# January Advocacy Recap

February 7, 2022

**Alec Bose:**

Hello, and welcome to the CAP Advocacy recap. A monthly podcast dedicated to catching you up on the top news for pathologists. I'm Alec Bose from the CAP's Advocacy Communication Team, here with your January recap. This month, we'll look at testing supply shortages caused by the Omicron variant, new dispute guidelines in the No Surprises Act and more. Later, we will be speaking with the CAP's vice chair on the Economic Affairs Committee, Dr. Ronald McLawhon about the recent updates to clinical consultation codes for pathology.

Starting with COVID news today, as the US saw a rise in cases with the spread of the Omicron variant, we also saw continued testing supply shortages reported across the country. The CDC had encouraged laboratories with testing capacity to contact state and local health departments to coordinate the logistics of the surge in testing demand. In December, the CAP discussed the various needs of laboratories to handle the testing surge with officials from the Centers for Disease Control and Prevention, the Department of Health and Human Services Testing and Diagnostic Task Force, and other laboratory groups. Due to long lines reported at testing sites, the CDC encouraged laboratories to assist with specimen collection or standup drive-through testing sites. The federal government also urged laboratories to contact them if your laboratory is experiencing supply chain issues. These shortages can be reported to the CDC at locs@cdc.gov or to the HHS testing and diagnostic working group at tdwginfo@hhs.gov.

We turn now to the No Surprises Act, where the HHS release guidance for the patient provider dispute resolution process, which helps providers understand what information to include for the good faith estimates. The CAP worked closely with Congress during the development of the No Surprises Act and advocated for patient protections, but has continued to point out the serious risks for patient harm and substantial difficulty in determining the cost of pathology services in advance of services conducted by pathologists. While the No Surprises Act established an independent dispute resolution process for payment disputes between plans and providers, it also offers new dispute resolution opportunities for uninsured or self-pay individuals who are billed more than the good faith estimate. The process uses a third party arbitrator to review a patient's good faith estimate, final bill, and other information submitted by a provider or facility to determine a payment amount. The HHS will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured or self-pay individual does not include expected charges from other providers and facilities that are involved in the individual's care. For info on related guidance, visit our website.

In other important news, the CAP and 10 other healthcare professional organizations urged the CMS to increase transparency and clarify stakeholder engagement during Medicare's medical coverage determination process. The issue stems from concerns with Medicare Administrative Contractors or MACs over the past several years. The organizations have asked the CMS in a letter for holistic changes to the process. In the letter, the group said, "Our organizations are concerned that MACs are establishing policy without providing adequate opportunity for notice in comment." They also outlined how to maximize transparency and stakeholder engagement by increasing opportunities for public notices and comments clarifying contractor advisory committee engagement, and making the details of coverage policies clearer. The CAP will continue to monitor the next steps as this issue moves forward.

Finally, we end the recap with consultation codes for pathologists. This month, the CAP hosted a webinar where experts reviewed the most recent changes and some tips for implementation. One of those experts was Dr. Ronald McLawhon, vice Chair of the Economic Affairs Committee. We sat down with Dr. McLawhon to answer some of the frequently asked questions about clinical consultation codes. So Dr. McLawhon, thank you so much for joining us, we really appreciate you being here with us today.

**Dr. Ronald McLawhon:**

Thank you for inviting me.

**Alec Bose:**

So just to start out, can you define what is pathology clinical consultation defined as in the CPP?

**Dr. Ronald McLawhon:**

So the pathology clinical consultation services are defined by four codes: 80503, 80504, 80505, and 80506. These services describe physician based pathology clinical consultations that are provided at the request of another physician or another qualified healthcare professional. And that could be [inaudible 00:05:29] to your own institution or different institution. It includes a written report at the request of, as I said, a physician or qualified healthcare professional. This request could be a written request, a verbal request, an electronic request, phone request, face-to-face request in the hallway. And it's really related to clinical assessment of the patient, evaluation, pathology and laboratory findings or other relevant clinical or diagnostic information that requires additional medical interpretive judgment of a pathologist. That's kind of encapsulates what these services are.

**Alec Bose:**

Thank you. So what are some of the main differences between the old codes and the most recent codes that were provided?

**Dr. Ronald McLawhon:**

So the old codes were the clinical consultation services, [inaudible 00:06:41] clinical pathology. Those are the 80500 and 80502. And the big difference with the new codes is that the services can be differentiated based on time requirements, the different levels of services, basically 10 minute, 20 minute intervals as you go up and then the 80506 is the add-on code for extended or prolonged services. The other way you can code for the new services is with what's called medical decision making. And that's really determined about the complexity of the service. And there are tables available in the CPT manual that, or CCPT codebook, that defines the different levels of medical decision making. So there's low, moderate, high complexity medical decision making, and there's criteria that you have to satisfy, much like evaluation management services if you've used DNM services in your practice for face-to-face encounters with the patient directly. So those are the two elements that really differentiate from the old codes. It's time-based service or it's an MDM based service. Those options were not available to the previous codes.

**Alec Bose:**

And can you discuss some of the details of these consultation codes, specifically how to document for time... No, excuse me. Specifically how to document for time for service and determining the complexity of a service?

**Dr. Ronald McLawhon:**

Okay. These clinical consultation services require a written report. And within that written report, you would be documenting if you're using time, the total time of the service. That could be all aspects of what takes surrender the service, including up to and including writing the report, that would be encompassed within the total timeframe of those roughly 20 minute intervals. Medical decision making levels, you would have to define what elements in the medical decision making table in that report, that written report, that you used to render a consultation. So if we looked at multiple lab results, elements of the patient chart, other kinds of things in the MDM tables, medical decision making table related to the morbidity, mortality risk of the patient, things of that nature would have to be specifically documented in the written report. The other thing that needs to be documented in the written report is the request where you received it from, and whether that was a written request or a verbal request, phone request, those kinds of elements would also need to be documented in that written report that you provide to the physician for the consultation service.

**Alec Bose:**

Thank you. And then finally, where can pathologists go to find more information about payment or reimbursement rates for new clinical pathology codes?

**Dr. Ronald McLawhon:**

So the best place to find it would be on the CAP Advocacy website. There's information out there. There'll be FAQs out there for our members to look at. The other contacts you could have would be the CAP Advocacy staff in the Washington D.C. office, they'll also be able to help you with that.

**Alec Bose:**

Great. Thank you for that, Dr. McLawhon, we really appreciate you being here with us today.

**Dr. Ronald McLawhon:**

Thank you again. Appreciate the opportunity to talk about these new codes.

**Alec Bose:**

That's it for this edition of your monthly recap. Thank you so much for listening. For more information on these stories and others, visit our website at cap.org/advocacy or follow us on Twitter at CAP DC Advocacy. With advocacy communications, I'm Alec Bose, and we'll see you next month.