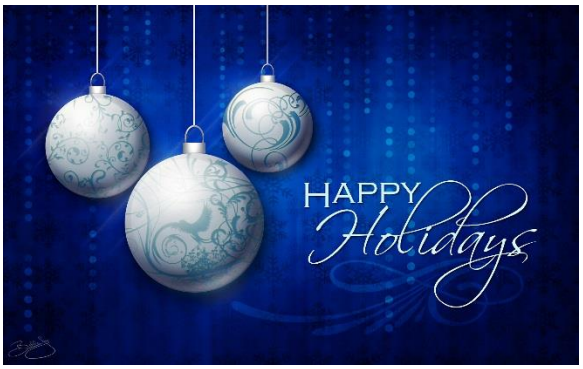
Volume 12 Issue 61 401 North 9th Street, Bismarck ND 58501-4507 December 2016



From All of Us At Northern Plains Laboratory

2017 ICD-10 Diagnosis Code Updates

By Rhonda Burgard, Client Services Supervisor

The 2017 ICD-10 diagnosis code set became effective on October 1, 2016. This is the first ICD-10 update that CMS has released since ICD-10 was implemented in 2015.

There are over 1900 new codes and 300 codes that will be deleted. In addition, these changes will affect a significant number of National and Local Coverage Determination (NCD) updates.

Please see the CMS website for additional information https://www.cms.gov/medicare/coverage/coveragegeninfo/icd10.html.

Reference: CodeMap, Sept 15, 2016

Quality Corner: CLIA and Quality Assurance

By Rhonda Burgard, Client Services Supervisor

As you make plans for your 2017 quality program, remember the Code of Federal Regulations (42 CFR) 493 states laboratories "must establish and follow written policies and procedures for a comprehensive quality assurance program that is designed to monitor and evaluate the ongoing and overall quality of the total testing process. CLIA '88 identifies ten processes that must be included in the laboratory quality program:

1. Patient Test Management.
2. Quality Control
3. Proficiency Testing
4. Comparison of Test results
5. Relationship of patient information to patient test results.
6. Personnel assessment
7. Communication
8. Complaint investigation
9. Quality Assurance
10. Records and Documents

Patient test management includes monitoring and evaluating the following processes:

- Patient preparation
- Specimen collection
- Labeling of specimens
- Preservation and transportation
- Test requisition
- Medical necessity
- Criteria for specimen rejection
- Test report completeness
- Relevance and accuracy
- Timely reporting of results
- Accuracy and reliability of test reporting systems
- Storage and retrieval of results

Quality control requirements should state two levels of QC be performed each day of testing or that an IQCP has been approved by the laboratory medical director for any non-waived tests that have reduced QC requirements. Calibration and linearity studies must be performed as required by the manufacturer and/or according to CLIA requirements. There must be documentation of corrective action of any QC outliers.

Proficiency testing must be used to evaluate the accuracy of the laboratory's results. Corrective action must be taken for any unsatisfactory or ungraded proficiency testing results.

If the laboratory has more than one method of performing the same test, the lab must twice a year compare the results obtained by the two methods.

The laboratory must have a system in place to identify and evaluate patient test results when they appear inconsistent with the patient's age, sex, diagnosis and relationship to other test results. Electronic systems that offer delta checking are useful in identifying these discrepancies.

The laboratory must have a competency assessment program that incorporates each of the six competency methods required by CLIA. If the laboratory has an outside consultant, the lab should also have a method for evaluating their effectiveness.

The laboratory must have a process for written and/or electronic communication with both internal and external customers. The laboratory medical director is responsible for reviewing the format for all laboratory test results.

There should be a system for complaint documentation and investigation that includes documentation of any corrective actions taken.

The laboratory must have a quality assurance program and share this information with staff.

All documents and forms must be part of document control program and stored according to CLIA regulations.

Annually, review your quality documents to confirm your program covers the ten CLIA required elements. Summarize your quality improvement activities and review this information with your laboratory medical director. Your laboratory medical director should evaluate your program for effectiveness and assist you in determining audits for the following year.

Reference: CLIA and Quality Assurance
www.aafp.org

Test Utilization: Cardiac Risk

By Rhonda Burgard, Client Services Supervisor

Cardiovascular disease is the number one cause of death in the United States with an estimated 1.5 million heart attacks and 0.5 million strokes occurring annually. Identification of patients with residual risk is important to target lifestyle and pharmaceutical intervention for those patients at higher risk.

According to the guidelines from the American College of Cardiology Foundation and the American Heart Association the lipid panel is the preferred initial tests for cardiovascular disease (CVD) screening in the general population. A lipid panel includes cholesterol, triglycerides, HDL and LDL.

Neither of these organizations recommend routine use of most "novel markers" such as VAP cholesterol, homocysteine and lipoprotein sub-fractionation tests to assess coronary artery disease in the general population.

However, for intermediate-risk patients, to augment risk classification and to guide therapy, two markers may be useful. High sensitivity C-reactive protein and lipoprotein (a) have been shown to be independently associated with increased risk of future CV events.

Some Medicare Administrative Contractors (MACs) have recently published LCDs that limit coverage for CV risk assessment, except for the basic lipid panel.

References

1. Mayo Medical Laboratories Cardiovascular Risk Marker Panel Clinical Information
2. ARUP ATOP report

Providing Exceptional Customer Service for Your Elderly Patients

By Rhonda Burgard, Client Services Supervisor

The Medicare population will double in the next 40 years from 40.2 million in 2010 to 88.5 million in 2050. This aging population is a diverse group and while you should not assume they have a disability, you should be prepared to accommodate for one. Of this group:

- 42% report hearing problems
- 26% have writing problems
- 7% have problems using the telephone
- 14% have dementia with Alzheimer disease being the most common form of dementia. Alzheimer disease impacts memory, language, judgement and activities of daily living. Many early Alzheimer's patients are able to mask their disability and may appear to understand or retain information when they actually do not.
- 30% have inadequate or marginal literacy
- One million people have aphasia (language impairment) commonly as a result of a stroke.

As children, this group of patients, often referred to as Traditionalists or the World War II Generation, was raised to be "seen and not heard". Their parents were encouraged to stick to a strict schedule and defined set of rules for their children. Parents were less apt to openly display affection because kissing and cuddling would "spoil" the child. As a result this group of patients tend faithfully to follow rules or directions.

Many members of this group stayed in one job for their entire working career. They were used to hierarchal management styles and are respectful of authority. They are uncomfortable with ambiguity and change and dislike conflict. They hesitate to express disagreement.

Because many members of this generation were raised during the Great Depression, they tend to be thrifty and will defer rewards to save for the future.

These characteristics can impact the behavior of your elderly patients. They may not hear or see well, but will not question what they think their provider has told them to do, even if it does not make sense. Their thriftiness may lead them to not take medications as prescribed or not fill what they perceive as expensive prescriptions.

To accommodate your elderly patients:

- Minimize distances to be walked
- Allow spaces for wheelchair access
- Make sure there is adequate lighting
- Provide furniture at a height that allows direct eye contact. Many elderly patients with hearing problems use lip reading and facial expressions to facilitate understanding.
- Minimize back-ground noise for elderly patients with hearing aids.
- Speak slowly, clearly, in a low tone of voice and simplify your sentences. If you think there is a hearing deficit, speak loudly but do not shout. Avoid medical terminology and abbreviations.
- Use a proper form of address like Mr. or Mrs. Do not use terms like "dear" and "hon" which sound patronizing.
- Listen to what the patient has to say without interrupting and give the patient a chance to ask questions.
- Use multiple forms of communication including verbal and written instructions. Confirm understanding with teach-back approaches.
- When providing written material use large print, simple line drawings, graphs or pictures and write at a 5th or 6th grade level.

By considering your elderly patients when designing phlebotomy spaces and including communication with elderly patients in your staff training modules you will improve the customer experience for this vulnerable group of patients.

Cold Weather Specimen Packaging

By Rhonda Burgard, Client Services Supervisor

Please remember with colder weather to package specimens to avoid freezing. Place specimens in the center of the shipping container and avoid direct contact with refrigerator packs. Fill empty spaces in the shipping container with paper towels, bubble wrap or other packing material.

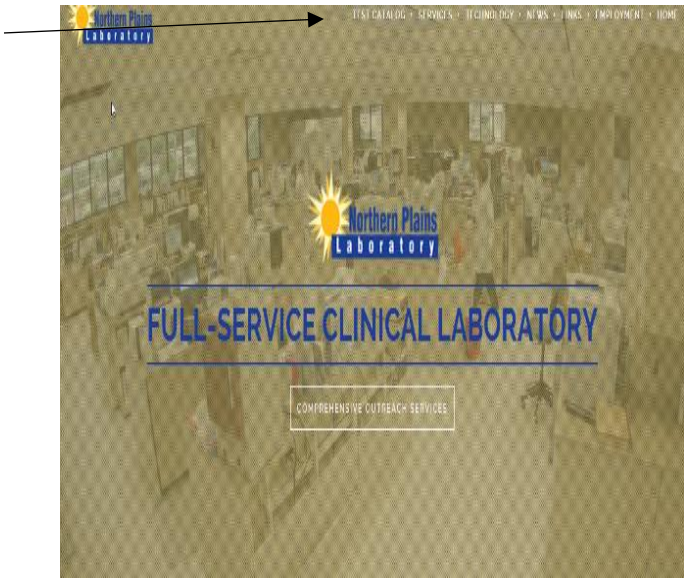
If sending EDTA specimens for CBC's you may request NPL provide you with Styrofoam tube holders which provide extra insulation and may help reduce platelet clumping.

To preserve specimen integrity, do not pack specimens preserved in formalin in the same container as slides for hematology.

Updated Website

By Rhonda Burgard, Client Services Supervisor

Northern Plains Laboratory (NPL) is pleased to announce that we have updated the format of our website viewable at www.northernplainslab.com. Tabs at the top of the screen provide links to the Northern Plains Laboratory Test Catalog, information about Northern Plains Laboratory, to newsletters and memos, to professional organizations and to employment information. After pressing on a tab, scroll down to view the displayed information.



The new website, including the Northern Plains Laboratory Test Catalog, is also viewable and searchable using smart phone technology.

Please take a few minutes to view our new website and email your comments or concerns to Rhonda Burgard, Client Services Supervisor at rburgard@primecare.org.

CRE / CRO Screen by PCR

By Ron Piatz, Research and Development

Northern Plains Laboratory (NPL) is pleased to announce the addition of the Cepheid Xpert Carba-R assay to our in house test menu. The Xpert® Carba-R Assay is a qualitative *in vitro* diagnostic test designed for the detection and differentiation of the *bla*KPC, *bla*NDM, *bla*VIM, *bla*OXA-48, and *bla*IMP gene sequences associated with carbapenem-non-susceptibility utilizing automated real-time polymerase chain reaction (PCR). Typical turn-around-time is about two hours after sample is received at NPL.

The Xpert Carba-R Assay is intended as an aid to infection control in the detection of carbapenem-non-susceptible bacteria that colonize patients in healthcare settings. The Xpert Carba-R Assay is not intended to guide or monitor treatment for carbapenem-non-susceptible bacterial infections. A negative Xpert Carba-R Assay result does not preclude the presence of other resistance mechanisms.

The global spread of carbapenemase-producing *Enterobacteriaceae*, *Pseudomonas aeruginosa*, and *Acinetobacter* species is a critical medical and public health issue. Carbapenem-Resistant Organisms (CRO) are usually resistant to all β-lactam agents as well as most other classes of antimicrobial agents, therefore, treatment options for patients infected with CRO are very limited. Healthcare-associated outbreaks of CRO have been reported. Patients colonized with CRO are thought to be a source of transmission in the healthcare setting. Rapidly identifying patients who

are colonized with CRO and placing these patients in isolation precautions may be an important step in preventing transmission.
CRE / CRO Screen by PCR may also be used to test pure colonies of bacteria that exhibit some degree of carbapenem resistance. This assay will replace the Modified Hodge Test.

Note: CRE Screen by Culture "CRESC" will be discontinued.

Specimen: Collect rectal swab sample using a red-capped Copan double swab. Carefully insert both swab tips approximately 1 cm beyond the anal sphincter and rotate gently. Samples with excess stool on the swab will be rejected. Following collection, place swab pair back into the original transport tube and transport to lab ASAP. Swabs in the transport tube can be stored at 15–28°C for up to five days.

For questions and/or additional testing information, please contact NPL at 701-530-5700 or 1-800-645-1003.

Test Code	CPT Code	Test Name	Specimen Requirements	Reference Range
CROSP	87150 (x5)	CRE / CRO Screen by PCR	Rectal swab	Negative

Duplicate Test Orders

By Rhonda Burgard, Client Services Supervisor

When placing test orders please watch for duplicate tests that may be included in more than one profile or reflexed as a result of a positive test result. For example test code:

- HCVRQ (ARUP test #98268) and HCRNQ (ARUP test # 2002685) are the same test except that the HCRNQ test reflexes to genotyping.
- IBDDA (ARUP test # 2013270) includes Anti-Neutrophil Cytoplasmic Antibody, IgG (0050811) which should not be ordered as a separate test.

Medicare and private insurance payers will not pay for duplicate testing with the same date of service.

CPT CODING FOR 2017

By Ann Oie, Compliance Officer

The 2017 CPT codes for clinical laboratory tests will be effective January 1, 2017. Remember, Medicare no longer allows a "grace" period so CPT 2017 changes must be incorporated on January 1, 2017. Below is a list of new, deleted and modified CPT codes excluding any changes to the molecular pathology section (CPT codes 81162 thru 81479) and Multianalyte Assays with Algorithmic Analyses (MMAA) (CPT codes 81490 thru 81599).

Deleted CPT Codes excluding Molecular Pathology &MMAA codes

Code	Description
80300	Drug screen, any number of drug classes from Drug Class List A; any number of non-TLC devices or procedures, (eg, immunoassay) capable of being read by direct optical observation, including instrumented-assisted when performed (eg, dipsticks, cups, cards, cartridges), per date of service
80301	Drub screen, any number of drug classes from Drug Class List A; single drug class method, by instrumented test systems (eg, discrete multichannel chemistry analyzers utilizing immunoassay or enzyme assay), per date of service
80302	Drug screen, presumptive, single drug class from Drug Class List B, by immunoassay (eg, ELISA) or non-TLC chromatography without mass spectrometry (eg, GC, HPLC), each procedure
80303	Drug screen, any number of drug classes, presumptive, single or multiple drug class method; thin layer chromatography procedure(s) (TLC) (eg, acid, neutral, alkaloid plate), per date of service
80304	Drug screen, any number of drug classes, presumptive, single or multiple drug class method; not otherwise specified presumptive procedure (eg, TOF, MALDI, LDTD, DESI, DART), each procedure

New 2017 CPT Codes excluding Molecular Pathology & MMAA codes

Code	Description
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg. Immunoassay); capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg. Immunoassay); read by instrument assisted direct optical observation (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service
84410	Testosterone; bioavailable, direct measurement (eg, differential precipitation)
87483	Central nervous system pathogen (eg, Neisseria meningitides, Streptococcus pneumoniae, Listeria, Haemophilus influenza, E. coli, Streptococcus agalactiae, enterovirus, human parechovirus, herpes simplex virus type 1 and 2, human herpesvirus 6, cytomegalovirus, varicella zoster virus, Cryptococcus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets

Revised 2017 CPT Codes excluding Molecular Pathology & MMAA codes

Code	2016 Description	2017 Revised Description
83015	Heavy metal (eg, arsenic, barium, beryllium, bismuth, antimony, mercury); screen	Heavy metal (eg, arsenic, barium, beryllium, bismuth, antimony, mercury); *qualitative, any number of analytes*
83018	Heavy metal (eg, arsenic, barium, beryllium, bismuth, antimony, mercury); quantitative, each	Heavy metal (eg, arsenic, barium, beryllium, bismuth, antimony, mercury); *quantitative, each, not elsewhere specified*
83704	Lipoprotein, blood; quantitation of lipoprotein particle numbers and lipoprotein particle subclasses (eg, by nuclear magnetic resonance spectroscopy*)*	Lipoprotein, blood; quantitation of lipoprotein particle *number(s)* (eg, by nuclear magnetic resonance spectroscopy), *includes lipoprotein particle subclass(es), when performed*

NPL will be changing CPT codes for the following tests effective January 1, 2017.

Test Code	Description	2016 CPT Code	2017 CPT Code
UOXY	Oxycodone Screen, Urine	80300 (alt MC G0477)	80305 (alt MC G0477)
DSCR	Drug Screen, Urine (NPL)	80301 (alt MC G0479)	80307 (alt MC G0479)
AMPH	Amphetamine Screen, Urine	80301 (alt MC G0479)	80307 (alt MC G0479)
BARB	Barbiturate Screen, Urine	80301 (alt MC G0479)	80307 (alt MC G0479)
BENZ	Benzodiazepine Screen, Urine	80301 (alt MC G0479)	80307 (alt MC G0479)
CANN	Cannabinoid Screen, Urine	80301 (alt MC G0479)	80307 (alt MC G0479)
COC	Cocaine Screen, Urine	80301 (alt MC G0479)	80307 (alt MC G0479)
UP	Opiate Screen, Urine	80301 (alt MC G0479)	80307 (alt MC G0479)
MEP	Meningitis/Encephalitis Panel by PCR	87496; 87498; 87529 x2; 87532; 87653; 87798 x8	87483

Reference: Current Procedural Terminology (CPT) 2017, American Medical Association