

PATHOLOGY QUARTERLY

A Message From IPMS's Training Specialist

New Medicare Adjustment Code

Effective January 1, 2009 Medicare is implementing a new adjustment code #213: "Non-compliance with the Physician Self-Referral Prohibition Legislation or Payer Policy." This means that a physician cannot refer a patient for "designated health services (DHS)" if that referral will financially benefit that physician or that physician's immediate family. Per Medicare, this financial benefit would include "both ownership/investment interests and compensation arrangements (ex., contractual arrangements)".

DHS that would be included are listed in the MLN Matters Number: MM6131, released on August 15, 2008, which can be found on the Medicare website.

This is a new code and there was no previous code for this situation. This adjustment code follows section 1877 of the Social Security Act also referred to as the "Stark Law".

—Michele Krpata, CPC
Training Specialist

2009 ICD-9 CHANGES AFFECT PATHOLOGY CODING

Watch for these 2009 ICD-9 changes for more specific path-related diagnoses:
Hematuria (formerly 599.7) will now require a 5th digit:

- 599.70 Hematuria, unspecified
- 599.71 Gross hematuria
- 599.72 Microscopic hematuria

"Nonspecific abnormal Pap smear of other site" (formerly 795.1) now requires 5th digits as well. It is redefined as "Abnormal Pap smear of vagina and vaginal HPV".

- 795.10 Abnormal glandular Pap smear of vagina
- 795.11 Pap smear of vagina with atypical squamous cells of undetermined significance (ASC-US)
- 795.12 Pap smear of vagina with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)
- 795.13 Pap smear of vagina with low grade squamous intraepithelial lesion (LGSIL)
- 795.14 Pap smear of vagina with high grade squamous intraepithelial lesion (HGSIL)
- 795.15 Vaginal high risk human papillomavirus (HPV) DNA test positive
EXCLUDES: condyloma acuminatum (078.11)
EXCLUDES: genital warts (078.11)
- 795.16 Pap smear of vagina with cytologic evidence of malignancy
- 795.18 Unsatisfactory vaginal cytology smear (inadequate sample)
- 795.19 Other abnormal Pap smear of vagina and vaginal HPV (vaginal low risk HPV)



A brand new pap category is:

- Abnormal cytologic smear of anus and anal HPV
- 796.70 Abnormal glandular Pap smear of anus
- 796.71 Pap smear of anus with atypical squamous cells of undetermined significance (ASC-US)
- 796.72 Pap smear of anus with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)
- 796.73 Pap smear of anus with low grade squamous intraepithelial lesion (LGSIL)
- 796.74 Pap smear of anus with high grade squamous intraepithelial lesion (HGSIL)
- 796.75 Anal high risk human papillomavirus (HPV) DNA test positive
- 796.76 Pap smear of anus with cytologic evidence of malignancy
- 796.77 Satisfactory anal smear but lacking transformation zone
- 796.78 Unsatisfactory anal cytology smear (inadequate sample)
- 796.79 Other abnormal Pap smear of anus and anal HPV (anal low risk HPV)

The above changes are effective with October 1, 2008 dates of service.

—Sharon Donelli, CPC
Administrative Officer

CODING CORNER



*Sharon Donelli, CPC
Administrative Officer*

Use "V" for Screening Pap Smears

When labs run screening paps, which diagnosis should they use?

It depends on the outcome. If they turn out to be normal, the ordering physician's clinical diagnosis, which is normally a screening code, should be used: V76.2 (special screening for malignant neoplasms, cervix).

What if it turns out to be abnormal and needs to be reviewed by a pathologist? It depends upon payer preference. Medicare requires both the screening code and a code for the findings and some private insurers follow suit. Sequence the screening code first and the code for the findings second.

If the pap is diagnostic in nature and not a routine screening, then only the diagnostic findings need to be coded.



KNOWING THE ABC'S OF PQRIS

Pay-for-performance (P4P) programs are being implemented by many payors, including the Centers for Medicare and Medicaid Services (CMS). This quality initiative has made physicians collect and report data—which in the long run will improve the quality of care that patients receive. Several organizations have developed performance measures that are currently being reviewed for implementation.

The American Medical Association's Physicians Consortium for Performance Improvement (PCPI) and the National Committee for Quality Assurance (NCQA) are two of the major organizations that are responsible for developing performance measures. To help alleviate the problem of multiple, similar measures, the PCPI and NCQA have recently agreed to come together in the development of performance measures.

The National Quality Forum (NQF) is a not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. The NQF is made up from various parts of the healthcare system, including national, state, regional and local groups representing consumers, employers, healthcare professionals, provider organizations, health plans and organizations involved in quality improvement in healthcare. Once the PCPI and NCQA have developed and voted on the measures, they are sent to the NQF where they are reviewed.

Once approved by the NQF, the Ambulatory Care Quality Alliance (AQA) must approve measures before they are scheduled for implementation by payors. The AQA is a collaborative venture of physicians, consumers, purchasers and health insurance plans. Their hope is to improve health care quality and patient safety through a collaborative process in which all organizations agree upon a performance measurement at the physician or group level in the least burdensome way while reporting meaningful information to improve patient care. The physician members of the AQA are pushing for a universal implementation of AQA-approved measures to prevent overlapping of reporting measures.

The Surgical Quality Alliance (SQA) is a consortium of 20 surgical specialties that meets prior to AQA meetings to discuss issues. The SQA helps to ensure that all surgical specialties present a united front at the AQA and ensure that the issues and characteristics of surgical care measurement, data collection and reporting are addressed.

Although this process may seem complex, it is a greater comfort than the alternative, which would allow for measures to be developed by nonprovider groups.

—Tina Scavetta
HPAAccount Manager

PQRIS

CIGNA ACQUIRES GREAT-WEST

CIGNA has acquired Great-West Healthcare. This means Great-West is now part of CIGNA. There are no changes to claims submission, fee schedules, patient benefits or contracts at this time. Providers are to continue to process claims for CIGNA and Great-West as they are currently processed. Providers will be contacted regarding how this will affect them once the merge of the two carriers begins.

Additional information and frequently asked questions regarding this issue can be found on the CIGNA website, www.cignaforhcp.com; click on Important Information in the [News You Can Use](#) column (on the right of the screen).

—Michele Krpata, CPC

NEW LAW RE-DEFINING DEPENDENTS

Last year, Connecticut passed a law that changed the definition of dependent under group and individual health policies. This law will extend coverage to children until the age of 26. The former definition under most plans was "a child under age of 19 or a child under 23 who is a full time student". The new definition will change to "a child under 26 who resides in the State of Connecticut" subject to certain conditions in the law.



Cynthia Ambrose
Human Resources Manager

This law takes effect for group health plans on January 1, 2009. Changes for individual policies take effect for new policies issued on or after January 1, 2009 and for existing policies on the first date of policy renewal after January 1, 2009. This definition does not require an economic relationship, i.e., no requirement that the child rely on the employee-parent for support in order to be a dependent under their health plan.

The right of enrollment ends when the child:

- Marries
- Ceases to be a resident in the state (except for students)
- Becomes covered under a group health plan through the dependent's own employment; or,
- Attains the age of 26

If you are covered under a group plan with a January 1 renewal, you will be able to add dependents that are under age 26 effective January 1, 2009.



UPDATES FROM MELANIE



Melanie Vail
Director, Ops & Marketing

At IPMS, our state of the art billing software has been customized to what IPMS feels is most important—capturing every penny of revenue you're



WHY DAYS IN AR MATTER



Liz Dickman
Chief Financial Officer

While the argument could be made that there is really no difference between 30 and 60 days in AR because the accounts are still paid—the reality is that the older a claim is, the greater the risk that it will not be paid. Most carriers have timely filing limits, meaning the provider will not be paid if a charge is not submitted within a certain number of days from the date of service. A service that is payable, but not submitted timely, is basically being provided for free.

Electronic claims submission and direct payer billing have sped up the payment process significantly over the past five years. With the average payment turnaround time for Medicare and Blue Cross Blue Shield being within 15 days, and the other major payers being within 30 days, a high days in AR is the result of poor performance by the billing service or department. It is often due to a slow charge process, lack of follow-up on unpaid accounts, or a combination of the two.

In addition, the excess cash sitting in AR could be used to either invest or pay out bonuses sooner to the owners.



entitled to. We pride ourselves on our follow through.

We have created special no response reports that we run on a weekly basis to capture any charges that have not been responded to within 30 days of submission. This ensures that nothing falls through the cracks and each and every one of your services are accounted for and followed-up on until we receive payment in the door.

At IPMS no stone is left unturned—IPMS will turn the services you provide into the reimbursement you deserve, both timely and effectively.

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.
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