



COLLEGE of AMERICAN PATHOLOGISTS

December 12, 2023

Sent via email

Dr. Naim Munir
Vice President, Chief Medical Officer
Wellmark Blue Cross and Blue Shield

Dear Dr. Munir:

On behalf of the College of American Pathologists (CAP), I write to express concern about Wellmark's recent collaboration with eviCore in a policy that limits coverage for certain immunohistochemistry (IHC) services. As the world's largest organization of board-certified pathologists and the leading provider of laboratory accreditation and proficiency testing programs, the CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide.

We understand that as of October 1, 2023, Wellmark is collaborating with eviCore healthcare to provide utilization management services for "molecular testing procedures". The CAP appreciates the need to address escalating health care costs, but we have serious concerns about policies that have the potential to inappropriately limit physician and other health care provider decision-making in the provision of patient care, as such policies improperly impinge on the practice of medicine by encumbering medically necessary laboratory and pathology services. **Specifically, we are concerned with the blanket reimbursement denials of IHC when the claim includes any one of the following ICD codes:**

- **C44.X: Other malignant neoplasms of skin**
- **D03.X: Melanoma in situ**
- **D04.X: Carcinoma in situ of skin**
- **D22.X: Melanocytic nevi**
- **D23.X: Other benign neoplasms of skin**
- **D48.5: Neoplasm of uncertain behavior of skin**
- **L57.0: Actinic keratosis**
- **L82.X: Seborrheic keratosis**

First-and-foremost, IHC is not a standalone molecular test, but rather an immunologically directed histochemical stain that is always used and interpreted in context of the microscopic examination of a patient's tissue specimen by a pathologist. The decision as to whether IHC is needed to make or to exclude a diagnosis in any specific case is complex, and dependent upon several factors including clinical history and presentation, patient demographics, anatomic location, and microscopic morphology.

Rigid exclusion criteria, based solely on the reporting of any one of these ICD-10 codes, fails to take into consideration the complexity of this process, and will likely compromise establishment of the correct diagnosis in many cases. For example, "other malignant



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neoplasm of skin” includes a wide range of tumors that may need to be differentiated from each other by methods supplemental to routine morphological assessment, including IHC stains. Furthermore, “other benign neoplasms of skin” includes various benign tumors that may be associated with specific syndromes, and differentiating these (which may require IHC) can have a significant impact on early diagnosis and screening.

Another fundamental flaw in this guideline is an evident misunderstanding as to how ICD-10 code(s) are to be reported. The ICD-10 code reported is assigned based on the final pathology diagnosis which, in this setting will necessarily be after any IHC stains are performed to exclude alternative diagnoses. Therefore, the final ICD-10 code for the case cannot be used alone to determine the medical necessity of the workup that led to its diagnosis, as this will intrinsically exclude recognition of all excluded diagnoses – and the essential value of the workup is in the diagnoses excluded just as much as in the diagnosis finally made. Even with the consideration of exceptions on a “case-by-case” basis, the significant burden on pathologists and their systems to challenge each and every medically necessary immunostain impedes the provision of important care and services to patients.

Pathologists know that the right stain at the right time can make all the difference in a patient’s diagnosis, treatment, and outcome. The decision to use a certain stain should be left to the pathologist responsible for diagnosis of the case, who is best positioned to know what is needed to make that determination. **The CAP urges Wellmark to revise its restrictive policy and requests a meeting to further discuss this issue.**

Elizabeth Fassbender, JD, Director, Economic and Regulatory Affairs, is the contact person for further discussions. She can be reached at efassbe@cap.org or 608-469-8975. Thank you for engaging with us on this important issue.

Sincerely,



MD, FCAP

A. Joe Saad, MD, FCAP, CPE
Chair, Council on Government and Professional Affairs