Cervical Cancer Screening

Update Your HPV Testing Protocol

Every five years passes CMS muster.

If your lab is stuck in the biennial Pap/reflex to HPV rut, you might encounter denials or missed billing opportunities, depending on your payers.

That’s because the landscape is changing regarding how to best screen for cervical cancer using tools such as Pap smears and human papilloma virus (HPV) tests.

Learn New Recommendations

Biennial Pap screening is a long-held practice for early detection of cervical cancer in low-risk women, or annual Pap tests for high-risk women. Plus, some labs have routinely processed client orders for a reflex HPV test if the Pap smear resulted in findings of atypical squamous cells of undetermined significance (ASCUS) or greater cellular changes.

Now several professional organizations have amended those cervical cancer screening recommendations, including the American Society for Clinical Pathology (ASCP), American Society for Colposcopy and Cervical Pathology (ASCCP), American College of Obstetricians and Gynecologists (ACOG), American Cancer Society (ACS), and the U.S. Preventative Services Task Force (USPSTF).

Know this: For women aged 21 through 65 years, the aforementioned agencies now stand behind Pap testing once every three years. And for women aged 30 through 65 years, the agencies actually recommend a preferred regimen of performing a Pap test plus an HPV test together once every five years, instead of just a Pap test once every three years. HPV testing is not recommended for women younger than 35, and is not advised as a stand-alone test at any age to screen for cervical cancer.

CMS on board: If you’re billing for a Medicare beneficiary, you should know that CMS issued a decision memo stating “that the evidence is sufficient to add HPV testing once every five years as an additional preventive service benefit under the Medicare program for asymptomatic beneficiaries aged 30 to 65 years in conjunction with the Pap smear test.”

Check with payers: Your lab may find that some payers have added HPV testing as a covered screening service, but they may also have increased the time between allowable Pap tests. That means you need to contact your major payers, and then
alert clients to the new coverage paradigm. That way your lab can avoid Pap test frequency denials, and also ramp up legitimate HPV test orders for cervical cancer screening.

Know the codes: Labs may perform one of several HPV tests, as follows:

- **87623** — *Infectious agent detection by nucleic acid (DNA or RNA): Human Papillomavirus (HPV), low-risk types (e.g., 6, 11, 42, 43, 44)*
- **87624** — *… Human Papillomavirus (HPV), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)*
- **87625** — *… Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed.*

“You should select the appropriate code based on the HPV types you test for,” says **William Dettwyler, MT AMT**, president of Codus Medicus, a laboratory coding consulting firm in Salem, Ore.

Caution: Payers typically cover screening tests for high-risk HPV types, but may not cover a test for low-risk HPV types.

Get the Diagnosis Right

Payers generally cover screening tests only when you meet certain criteria, including using the correct diagnosis code. You’ll need to ensure that your lab clients know which ICD-10 codes indicate medical necessity for cervical cancer screening using Pap and HPV testing, as follows:

- **Z12.4** — *Encounter for screening for malignant neoplasm of cervix*
- **Z11.51** — *Encounter for screening for human papillomavirus (HPV)*

Problem: The 2015 ICD-10 contains an error, which assigns an “Excludes1” note to the HPV screening in addition to an encounter for cervical screening code.

Remember: An “Excludes1” note means that you cannot report the two conditions at the same encounter.

The 2016 ICD-10 will correct the error by changing the statement to an “Excludes2” note — meaning that you can report both codes together if the conditions occur together.

Bottom line: If your clients order concurrent Pap and HPV tests to screen for cervical cancer, they should request the tests from your lab by assigning both Z12.4 and Z11.21.
Finally — the rule for re-valuing the Clinical Laboratory Fee Schedule (CLFS) that was due by June 30 arrived Oct. 1, 2015.

The rule implements section 216 of the Protecting Access to Medicare Act of 2014 (PAMA). It requires “applicable” labs to tell CMS how much private payers reimburse them for specific lab tests, so that CMS can use the data to establish new CLFS payment rates.

Read on to get the lowdown on the rule, and what it means for your lab.

See If You Need to Report

If you’re an “applicable” lab, you need to get ready to report specific data to CMS. The rule defines applicable labs as CLIA certified entities that earn more than 50 percent of their Medicare revenue for the entire organization (if the lab is part of a larger organization) from CLFS and physician fee schedule (PFS) payments. Also, an applicable lab must earn at least $50,000 per year from CLFS payments. CMS predicts that these criteria will exclude most hospital labs, more than half of independent labs, and more than 90 percent of physician office labs from the reporting requirement.

Learn the schedule: As an applicable lab, you must report data from the time period of July 1 through Dec. 31, 2015. Your reporting window is January 1 through March 31, 2016. Mistakes will cost you — CMS can levy penalties of up to $10,000 per day for misrepresentation or failure to report.

Problem: With the mandatory comment period schedule, it appears that CMS may not release the final rule until after the reporting period begins. This doesn’t allow labs and billing vendors “adequate time to prepare for and reconfigure laboratory claims management systems and software to ensure that they provide accurate, timely and adequate reporting of claims data,” as envisioned by William G. Finn, MD, FASCP president of the American Society for Clinical Pathology (ASCP) in an open letter to CMS’s deputy administrator, Sean Cavanaugh.

Price determination: After applicable labs report private payer reimbursement rates and test volume for each test on the CLFS (approximately 1300 tests), CMS will use the data to establish the Jan. 1, 2017 CLFS payment rate. CMS will set the rate for each test as the weighted median of private payer rates reported by applicable labs.

Understand ADLT’s

CMS won’t use this method to determine payment rates for every test — it’s different for Advanced Diagnostic Laboratory Tests (ADLTs). These are tests that Medicare covers, but that only one lab performs, and that meet at least one of these criteria:

» Test is analysis of multiple DNA, RNA, or protein biomarkers, combined with a specific predictive algorithm
» Test is cleared or approved by the Food and Drug Administration (FDA)
» Test meets other similar criteria established by the Health and Human Services Secretary.

CMS will pay for new ADLTs at their actual list charge for three quarters. Then payment for ADLTs would be based on the weighted median private payer rate reported by the single laboratory that performs the ADLT.

Anticipate Your Financial Impact

Repricing the entire CLFS could have a tremendous impact on your lab’s future bottom line — or not. The effect will depend on your lab’s specific circumstances.

For instance: CMS expects that hospital labs may see little impact from the change, because most payments that hospitals receive for lab work come through the Inpatient or Outpatient Prospective Payment Systems, not the CLFS.

On the other hand, independent labs and physician office labs, which generally get paid at the CLFS rate, will bear the brunt of the change. CMS estimates that re-valuing the CLFS will result in $5 billion in Medicare savings over 10 years. That’s $5 billion that will come out of labs’ pockets.

Near term, CMS expects a 4.5 percent pay cut to the CLFS in 2017 — but no one really knows until the data come in.
Keep Up the Good Work — Smooth Transition Underway

CMS reports 90 percent claims acceptance rate

Maybe the sky didn’t fall when we transitioned to ICD-10 on Oct. 1, based on some reports that are trickling in.

Let’s take a closer look at recent experiences from both payers and billers, and see how your lab’s changeover stacks up.

**Payers:** Large groups like Humana and United Health Group reported very few errors due to the new diagnosis coding system in the early weeks following the change from ICD-9, according to a recent *Forbes* article.

CMS released some stats about the new diagnosis coding system on Oct. 29, and those numbers are quite positive. Between Oct. 1 and Oct. 27, Medicare processed 4.6 million ICD-10 claims per day, and only 10.1 percent of them were denied. Out of the denials, 0.1 percent were rejected due to an invalid ICD-10 code, and another two percent were denied because of incomplete or invalid information.

But many naysayers claim that insurers have the easy side of the deal, whereas medical coders and billers are toiling in the stress of the adjustment. To that end, The Coding Institute polled several practice management professionals to get the full story on how the transition has gone since ICD-10 implementation took place on Oct. 1. Read on for the results.

**Most Find Smooth Sailing—With A Few Glitches**

**Robert Perez** of Kingsbrook Jewish Medical Center in Brooklyn, NY, reported an easy transition to ICD-10, and also discovered that his payer had implemented some diagnosis coding edits. “The insurance company already denied the ICD-9 codes for a claim with an Oct. 1, 2015 date of service,” he said. “I have been successful in finding diagnosis codes so far using two helpful programs from Supercoder and the AAPC website.” He also considers it a good sign that he hasn’t gotten an influx of calls to help other hospital departments with their diagnosis codes, although the admitting and surgery departments have requested help with authorizations.

**Vinod Gidwani,** founder of Currence Physician Solutions in Skokie, Ill., notes that the transition has gone quite smoothly. “Frankly, the ICD-10 so far, as far as submitting claims and getting the claims accepted the experience, has been great!” he reports. “We are still in the process of analyzing payments. This whole ICD-10 reminds me of Y2K transition, all the hoopla but really ‘much ado about nothing!’”

**Delinda M. Casey,** billing coordinator at Specialty Care Institute, echoes that statement, noting that she says she hasn’t seen anything out of the ordinary yet. “So far so good, knock on wood,” she told The Coding Institute.

The experience of **Sharon Cohen, MSM, RHIA** of Partners Healthcare, shows that the ease of the ICD-10 transition might be dependent on the practice’s specialty. For instance, pathology, laboratory, and radiology may be more difficult because the “diagnoses are much more diverse than those of a particular specialty, and we are dealing with limited information from the referring practitioner,” Cohen says. “It’s too soon to really say how it is going with ICD-10, although it certainly is much more time consuming,” she says.

**Donelle Holle, RN,** a healthcare, coding and reimbursement consultant, says she is getting payments, but has also seen some denials. Some of those may have been due to her carrier “really not being I-10 friendly.

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Thank you in advance for your input!
yet,” but she adds that most carriers were more prepared than practices had expected, and payments have been appropriate thus far. If you get a denial, “refile it to see if [the payer] was just not ready,” Holle advises.

Payments May Not Be Speedy

In response to provider questions about the timing of Medicare payments under the ICD-10 system, CMS created a resource document last week advising practices about the payment timelines.

“Generally speaking, Medicare claims take several days to be processed and must also – by law – wait two weeks before payment is issued,” CMS said in the statement.

“The truth is very few health care providers file claims on the same day a medical service is given. Most providers batch their claims and submit them every few days. If you want to check on the status of your claim before that time, you can access your Medicare Administrator Contractor’s interactive voice response or portal as you do today to check on the status of your claim. Medicaid claims can take up to 30 days by law to be submitted and processed by states. However, most states process claims before that time.”

Resources: You can access the CMS listing of contact numbers for each state by visiting www.cms.gov/Medicare/Coding/ICD10/ICD-10-Provider-Contact-Table.pdf.

For updates on ICD-10 reporting, visit www.cms.gov/medicare/Coding/ICD10/index.html.

Reader Questions

Don’t Double Dip for Lab Method

Question:
Our lab performs a procedure to assay non-drug analytes that involves column chromatography plus mass spectrometry. Should we report the service as 82542 and 83789?

Answer:
No, you should not report both 82542 (Column chromatography/mass spectrometry [e.g., GC/MS, or HPLC/MS], non-drug analyte not elsewhere specified; quantitative, single stationary and mobile phase) and 83789 (Mass spectrometry and tandem mass spectrometry [MS, MS/MS], analyte not elsewhere specified; quantitative, each specimen) for the lab method you describe.

You can see from the 82542 code descriptor that the procedure includes a combination approach using both column chromatography and mass spectrometry (MS). You should not additionally report a second code for the MS procedure.

Heads up: CPT® 2016 changes the definitions for these codes as follows, but the code revisions won’t change the answer to your question:

» 82542 — Column chromatography, includes mass spectrometry, if performed (e.g., HPLC, LC, LC/MS, LC/MS-MS, GC, GC/MS-MS, GC/MS, HPLC/MS). non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen

» 83789 — Mass spectrometry and tandem mass spectrometry (e.g., MS, MS/MS, MALDI, MS-TOF, QTOF), non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen.

You Be the Coder

Check Out This Lung Case

Question:
Our pathologist evaluated a frozen section of a lung wedge biopsy during surgery, and later processed the biopsy specimen. Based on the pathologist’s frozen section findings, the surgeon proceeded with a lung lobe resection, and our pathologist consulted on the margins of this specimen, preparing three blocks for frozen sections and reporting to the surgeon that the margins were clear. The pathologist also processed and evaluated the lung resection specimen. How should we code the case?

Answer: See page 7.

SuperCoder Subscriber
Pay Attention to ICD-10 Combination Codes

**Question:**
Our lab performed a culture ordered for a patient with a diagnosis of sepsis, and testing identified the organism as Methicillin-resistant Staphylococcus aureus (MRSA). I think we should report the condition as A41.02 and B95.62, but my co-worker disagrees. Who is right?  
   Tennessee Subscriber

**Answer:**
Whether your co-worker is right depends on her suggestion, but you would not be correct to code the diagnosis as both A41.02 (Sepsis due to Methicillin resistant Staphylococcus aureus) and B95.62 (Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere).

Here’s why: ICD-10 instructs that B95.62 is not necessary if the primary “combination code” identifies the organism as MRSA. Because A41.02 correctly identifies the entire condition — sepsis due to MRSA, you should report A41.02 alone.

If the physician indicated a different condition caused by MRSA that doesn’t have a combination code, you would report the condition code plus B95.62.

Zero In on Lipid Order for Proper Coding

**Question:**
A physician ordered cardiovascular lipid panel screening. How should I code the work?  
   Oregon Subscriber

**Answer:**
Your coding will depend on exactly what the physician ordered and what the lab performed. Physicians may order any or all of the following tests to screen for cardiovascular disease:

- 82465 — Cholesterol, serum or whole blood, total
- 83718 — Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
- 84478 — Triglycerides.

**Alert:** These three tests comprise the lipid panel, so if the lab performs all three tests, you should report 80061 (Lipid panel) instead of the individual test codes.

Beware calculated value: Although physicians may need to know low density lipoprotein (LDL), and CPT® provides a code for the test (83721, Lipoprotein, direct measurement; LDL cholesterol) you’ll notice that it’s not a covered test for screening. That’s because the lab typically calculates LDL from the other lipid fractions measured in a lipid panel, so you shouldn’t separately charge for a calculated value.

Waived test: If you’re a waived-status lab under the Clinical Laboratory Improvement Amendments (CLIA), you’ll need to report the lipid tests 82465, 83718, 84478, or 80061 with modifier QW (CLIA waived test).

Ignore ‘Direct’ or ‘Indirect’ for Immunofluorescence Studies

**Question:**
I understand that coding for immunofluorescence studies to aid in the diagnosis of conditions such as lupus will change under CPT® 2016. Can you please explain the change?  
   Texas Subscriber

**Answer:**
Currently, you report immunofluorescence studies using one of two codes depending on whether the method is direct (direct immunofluorescence, called DIF) or indirect. The codes are 88346 (Immunofluorescent study, each antibody; direct method) and 88347 (… indirect method). You should report one unit of either code for a single antibody test.

For example: In a DIF test, the lab analyst covers a tissue specimen with a solution containing fluorescently labeled antibodies. During an incubation period, the antibodies, typically IgA, IgM, or IgG, bind to specific antigens that indicate autoimmune disorders, such as lupus.

Beginning in 2016, you no longer need to worry about whether the lab method is DIF or indirect immunofluorescence. CPT® 2016 revises 88346 (Immunofluorescence, per specimen; initial single antibody stain procedure) to describe either a direct or indirect immunofluorescence study. Notice that you’ll use the code for the first (or only) antibody stain procedure on a single specimen.

CPT® 2016 deletes the code for indirect immunofluorescence (88347), and adds a new code
to report additional antibody immunofluorescence studies on a single specimen following the initial study. The new code is +88350 (…each additional single antibody stain procedure). This is an add-on code, so you should report it only in addition to 88346 for the initial antibody immunofluorescence study. You may report multiple units of +88350 if the lab performs more than two immunofluorescence antibody studies on the same specimen.

Look for SSN Protection

**Question:**
I’ve heard that Medicare is removing the patient’s Social Security Number (SSN) from their Medicare insurance cards. Is that true, and if so, what is the timeline and how should we prepare?

**Oklahoma Subscriber**

**Answer:**
Yes, that’s true. According to Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Medicare cards would no longer contain SSNs beyond the next four years, by the end of fiscal year 2018.

Despite the known risks of identity theft when using SSNs, the Medicare program has continued to utilize beneficiaries’ SSNs, or an easily identifiable derivative of the SSN, as the identifier appearing on the Medicare beneficiary’s insurance card. But all that will change.

Under MACRA, Medicare and the Social Security Administration (SSA) will embark on a multi-year process to issue or re-issue Medicare identification cards that do not include SSNs. The process will not necessarily eliminate Medicare’s continued use of a beneficiary’s SSN, but it will put an end to the use of a beneficiary’s SSN on his Medicare ID card, which today is routinely presented when seeking health services and then is subsequently re-disclosed in medical records and health claims forms, which all create opportunities for theft or misuse of such numbers. Industry experts speculate that this change is in response to the recent high-profile data breach cases involving major insurers like Anthem and Premera.

The complete text of MACRA is available at www.gpo.gov/fdsys/pkg/BILLS-114hr2enr/pdf/BILLS-114hr2enr. pdff. “Prohibition of Inclusion of Social Security Account Numbers on Medicare Cards” is in Section 501 of the law.

Reader Questions and You Be the Coder were prepared with the assistance of R.M. Stainton Jr., MD, president of Doctors’ Anatomic Pathology Services in Jonesboro, Ark.
Pathology/Lab Coding Alert

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