



Comparative Billing Report

August 14, 2014

CBR #: CBR201407
NPI #: 1111111111
Fax #: (888)555-5555

Full Name
123 Street Lane
Suite 4000
Anytown, XX 55555-4444

Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. In an effort to accomplish these goals, CMS has contracted eGlobalTech, a professional services firm in Arlington, VA, to develop Comparative Billing Reports (CBRs). CBRs are designed to educate providers on their billing or referral patterns for selected topics through a comparison to other providers across their state and the nation. As CBRs are for educational purposes, no reply is necessary; the data provided is solely for your information.

Attached is a CBR that reflects your billing or referral patterns compared to peer provider's billing or referring the same services in your state and nationwide. We hope you find this CBR beneficial as an educational tool to assist you in identifying opportunities for improvement. If you have any questions regarding this CBR, or if you want to change the way you receive CBRs in the future, please contact the CBR Support Help Desk via:

- Calling the Toll Free Number, 1-800-771-4430;
- Sending an email to cbrsupport@eglobaltech.com;
- Visiting the website at <http://www.cbrinfo.net>.

REMINDER: If you have changed your mailing address or contact information and have not notified the National Plan and Provider Enumeration System (NPPES) and/or CMS' provider enrollment contractor via the internet or the appropriate Medicare enrollment application, please take time to review and update the system.

You can update your National Provider Identifier (NPI) and contact information on NPPES at <https://nppes.cms.hhs.gov/NPPES>. If you have forgotten your User ID and/or password or need assistance, contact the NPI Enumerator at 1-800-465-3203 or email customerservice@npienumerator.com.

For more information regarding the Medicare enrollment process or to obtain a copy of the Medicare enrollment application for your provider type, refer to <http://www.cms.gov/MedicareproviderSupenroll>.

We thank you for your cooperation and hope you find the attached report informative.

Sincerely,

A handwritten signature in black ink, appearing to read 'J.R. Glass'.

J.R. Glass
CBR Project Director
eGlobalTech
Enclosure

Comparative Billing Report (CBR): NPI 1111111111 Immunohistochemistry (IHC) and Special Stains

Introduction

This CBR focuses on providers that billed claims for pathology services for Medicare Part B beneficiaries for dates of service between January 1, 2013 and December 31, 2013. According to a June 2013 Office of Inspector General (OIG) report, “Comparing Lab Test Payment Rates: Medicare Could Achieve Substantial Savings,” Medicare is the largest payer of clinical laboratory services in the nation. Medicare paid approximately \$8.2 billion for lab tests in 2010, up from \$7 billion in 2008. The Health and Human Services OIG Work Plan for Fiscal Year 2013 states that much of the growth in laboratory spending was the result of increased volume of ordered services.

This CBR specifically examines billing for IHC, level IV surgical pathology, special stains group I, and special stains group II performed on gastric and combined gastric/colon biopsies and includes the following metrics:

- Average allowed charges per episode of care
- Average services per episode of care
- Percentage of episodes of care with a IHC or special stain

The current procedural terminology (CPT®) codes included in this CBR:

- 88305 - Tissue exam by pathologist
- 88312 - Special Stains - group I, for microorganisms
- 88313 - Special Stains - group II, other than those for microorganisms or enzymes
- 88342 - IHC

Coverage and Documentation Overview

This portion of the CBR offers a broad look at the coverage and documentation requirements to ensure compliance with Medicare Guidelines. **The information provided does not supersede or alter the coverage and documentation policies as outlined in the Medicare Administrative Contractor (MAC) local coverage determinations (LCDs) and Policy Articles.** Please refer any specific questions you may have to the MAC for your region.

Basic Coverage Criteria:

According to the Medicare Benefit Policy Manual; Chapter 15 - Covered Medical and Other Health Services §80.6.5 - Surgical/Cytopathology Exception, “While the pathologist will generally perform some type of examination or interpretation on the cells or tissue, there may be additional tests, such as special stains, that the pathologist may need to perform, even though they have not been specifically requested by the treating physician/practitioner. The pathologist may perform such additional tests under the following circumstances:

- These services are medically necessary so that a complete and accurate diagnosis can be reported to the treating physician/practitioner;
- The results of the tests are communicated to and are used by the treating physician/practitioner in the treatment of the beneficiary; and
- The pathologist documents in his/her report why additional testing was done.”

According to the National Correct Coding Initiative (NCCI) Policy Manual For Medicare Services, Chapter 10 - CPT® codes 80000-89999, “The unit of service for special stains (CPT® codes 88312-88313) is each stain. Physicians should not report more than one unit of service for a stain performed on a single tissue block. For example it is common practice to cut multiple levels from a tissue block and stain each level with the same stain. The multiple levels from the same block of tissue stained with the same stain should not be reported as additional units of service. Only one unit of service should be reported for the stain on multiple levels from the single tissue block. Additionally controls performed with special stains should not be reported as separate units of service for the stain.”

According to the Pathology Service Coding Handbook® stains such as hematoxylin-eosin (H&E) on tissue, Wright-giemsa on bone marrow smears, and DiffQuik on fine needle aspirations (among others) are considered to be routine and are not separately chargeable under any circumstances. In addition, counter-stains may not be billed separately.

During the 2013 calendar year, procedure code 88342 for IHC, which included tissue immunoperoxidase, was in place and was to be billed for each antibody. Because our data reviewed services billed in 2013, we are reporting on that procedure code. However, effective in 2014, the Centers for Medicare and Medicaid Services (CMS) discontinued procedure code 88342 and replaced it with HCPCS Level II code G0461, “Immunohistochemistry or immunocytochemistry, per specimen, first single or multiplex antibody stain” for services billed to the Part A or Part B MAC for a Medicare beneficiary. Also effective in 2014, CPT® changed the definition for 88342 to include “each separately identified antibody per block, cytological preparation or hematologic smear; first separately identified antibody per slide” and added a new procedure code, 88343, for “each additional separately identifiable antibody per slide.” CMS also does not recognize 88343. When billing Medicare for additional *unduplicated qualitative IHC stains*, either single or multiplex, on the same specimen, each stain is now reported as HCPCS Level II code G0462. The code (G0462) should be listed separately in addition to the code for the primary procedure, HCPCS Level II code G0461.

According to the Pathology Service Coding Handbook® regarding IHC, providers should “bill for services to Medicare beneficiaries based on the primary stain, not on the basis of the number of individual antibodies that can be detected and resulted using that stain.” In the case of both G0461 and G0462, only one unit of service is allowed for each *unduplicated* single or multiplex IHC stain. The 2014 NCCI manual states that “physicians should not report more than one unit of service per specimen for an immunohistochemical/immunocytochemistry antibody(s) stain (procedure) even if it contains multiple separately interpretable antibodies.”

References

The coverage and documentation guidelines for IHC and Special Stains are listed below. Please follow the guidelines pertinent to your region.

- LCD,
<http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>
 - CGS Administrators, LLC, L31873 (current)
 - CGS Administrators, LLC, L34369 (for services after 10/1/14)
- Local Coverage Article
 - CGS Administrators, LLC, A50751

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- Office of Inspector General, <http://oig.hhs.gov>
 - *Questionable Billing for Medicare Part B Clinical Laboratory Services*, July 2014, OEI-0311-00730
 - *Comparing Lab Test Payment Rates: Medicare Could Achieve Substantial Savings*, June 2013, OEI-07-11-00010
 - *Office of Inspector General Work Plan*, Fiscal Year 2013
 - Medicare Manuals, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/>
 - *Benefit Policy Manual*
 - * *Chapter 15, Covered Medical and Other Health Services*, Section 80.6.5
 - *Claims Processing Manual*
 - * *Chapter 16, Laboratory Services*, Section 40.8, Section 70.9 update Transmittal 2857
 - * *Chapter 23, Fee Schedule Administration and Coding Requirements*, Section 20
 - *National Correct Coding Initiative (NCCI) Policy Manual*, Revision Date: 1/1/2014, Chapter 10, Section J
 - Physician Fee Schedule (PFS) Federal Regulation Notice
 - *Federal Register / Vol. 78, No. 237 / Tuesday, December 10, 2013 / Rules and Regulations, Immunohistochemistry (CPT codes 88342 and 88343)*, CMS-1600-FC

Methodology

This report is an analysis of Medicare Part B claims with allowed services for the Pathology CPT[®] codes 88305, 88312, 88313, and 88342 with dates of service from January 1, 2013 to December 31, 2013. This report's population of claims was restricted to beneficiaries with gastric biopsy services (CPT[®] codes: 43200, 43202, 43211, 43216, 43217, 43232, 43235, 43238, 43239, 43242, 43247, 43250, 43251) on the same date of service as the pathology claim.

Each provider's distinct interaction with a beneficiary on a date of service will be referenced as an episode of care. Gastric biopsies should be examined under CPT[®] code 88305, and therefore any episode of care without an allowed service of 88305 was dropped from the analysis. This analysis was based on the latest version of claims available from the Integrated Data Repository as of July 8, 2014.

Average Allowed Charges per Episodes of Care: Breakdown by CPT[®] Code

The average allowed charges per episodes of care broken down by CPT[®] code for you, your state, and the nation are calculated as follows:

$$\frac{\text{Total Allowed Charges for the CPT}^{\text{®}} \text{ Code}}{\text{Total Number of Episodes}}$$

Your average allowed charges per episode of care by CPT[®] code were then compared to your state and the nation using a t-test at the alpha value of 0.05.

Average Allowed Services by CPT® Code per Episode of Care

The average allowed services by CPT® code per episode of care for you, your state, and the nation are calculated as follows:

$$\frac{\text{Total Allowed Services for the CPT® Code}}{\text{Number of Episodes for the CPT® Code}}$$

This analysis provides the average number of allowed services for each CPT® code when this code was submitted for an episode of care. Therefore, any episode of care that did not include this CPT® code was excluded from the row calculations. This analysis differs from the previous analysis on allowed charges by CPT® code since the previous analysis includes all episodes of care in the calculations for each code. Your average allowed services per episode was then compared to your state and the nation using a t-test at the alpha value of 0.05.

Percentage of Episodes with Special Stains

IHC and special stains are identified by CPT® codes: 88312, 88313, and 88342. If an episode of care has any allowed services for any special stain then the episode is grouped as “With Stains.” Percentage of episodes with special stains for you, your state, and the nation are calculated as follows:

$$\left(\frac{\text{Total Number of Episodes with a Special Stain}}{\text{Total Number of Episodes}} \right) \times 100$$

Your percentage of episodes with special stains are then compared to your state and the nation using a chi-squared test at the alpha value of 0.05.

Comparison Outcomes

There are four possible outcomes for the comparisons between the provider and the peer groups.

- **Significantly Higher** - Provider’s value is higher than the peer value and the statistical test confirms a significance
- **Higher** - Provider’s value is higher than the peer value but the statistical test does not confirm a significance
- **Does Not Exceed** - Provider’s value is not higher than the peer value
- **N/A** - Provider did not have any allowed charges in this category

It is to the advantage of the provider to incorporate these significance tests. Even though a provider’s value may be greater than the value of his peer, the statistical test gives the provider the benefit of the doubt since significance is based on the total number of claim lines and/or beneficiaries and the variability of those values.

Results

Table 1 provides a breakdown of the average allowed charges per episode of care by CPT® code for you, your state (OH), and your national peers. The first column provides the CPT® code summarized or indicates the total average charges. The statistical comparisons for the “Total” row are marked as “-” as this total is dependent on the four individual CPT® codes.

**Table 1: Average Allowed Charges per Episodes of Care: Breakdown by CPT® Code
January 1, 2013 - December 31, 2013**

CPT® Code	Your Average Allowed Charges Per Episode	Your State's Average Allowed Charges Per Episode	Comparison with Your State's Average	National Average Allowed Charges Per Episode	Comparison with the National Average
88305	\$50.65	\$81.35	Does Not Exceed	\$102.20	Does Not Exceed
88312	\$102.03	\$18.03	Significantly Higher	\$32.05	Significantly Higher
88313	\$68.17	\$11.01	Significantly Higher	\$23.15	Significantly Higher
88342	\$0.00	\$22.70	Does Not Exceed	\$36.74	Does Not Exceed
Total	\$220.85	\$133.09	-	\$194.14	-

A t-test was used in this analysis, alpha=0.05.

Table 2 provides a statistical comparison of your average services by CPT® code per episode of care to that of your state and the nation. Each category was analyzed and displayed separately in the table.

**Table 2: Average Allowed Services by CPT® Code per Episode of Care
January 1, 2013 - December 31, 2013**

CPT® Code	Your Average Services Per Episode	Your State's Average Services Per Episode	Comparison with Your State's Average	National Average Services Per Episode	Comparison with the National Average
88305	1.70	1.99	Does Not Exceed	2.27	Does Not Exceed
88312	1.69	1.27	Significantly Higher	1.44	Higher
88313	1.74	1.35	Higher	1.74	Does Not Exceed
88342	N/A	1.35	N/A	1.44	N/A

A t-test was used in this analysis, alpha=0.05.

Table 3 provides a statistical comparison of your percentage of episodes of care with a special stain with the percentages of your state and the nation.

**Table 3: Percentage of Episodes with a Special Stain
January 1, 2013 - December 31, 2013**

Group	Your Percentage of Beneficiaries	Your State's Percentage of Beneficiaries	Comparison with Your State's Percentage	National Percentage of Beneficiaries	Comparison with the National Percentage
With Stains	100%	69%	Significantly Higher	76%	Significantly Higher

A chi-square test was used in this analysis, alpha=0.05.

Resources

The resources below are pertinent to this CBR and will assist providers with documentation guidelines for IHC and Special Stains:

- **Government Accountability Office**,
<http://www.gao.gov/products/GAO-13-445>
 - *Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer*, June 2013, GAO-13-445
- **Code of Federal Regulations**,
<http://www.ecfr.gov/>
 - *Diagnostic x-ray, diagnostic laboratory tests, and other diagnostic test: Conditions*, 42 CFR Section 410.32
- *Medicare Payment for Qualitative Immunohistochemistry: Policy Clarification*, March 19, 2014
- **Leica Biosystems**,
<http://www.leicabiosystems.com/>
 - *An Introduction to Routine & Special Staining*, June 1, 2011
- **The American Pathology Foundation**,
<http://www.apfconnect.org/>
 - *APF Pathology Service Coding Handbook*, Version 14.3, July 2014

The Next Steps

We encourage you to check with your MAC to ensure you meet the Medicare Special Stains and Immunohistochemistry standards for your services. Please use the above references and resources as a guide.

Join us for the CBR201407 webinar on August 27, 2014 from 3:00 - 4:00 PM ET. Space is limited, so please register early.

Register online at www.cbrinfo.net/cbr201407-webinar.html.

If you are unable to attend, you may access a recording of the webinar 5 business days following the event at the website above.

For detailed links to information listed in the references and resources section, visit:

<http://www.cbrinfo.net/cbr201407.html>.

If you have any questions or suggestions relating to this CBR, please contact the CBR Support Help Desk via email at CBRSupport@eglobaltech.com or via telephone at (800) 771-4430.