

# PATHOLOGY QUARTERLY

## A Message From IPMS



*Tina Scavetta*  
*Pathology Account Manager*

As everyone knows, May 23rd was the deadline for “NPI only”. The provider’s NPI number must now be used in lieu of legacy provider identifiers in the HIPAA standards transactions for all claim submissions to Medicare, Medicaid and managed care payors.

Medicare allowed legacy-only numbers in the secondary fields until May 23rd to assist billing providers that were unable to obtain NPIs for secondary providers. Provider offices that were unprepared for the deadline can expect cash flow issues. IPMS stayed ahead of the deadlines. As a result, we have successfully made the switch and are monitoring all claims to ensure that our providers do not experience an interruption in their reimbursement flow. You can be assured that IPMS will make this transition a seamless one to your wallet.

## ANATOMIC PATH CONSULTATIONS

You’ve done your research, completed the work and arrived at a conclusion. Now it’s time to document the process—a necessary evil in the record keeping and reimbursement process. The following are some general documentation tips that may assist with recording pathology consult services.

- **Referring Physician**

The referring physician should always be documented. When Medicare audits a claim for a pathology consultation, they may request related documentation from the referring physician.

- **Documentation From Referring Physician**

The referring physician should describe to the consultant the reason for the consultation. Mailing the patient’s slide and billing information to a pathologist does not document medical necessity. It is the responsibility of the billing provider to ensure that an ordering physician has properly requested services which may be billed to Medicare.

- **Comprehensive Review**

CPT 88325 is for a special review of comprehensive medical records. When 88325 is billed, the report should contain enough information to document that a review of comprehensive records was performed and necessary. This code is usually billed once per patient’s set of cases.

Consults also include 88323 (slides and blocks—if new slides are prepared from the blocks, i.e., for immunostains, then these new slides would be considered de novo and may also be charged—88342 with the 59 modifier).

88321 is the other pathology consult code. This is used when review of an outside facility’s slides is performed, but no new slides are prepared and no medical records are reviewed.

An example of this is when a surgeon will send in slides for a biopsy that was performed at another institution to confirm that a suspected malignant neoplasm exists. This clears the way for the patient’s physician to proceed with cancer treatment including any surgical excision.



—Sharon Donelli, CPC  
Administrative Officer

## CODING CORNER



Sharon Donelli, CPC  
Administrative Officer

### Flow Cytometry Notation

CPT 2008 contains a new note following the flow cytometry codes (88187-88189). In support of the addition of codes 86356 (mononuclear cell antigen) and 86486 (skin test; unlisted antigen), to clarify reporting for quantitative mononuclear cell analyses, an exclusionary parenthetical note has been added following code 88189. The note basically precludes separate reporting of codes 88187-88189 for interpretation of codes 86355-86357, 86359-86360, 86361 and 86367.

86356  
86486



## MEDICARE ALERT ~ARE YOU UP TO DATE?

- **Changes to Information Required When Calling Medicare** – Important changes to the information required when calling Medicare took effect on May 23, 2008 in conjunction with final implementation of the national provider identifier (NPI).
- **Remember to Have Your NPI and PTAN Available** – Beginning May 23, 2008, Medicare guidelines require that contractors ask providers for both their provider transaction access number (PTAN) and NPI number, via both their interactive voice response system (IVR) and customer service representative (CSR) lines. Therefore, it is vitally important you have this information available when calling any of the Medicare service lines.
- **Always Use Your MOST Current NPI When Asked to Provide This Information Via Medicare's Customer Service and/or IVR Service Lines** – First Coast Service Options, Inc. (FCSO) recognizes that some providers may have new NPI numbers as a result of a change you may have made. When calling FCSO service lines, please be prepared to provide your most current NPI number. Having the most current NPI number can help in validating this information at the start of each call.
- **Providers With One NPI and Multiple PTANs** – FCSO is aware that some providers have one NPI and multiple PTANs and multiple NPIs to one PTAN. Beginning May 23, 2008, when calling the IVR line their system will be able to validate multiple NPI/PTAN combinations. However, it is possible you may experience a short delay while your information is being validated. They ask that you be patient and not hang up. The IVR will most likely be able to provide the information you are looking for. Providers are encouraged not to call the CSR line for status, eligibility, and other information currently available via their IVR systems. CSRs are now required to re-direct providers back to the IVR to obtain any information available via the IVR systems.

—Michele Krpata, CPC  
Training Specialist

## NATIONAL INCREASE IN CONSUMER-DIRECTED HEALTH PLANS

The number of companies that offer a consumer-directed health plan (CDHP) to their employees is seeing a slow but steady increase according to results of a survey by the National Business Group on Health and the Center for Studying Health System Change and the Commonwealth fund. Nearly half of large employers surveyed nationally say they have offered a CDHP to their employees, and the number of employees enrolled in the programs has nearly doubled over the last two years according to the results of these surveys.

These surveys suggest that CDHPs—typically high-deductible health plans accompanied by either a health reimbursement arrangement (HRA) or health savings account (HSA)—are being offered by a growing number of employers. It is projected that by 2009, 54 percent of companies plan to offer a CDHP.

With more employers offering this type of health plan, the number of employees who enroll rises as well. But does enrolling in a CDHP really save money? Of those companies with at least half of their workforce enrolled in a CDHP, the two-year median medical and pharmacy cost increase was about 3.6 percent. That's about half of the increase for companies with no CDHP offering.

Overall, companies with a CDHP experienced a two-year cost increase of 5.5 percent, versus 7 percent without a CDHP. As the popularity of the consumer-driven approach to health care grows, companies are better able to manage costs and workers will begin to take a more active interest in their own health care.

—Tina Scavetta

## THE BUNDLING GAME

Bundling is a billing term that refers to when insurers lump codes together in pairs under one reimbursement. The rationale is that one of the services is similar to or inclusive in the payment of another. Sometimes separate codes can be legitimately unbundled from the edits when circumstances allow, i.e., the same service performed on separate specimens. Documentation is key to successful and legitimate unbundling.

Lymph coding is an example of this. When the pathologist examines lymph nodes from the pelvic and periaortic regions, you'll need to decide what constitutes separate specimens. Based on CPT definition or coding convention, sometimes you should bundle lymph nodes with surgical pathology specimens, but sometimes you should code them separately.

When CPT definition includes lymph nodes, such as some breast specimens (88309, . . . breast, mastectomy—with regional lymph nodes), you can't separately report the lymph nodes. But you have to bundle lymph nodes with some other specimens, even though the definition doesn't say so. You should not separately report lymph nodes that are "part of the resected 88309 specimen," according to CPT Assistant Fall 1993. Based on this coding principle, a hysterectomy specimen does not ordinarily include lymph nodes, therefore, you do not have to bundle them. If, however, a simple mastectomy is performed (88307) and a second specimen is received (regional axillary nodes), then an additional 88307 may be charged.

IPMS coders and billers rely on current NCII bundling edits to apply these rules correctly and receive reimbursement for separate services whenever possible.

—Sharon Donelli, CPC

## PERFORMANCE MEASURES ~ COMMON SIZE INCOME STATEMENT



Liz Dickman  
Chief Financial Officer

When evaluating financial performance, one very useful tool is the Common Size Income Statement. This statement expresses all company revenue and expenses as a percent of total revenue. The statement details the relative contributions from all revenue sources and can also be used to determine the consistency of expenses over time as revenue fluctuates.

As a practice experiences growth, many expenses also increase as a result. It is important to determine whether the expense increases are in line with the revenue growth or if the expenses are growing at a higher rate. If an expense line item increases to a higher percent of total revenue than in prior years, this is an indication that the growth is outpacing the revenue grown and the line item should be researched to determine the underlying cause.

Common Size Income Statements can be a powerful tool to monitor your expenses. If you would like more information on this topic, please contact me at 860-282-0167.

## MEDICAID HOT TOPICS ~ KEEPING YOU IN THE LOOP

Medicaid has developed a website to keep providers informed of system issues or ways to resolve common denial issues. Your office will benefit from logging onto [www.ctdssmap.com](http://www.ctdssmap.com) for their weekly Hot Topics listing.

This website can be instrumental to your follow-up on Medicaid claims as they identify system issues as they arise and offer specific instructions on how to get your claims re-processed as necessary for all specialties. It also references other Medicaid Managed Care plans and offers updates to system issues within their programs as well.

—Tina Scavetta

## UPDATES FROM MELANIE



Melanie Vail  
Director, Ops & Marketing

Knowledge is power. "Pathology Quarterly" is our way of keeping you informed of industry news, market trends and what's happening at IPMS. We issue quarterly, specialty specific newsletters that explore the ever-changing world of billing and collections with informative articles written by our very own billing and collections experts.

The IPMS newsletters are a must-read for anyone looking to stay ahead of the curve.

Check out our website at [www.ipmscorp.com](http://www.ipmscorp.com) for our past newsletter publications. Stay informed so you can stay ahead.



# WHAT OUR HIGHLY VALUED CLIENTS HAVE TO SAY ABOUT IPMS . . .

*“HPA has enjoyed the personalized billing and management services provided by IPMS for nearly a decade. It has been an outstanding relationship that has benefited our group immensely in improving billing and collections significantly over our past experience with two previous companies with regional and national reputations. Our collection rates on allowances and A/R are the best of any to my knowledge. IPMS’s assistance with management and benefits programs has also been of great value and provided at a very high level of quality and personalized attention. From my awareness of the experience of other groups using other firms, IPMS is the standard of performance that other companies in the field should be striving to emulate.”*

**~William Pastuszak, M.D.  
Hartford Pathology Associates  
Hartford, Connecticut**



**IPMS** Integrated Physicians  
Management Services

111 Founders Plaza, Suite 300  
East Hartford, CT 06108  
Main Phone # (860) 282-0833  
Fax # (860) 282-0170

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#### **Pathology Quarterly Staff**

Tina Scavetta, Editor-in-Chief  
Email: [tina\\_scavetta@ipmscorp.com](mailto:tina_scavetta@ipmscorp.com)  
Phone #: 860-282-4118

Bea George, Editorial Assistant

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