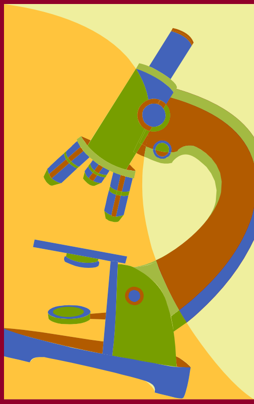
Examiner

Specializing in Pathology and Clinical Laboratory Business Solutions

June 2011



5010 Billing and ICD10 Coding Conversion

Beginning January 2012, the means by which providers exchange data with payors will change dramatically over the next several years. The changes – upgrading ANSI 4010 to ANSI 5010 and ICD-9 to ICD-10 – are required by a new directive from the U.S. Department of Health and Human Services (HHS).

5010 What You Need to Know

As a part of the industry conversion for professional claims (837) from the 4010 standard to the 5010 standard there are a number of data reporting changes. The federal deadline for implementing these changes and complying with the HIPAA 5010 financial and administrative transaction sets is January 1, 2012. Improvements in the 5010 transactions include clarified instructions, reduced ambiguity among common data elements used in different transactions, and elimination of redundant and unnecessary data elements.

Some of the changes that have been identified are: 5010 requires the same NPI to be sent for all payers for a single billing provider; 5010 requires the billing provider address to be a street address and not a P.O. Box/ Lockbox address (2010AA loop); a new Pay To loop (2010AB) has been added to store remittance addresses, such as P.O. Boxes or bank lockbox addresses, if they differ from the street address of the billing provider address; a 9-digit ZIP code needs to be sent for the billing provider; and for all health plans that assign a unique identifier per member, the patient must be listed as the subscriber.

PSA 5010 Billing Provider Changes

In 2010, PSA developed a detailed project plan to update all claim formats to version 5010 for those clients we bill and send claims for. This year PSA started the conversion process and began version 5010 testing internally.

We are also confirming with payors how they will be handling the changes to the Billing Provider segments and will begin testing once they are ready. Once the payor is ready and testing has been completed, PSA will begin exchanging data with that payor in the 5010 format.

These new guidelines may require providers to change the way they are credentialed with the payer and also may require changes to their National Plan & Provider Enumeration System (NPPES) information. Any necessary updates needed for PSA's billing clients will be handled by our Credentialing Department.

CMS National 5010 Testing Day-June 15, 2011

With less than six months until the compliance date, billing providers should be taking steps to ensure compliance, including conducting external testing with payors. To assist in this effort, CMS has scheduled a National 5010 Testing Day to for Wednesday, June 15, 2011. This will provide an opportunity to test compliance efforts with the added benefit of real-time help desk support and direct and immediate access to MACs.

ICD-10 What You Need To Know

On October 1, 2013 the health industry is changing from ICD-9-CM to ICD-10-CM for diagnosis coding. In going from ICD9's 13,000 codes to ICD-10's 68,000 codes, ICD-10-CM contains a more extensive vocabulary of clinical concepts, body part specificity, patient encounter information, and other components from which codes are built.

For Example: ICD-9 code "599.72 Microscopic hematuria" would be coded in ICD-10 as either "R31.1 Benign essential microscopic hematuria" or "R31.2 Other microscopic hematuria".

Stated benefits of ICD-10 are: improvements in data, quality, and disease management; decreased need for back-up documentation for claims; and less ambiguity in coding, leading to fewer payer-by-payer differences in interpretation.

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Upcoming Events

June 29, 2011
PSA Hosted Audio Conference titled, "Analyzing Accountable Care Contracts and their Impact on Pathologists and Laboratories"

July 18, 2011
PSA Practice Management and Marketing Audio Call titled, "Cold Calling: Nail the First 20 Seconds and Engage the Prospect"

August 15, 2011
PSA Practice Management and Marketing Audio Call titled, "Boosting Client Communication by Speaking the Coding Language"

September 21-23, 2011
2011 MED3OOO National Healthcare Leadership Conference
(PSA Pathology Business Conference)
Palm Springs, CA

November 15-16, 2011
2011 Lab Quality Confab
San Antonio, TX
www.labqualityconfab.com

www.PSAPath.com
www.PSABilling.com
www.PathLabCoding.com

How You Can Prepare for ICD-10

- In the coming months PSA will issue regular updates to clients we perform diagnosis coding for in order to keep you informed of how we are preparing for the transition. PSA will recommend training resources and provide information for our clients to assist them in understanding and implementing ICD-10 and educating their referring physician clients.

- If your practice performs your own diagnosis coding, coding professionals recommend that ICD-10 training take place approximately 6 months prior to the October 1, 2013 compliance date. There are a wide variety of training opportunities and materials available through professional associations. Because of the greater specificity in ICD-10 your coding staff may also require more training in anatomy and physiology concepts.

- Whether PSA performs your diagnosis coding or you do it in-house, you should go ahead and identify your current systems and work processes that use ICD-9 codes. This could include clinical documentation, encounter forms/requisitions, contracts (because ICD-10 codes are much more specific than ICD-9 codes, payers may modify terms of contracts, payment schedules, or reimbursement), etc. It is likely that wherever ICD-9 codes now appear, ICD-10 codes will take their place. Consider what you will need to do to update affected processes.

- The #1 most important thing pathology practices and laboratories can do now is to ensure you are receiving complete diagnosis information from your referring physicians on every case. This may require both enhancement of your lab intake protocols and education of referring physicians to make certain the clinical reason for each request is properly and thoroughly documented.

- Remember, if your current requisitions include ICD-9 numeric codes, they will be outdated and unacceptable in 2 years. PSA's coding staff is available to review your requisition form to ensure compliance and all necessary information is captured.

Coding Question?

Question

Our radiologist performed a thyroid FNA and sent slides from three passes for immediate evaluation by the pathologist. Is this coded 88172, 88177 x 2?

Answer

It depends on how the radiologist submitted the three passes for immediate evaluation and how the pathologist documented his/her services. The 88172 and 88177 codes were updated in 2011, and are now reported per evaluation episode.

> **88172: *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site***
>
> **88177: *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)***

Your inquiry does not indicate how the radiologist submitted the three passes. If all three passes were submitted for the pathologist to evaluate during a single episode, only a single unit of 88172 would be reported. However, if passes were sequentially submitted and the pathologist reviewed and provided a determination of adequacy before the next pass was submitted for evaluation, it would be appropriate to code separately for each evaluation. If this is the case, the 88172 code would be reported for the initial immediate evaluation, and two units of 88177 for the two subsequent immediate evaluations. Report documentation plays a vital role in the code selection; therefore, it is important that each evaluation episode is clearly documented.

Capture the charge for the final examination and diagnosis of the aspirate smears by assigning the 88173 code (*Cytopathology, evaluation of fine needle aspirate; interpretation and report*). Ancillary services, such as a cell block or special stains should also be reported when performed and appropriately documented.

Analyzing Accountable Care Organizations and their Impact on Pathologists & Laboratories

Interactive Presentation by:

Louis D. Wright, Jr., MD

PSA, LLC - Founder and Senior Advisor

CAP Board of Governors, and Chairman Council on Government and Professional Affairs

Moderated by:

John Outlaw, CHC

PSA, LLC Chief Compliance Officer

Wednesday, June 29, 2011

11amPT / 12pmMT / 1pmCT / 2pmET

Join this 90 minute audio conference to:

- Understand the intended purpose of an Accountable Care Organization (ACO) Model and its role in Health Care Reform;
- Review the different Accountable Care Models, management strategies and payment methodologies being discussed and implemented;
- Examine the role of pathologists, laboratories, hospitals and other specialties in these models; and
- Discuss the opportunities for pathologists and laboratories within these models.

Register Online at www.PSAPath.com or call 800-832-5270 x 2941.

CONVENIENT and COST-EFFECTIVE

Dial - in from your office, laboratory or hospital

Registration Fee is $200 (unlimited attendance per site)

No Cost for PSA Clients

Examiner
Providing Business Solutions for Pathologists
PSA LLC A MED3000 COMPANY
June 2011

PECOS Enrollment for Pathologists and Referring Physicians

PSA has been processing PECOS updates for the 500 pathologists PSA bills for, who were not already enrolled and is pleased to announce that all PSA affiliated pathologists, requiring enrollment, have been successfully enrolled in PECOS.

While claims for PSA billing clients are being processed normally, PSA has received warning messages from some carriers indicating that many of our client's referring physicians are not enrolled in PECOS or otherwise not found in the carrier's claim systems. In order to assist in educating our client's referral sources, PSA has been providing our clients with a listing of referring physicians for which we receive these warning messages and has developed a handout which can be personalized with each practice's logo and contact information.

The Centers for Medicare and Medicaid Services (CMS) has not set an official deadline for PECOS enrollment and has indicated that ample notice would be provided before claim denials are implemented for physicians if both the physician and referring provider were not enrolled. PSA will continue to keep you informed of any future developments.

Newsletter for Physicians and Clinical Staff **April 2011 Edition**

"Building Partnerships"

By Paul McLeod, M.D., MED3OOO Chief Medical Executive

As medicine transitions to value-based payments, a fundamental shift in the provision of healthcare services will follow. Speculation, skepticism, and uncertainty surround the concept of bundled payments and the intent to hold providers "accountable" in the context of ACOs, while one thing seems apparent: the players will be compelled to work together. Success will require partnerships among those currently competing for some of the same market share.

Health Plans will partner with employers. Their traditional "middle man" role may need to expand. Employees expect choice among a broad range of physicians and facilities, yet quality improvement and cost savings tend to be more manageable using smaller networks. Employees expect rich benefits, yet employers see the cost of benefit-driven health insurance as a huge threat to the bottom line. Health plans will also need partnerships with providers. Physicians are diverse in their business models, which include small private practices, large independent groups, IPAs and the rapidly growing hospital employed groups. It will be a significant challenge for health plans to build partnerships with physicians while also meeting employer expectations. Success may depend on the degree to which the health plans can support physicians in doing their jobs without rigid requirements around how it is done. Only this could create a partnership mentality. We may actually see health plans take on a greater role as physician employers in the near future as well. The sweet spot for the health plans is their role in disease and population management support and implementation, especially if combined with data sharing.

Providers will develop partnerships among themselves. This could occur by means of full integration into large multispecialty groups or the more likely scenario of virtual integration among groups that will also include hospital systems. IPAs in some markets could position themselves to "anchor" the local provider community. A giant hurdle currently stands in the way of provider partnerships as each entity competes for a "share" of healthcare dollars. Many years of fragmented, fee-for-service, volume-based productivity have created incentives that prevent partnerships among providers. New approaches to care will require new ways of thinking in the context of "Accountable Care." The successful organizations will be skilled in the creation of a culture of collaboration around common purpose supported by aligned financial incentives. Too often, the discussions about ACOs center around technologies like health information exchanges, reporting programs, patient portals, and electronic medical records. Indeed, these are important tools, but not as important as partnerships that lead to trust and true collaboration. In this scenario, low-tech relationship building could be the glue that holds successful organizations together.

Clarifying Common New Physician Credentialing Misconceptions

PSA clients are continually hiring new physicians or replacing retiring physicians. Therefore, PSA wanted to take this opportunity to clarify some common misconceptions regarding new physician credentialing.

A PRACTICE CAN SIMPLY DECIDE NOT TO BILL A PAYOR UNTIL THE CREDENTIALING PROCESS IS COMPLETE.

FALSE. *Most commercial payors assign an effective date when their process is complete – not when the provider joined the group. Therefore, if a practice decides to postpone billing until the credentialing process is complete reimbursement may be based on out of network rates impacting both the practice and the patient.*

ONCE A PHYSICIAN IS CREDENTIALED FOR THE FIRST TIME, HE/SHE IS COVERED FOR ANY FUTURE CHANGES.

FALSE. *Anytime there is a change of Tax Identification Number (TIN), this must be relayed to all payors. Therefore it is necessary to credential all new physicians within your practice.*

IT IS NOT NECESSARY TO NOTIFY PSA WHEN A NEW PHYSICIAN JOINS THE GROUP OR PRIOR TO THEIR START DATE.

FALSE. *Advance notice of at least 60-90 days prior to the new physician start date will give the PSA Credentialing Department the opportunity to notify as many payors as possible and hopefully complete most of the necessary updates prior to the physician's start date. As previously mentioned, whenever there is a change in TIN for a physician, this must be relayed to all payors.*

THE CREDENTIALING PROCESS IS NOT LENGTHY ESPECIALLY IF THE PHYSICIAN HAS BEEN CREDENTIALED BEFORE.

FALSE. *Medicare typically takes 60 – 120 days to process applications while Commercial Payors can take between 2 weeks to 6 months to process applications, depending on the physician's current credentialed status. Timelines for credentialing are affected by many variables – such as: A new physician just out of school/training or a physician moving from another state will take longer to credential than a physician moving from one practice to another within the same state.*

The fundamental purpose of credentialing is to ensure that physicians meet minimum requirements as a part of risk management. Negligent credentialing of new and existing physicians within a practice can hold insurance plans liable for exposing an insured patient to an unqualified physician.

In order to comply with the current requirements of regulatory governmental agencies and insurance providers, credentialing has taken on a new dimension. Credentialing is no longer a part-time assignment; it requires the full-time attention of trained credentialing specialists. This is why many billing providers charge an extra fee for the service. PSA provides credentialing to our clients at no additional charge.

PSA Credentialing Specialists provide our billing clients with a full service Credentialing Department.
Services include:

- Completion of all research, application and verification forms;
- Routing, tracking, and follow-up on verifications, queries, reports and reviews.

For additional information on Credentialing please contact Tanya Canup at 843-628-2552 or tcanup@psapath.com

5th Annual Lab Quality Confab and Process Improvement Institute

November 15-16, 2011 – Hyatt Regency – San Antonio, TX

Our 2011 agenda will include two full days, and over 50 sessions devoted exclusively to process improvement and quality management techniques!

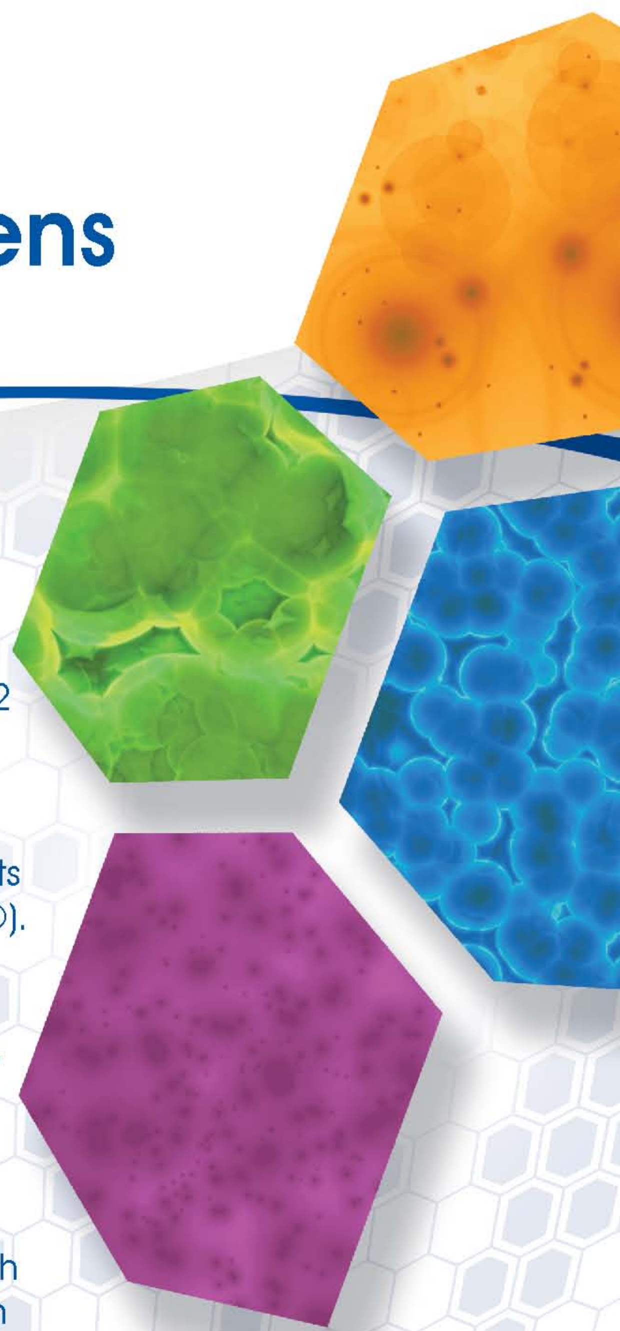
- Rapid Process Improvement
- Lean – Six Sigma – ISO 15189
- Powerful Case Studies
- Master Classes on Quality Methods
- Hands-on Learning
- Lessons from innovative labs
- Access experts, vendors, products
- Exhibition Hall with services and vendors

Lab Quality Confab
Process Improvement Institute
Pursuing Excellence in Continuous Improvement

For additional information please visit www.labqualityconfab.com or www.darkreport.com

HER2 FISH for Non-Breast Specimens

NOW AVAILABLE!



- Estimates of patients with gastric tumors with amplified HER2 vary considerably; however, recent reports suggest that the overall level of HER2 positivity in gastric cancer is approximately 20%, similar to that observed in breast cancer.
- Accurate HER2 testing is required to identify patients eligible for treatment with trastuzumab (Herceptin®).
- The FDA has approved the use of Herceptin® in combination with chemotherapy for HER2-positive, metastatic stomach cancer or cancer of the gastroesophageal junction.
- Results from a recent clinical study indicate that patients with HER2-positive metastatic stomach cancer live longer when treated with Herceptin® in combination with chemotherapy, compared to chemotherapy alone.

NeoGenomics Laboratories

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Join PSA at the following Upcoming Events

Randal Sanderson,
PSA VP of Business Development

Diana Brooks
PSA Regional Business Development Manager

September 11-14
CAP'11
Dallas, TX

September 16-18
SC Society of Pathologists
Ashville, NC

September 21-23
2011 National Healthcare Leadership Conference
(PSA Pathology Business Conference)
Palm Springs, CA

September 22
G2 Molecular Diagnostics
San Francisco, CA

October 19-23
ASCP
Las Vegas, NV

October 22-23
Pathology MGMA
Las Vegas, NV

December 1-3
CA Society of Pathologists
San Francisco, CA

December 4
CA Tumor Tissue Registry
Las Vegas, NV

December 12-14
G2 LabCompete
Chandler, AZ

2011 PSA Pathology Business Conference Dates & Location Announced!

Palm Springs, CA
September 21st – 23rd

PSA's Pathology Business Conference will be held September 21 - 23 in conjunction with MED3OOO's National Healthcare Leadership Conference in Palm Springs, CA. Please join us at the JW Marriott Desert Springs Resort and Spa to obtain valuable information from industry leaders regarding pathology and other healthcare-related issues impacting your business today. This meeting will provide you with the opportunity to network with your peers, meet our business partners, and spend time with experts in the industry.

Additional information will be announced in the upcoming months. We hope to see you in Palm Springs!

Upcoming PSA Practice Management and Marketing Audio Calls

"Cold Calling: How to Nail the First 20 Seconds and Engage the Prospect"

Monday, July 18, 2011
11amET - 10amCT - 9amMT - 8amPT

Join this interactive audio conference to learn:

- The #1 Cold Calling Mistake
- Why Cold Calling is NOT a Numbers Game
- The Three Parts of a Rock-Solid Cold-Calling Script
- Why Great Sellers Rarely Feel Rejected

"Boosting Client Communication by Speaking the Coding Language"

Monday, August 15, 2011
11amET - 10amCT - 9amMT - 8amPT

Guest Speaker:
Chappy Manning, RN, CPC
PSA Billing Support Services, Coding Coordinator

Chappy will be covering basic coding knowledge to increase the communication between CSRs/BDRs and the referring physician office staff. This call should be attended by those not familiar with coding or those who would like a refresher on the introduction of coding.

Some of the items discussed will include:

- Introduction to Pathology/Laboratory CPT Coding
- Professional Clinical Lab Codes
- AP Cytopathology, Non-gyn Cytopathology, and Gyn Cytopathology
- AP Surgical Pathology
- Common Ancillary Services
- Some Additional CPT Coding Issues

Recent PSA Practice Management and Marketing Audio Calls

A recording of the calls along with handouts are located on the PSA Extranet.

"Open Discussion: Pap Result Notification Systems"

Monday, May 23, 2011
11amET - 10amCT - 9amMT - 8amPT

Guest Speakers:
David Lawson, Information Systems Manager,
Pee Dee Pathology Associates in Florence, SC
John Outlaw, PSA Chief Compliance Officer

During this interactive call, David Lawson discussed Pee Dee Pathology's new Patient Pap Test Status Service that was created in-house and John Outlaw discussed the compliance guidelines for providing these types of services.

"The Challenges of Generational Difference in the Workplace"

Monday, June 13, 2011
12pmET - 11amCT - 10amMT - 9amPT

Presented by:
Paul McLeod, MD, MED3OOO Chief Medical Executive

During this interactive call, Dr. McLeod discussed the basic understanding of generational differences, personal values, and professional motivators and how to communicate and work with different generations in the workplace.

For more information on these audio calls please contact Amanda Winburn at awinburn@psapath.com or 800-832-5270 x 2921.