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# THE PATHOLOGY CENTER NEWSLETTER

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Volume 7, Issue 2

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## IS YOUR LAB FOLLOWING COMPLIANCE GUIDELINES?

This issue of the Pathology Center Newsletter looks at testing issues that affect the billing and reimbursement for the federally funded Medicare and Medicaid programs.

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### **PAP SMEARS What to Order**

#### *Is it Routine or High Risk?*

Marge M. Patient calls our business office because Medicare is not paying for the Pap smear she had last month. She knows she is **high risk** but the Pap smear requisition was coded **routine** at her doctor's office so Medicare denied payment.

The physicians office staff need to ensure that the correct information is on the requisition so Medicare (or Medicaid) can be billed correctly.

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### **ORDERING MULTIPLE PANELS ON THE SAME DATE OF SERVICE**

It is important to know which tests are included in a panel and how to order the appropriate panel or tests. Duplicate test orders on the same date of service result in a denial on insurance claims. **The makeup of each panel is listed on the back copy (yellow) of the clinical requisition.**

TEST	PANELS		
	CMP	BMP	HFP
Albumin	X		X
Alkaline Phosphatase	X		X
ALT	X		X
AST	X		X
Calcium	X	X	
Carbon Dioxide	X	X	
Chloride	X	X	
Creatinine	X	X	
Direct Bilirubin			X
Glucose	X	X	
Potassium	X	X	
Sodium	X	X	
Total Bilirubin	X		X
Total Protein	X		X
Urea Nitrogen (BUN)	X	X	

When a combination of Comprehensive Metabolic Panel (CMP), Basic Metabolic Panel (BMP) or Hepatic Function Panel (HFP) is ordered on a patient on the same date of service,

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The choices on the requisition are:

- Routine \_\_\_\_\_  
ICD-9
- High Risk \_\_\_\_\_  
ICD-9
- Diagnostic \_\_\_\_\_  
ICD-9

Check the **ROUTINE** box only if the patient has no signs or symptoms of disease. For the service to be covered, the routine (screening) pap must be reported with the ICD- 9 code V76.2 (special screening for malignant neoplasms, cervix). The definition for a routine pap is “no suspicion of current atypia per referring physician and no history in medically relevant prior years of atypical findings. The ICD-9 code V700 should not be used for a screening pap as it will be denied by Medicare. Medicare will pay for a routine Pap smear once every two years.

The patients medical history or other findings will identify those who are at high risk of developing cervical or vaginal cancer. The following clinical history will qualify the Pap smear as **HIGH RISK**:

- ◆ Early onset of sexual activity (under 16 years of age,
- ◆ Multiple sexual partners (5 or more in a lifetime),
- ◆ History of sexually transmitted disease.
- ◆ Having fewer than three negative Pap smears within seven years.
- ◆ The daughter of a woman who took DES (diethylstilbestrol).
- ◆ Is of childbearing age and has had a Pap smear during the preceding 3 years indicating the presence of cervical or vaginal cancer or other abnormalities

The Pap smear requisition for high risk patients must be marked with the ICD-9 code V15.89. Medicare will pay for a yearly Pap smear for high risk patients.

In order for a pap to be marked as **DIAGNOSTIC**, one or more of the following circumstances should apply.

- ◆ The patient has been previously diagnosed with cancer of the vagina, cervix, or uterus that has been or is presently being treated.
- ◆ The patient has had a previously abnormal Pap smear.
- ◆ The patient presents any current abnormal findings of the vagina, cervix, uterus, ovaries or adnexa.
- ◆ The patient presents any significant complaint referable to the female reproductive system
- ◆ The patient shows any sign or symptom that might, in the referring physician’s judgment, reasonably be related to a gynecologic disorder.

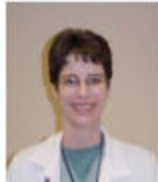
Medicare covers Pap smears ordered as diagnostic with no time restrictions. ❄❄

**ABN ON FILE**

There has been some confusion about the box in the cytology section of the anatomical pathology requisition that reads “ABN on file Yes\_\_\_No\_\_\_”. This does not mean abnormal pap on file.

The **Advance Beneficiary Notice (ABN)** is a written document used to notify us that the Medicare patient has signed the agreement to accept responsibility for payment if Medicare does not cover the service. If it is likely that Medicare will not cover the Pap Smear due to one of the coverage limitations described above, please obtain an ABN. Once an ABN signed by the beneficiary is on file, we may bill the beneficiary if Medicare denies payment. If you have questions about ABN’s, please contact our client service department. ❄

## *PATHOLOGISTS CORNER*



**Dr. Stacey McManigal**

For accurate interpretation and reporting, please include relevant clinical information on the requisition when sending biopsy specimens. Because different diagnosis processes can result in similar histologic patterns, we can be of the most help to your patients if we know the clinical background.

Completely spell out the source of the tissue specimen on the requisition. Reports can be delayed when it is not clear the exact source of the tissue.

It is not necessary to include a diagnosis code on the requisition (this applies to biopsy/tissues only). The diagnosis codes are assigned as part of the final billing process.

*MULTIPLE PANELS – continued from page 1*

all the tests will be duplicated except the direct bilirubin.

Assuming all of the tests are medically necessary, order a CMP and a direct bilirubin. This will eliminate duplicate billing and also reduce costs associated with running the duplicate laboratory tests.

Our laboratory requisition provides the option to order as a panel or individually as needed. So remember when ordering overlapping panels, order the panel that has the majority of the tests you want and all other tests individually. \*\*

## **REQUISITION INFORMATION**

Accurate and thorough demographic information on both clinical and anatomic requisitions can eliminate processing errors, results reporting delays, and billing claims submission and reimbursement process errors.

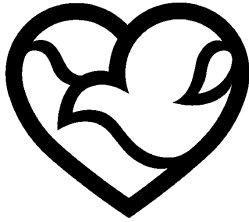
Many of the requisitions that are hand written are difficult to read or are received with missing information that is critical to a complete laboratory record.

Please provide our registration personnel with the patients complete LEGAL name, date of birth and social security number.

There are over 5000 doctors in our database. Therefore, it is critical that you provide the physician's first and last name.

ICD-9 codes or narrative diagnosis information is necessary for billing.

To eliminate collection or billing problems for your patients, if the laboratory is to bill the patient and/or insurance, you must provide the patient address and copies of current insurance cards (copies must be legible). Indicate primary insurance on forms. \*\*



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ADDRESS CORRECTION REQUESTED

## LATE BREAKING NEWS

‡ **TRIPLE SCREENS** Testing location for triple screen test performance will change as of July 1. The Genetics laboratory at the University will only offer **QUAD SCREENS** (which will include Inhibin) after July 1. For those clients who still wish to have a triple screen performed, we will forward the test to ARUP. Watch for a Technical Bulletin on Quad Screens in the near future.

‡ **NEWBORN SCREENS** The state of Nebraska law changes on July 20, 2002 for the newborn screen. Newly required is Medium Chain Acyl CoA Dehydrogenase Deficiency testing (otherwise known by the easier to pronounce acronym – **MCAD**) for all newborns. Also required is an informed dissent/consent if you are offering other than state required genetic testing (supplemental screen). The Pathology Center will continue to send supplemental screening to Baylor. Note however that Baylor will require parent or legal guardian written consent before performing the test after July 1. Testing for MCAD only will be sent to Iowa State Public Health Laboratory.

