Labview Quarterly

FOR CLIENTS OF PARKVIEW HEALTH LABORATORIES November 2010

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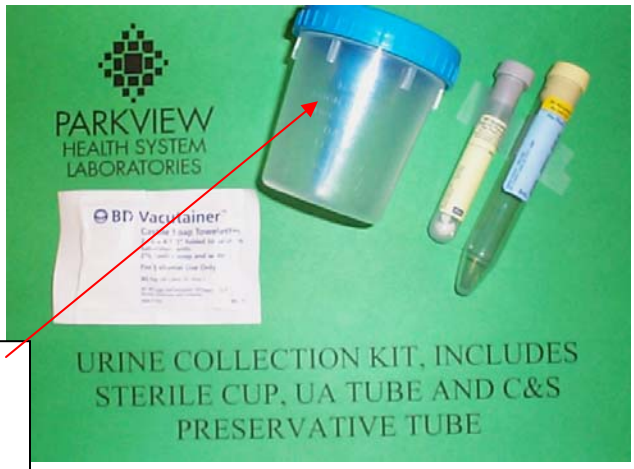
Transporting Urine Collection Kits Safely

The Urine Specimen Collection Kit Cup should not be used to transport urine or stool specimens to the laboratory. The blue cap urine collection cup should only be used as a collection device to transfer the urine specimen in the UA and C&S Preservative tubes, which are provided in the kit. Urine should only be sent to the lab in these tubes. The transfer device does not have a tight seal and the specimen will leak during transit. In addition, the transfer device contains a needle, which is a potential safety risk for laboratory workers**.** If a specimen container must be sent for additional testing, please utilize Parkview Lab's sterile cups, which are approved for courier transport. **Effective immediately**, **all blue cap urine cups received in the laboratory will be rejected and discarded to protect laboratory personnel from potential exposure. Please post this memo and educate appropriate coworkers.** Parkview Health Laboratories appreciates your effort in adhering to this important safety requirement. If you have any questions or concerns, please feel free to contact Kevin Schaefer at Office: 260-373-9403, Cell: 260-241-5090, or Email: kevin.schaefer@parkview.com



Please do not send this container

Central Laboratory
Parkview Hospital
Parkview Huntington Hospital
Parkview Whitley Hospital
Parkview North Hospital
Parkview Noble Hospital
And Parkview Lagrange Hospital

PARKVIEW HEALTH LABORATORIES

Reference Range Changes

As of 11-16-2010, Parkview Health Laboratories has new reference ranges for the Bleeding Time (Test Code-BLED) and Aspirin Response by PFA (Test Code-ASA) tests.

New Ranges:
Collagen/EPI: 69 - 173 Seconds
Collagen/ADP: 54 - 126 Seconds

Please refer questions to Dr. Wan 373-3660.

Reminder Regarding Diagnoses/Reason for Testing

You can greatly reduce the number of faxes sent to your office from the lab billing department requesting diagnosis/reason for testing information when every lab order/requisition includes all reasons for each test ordered.

Partial Code Freeze Prior to ICD-10 Implementation

At the ICD-9-CM Coordination & Maintenance Committee Meeting (September 15, 2010), it was announced that the committee had finalized the decision to implement a partial freeze for both ICD-9-CM codes and ICD-10-CM and ICD-10-PCS codes prior to implementation of ICD-10 on October 1, 2013. There was considerable support for this partial freeze.

The partial freeze will be implemented as follows:

• The last regular annual update to both ICD-9 and ICD-10 code sets will be made on October 1, 2011.
• On October 1, 2012 there will be only limited code updates to both ICD-9- CM and ICD- 10 code sets to capture new technology and new diseases.
• There will be no updates to ICD-9 -CM on October 1, 2013 as the system will no longer be a HIPAA standard.

On October 1, 2014 regular updates to ICD-10 will begin. The ICD-9 Coordination & Maintenance Committee will continue to meet twice a year during the freeze. At these meetings the public will be allowed to comment on whether or not requests for new diagnosis and procedure codes should be created based on the need to capture new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on or after October 1, 2014, once the partial freeze is ended.

CMS (Medicare) HIV Screening Benefit

CMS will cover HIV screening with a Food and Drug Administration-approved EIA, ELISA, or rapid HIV antibody test, as follows:

* A maximum of once annually for Medicare beneficiaries at increased risk for HIV infection under guidelines of the U.S. Preventive Services Task Force:

– Men who have had sex with men after 1975.
– Men and women having unprotected sex with multiple (more than one) partners.
– Past or present injection drug users.
– Men and women who exchange sex for money or drugs, or have sex partners who do.

– Persons being treated for sexually transmitted diseases.
– Persons with a history of blood transfusion between 1978 and 1985.
– Persons who request an HIV test despite reporting no risk factors, since this group is likely to include individuals not willing to disclose high-risk behaviors.

* A maximum of three times per term of pregnancy for pregnant beneficiaries beginning with the date of the first test when ordered by the woman's clinician.

Patients with any known prior diagnosis of HIV-related illness are not eligible for this screening benefit.

Diagnosis coding requirements for screening benefit:

* When increased risk factors are reported: V73.89 as primary, V69.8 as secondary.
* When increased risk factors are *not* reported: V73.89 as primary only.
* For pregnant beneficiaries, submit the following diagnosis codes in addition to V73.89 to allow for more frequent screening than once per 12-month period:
    * V22.0 – Supervision of normal first pregnancy
    * V22.1 – Supervision of other normal pregnancy
    * V23.9 – Supervision of unspecified high-risk pregnancy

The new coverage and payment policy is presented in CMS Transmittal 113 and the related update to the National Coverage Decision (NCD) on HIV screening is presented in Transmittal 1918, Change Request 6786.

Compliance Corner

2011 OIG (Office of the Inspector General) Work Plan

The "Office of Inspector General Work Plan for Fiscal Year 2011" provides brief descriptions of activities the OIG plans to initiate or continue in 2011 with respect to the programs and operations of the U.S. Department of Health and Human Services (HHS), such as the Centers for Medicare & Medicaid Services (CMS).

+ Medicare Part B Payments for Glycated Hemoglobin A1C Tests
Will review Medicare contractors' procedures for screening the frequency of clinical laboratory claims for glycated hemoglobin A1C tests. CMS's Medicare National Coverage Determinations Manual, states that it is not considered reasonable and necessary to perform a glycated hemoglobin test more often than every 3 months on a controlled diabetic patient unless documentation supports the medical necessity of testing in excess of national coverage determinations guidelines.

What does this mean for your Medicare patients? CMS (Medicare) will begin evaluating all claims for Glyco Hgb – A1C tests and denying if done more than every 3 months for a controlled diabetic patient. Please review ordering practices/order sets for diabetic patients to ensure that compliance with CMS frequency guidelines can be achieved. And remember that Medicare does NOT cover this testing as a screening for diabetes.