APS Update

PATHOLOGY NEWSLETTER

Volume 4 *January 2007* *Issue 1*

What is an NPI?

An NPI or National Provider Identifier, is an outcome from the Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA) and establishes unique identifiers for healthcare providers, health plans, and employers involved in HIPAA standard ransactions. The purpose of the NPI, which is a 10-digit number that contains no embedded intelligence, is to improve the efficiency and effectiveness of the electronic transmission of health information. To comply with this mandate, all health care providers must obtain a National Provider Identifier number or NPI by May 23, 2007.

APS Medical Billing has taken the steps to enroll all of their physicians and have made the necessary computer systems changes to accommodate this change. In fact, APS started using NPI numbers for electronic claims in October 2006.

In addition to utilization of the NPI to identify the healthcare provider rendering services, HIPAA mandates the use of this number in claims submission to identify the referring provider. To date, a national database of NPI numbers has not yet been created. NPI will become one of the mandatory data elements clients are required to provide enabling APS to submit a claim for our providers. APS is working closely with all business partners, both carriers and facilities in which our clients provide services, to obtain NPI numbers for referring providers on behalf of our clients.

Any information you may have about efforts of others creating a database for sharing of NPI numbers, can be passed onto your Practice Manager or Client Representative.

Ohio Law for Copies Of Medical Records

The State of Ohio has established a maximum fee that may be charged by a healthcare facility or medical records company when requested a copy of a patient's medical record. Additionally, the law provides limitations for situations in which medical records may be obtained free of charge.

Effective January 1, 2007, there are two instances in which maximum fees may be charged (maximum amounts will be adjusted on an annual basis).

Maximum fee applies below when the request comes from a patient or patient's representative:
⇒ No records search fee is allowed;

For data recorded on paper:
⇒ Maximum fee is $2.67 per page for the first 10 pages; $0.55 per page for pages 11-50; $0.22 per page for pages 51 and higher.

For data recorded other than on paper:
⇒ Maximum fee is $1.82 per page; the actual cost of postage may also be charged.

Maximum fee applies when the request comes from a person or entity other than a patient or a patient's representative:
⇒ $16.38 records search fee.

For data recorded on paper:
⇒ Maximum fee is $1.08 per page for the first 10 pages; $0.55 per page for pages 11-50; $0.22 per page for pages 51 and higher.

For data recorded other than on paper:
⇒ Maximum fee is $1.82 per page; the actual cost of postage may also be charged.

2007 EDUCATION CALENDAR

Hope to see you there!

Feb 2-4: Orlando, FL
FL Society of Pathologists

Feb 28-Mar 2: Las Vegas, NV
American Pathology Foundation

Mar 25-27: Houston, TX
CLMA ThinkLab '07

Mar 26-28: San Diego, CA
USCAP

Apr 14: Gettysburg, PA
PA Association of Patholoigsts

Apr 28: Carmel, IN
IN Assoc. of Pathologists

May 4-5: Oak Brook, IL
IL Society of Pathologists

June 25-28: Hilton Head, SC
Scientific Symposiums Int'l

June 30: Chicago, IL
CAP Pathology Practice Mgmt.

Sept 30-Oct 2: Chicago, IL
CAP '07

Tzancks Smears

When coding for a Tzanck smear test you will have two choices depending on the circumstances. First, if a cytotechnologists processes and reads the smear to identify inclusion bodies, code 87207 (Smear, primary source with interpretation; special stain for inclusion bodies or parasites [e.g., malaria, coccidia, microsporidia, trypanosomes, herpes viruses]). If the test is interpreted by a pathologist, report code 87207 and append modifier 26 to indicate the professional component. Ohio Medicare will reimburse $18.18 for this service.

The other choice applies, when the smear is being evaluated for more than just inclusion bodies, CPT code 88160 (Cytopathology, smears, any other source; screening and interpretation) would be reported even if it includes a Tzanck evaluation. The 88160 code family's description of "any other source" refers to specimens that are not fluids, washings or brushings; cervical or vaginal. This would include a direct smear from the skin where this is typically taken for the Tzanck test. Ohio Medicare will reimburse $24.51 for the professional component for code 88160.

In the June edition of 2005 CAP Today, the coding of the Tzanck test was clarified stating "Direct evaluation of smears for cellular inclusions by microbiology is coded as 87207 when the evaluation is limited to mere reporting of the specific type of inclusion without consideration of etiology."

Process New NPI for Revised 1500 Health Insurance Claim Form

It began on October 1, 2006, health plans, clearinghouses and other information support vendors were required to be ready to handle and accept the revised (8/05) 1500 Claim Form. From now until March 31, 2007, providers can use either the current (12/90) version or the revised (8/05) version of the 1500 Claim Form. The newly revised form includes the splitting of box 17a to provide for reporting of the NPI number or other identifying number with similar changes made to box 241 and box 33. Additional minor changes include the removal of the bar code on the top of the form and the addition of Tricare above Champus.

The revised 1500 Claim Form (8/05) was approved by OMB and can now be recognized for use within the federal government and other various federal health care programs. Private health payers will utilize the revised 1500 Claim Form (8/05) due to the administrative simplification for standardized claims processing.

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On April 1, 2007 the current (12/90) version of the 1500 Claim Form will be discontinued and only the revised (8/05) version will be allowed for usage. The instructions clearly state all resubmissions/rebilling of claims should use the revised (8/05) form from this date forward, even if earlier submissions have been on the current (12/90) 1500 Claim Form.

Additional instructions on how to use the new 1500 (8/05) Claim Form can be found on the National Uniform Claims Committee website, it provides general guidance on the use of the new 1500 Claim Form.

Coding Corner

When is Hip Arthroplasty considered a joint resection?

The femoral head is what is usually submitted when a Hip Arthroplasty procedure is performed. CPT specifically lists femoral head as either code 88304 (femoral head, other than fracture) or code 88305 (femoral head, fracture). If the procedure is done for a fracture and the femoral head is submitted, report code 88305. If the procedure is done due to steoarthrosis and the femoral head is submitted, report 88304. If the femoral head is submitted for osteoarthrosis and included the acetabulum, then it is considered a joint resection and code 88305 would be reported.

For 2007 the wording has changed for CPT codes 88106 and 88107 to "simple" filter methods. What are considered "simple" filters?

For 2007, CPT changed the definition of codes 88106 and 88107 to state that the lab method involves only simple filtration. One example of a simple filtration would be the Millipore filter, which is an older technique. Bottom line, when examining smears prepared after filtering the specimen, report code 88106 or when doing both direct smears and smears following filtration, report code 88107. When performing the more complex filter transfer technique used in monolayer preparations, code 88112.

Do you have a coding question or maybe a specimen that you just want clarification on? A comment or coding concern? E-mail it to me at tscheanwald@ucbinc.com and I will provide answers and/or feedback.