Please enjoy the new summer issue of the APF Review. In his interview, Will Informatics Be The Next Big Thing?, with James Sharp, MD, president of JWS InfoCorp of Poughkeepsie, NY, for Laboratory Economics, Jondavid Klipp summarizes Dr. Sharp’s views of the ever-important role that informatics play now and will play in the future delivery of laboratory services. Drawing particular attention to the need for better comparability, predictability and interoperability of laboratory services as our value proposition, Dr. Sharp emphasizes the opportunity that data normalization presents for the laboratory industry. Bruce Alexander, of the University of Alabama—Birmingham, in the Academic Corner, reviews the distribution and demographics of pathology residents into fellowship programs over the past five years. David Hoak, of Spokane, WA, dissects the Budget Neutrality Factor’s role in adjustments made to Medicare reimbursement. From The Dark Report, Robert Michel’s story Study Indicates Errors in Breast Cancer Testing in Canadian Province of Quebec reports on error rates for breast cancer hormone receptor testing reported recently in Quebec. The article includes links to a number of related stories. And, in Lost Dollars: Avoiding 5 Costly Coding & Documentation Errors, Chappy Manning, of Pathology Service Associates, describes important steps in reducing the risk of claims documentation and coding errors.

I also want to draw your attention to two new categories of APF membership just approved and initiated by the Board of Directors: one for group practices and one for academic practices. Both afford significant incentives for membership, allowing APF the opportunity to draw on a much larger base of pathology practice types. Details and benefits of our new membership categories can be found in the APF News and Events article in this issue of the APF Review or by visiting our newly updated website www.apfconnect.org.

Finally, like all of you, the APF Board is watching closely and with great interest the continuing debate in Washington on health care reform. We join with other pathology organizations in educating policy makers on the value of what we provide to patients on a daily basis, and in protecting our ability to continue to do so. As important news breaks over the coming months look to the APF for more information.

Ronald L. Weiss, MD
President, American Pathology Foundation
Summer is officially here! Between the vacations, trips to the beach and barbecues you’re planning, be sure to make room on your calendar for the APF’s new distance learning programs that will be held over the summer. The full schedule of distance learning program topics can be found on our Calendar of Events (page 6). Our next program will be a webinar titled, The Expanding Role of Pathology Middleware in the Rush to Integrate EMRs, scheduled for Thursday, August 27th. To register, please visit the APF website.

We are excited to announce an “updated look” for the APF website, as well as, the debut of two new options for Foundation membership. Group Membership gives the option for multiple members from the same pathology practice to join APF at a tiered price rate. Academic Institution membership is open to all ACGME accredited pathology training programs. Academic membership is inclusive of the practice administrator, all full time faculty members, residents and fellows. For additional information or to join under one of the new membership types, we invite you to visit us online at www.apfconnect.org and learn more!

A new event for the Foundation this summer is the APC/PRODs conference, Pathology Practice & Management; Sharing Successes, Avoiding Failures and Preparing for the Future, to be held July 15-17 in Seattle, WA. The conference takes place at the Fairmont Olympic Hotel. APF has collaborated with the ASCP and collected data from program chairs around the nation to develop a workshop, Moving Towards Solutions; Laboratory Management Training For Residents. The workshop program will be held on Wednesday, July 15, from 2-5 pm. The program aims to provide a comprehensive look at how management is taught during residency, generate discussion of the obstacles and issues that surround teaching practice management topics and provide practical solutions that program directors can implement to improve the curriculum and methods used in their own programs. For more information or to register for the workshop please visit the Association of Pathology Chairs website at www.apcprods.org.

As we move into Fall, APF and the ASCP will collaborate for a second year on presentations for the ASCP’s Annual Residents’ Day Program. The Residents’ Day Program will be held on Saturday, October 31 in conjunction with ASCP’s Annual Meeting, The Heart and Science of Pathology, held October 28-November 1. The conference will take place at the Sheraton Chicago Hotel & Towers in downtown Chicago. Look for APF in the conference exhibit area and at the Resident’s Networking Reception. Visit www.ascp.org for more information on program topics or to register for either the Resident’s Program or Annual Meeting.

Summer is also Board election time for the Foundation. Election ballots will be mailed to all members who are eligible to vote, on or around August 1st. Watch the mail for your ballot and make sure that your vote is counted. Members belonging to the Active Pathologist or Active Associate membership categories are eligible to run for open Board seats. If you are interested in serving as a Board Member or in committee work, please contact the APF National Office or Dr. Karl Proppe, Chair of the 2009 Nominating Committee. Please be sure to visit the APF website on a regular basis to stay up-to-date on Foundation news and events. If you have questions about your membership account, how to access the members-only sections of the website or register for APF events online, contact the national office at 877-993-9935 and we will be happy to assist you.

Wishing everyone a splendid summer,

Melissa Lord-Toof
Associate Director, American Pathology Foundation
Informatics and predictive formulas have the potential to greatly raise the value of all lab tests, but it will require cooperation and test data sharing among all labs, James Sharp, MD, president of JWS InfoCorp (Poughkeepsie, NY), tells Laboratory Economics. “We are the only industry in the measurement business that chooses to directly report raw data values. We make no effort to transform, rescale or normalize the raw data so that the reported results convey more information,” says Sharp. “The lab industry can standardize or someone else [e.g., pharmaceutical or managed care companies] will do it for them,” he adds.

Sharp says there are three basic ways to improve results reporting: 1) Report only the levels or categories that are not obscured by measurement error; 2) Equate test results across different instruments and methodologies; and 3) Normalize and rescale all raw values.

Mathematical conversion factors such as those used in the currency market need to be developed for lab tests, according to Sharp. Conversion factors make it possible to compare dollars to euros to yen in the currency market. Similarly, conversion factors need to be developed so that, for example, a PSA test performed by Quest Diagnostics on a Roche instrument can be compared to a PSA test performed by a hospital lab on an Abbott instrument. One method needs to be selected as the standard test so that others can be converted into that standard, explains Sharp.

Making all tests—produced by any lab using any instrument—directly comparable (i.e., harmonized) would allow for predictive formulas to be developed. “Labs perform more than 2,000 mostly quantitative tests on highly interdependent patient samples, yet all we have to show is the anion gap and bun/cr ratio,” notes Sharp.

He says the need for conversion factors and standardized test result reporting is becoming more important because of two key trends:

- **Electronic medical records** (EMRs) are becoming more and more popular among physicians and lab test results are a key component of patient medical records. However, test results fed into EMRs from different labs using different methodologies cannot be directly compared. The inability to directly compare, for example, blood glucose test results from a hospital lab and those from LabCorp and/or a local independent lab reduces the value of the test results and the EMR to physicians.

- **Molecular Diagnostics** have become a strategic focus for most large labs because of the high reimbursement for these tests. But given that the human physiology is highly interrelated, and given that at the biochemical level the end result of one enzymatic reaction is often the starting material for a second reaction, where are all the predictive formulas for these tests? Labs need to be able to prove that spending $500 on a test will avoid a more expensive CAT scan or cardiac cath lab visit. Otherwise, it’s just a matter of time before payers start squeezing down on reimbursement for molecular tests.

Sharp believes proficiency tests should be used to develop conversion formulas for all lab tests. A central repository could then be set up that would collect test results from all commercial, hospital and independent labs. The data would be made available to mathematicians and statisticians who could link test results to patient outcomes. This data could be used to demonstrate to payers how lab testing can eliminate overutilization and improve patient outcomes.

Sharp says that if the two biggest national labs would cooperate and begin this project, other labs would follow suit. “They don’t realize the gold mine [of data] they are sitting on….They need to start competing with other healthcare sectors [radiology, pharmacy, inpatient days, etc.] and show why labs should get more of each premium dollar,” he concludes.

*Laboratory Economics, June 2009.*

www.laboratoryeconomics.com
The distribution of positions approved and filled and the turnover rate of Program Directors are listed in the tables shown below. These data show that even in the competitive fellowships such as Dermatopathology and Hematopathology, there are, on an annual basis, a number of approved positions that are not filled. In addition, there is the relative lack of increase in the number of programs and trainees, with the exception of the Molecular Genetic Pathology fellowships. This could lead to a greater demand for the graduates of these ACGME approved fellowships. Not included in these numbers are the “Surgical Pathology” fellowships, with the exception of the Selective Pathology programs. Selective Pathology fellowships originally were created for institutions that do not have a general residency program. In my opinion, the growth of the Selective Pathology fellowships increases the potential for including training in certain areas of Surgical Pathology in an ACGME approved fellowship. At present, these Selective Pathology fellowships are ACGME approved with no Board Certification from the ABP.

### 2003-2008 Fellowships: Cytopathology and Dermatopathology

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### 2003-2008 Fellowships: Forensic Pathology and Hematopathology

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(Academic Corner continued from p. 4)

2003-2008 Fellowships: Molecular Genetic Pathology and Neuropathology

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2003-2008 Fellowships: Pediatric Pathology and Selective Pathology

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AUGUST 27, 2009

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APF Webinar: The Expanding Role of Pathology Middleware in the Rush to Integrate EMRs
Speaker: Ulysses Balis, MD

SEPTEMBER 13-15, 2009

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OCTOBER 1, 2009

*Distance Learning Leadership Science Series*

APF Webinar: Practical Applications of Digital Whole Slide Imaging
Speaker: Andrew Evans, MD

OCTOBER 11-13, 2009

*APF Exhibiting at “The Pathologists’ Meeting” CAP ’09* • Washington, DC

OCTOBER 28-20, 2009

*APF Exhibiting at “Heart and Science of Pathology,” ASCP 2009 Annual Meeting* • Chicago, IL

OCTOBER 31, 2009

*APF is a co-presenter at the annual ASCP Resident’s Day*

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☐ AMEX Coding Metrix, Inc.

Pricing is subject to change. PO orders are NOT accepted for online products.

CREDIT CARD #: _____________________________________________
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Private payors such as United Healthcare have adopted CMS’s Budget Neutrality Adjuster (BNA) to lower payments to physicians. If a pathology group or it’s billing vendor are not vigilant, they may not even be aware that a private payor has adjusted the payment lower by using CMS’s Budget Neutrality Adjuster.

**WHAT IS THE BNA?**

In 2006, the AMA Relative value Update Committee (RUC) substantially increased the Relative Value Units (RVUs) for each Evaluation and Management CPT code (E & M codes). These are the most commonly used CPT codes because they are used for physician office visits, and are billed mostly by primary care physicians. An increase in the RVU of a CPT translates into increased payment. Since the E & M codes are the most commonly billed CPTs, it has been estimated that this shifted about $4 billion dollars in payment to those physicians using E & M codes. Unfortunately, Congress only approved about $40 Million in new dollars for increased payment. In order for CMS to keep the budget neutral for physician payment (i.e., balanced), each physician work component RVU was reduced by multiplying by 0.8994 for the 2007 Physician Fee Schedule.

In 2007, the AMA RUC substantially increased payment for the anesthesiology CPT codes. Again CMS did not have enough money to pay for these increases, so the Budget Neutrality Adjuster was reduced even further to 0.8806 for the 2008 Fee schedule. The application of the BNA to the only the physician work component, hurt pathologists, who billed just the Professional component, the most.

For the 2009 Physician Fee Schedule CMS applied the BNA to the conversion factor. Now the reduction is spread more evenly between the professional and technical components of a CPT.

**HOW DID THE BNA AFFECT PAYMENT?**

In 2007 and 2008 Professional Component Payment = {((Physician Work RVU x GPCI) x budget neutrality adjuster) + (Practice Expense RVU x GPCI) + (Malpractice RVU x GPCI)} x the Conversion Factor. The Technical component was not multiplied by the BNA.

In 2009 the Professional component payment = {((Physician Work RVU x GPCI) + (Practice Expense RVU x GPCI) + (Malpractice RVU x GPCI)) x (Conversion Factor x BNA). Because the BNA is applied to the Conversion Factor, and thus to all RVUs both professional and technical, the overall reduction in payment is less severe to PC only billers than it might have been.

In 2008, our practice began noticing commercial insurers adopting CMS’s Budget Neutrality Adjuster. These commercial plans, of course, are not under any Congressional mandate for budget neutrality. So the adjustment became a mechanism for the plans to save money by reducing payment. The commercial plans are not likely to notify your practice that they have either “adjusted” the physician work component or have “adjusted” the conversion factor. Find out what your commercial insurers are paying for the most common pathology codes (88305, 88304, 88307, 88342, 88112). Our practice has been successful in negotiating a higher conversion factor from some commercial insurers, when we made it plain that we were aware of this behavior.

*GPCI, commonly known as the “gypsies” are the Geographic Practice Cost Indices and are CMS adjustments for the differences in cost of living throughout the country.
Study Indicates Errors in Breast Cancer Testing in Canadian Province of Quebec

Robert L. Michel, Editor In Chief, The Dark Report

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Questions about a possible high rate of errors in breast cancer testing done in the Canadian province of Quebec surfaced (in late May). Government health officials were forced to publicly acknowledge that they had received a report in April of a limited study that indicated an error rate of between 15% and 20% in hormone receptor testing, and an error rate as high as 30% in HER2/neu testing.

Following the first news reports of this situation, Quebec health officials scrambled to respond to public concerns. In response to calls for the Health Ministry to release the full report to the public, Quebec’s Health Minister, Yves Bolduc, convened an extraordinary Sunday meeting. He met with pathologists and oncologists from the province to review the details of the report on errors in breast cancer testing and determine a course of action.

What is interesting about this situation is that it was pathologists who conducted the survey of breast cancer testing accuracy among laboratories in Quebec, then submitted a report of their findings to provincial health officials. Part of the intense public reaction resulted from the disclosure that health officials, made aware of these problems in April, had not immediately taken steps to inform the public about the situation. Another factor is that the report is based on a sample of only 15 patients, whose specimens were sent to 25
of the 140 pathology laboratories in Quebec.

In fact, at the press conference, following his conference with pathologists and oncologists, Balduc stated that “Things that have been said about the study have been false… We can reassure people that the majority of tests that were done were good.”

Because of public concerns over the possibility of unacceptable error rates in breast cancer testing in Quebec, another press conference was scheduled (for Monday, June 8.) Quebec health officials (discussed), in more detail, their assessment of the pathology study about the accuracy of hormone receptor testing and HER2/neu testing in the province.

In recent years, Canada has been rocked by disclosures of unacceptable error rates in breast cancer testing in other provinces, including Newfoundland/Labrador, Manitoba, New Brunswick, and Ontario. Quebec is now the fifth province in Canada to uncover inaccuracies in breast cancer testing. An analysis of these earlier episodes was published in the most recent issue of The Dark Report (“ER/PR Testing in Canada Continues to Make News, TDR, May 18, 2009).

This is an important story for the pathology profession in all major countries across the globe. For years, pathologists and laboratory professionals in Canada have warned health service officials that ongoing budget cuts and consecutive waves of regional laboratory restructuring would eventually undermine the quality, reliability, and integrity of laboratory testing.

In fact, following each disclosure about a new finding of unacceptable error rates in histopathology testing at some laboratory around the country, some experts raise the possi-

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Online registration will be available in June 2009.

For information on sponsorship and exhibits go to www.calpath.org or contact the CSP office at (916) 446-6001 or ttyler@amgroup.us.

Look for the attendee program and hotel information at: www.calpath.org
The American Pathology Foundation is pleased to welcome the following new members:

**ACTIVE PATHOLOGISTS:**
- Brian Bock, MD  
  Pathology Laboratory Associates • Tulsa, OK
- Nicole Finke, MD  
  Pathology Consultants of Western Montana • Missoula, MT
- Matthew Smolkin, MD  
  Mountain West Pathology/Big Sky Diagnostic Labs • Helena, MT
- Connie Vitali, MD  
  RMH Pathologists LTD • Rockford, IL

**AFFILIATES:**
- Lindsay Cole  
  Pathology Associates of Tyler • Tyler, TX
- Marcella Pyke  
  HCT Pathology Services • Baltimore, MD

(continued from p. 8)

Bility that aspects of the laboratory medicine establishment in certain Canadian provinces may have finally reached a breaking point. The June 8 issue of The Dark Report (provides) analysis and commentary about the latest unfolding events concerning breast cancer testing in Quebec.

**RELATED INFORMATION:**
Cancer report blown out of proportion: Quebec minister:  
Quebec re-examining breast cancer study: [www.cbc.ca/health/story/2009/05/30/breast-cancer-quebec.html#socialcomments](http://www.cbc.ca/health/story/2009/05/30/breast-cancer-quebec.html#socialcomments)
Quebec breast cancer patients kept on hold: [www.thestar.com/printArticle/642979](http://www.thestar.com/printArticle/642979)
Minister, MDs agree there are reasons to worry over Quebec cancer report: [news.guelphmercury.com/Wire/News_Wire/National/article/487429](http://news.guelphmercury.com/Wire/News_Wire/National/article/487429)

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With expanding regulations and declining reimbursement, it is more important than ever for pathologists and their staff to stay informed of codes and payer rules and regulations, and to solicit independent audits. A review by an independent expert is an excellent opportunity to put the group’s practices ‘under the microscope’ and critique documentation, coding, and billing from an impartial perspective.

Often, just making a few minor revisions can go a long way toward streamlining the process and improving the bottom line. To help assess your group’s practices, ask yourself the following questions.

1. **Are your requisitions well-designed and are they properly completed?**

   Just as your lab wouldn’t accept a specimen requisition without the patient’s name or description of the specimen, the same protocol should be followed if the requisition is missing diagnosis and other information necessary for filing a clean claim. Knowing the patient’s signs and symptoms or the clinician’s diagnosis may be critical to you getting paid.

   All clinical labs, Pap tests, and some anatomic pathology specimens (those with normal/negative findings) must be assigned ICD9 codes from the referring MD’s reason for ordering the test. Federal law (the Balanced Budget Act) requires the referring physician to provide diagnostic information to the lab at the time the test is ordered, and if not provided, the lab must request this information. Diagnoses indicating uncertainty, such as “rule out” or “suspicious for”, may not be used.

   PQRI and a growing list of services (such as flow cytometry and molecular diagnostics) with associated National and/or Local Coverage Determinations have made accurate diagnosis information even more important for pathologists. Coverage determinations are rules that limit the diagnoses for which the services are paid. The requisition should be designed to elicit all necessary information to bill the service appropriately. For example, if your flow cytometry requisition provides check-off boxes listing only rule out conditions (t/o lymphoma, myeloma, leukemia, etc.), and the flow findings are negative, you will not have enough information to assign a diagnosis code. You need the confirmed diagnosis or patients’ signs/symptoms that caused the clinician to suspect the lymphoma/myeloma/leukemia – and if it’s not on the NCD/LCD list, you’ll need a signed ABN.

2. **Do you reference the current CPT manual regularly for coding?**

   Most surgical specimens are specifically listed in the 88302-88309 section of CPT, often in multiple levels. But unless you are very familiar with the manual, it is easy to assign the wrong code.

   Who would think to look under the “B” section to find synovial cyst? But that’s where you’ll find it, listed under Level III as “Bursa/synovial cyst”. There’s no substitute for repeated perusal of the list to become familiar with all the listed specimens.

   And pay close attention to the descriptors used to differentiate the specimens at different levels. Using these distinguishing terms in your report, such as “bladder, TUR” vs. “bladder biopsy” leaves no doubt as to the correct code. Just stating “bladder tumor” isn’t sufficient to determine the appropriate code.

   Remember too that CPT-4 manuals are updated annually—make sure you use the current edition.

3. **Do you meet requirements for billing clinical lab tests requiring professional interpretation?**

   Medicare lists as payable under Part B approximately 20 clinical lab tests which may require a pathologist’s inter-
pretation. If you are providing the professional interpretation for any of these services, such as immunoelectrophoresis or fibrinolysin screening, make sure you meet Medicare’s 3 criteria, and bill the clinical lab code with a -26 (professional component) modifier. Reimbursement averages $16 - $20 per test, making them worth the extra effort. Two requirements – issuing a written narrative report and the exercise of medical judgment – are likely already being met. But make sure you have a hospital standing order (by Medical Executive Committee) for the interpretations, or receive an order for the physician interpretation of each test. Having an order only for the test itself, or having a ‘lab policy’ requiring professional interpretation of these tests, is not sufficient.

4. Have you investigated coding and reimbursement of new procedures?

Before purchasing new equipment or offering new services to your clients, make sure you know the correct CPT codes, can add them to your third-party-payer contracts for satisfactory reimbursement, and investigate whether Medicare or other payers have national or local coverage determinations (NCDs or LCDs) associated with the service. You want to find out before you make a large capital investment if your largest payer considers the associated service “investigational”, or severely limits diagnoses for which they will cover it. As stated in #1 above, you may need to update your requisition to elicit appropriate diagnosis information for the new test, or direct referring MD to get a signed ABN. Be careful not to ‘steer’ clinicians toward payable diagnoses only.

5. Do you follow edit rules and apply modifiers appropriately?

PQRI, genetics modifiers, MUEs – the list of cases that may require modifiers for proper payment is growing. Make certain you know each payer’s rules about when to use each modifier, document properly to support them, and apply them correctly. Perhaps still the modifier with the biggest potential impact is the -59. CMS’ initiative to control improper payment for Part B claims led to the NCCI edits. Billing certain code pairs for the same patient, same date of service, requires the addition of a 59 modifier in order for both services to be paid. Because of the high potential for abuse, the OIG has identified the 59 modifier as a priority for investigation. It is imperative for pathologists to document appropriately when medically necessary to perform both methodologies in cases that Medicare considers ‘duplicate testing’.

The -59, or other modifier, may also be necessary to justify units of a single code billed in excess of the MUE allowable. Coders must be able to review reports and determine whether the 59 or other modifier is warranted. If you are simply adding a modifier to the codes and re-billing when services are denied you are setting yourself up for penalties, fines, or worse – exercise caution in this area!

An outside expert analysis may be the most effective way to get the real measure of your group’s performance, but ongoing self-examination and education is critical to simplifying your procedures while improving collections.

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