Part B Insider (Multispecialty) Coding Alert

Reader Question: 'Grandfather Provision' Expiration Causes Headaches for Labs

Question: Since the TC Grandfather Provision ended July 1, 2012, we're receiving approximately six denials per week from our Medicare contractor for anatomic pathology services for non-hospital patients. For example, a Medicare patient went to a physician's office and had a skin lesion removed. Our pathology lab received the skin specimen, processed it, and reported back to the physician. We billed 88305, but received a denial indicating "not a covered service -- Must bill to part A contractor."

Our MAC representative told us that the patient received another service on the same day as a hospital outpatient (place of service 22). That made our global 88305 claim deny, as though we were charging the technical component (TC) for a hospital outpatient. Is there a modifier we can use, such as 59, to indicate that our service was for a non-hospital patient?

Answer: Unfortunately, no, there is not a modifier to get you out of this conundrum. Modifier 59 (Distinct procedural service) wouldn't work, because that's for two procedures performed on the same day that are bundled unless they are "distinct." In your case, the contractor is not claiming that the pathology lesion exam is "bundled," rather, they're confused about the place of service.

You are correct that you're claiming the technical component (TC) when you bill a global 88305 (Level IV - Surgical pathology, gross and microscopic examination). And under Medicare rules since the expiration of the TC Grandfather exception, pathologists can no longer bill Medicare for TC services for hospital patients.

Heads up: Pathologists should monitor claims for denials for TC or global anatomic pathology services. If you're finding problems like this, you'll need to alert your Medicare contractor and work out a solution. Until the problem is resolved, your only course of action is to file appeals.