Answer:
You should turn to the ICD-10 “Z” codes, which describe factors that influence health status or lead to contact with health services. You don’t say what the lab tests are, so it’s difficult to assign a specific code to answer your question.

Depending on what the test is for, you might use one of the following codes:

» Z00.00 — Encounter for general adult medical examination without abnormal findings
» Z00.01 — Encounter for general adult medical examination with abnormal findings
» Z01.89 — Encounter for other specified special examinations
» Z02.1 — Encounter for pre-employment examination
» Z02.83 — Encounter for blood-alcohol and blood-drug test

If you have a specific scenario, such as a nurse who needs a tuberculosis screening prior to hiring, you should select a more specific Z code, if available, such as Z11.1 (Encounter for screening for respiratory tuberculosis).

Understand CLFS Re-Pricing

Question:
I’ve heard that PAMA requires Medicare to re-figure all clin lab fees based on technical changes and difficulty of tests. Is that true, and can you explain the expected impact?

Iowa Subscriber

Answer:
You’re correct that the Protecting Access to Medicare Act (PAMA) requires CMS to set new pricing for tests on the Clinical Laboratory Fee Schedule (CLFS). But you’ve got old news about how CMS will go about that task.

An earlier proposal required CMS to consider improvements and cost savings in technical processes to re-value clinical lab codes. But that proposal was disbanded, and PAMA section 216 establishes a new method to establish new CLFS values.

Here’s how: “Applicable” labs (those earning more than 50 percent of their Medicare revenue from the CLFS and physician fee schedule, and earning at least $50,000 per year from the CLFS) will report private-payer data for tests provided between July 1 and Dec. 31, 2015.

After applicable labs report private payer reimbursement rates and test volume for each test on the CLFS (approximately 1300 tests), CMS will use the data to establish the Jan. 1, 2017 CLFS payment rate. CMS will set the rate for each test as the weighted median of private payer rates reported by applicable labs.
Focus on FOBT Coding

Question:
We received an order for a fecal specimen collected during a DRE for a patient with abdominal pain and dark stools. How should we code the case?

Texas Subscriber

Answer:
For the diagnosis, you should report R10.9 (Unspecified abdominal pain). If the physician states that the condition is acute, you might use R10.0 (Acute abdomen) instead. Don’t report the screening code for fecal occult blood test (FOBT) (Z12.1, Encounter for screening for malignant neoplasm of intestinal tract), because the physician orders the test based on signs and symptoms of disease.

For the test itself, you should report 82272 (Blood, occult, by peroxidase activity [e.g., guaiac], qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening) if the lab method is peroxidase activity. As with the diagnosis code selection, you should avoid the screening procedure code in this case (82270, Blood, occult, by peroxidase activity [e.g., guaiac], qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening [i.e., patient was provided three cards or single triple card for consecutive collection]).

Option: If the lab uses the immunoassay test for fecal occult blood, you should report 82274 (Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations) instead of 82272.

Reader Questions and You Be the Coder were prepared with the assistance of R.M. Stainton Jr., MD, president of Doctors’ Anatomic Pathology Services in Jonesboro, Ark.

You Be the Coder

Zero In on ICD-10 Flu Diagnosis

(Question on page 13)

Answer:
For swine flu influenza, look to ICD-10-CM code category J09 (Influenza due to certain identified influenza viruses). Report influenza due to identified novel influenza A virus using (J09._), which also requires a fifth digit to further identify any manifestations. This subcategory of codes includes avian influenza, bird influenza, influenza of other animal origin, and swine influenza.

Look for related conditions: In addition to influenza type, you’ll need to have documentation of any manifestations to choose the correct code, such as one of the following:

» J09.X1, Influenza due to identified novel influenza A virus with pneumonia
» J09.X2, Influenza due to identified novel influenza A virus with other respiratory manifestations
» J09.X3, Influenza due to identified novel influenza A virus with gastrointestinal manifestations
» J09.X9, Influenza due to identified novel influenza A virus with other manifestations.

You should additionally report any conditions related to the influenza such as otitis media or lung abscess.

Example: Code J09.X1 includes this note:
Code also, if applicable, associated:
» lung abscess (J85.1)
» other specified type of pneumonia

The J10 code set (J10._) includes other identified viruses, such as H1N1 not identified as “Novel” along with influenza B and C types. There is an additional code set for unidentified influenza (J11._) which is used when the influenza type is unknown.

Follow the instructional notes: The ICD-10 Official Guidelines for Coding and Reporting for influenza instruct coders to code only confirmed cases of influenza due to certain identified influenza viruses (category J09), and due to other identified influenza virus (category J10). In this context, “confirmation” does not require documentation of positive laboratory testing specific for avian or other novel influenza A or other identified influenza virus. However, coding should be based on the provider’s diagnostic statement of what strain of influenza the patient has. If the provider records “suspected” or “possible” or “probable” avian influenza, novel influenza, or other identified influenza, coders should report the appropriate influenza code from category J11 (Influenza due to unidentified influenza virus).

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