Laboratory Medicine: Basic Coding, Billing, & Reimbursement Compliance

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Presented by

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Objectives

- Briefly review coding system levels, use and interrelationship; include modifiers
- Discuss reimbursement mechanisms for laboratory services
- Describe Medicare editing systems
- Define medical necessity and describe related nuances for coverage

HCPCS Codes

HCPCS (CMS - Healthcare) Common Procedural Coding System

- Identify Procedures
- Three Levels of Coding
  - Level I — CPT assigned
  - Level II — Medicare assigned
  - Level III — now eliminated
HCPCS Codes

- LEVEL I
  - Authored by the AMA
  - 5 Digits, Numerical
  - Required by Medicare, Medicaid, and other third party payers
  - Changes Occur Annually
  - May be Modified

CPT Changes

- Announced annually and new CPT books typically available in November
- Changes are effective January 1 of each year
- A 90 day window no longer granted for implementation
  - All changes must be implemented and codes reported for services on January 1 of each year
## Flow Cytometry CPT Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>88182</td>
<td>Flow cytometry, cell cycle or DNA analysis</td>
</tr>
<tr>
<td>88184</td>
<td>Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker</td>
</tr>
<tr>
<td>+88185</td>
<td>each additional marker (List separately in addition to code for first marker)</td>
</tr>
</tbody>
</table>

### Flow Cytometry CPT Examples

<table>
<thead>
<tr>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>88187</td>
<td>Flow cytometry, interpretation; 2 to 8 markers</td>
</tr>
<tr>
<td>88188</td>
<td>9 to 15 markers</td>
</tr>
<tr>
<td>88189</td>
<td>16 or more markers</td>
</tr>
</tbody>
</table>
CPT Modifiers

- Typically Indicated for Pathology:
  - -22 Unusual Procedural Services
  - -26 Professional Component
  - -32 Mandated Services
  - -52 Reduced Services
  - -59 Distinct Procedural Service
  - -90 Reference (Outside) Laboratory
  - -91 Repeat Clinical Diagnostic Laboratory Test

Modified Procedure

- Laboratory Example:
  - CPT 80051-91 (lytes)

- Intent of Modifier
  - Repeat test on same day
  - Subsequent results reasonable and necessary
  - Not for retesting to confirm previous results
  - Clinical laboratory fee schedule test (?)
HCPCS Codes (cont.)

- LEVEL II
  - Supplement CPT
  - CMS Derived, maintained jointly with BC/BS and HIAA
  - 5 Digits, Alpha-numeric
  - Change Effected Annually or Interim Basis
  - Carrier Recognition Varied in Past
  - May Be Modified

Level II Code Delineation

- G Codes – Temporary codes for certain services (Screening FOBT, Pap)
  - G0103 Prostate cancer screening, prostate specific antigen test (PSA)

- J Codes – Drugs/Biologics
  - J7193 Factor IX (antihemophilic factor, purified, nonrecombinant), per IU
Level II Code Examples

- P Codes – Pathology & laboratory
  - P9012  Cryoprecipitate, each unit
  - P9021  Red blood cells, each unit
- Q Codes – Temporary codes, misc.
  - Q0113  Pinworm examination
- S Codes -  Temporary codes, non-Medicare
  - S3818  Complete gene sequence analysis; BRCA1 gene

Level II Code Changes

- Announced annually and new HCPCS books available in January
- Changes are effective January 1 of each year
- Additional changes may occur throughout the year.
HCPCS Level II Modifiers

- Indicated for Laboratory/Pathology:
  - QW – CLIA waived test
  - TC – Technical component
  - LR – Laboratory roundtrip

Modified HCPC Level II Procedure

- Laboratory Example:
  - P9604-LR, Travel allowance (one way) for collection of specimen from homebound patient; prorated trip charge
  - Intent of Modifier
    - Indicate that the trip charge is for one patient and the trip was roundtrip
ICD-9 DIAGNOSTIC CODES

- **VOLUME 1** - Numerical list of diseases and injuries by etiology and organ system (17 chapters)
- **VOLUME 2** - Alphabetical listing of diseases and injuries
- **V CODES** - Supplemental alphanumeric listing of factors influencing health status and contact with health services
  
  Ex: **V61.4** - Health problem in family (5th digit required to indicate alcoholism, substance abuse, handicapped member, etc.)

ICD-9 DIAGNOSTIC CODES (cont.)

- **E CODES** - Supplemental alphanumeric listing of external causes of injury and poisoning
  
  Ex: **E917.0** – Striking against or struck accidentally by object or persons in sports without subsequent fall

- **VOLUME 3** - Intended for Hospital Reporting
  Alphabetical listing of procedures and Numerical listing by anatomic site
ICD-9 CODING REQUIREMENTS

- CODING MUST BE ATTAINED TO THE HIGHEST DEGREE OF SPECIFICITY:
  - 283  Acquired hemolytic anemia
  - 283.0  Autoimmune hemolytic anemia
  - 283.1  Non-autoimmune hemolytic anemia
  - 283.11  Hemolytic-uremic syndrome

REVENUE CODES

- REQUIRED FOR ALL HOSPITAL CLAIMS
- REQUIRED FOR EACH SERVICE RENDERED
- THREE DIGIT CODE WHICH IDENTIFIES THE COST CENTER:
  - Accommodation codes  100-219
  - Ancillary services codes  220-999
REVENUE CODES (cont.)

- Example: Anti-emetic drugs
  - Usual code: 250 pharmacy general
  - When with chemotherapy, code: 636
    - drugs requiring specific identification and
detailed HCPCS

Laboratory Revenue Codes

- 300 General Classification
- 301 Chemistry
- 302 Immunology
- 303 Renal patient
- 304 Nonroutine dialysis
- 305 Hematology
- 306 Bacteriology and Microbiology
- 307 Urology
- 309 Other laboratory
Certification Codes

- REQUIRED FOR LABORATORY CLAIMS FILED TO A CARRIER
  - Independent laboratories, POLs, Clinics
  - Laboratory services ONLY
  - Indicates areas of CLIA approved testing

Certification Codes Examples

- 010 Histocompatibility
- 110 Bacteriology
- 115 Mycobacteriology
- 120 Mycology
- 130 Parasitology
- 140 Virology
- 210 Syphilis serology
- 220 General immunology
- 310 Routine chemistry
- 320 Urinalysis
Coding System Interdependency

- HCPCS (CPT) codes identify procedures and individual services
  - Guides outpatient reimbursement
  - Selects hospital APC categories
- ICD-9 codes identify diseases, disorders, conditions, signs & symptoms
  - Guides inpatient reimbursement
  - Leads to DRG classification
  - Supports medical necessity on outpatient services

ASSIGNMENT

- WHEN A PHYSICIAN OPTS TO ACCEPT ASSIGNMENT, HE/SHE AGREES TO ALWAYS ACCEPT THE MEDICARE APPROVED AMOUNT FOR THE MEDICARE COVERED SERVICES AS PAYMENT IN FULL
REQUIRED ASSIGNMENT

CERTAIN PROVIDERS ARE REQUIRED TO ACCEPT ASSIGNMENT FOR ALL MEDICARE COVERED SERVICES; THEY INCLUDE:

- CLINICAL LABORATORY SERVICES

MEDICARE OUTPATIENT PAYMENT METHODS

- MEDICARE PHYSICIAN FEE SCHEDULE
  Physician Services (Inpatient, too)

- CLINICAL LABORATORY FEE SCHEDULE
  Technical Component
  Subject to National Limitations

- AMBULATORY PAYMENT CLASSIFICATION (APC)
  Hospital Outpatient

- RATIO OF COST TO CHARGE (RCC)
  Hospital Interim Payment
  Dependent Upon Annual Cost Report
  Includes Exempt Laboratory Procedures
Reimbursement Factors

- Coding
  - CPT, HCPCS, ICD-9, Modifiers, DRGs, APCs, Certification, Revenue
- Billing Protocol
- Method of Reimbursement
  - Fee Schedule (National Limitations), MFS, RCC, UCR, RVS, Percent of Charge
- Payer Variances

MPFS Reimbursement - 2010

- Projected at -21.2%
- H.R. 3961 on 11/19/09
  - Remove SGR
  - Allow 1.2% increase ($195B)
- Senate would
  - Eliminate the SGR decrease
  - 0.5% increase for 2010 ($11B)
- How finance updates a concern
What’s happened?
- Congress blocked SGR based cuts scheduled for Jan 1 and extended 2009 reimbursement through February 28, 2010
- Draft bill from Senate Finance Committee would have extended benefit through September 30, 2010 – benefit stripped
- Senate votes on March 2 to extend benefit one more month

Senate passes bill on March 10 to extend benefit to October 1, 2010
Bill goes back to House
- Already voted to replace SGR with productivity growth measurement
CLFS Reimbursement - 2009

- CLFS 5 year freeze expired January 1, 2009
- Replaced by 5% increase in unadjusted CPI
  - Bureau of Labor Statistics
- Less 0.5%
  - Medicare Improvement for Patients and Providers Act (MIPPA)
- 4.5% overall increase

CLFS Reimbursement - 2010

- July 15, Bureau of Labor Statistics
  - Consumer Price Index = -1.4%
- Less 0.5%
  - Medicare Improvement for Patients and Providers Act (MIPPA)
    - 0.5% below the CPI for urban consumers through 2013
  - Overall adjustment is -1.9%
- First negative adjustment
HOPPS Reimbursement 2010

Projected:
- Small increases and moderate decreases in frequently used blood products
- Big decreases in infrequently used products
- Minimal increases in bone marrow and stem cell processing

Examples
- Based on 2008 claims data
  - P9011, Blood split unit: $31.12 to $91.05
  - P9020, PRP: $394.95 to $148.12
  - P9043, Plasma protein, 5%: $15.62 to $57.92
  - P9050, Granulocyte pher.: $1,669.99 to $48.64
### HOPPS Reimbursement 2010

- **CPT** 2009 2010
  - 88184 $16.50 $16.64
  - 88185 $16.50 $16.64
  - 88187 $10.06 $10.68
  - 88188 $34.55 $35.70
  - 88189 $32.75 $35.70
  - G0364 $42.69 $45.06

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### CLFS Vs. MPFS

- **95%**
  - Most laboratory tests carry only a TC and are reimbursed under the Clinical Laboratory Fee Schedule (CLFS)

- **Remaining 5%**
  - Typically associated with both TC and PC
  - PC and TC reimbursed under Medicare Physician Fee Schedule (MPFS)
    - Hospital TC under APC
-TC Modifier

- Technical Component
  - Technical component only reported
  - Usually employed when PC also performed
  - Used with CPT codes
  - Not reported by hospitals unless payer required
  - Example: Medicaid CPT 88305TC

-26 Modifier

- Professional Component
  - Professional component only billed
  - Ex: CPT 8830526
  - Not accompanied by TC billing
  - Hospital billing of both TC and PC may be an exception
    - May occur when pathologist is employee
    - Bill both components to FI or MAC
    - Bill separately on UB and CMS 1500
**-TC & -PC Vs. Global**

- Other than a hospital
  - Independent laboratory
  - Pathology laboratory
- Both TC and PC provided
- Reported without a modifier

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**Example Modifier**

- **CPT 83912-26**
  - Professional component only for interpretation of molecular diagnostic assay
    - Medicare reimburse under the MPFS
    - Approximately $18 – vary by locale
  - -TC does not apply with this code
    - Without a modifier, Medicare reimburse under CLFS
    - $5.74
Correct Coding Initiative (CCI)

- Editing system that Medicare implemented in the late 1990s
- Detect potential coding errors prior to precipitating payment
- Only apply to Medicare Part B services
- External organization contracts with CMS
  - Establishing, monitoring, and effecting change in the CCI edit program
- Two types of edits

CCI

- Column 1/Column 2 Edits
  - One reported code considered an integral part of another reported code
  - Payment is realized for only the column one code
  - Ex: CPT 83912 Molecular diagnostics; interpretation and report
  - CPT 80500 Clinical pathology consultation; limited, without review of patient’s history and medical records
  - CPT 83912 reimbursed; 80500 bundled
CCI

- Mutually Exclusive Edits
  - Detect procedures billed together but unlikely to be performed on the same patient, same day, same setting, etc.
  - Ex: CPT 83890 Molecular diagnostics; molecular isolation or extraction
  - CPT 83891 isolation or extraction of highly purified nucleic acid
  - One code bundled into other for payment

CCI & Use of Modifiers

- Each edit is accompanied by an indicator to determine if a modifier may be used to override an edit
  - “0” No modifier allowed
  - “1” Modifier allowed
CCI Issues: Policy Statement

- "Medicare does not pay for duplicate testing. CPT codes 88342 (immunocytochemistry, each antibody) and 88184, 88187, 88188, 88189 (flow cytometry) should not in general be reported for the same or similar specimens. The diagnosis should be established using one of these methods. The provider may report both CPT codes if both methods are required because the initial method is nondiagnostic or does not explain all the light microscopic findings. The provider can report both methods using the modifier -59 and document the need for both methods in the medical record."

CCI Issues: Policy Statement

- "If the abnormal cells in two or more specimens are morphologically similar and testing on one specimen by one method (88342 or 88184, 88187, 88188, 88189) established the diagnosis, the same or other method should not be reported on the same or similar specimen."
CCI Issues: Policy Statement

“Similar specimens would include, but are not limited to:

1. blood and bone marrow;
2. bone marrow aspiration and bone marrow biopsy;
3. two separate lymph nodes; or
4. lymph node and other tissue with lymphoid infiltrate.”

MUE Background

“Test” claims for:

- Same beneficiary
- Procedural code
- Date of service and Billing provider
- Against criteria for the number of units of service billed

Edits are not published

Knowledge is critical
Update on MUEs

- CCI manual now states that modifiers may be reported if appropriate
- Typically listed:
  - -59 (Distinct procedural service)
  - -76 (Repeat procedure by same physician)
  - -77 (Repeat procedure by another physician)
  - -91 (Repeat clinical diagnostic laboratory test)

CCI further states that providers

- “should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs.”
- “This manner of reporting should be infrequent”

Each line is separately adjudicated against the MUE edit
Update on MUEs

- CMS also states that modifiers are permitted in a recent response to Frequently Asked Questions (FAQs)
  - GD Units svc excd MUE value
  - No further information published
    - Contractor discretion

Coverage Issues

- Local Coverage Determinations (LCDs)
  - Carrier defined coverage policies
    - CPT and ICD-9 driven
  - Use of ABNs
  - Certain policies may become national in scope
  - Compliance protocols
Local Coverage Determinations

- Flow Cytometry
  - NGS
  - BC/BS Georgia
  - Riverbend
  - NHIC
  - Group Health
  - Cigna
  - Palmetto

ABNs

- New ABN adopted March 3, 2008
- Does not appear to impact modifier use
- Includes NEMB
  - Advance Beneficiary Notice of Noncoverage
- Implementation
  - Required by March 1, 2009
- Refer to CMS website for more instructions
Testing Protocols

Consider
- Medical necessity
- LCDs
- CCI

Presentation and approval by highest institutional medical authority

Testing Protocols

Establish a testing protocol that:
- Defines testing parameters
  - Both primary and reflex
  - Medical literature
- Provides rationale for testing
  - Standard of care
  - Quality of care
  - Medical literature
- Standardized within physician/hospital group
Discussion

Thank you for your courtesy!

Diana