The CPT code is the common denominator for evaluation of many mission critical laboratory functions

- **Compliance**: Provider responsibility per OIG
- **Operations**: Productivity and cost per test
- **Benchmarking**: Revenue and usage
- **Cost analysis**: Tied to chargemaster
- **Marketing**: Projected revenue streams
- **Billing**: Based on codes assigned
- **Medical records**: Basis of categorization of services
- **Administration**: Laboratory statistical reports and utilization parameters

www.cardinal.com/mps/focus/lab/article_chargemaster.asp

The reimbursement game

[Diagram showing the reimbursement process involving the laboratory provider, third party payer, ordering physician, and patient]

"...just plain dumb"
Newt Gingrich
The Strategy: Lab Provider

- You perform the right test on the right patient at the right time using the right procedures to obtain the right clinical outcome
  - Then...
- You assign the right code(s) to document the work performed and bill in the right way to obtain the right financial outcome

The Strategy: Payer

- Medicare: “To pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers”
- Third-party payer (BCBS): “To pay for the right care by the right provider at the right location and the right time at the right price”

The strategy for both: “Get it paid right”

1. Assign the right procedure code for the service performed
2. Make sure it complies with correct coding guidance
3. Make sure it is a covered service
4. File a clean claim
5. Monitor denials
6. Change the rules if they are wrong!

Rule #1

Assign the correct code for the service(s) performed
The CPT Coding System: The “chosen” procedure coding system

- Developed (1966), maintained, and copyrighted by the American Medical Association
- 5 digits and a narrative descriptor
- Also includes two digit alpha or numeric modifiers
- Updated and published annually
- Adopted as the “HCPCS” procedure coding system (HCFA Common Procedure Coding System)
- Adopted as the standard code set under HIPAA (2003)
- Accepted by all other third party payers for reimbursement purposes

What is CPT coding?

“A uniform language that describes medical, surgical, and diagnostic (including laboratory) services, and thereby serves as an effective means for reliable nationwide communication among physicians, patients, and third parties”

What is it really?

- “Coding is more of an art of interpretation than an exact science”
  Hughes and Stone
  www.aafp.org/fpm/20050600/17arey.html

- “CPT coding is a somewhat arcane science”
  Stephen Bauer, CPT Advisory Committee

How are codes used?

- Each code represents a discrete procedural element in the process of performing a laboratory analysis
- Each code does not necessarily lead to a result, but should be documented as a procedural occurrence in the overall process
- The codes reflect the work performed and not the results obtained
Coding categories: Category I codes

- FDA approval/clearance obtained plus
- Performed in many locations plus
- Performed by many healthcare providers plus
- Proven clinical efficacy

Microbiology coding components: Traditional methods

- Specimen management
- Direct microscopy
- Primary cultures including presumptive identification (except for urine)
- Presumptive identification, urine ONLY
- Definitive identification or typing of culture isolates (typing may be used in addition to "definitive" identification)
- Antimicrobial susceptibility testing

Microbiology coding, cont.

Non-culture dependent antigen detection (on primary specimens):

- Immunofluorescent method
- Enzyme immunoassay
- Optical immunoassay
- Latex agglutination (refers to immunology codes 86403, particle agglutination and 86406, titration)

Microbiology coding, cont.

Non-culture dependent molecular tests (on primary specimens):

- Direct probe
- Amplified probe (qualitative)
- Amplified probe with quantification
- Genotyping and phenotyping
Miscellaneous procedures performed in infectious disease diagnostic labs

- Immunoserology (antibody to specific infectious agents)
- Other immunology procedures
- Molecular, NOS (non-infectious agent)
- Miscellaneous procedures: body fluid/secretion analysis (e.g., WBC stool or nasal), vaginal pH/amines, “urine screens”, urinalysis

Category III codes

- Emerging technology codes
- Released publicly semi-annually on the AMA/CPT website
- May or may not eventually become Category I
- Infectious disease related:
  - 0010T Tuberculosis test, CMI measurement of gamma interferon antigen response*
  - 0023T Phenotype prediction using genotype comparison, HIV-1*
  - 0041T Urinalysis infectious agent detection, semiquantitative analysis of volatile compounds**
- If available, must use!

*Moved to Category I in 2006, 86480 and 87900
** “Sundowned” in 2009

How do you pick a code?

CPT hierarchy:
- Specific analyte
- Specific method
- Both analyte and method
- Generic analyte or method
- Unassigned codes

...and if you are unsure?

- Ask the manufacturer (but verify!)
- Ask AMA (Coding Helpline)
- “Ask It” (ASM)
- Ask CMS or your contractor
- Ask your Compliance Committee
- And get it in writing!
- “Creative coding suggested by consultants poses a potential hazard” (Stephen Bauer)
Category II codes

- Data collection for performance measurement and outcome improvement
- Optional use
- None currently directly related to laboratory procedures, but laboratory test use may be a component for effectiveness evaluation
- Potential for use in “P4P” initiatives

Modifiers

- Used to indicate that a service has been altered by some specific circumstance (generally affecting payment) but has not changed in its definition
- Two digit numerical (CPT) or alpha (HCPCS) values
- Usually appended by billing department based on pre-set, pre-pay system rules
- In microbiology, may need to identify select situations requiring modifiers

Modifiers in Pathology

CPT Modifiers
- -59 Distinct procedural service
- -91 Repeat clinical diagnostic laboratory service
- -90 Reference (outside) laboratory
- -26 Professional component (physician based, primarily inpatient, select outpatient services)

HCPCS Modifiers
- -QW Used by COW labs for waived tests
- -GA, -GZ, -GY Denote status of “waiver of liability” (Advance Beneficiary Notice)

Rule #2
Make sure the code(s) selected comply with correct coding guidance.
Coding Guidance

• Coding guidance is found in the CPT book, in both narrative elements and code descriptors
• Other coding guidance comes from federal payers (i.e. "As goes Medicare, so go other payers!")
  ➢ Office of the Inspector General Compliance Guidance for Clinical Laboratories
  ➢ National Correct Coding Initiative


• Provides a roadmap for how to monitor for correct coding and reimbursement
• Violations do result in repayments at best
• …and charges of fraud or abuse at worst
• Of note in laboratory medicine:
  ➢ Billing for tests not ordered
  ➢ Billing for tests not performed
  ➢ Reflex testing
  ➢ Composite billing
  ➢ Duplicate billing

Essential concepts per OIG for correct microbiology coding

• Code correctly according to hierarchy of analyte, method, generic, unlisted (don’t upcode or downcode)
• Use the most comprehensive code (don’t unbundle)
• Mutually exclusive (redundant) codes are not used together
• Avoid duplicate billing

Unique Concepts in Microbiology Coding

I. Ambiguous orders are an issue
II. “Composites” are common and acceptable
III. “Reflexes” are common and acceptable
IV. “Multiple analyte testing” is an emerging trend
V. Multiple uses of the same or presumed redundant codes are common
I. Ambiguous Orders in Microbiology

- “Swab for culture”
- “C & S”
- “Viral load”
- “Look for (organism)”
- “Serology for (organism)”
- “Meningitis (or any other --itis) panel”

Ambiguous orders cannot be correctly coded without communication with provider.

II. “Composites” in microbiology

- Two or more codes used simultaneously in accordance with regulatory, accreditory, or clinical practice guidelines.

These are not “bundles” or “custom panels”

---

### Test Choice and Compliance

e.g. Chlamydia testing

<table>
<thead>
<tr>
<th>Test</th>
<th>Code</th>
<th>NLA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture</td>
<td>87110 + 87140</td>
<td>28.60 + 8.14  (36.74)</td>
</tr>
<tr>
<td>DFA</td>
<td>87270</td>
<td>17.52</td>
</tr>
<tr>
<td>EIA</td>
<td>87320</td>
<td>17.52</td>
</tr>
<tr>
<td>OIA</td>
<td>87810</td>
<td>17.52</td>
</tr>
<tr>
<td>Direct probe</td>
<td>87490</td>
<td>29.27</td>
</tr>
<tr>
<td>Amplified probe</td>
<td>87491</td>
<td>51.25</td>
</tr>
</tbody>
</table>

There must be communication, verbal → written, before a codeable procedure is selected and billed.

---

### Infectious Disease Composite Examples

<table>
<thead>
<tr>
<th>Test</th>
<th>Additional code</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stain and culture</td>
<td></td>
<td>87XXX</td>
</tr>
<tr>
<td>Routine stool</td>
<td>Salmonella, Shigella</td>
<td>87045</td>
</tr>
<tr>
<td>+ Campylobacter</td>
<td></td>
<td>+ 87046</td>
</tr>
<tr>
<td>+ Shiga-toxin</td>
<td></td>
<td>+ 87427</td>
</tr>
<tr>
<td>Parasitology</td>
<td>Concentration and wet mounts plus trichrome</td>
<td>87177 + 87209*</td>
</tr>
<tr>
<td>CMV blood</td>
<td>Concentration, (antigenemia)</td>
<td>87015 + 87275</td>
</tr>
<tr>
<td></td>
<td>cell culture on “buffy coat”</td>
<td>+ 87271 + 87254</td>
</tr>
</tbody>
</table>
III. “Reflexes” in microbiology

- “Occurs when initial test results are positive or outside normal parameters and indicate a second related test is medically appropriate”

- Very common due to sequential application of codeable/billable processes in conventional microbiology

Infectious Disease Reflex Examples

<table>
<thead>
<tr>
<th>Test Name</th>
<th>Reflex to:</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>RPR Monitor or diagnostic</td>
<td>RPR titer and STS</td>
<td>86592-86593, 86781</td>
</tr>
<tr>
<td>HIV EIA</td>
<td>Western blot</td>
<td>86701-86689</td>
</tr>
<tr>
<td>Crypto antigen</td>
<td>Titer</td>
<td>86403-86406</td>
</tr>
<tr>
<td>GAS antigen</td>
<td>GAS culture</td>
<td>87880-87081</td>
</tr>
<tr>
<td>HSV culture</td>
<td>HSV typing</td>
<td>87252-87253 (x2), 87255-87140 (x2)</td>
</tr>
<tr>
<td>ELVIS</td>
<td></td>
<td>87255-87140 (x2)</td>
</tr>
<tr>
<td>+ Urine screen</td>
<td>Urine culture</td>
<td>81007-87086, 87088, 87077-87186</td>
</tr>
</tbody>
</table>

OIG Guidance for composites and reflexes

- These coding strategies are acceptable
  - However:
  - Seek and document approval (e.g. Annual Medical Staff)
  - Communicate policies (e.g. Annual Physician Notice, Service Manuals)
  - Provide option “to do or not to do”

Making sense of reflex ID’s

- Presumptive (colony morphology, gram stain on growth, up to three “simple/spot” tests) and definitive (additional tests >3) defined in microbiology preamble
- Presumptive included in primary code (except for urines) but definitive ID or “culture typing” may be reflexed
- For urines, primary code 87086 may reflex to presumptive code 87088 (for each isolate); however, a presumptive and a definitive code should not be coded for the same isolate
- Presumptive and definitive coding is generally based on work performed and not results obtained
- However, methods providing the same data should not be billed together
- Presumptive and definitive in a billing sense are NOT relevant to same terms in a microbiologic sense, rather depend on extent of work-up
...and reflex AST’s

- Reflex AST’s are an expected procedure, however…
- Multiple methods to provide the same data should not be billed, but...
- Multiple methods providing additional data, particularly in accordance with established guidelines, may be coded and billed
- e.g. “D-test”, “Hodge test”, “ESBL tests”

IV. “Multiple organism” coding: Another area of early controversy

- Giardia/Crypto IF or EIA, single or dual analyte codes? 87300/87451 or individual analytes (resolved in 2005 CPT book)
- For “poly” direct viral IF or EIA tests, is it 87300/87451 or individual analytes?
- For GC/CT molecular tests do you use 87800 and 87801 or individual analytes?
- For respiratory virus shell vials screened with “X-poly” antibody reagents, is it 87254 x “X reagents?”
- BD Affirm, 87797 from 2001 CMS PM or 87800?

Future “multiplex” assays??

Current multiplex guidance

- New clarification from AMA (2007):
  - “When separate assays are performed for different species or strains of organisms, each assay should be reported separately”
  - “For specific organism nucleic acid detection from a primary source, see 87470-87660”
  - “For detection of specific infectious agents not otherwise specified, see 87797, 87798, and 87799 one time for each agent”
- Therefore coding hierarchy is based on specific analyte (if an assay produces >1 specific analyte result, code by analyte)
- Non-infectious molecular diagnostics is on an "each" basis with new modifiers to add specificity
- Any strategy based on coding a number of unspecified analytical markers will lose ability to track specific analyte test utilization

So where do you use 87800/87801?
The BD Affirm (direct probe) saga

- 2001 PM: “Questions have arisen regarding the billing for a microbial identification test kit: Candida (87480), Gardnerella (87510), and Trichomonas (87797). When all three organisms are tested using one specimen for the test kit, regardless of the number of medically necessary tests performed, payment should reflect one unit of service using code 87797 and should not be billed individually”
- 2001: 87800/87801 probe and amplified probe for “multiple organisms”
- 2004: New code for Trichomonas (87660)
- BD has advised use of 87800 (multiple organism) BUT specific analyte coding now seems appropriate
- No clarification via new CMS “Change Request”
- Some contractors do not even recognize 87800/01
V. Dealing with “multiples” of the same code (avoiding “duplicates”)

- **“Units”:** Used for multiples of the same code from a single specimen (ID’s and AST’s), identified by term “each” in descriptor
- **-59 Distinct Procedural Service:** Generally applies to multiple uses of the same CPT code on the same day of service from different sites/samples (blood culture, 87040 x 2, lesion sites, 87070 x 2)
- **-91 Repeat Clinical Diagnostic Laboratory Test:** Repeat of the same test on the same date of service to obtain subsequent results
- **-59** may also be used to override CCI edits for different codes deemed non-compatible

**NCCI: CPT-4 vs. CPT-4**

**National Correct Coding Initiative**

- Developed for HCFA by Administar Federal in 1996; quarterly updates available from NTIS Currently administered by Correct Coding, LLC
- Now available free on-line (current 15.1, April 2009)
- “Mutually-exclusive procedures” would not be correctly ordered together
- “Comprehensive and compound procedures” are inclusive of all individual codes (Column 1 / Column 2)
- Defines when a modifier (-59) may be used to override an edit indicating services are distinct and necessary (“0” for no override, “1” for override possible)

**NCCI Websites**

- Manual
  [www.cms.hhs.gov/NationalCorrectCodInitEd](http://www.cms.hhs.gov/NationalCorrectCodInitEd)
- Carrier Edits
- Fiscal Intermediary Edits
- Q&A
  [www.cms.hhs.gov/NationalCorrectCodInitEd](http://www.cms.hhs.gov/NationalCorrectCodInitEd)

**When to use a “-59 override”**

- Is the edit eligible for an override? If YES
- Is the test a repeat, mandatory or not? NO
- Did you fail to obtain a valid result on the first test? NO
- Is the test a separately codeable confirmatory procedure? YES
- Does the second test provide unique clinically relevant actionable information? YES
CCI has great significance and great controversy for microbiology

- “A screening culture and a culture for definitive identification are not performed on the same day on the same specimen and therefore not reported together”

- “Multiple tests to identify the same analyte, or infectious agent, should not be reported separately”

- “Procedures performed to confirm initial results due to testing problems; or for any reason when a one-time reportable result is required should not be billed together”

Use or not of CCI overrides

- Many cultures denoted by one code cannot be billed with another code together without a modifier (e.g. 87086, urine, with 87070, miscellaneous)
- CP consults (80500 and 80502) cannot be billed with most microbiology codes; if applicable to another code type, add modifier
- Non-infectious analyte molecular process codes cannot be used to supplement infectious analyte codes; if noninfectious testing analyte testing performed on the same day, use modifiers
- “CPT code 83912 is for use with 83890-83906. It should not be used with infectious agent codes 87470-87904 or 88271-88275”

Recent CCI edit corrections

- 87086 and 87088 for urine cultures (ME)-- in 8.0, deleted in 8.1
- 87070 and 87075 for aerobic and anaerobic cultures (CC)---deleted in 9.1
- 87070 for lower respiratory and 87081 for Legionella (ME)---deleted in 10.1

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>In existence prior to 1996</th>
<th>Effective date</th>
<th>Deletion date</th>
<th>Modifier allowed 1 not allowed 0 not applicable 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>87086</td>
<td>87088</td>
<td>X</td>
<td>20020101</td>
<td>20020101</td>
<td>9</td>
</tr>
</tbody>
</table>

Current CCI issues:
Multiple “direct specimen tests”

- For influenza: 87275 and 87276 (DFA) with 87400 (EIA) or 87804 (OIA)
- For Group A Strep: 87880 (OIA) with 87650, 87651, 87652 (molecular)

❖ These are NOT subject to -59 overrides
Medically unlikely edits (MUE’s)

- Applicable January 2007
- Basically frequency units (number of times a code may be billed in a given time frame)
- Based on:
  - Anatomic considerations
  - Nature of equipment
  - Code descriptor
  - Nature of procedure
  - CPT coding instructions
  - Nature of analyte
  - CMS policies
  - Clinical judgment
- Can use modifiers if “medically necessary”
- Are reviewed by “stakeholders” confidentially but are ONLY published if MUE is <4!

NCCI MUEs

- MUE Overview
  www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage
- MUE FAQs
  www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage
- Medicare Learning Network “Claims Review Program”

Rule #3

Make sure it is a covered service

AND

If not, make sure the patient has accepted financial liability

Medical Necessity and coverage: CPT-4 + ICD-9-CM

- Coverage is a determination of whether and under what conditions a test may be ordered
- Medical necessity is based in principle on SSA 1862 (a)(1)(a), "reasonable and necessary" clause
- ICD-9-CM provides the information on "conditions" (diagnosis and signs/symptoms)

"reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body part" Medicare does not pay for "screening" services in absence of signs and symptoms EXCEPT by statute or CMS (MIPPA)

Policies may vary with other third party payers
ICD-9-CM

- International Classification of Diseases-9th version-Clinical Modification
- Systematic listing of diagnoses, signs and symptoms
- Provides the reason for performing a test
- Applicable primarily to outpatient settings
- Quarterly updates, public database

<table>
<thead>
<tr>
<th>ICD-10 use is mandated by October 1, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>155,000 codes vs. current 17,000 codes</td>
</tr>
<tr>
<td>Will require major LIT/HIT adjustments</td>
</tr>
</tbody>
</table>

Federal Payer Coverage Policies

- Two varieties of “limited coverage” decisions:
  - National Coverage Decisions
  - Local Coverage Decisions

Process for NCD’s

- Negotiated Rulemaking for National Coverage Policies: A process mandated by BBA ’97 in which interested parties “negotiated” administrative and national coverage decisions for laboratory tests
- Includes ongoing revision and process for submitting new policies for consideration

Current NCD’s

<table>
<thead>
<tr>
<th><a href="http://www.cms.hhs.gov/ncd/labindexlist.asp">www.cms.hhs.gov/ncd/labindexlist.asp</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious diseases</td>
</tr>
<tr>
<td>Urine culture</td>
</tr>
<tr>
<td>HIV, diagnosis</td>
</tr>
<tr>
<td>HIV, prognosis</td>
</tr>
<tr>
<td>Immunology</td>
</tr>
<tr>
<td>Tumor antigens</td>
</tr>
<tr>
<td>AFP</td>
</tr>
<tr>
<td>CEA</td>
</tr>
<tr>
<td>PSA</td>
</tr>
<tr>
<td>HCG</td>
</tr>
<tr>
<td>Hepatitis panel</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Blood counts</td>
</tr>
<tr>
<td>PTT/PT</td>
</tr>
<tr>
<td>Serum iron</td>
</tr>
<tr>
<td>Collagen crosslinks</td>
</tr>
<tr>
<td>Blood glucose</td>
</tr>
<tr>
<td>Glycated hemoglobin</td>
</tr>
<tr>
<td>Thyroid</td>
</tr>
<tr>
<td>Lipids</td>
</tr>
<tr>
<td>Digoxin</td>
</tr>
</tbody>
</table>

LCD’s may not conflict with NCD’s, however, where silent (e.g. frequency), they may be added.
Process for developing LCD’s

- Previously known as LMRP’s (Local Medical Review Policies)
- Developed by contractors with review by Carrier Advisory Committee or FI advisory group as a component of PI
- Developed as a result of a Focused Medical Review (FMR)
- Mandated by Program Integrity (PI)
- Other third party payers have similar medical review groups

Older Microbiology LCD’s

www.cms.hhs/mcd

- (Urine culture)
- Single isolate
- (HIV serology)
- (HIV viral load)
- Sensitivity testing
- Blood cultures
- Gram stains
- Allergy testing
- HPV ASCUS Triage
- Syphilis serology
- TORCH
- Molecular tests

(Now NCD coverage policies)

Examples of newer LCD’s

www.cms.hhs.gov/mcd

- Molecular infectious disease testing (Trailblazer)
- HIV genotyping and phenotyping (Trailblazer)
- Urinary fluorescent ISH test for recurrent bladder cancer (First Coast)
- Noncoverage (BCBS Tennessee)
- Clinical use of HCV molecular tests (National Heritage Insurance Company)
- Human papillomavirus DNA assay (First Coast Service Options)
- Payment for viral genomic testing (Blue Cross and Blue Shield of Kansas)
- Molecular Diagnostics (Associated Hospital Service)
- Molecular Diagnostics (HGSAdministrators)
- Molecular Diagnostics (National Heritage Insurance Company)
- Miscellaneous: HER-2 neu (Trailblazer Health Enterprises)
- Urinary tumor markers for bladder cancer monitoring (HGSAdministrators)

Considerations in coverage

- CPT code?
- FDA clearance/approval?
- Clinical outcomes?
- Practice guidelines?
- Professional organizations?
- Experimental (RUO or IUO)?
- Costs?
- Savings?
- Administrative, social, legal, or political factors?
- Public opinion?
- Existing coverage?

Secretary's Advisory Committee on Genetics, Health, and Society and The Battelle Report: Laboratory Medicine, A National Status Report have identified coding/ reimbursement as major obstacles in new technology
Components of a Coverage Policy

- Title
- Description (narrative)
- HCPCS Codes (CPT’s)
- Indications (narrative)
- Limitations (narrative)
- ICD-9-CM Codes Covered
- Reasons for Denial (narrative)
- ICD-9-CM Codes Denied (statutory)
- ICD-9-CM Codes That Do Not Support Medical Necessity
- Coding Guidelines (narrative)
- Documentation Requirements

Note: Standard format is “inclusionary”; “exclusionary” policies used for hematology services

If a service is not covered?
Use the ABN Process

- An Advance Beneficiary Notice (ABN) is a waiver of financial liability signed by the patient for use if a test is denied as “not medically necessary”
- AKA Notice of Exclusions from Medicare Benefits (NEMB)
- It is used only when a provider believes a specific test is likely to be denied
- Claims are amended with modifiers to show status of the ABN (-GA, on file; -GZ, not on file; -GY statutorily excluded)
- Particularly problematic for microbiology because there is no control of collections!
- A new lab specific format was previously used (See PM AB-02-114 (implementation October 1, 2002))
- However, a new “universal” ABN is in effect since March 1, 2009 (CMS-R-131) and requires reason for denial AND estimated costs

Other coverage guidance based on correct coding

- APC’s (OPP’s): Ambulatory payment classification (outpatient Prospective Payment System)
- ESRD: End stage renal disease (dialysis)
- SNF: Skilled nursing facilities
- DRG’s: Diagnosis related groups
- HEDIS: Health employer data information set

Rule #4

File a clean claim

It is JUST as important to document the work performed using correct coding for these payment mechanisms
Filing clean claims

• Primarily the responsibility of the billing department
• Uses "pre-claim" software to determine if “rules” have been followed
• However, the complexity of infectious disease diagnostics makes it essential for the lab to be involved

The laboratory's role

• Be familiar with “rules” of correct coding
• Be familiar with NCCI and other coverage issues
• Be involved in insuring the work you perform is appropriately coded
• Get to know your billing folk and explain it all to them

Rule #5

Monitor denials

Monitoring denials

• Denials will result from post-claims review based on pre-pay edits
• Major categories of coverage rules:
  ➢ Statutory rules
  ➢ NCCI: National Correct Coding Initiative
  ➢ NCD: National Coverage Decisions
  ➢ LCD: Local Coverage Decisions
• Denials are coded to identify the cause in EOMB’s (Explanation of Medical Benefits) and MSN’s (Medicare Summary Notices)
Basic reasons for denial

- Not medically necessary
- Frequency
- Date of birth not provided
- Date of service not correct
- Test not ordered by a physician or other qualified provider (UPIN number or National Provider Identifier)
- Failure to have appropriate CLIA certificate or failing to meet CLIA standards

These should be caught pre-claim

Critical post-claim denial codes

- CO-50: Medical necessity
- CO-18: Duplicate order
- CO-15: CCI
- PR-46: Non-covered service
- PR-49: Routine screening

CO = Contractual obligation      PR = Patient responsibility

NOTE: Under HIPAA, Claim Adjustment Reason Codes and Remittance Advice Remark Codes have been standardized and maintained by the NUBC and CMS effective January 1, 2009


http://www.wpc-edi.com/codes


- Most frequent denials:
  - Lipid panels 15%    Organism ID 7%
  - Urine culture 14%  Vitamin B12 6%
  - TSH 12%            Cholesterol 4%
  - HgbA1c 12%         Calcium 4%
  - PSA 12%            Others 14%

- Actions taken:
  - Distribute LMRP's
  - Redesign lab requisition
  - Execute ABN's

- Outcome:
  - 50X reduction over 12 months

Rule #6

Change the rules if they are wrong!
How are codes changed?

- Requests for additions, deletions, descriptor changes
- Coding change request form to AMA
- Extensive AMA committee reviews
- Pathology Coding Caucus recommendation
- CPT Editorial Panel
- New codes: July (since 2001)
- Fees recommended for new codes (July)
- New code book: October
- Implementation mandatory: January

TOTAL process 18 months!!!

For critical new technologies, a temporary HCPCS code may be established

New codes for 2009

- 87905: Infectious agent enzymatic activity other than virus (eg sialidase activity in vaginal fluid)
  - 82657 (Enzyme cell activity, nonradioactive substrate, each specimen) minus 87176 (Tissue homogenization)
  - $17.84

Most common mechanism to assign new NLA is “crosswalking” “Gap-filling” is uncommonly recommended

Molecular codes

- Changes in descriptor to clarify units of service
- “Code separately for each procedure used in an analysis”
- “Each” occurs in many descriptors indicating appropriate multiple use
- However, new conflicts over MUE Version VIII edits have arisen
Procalcitonin (PCT)

- Category III: 0194T
- May be used to differentiate inflammatory versus infectious disease
- Price set by MAC (Contractor)

...annually, you should

- Review and Revise handbooks
- Review and Revise requisitions
- Review and Revise chargemasters
- Review and revise any and all documents and files which mention CPT codes!

How do you have input into CCI?

- Monitor denials to find the problems!
- Recent requests by NCCI Contractor to ASM and others to review proposed edits including MUE’s
- Some edits removed as a result of professional society input

How can you change coverage policies?

- NCD’s: Defined process in place
  - MCAC (Medicare Coverage Advisory Committee)
  - TEP (Technical Expert Panel)
- LCD’s: CAC’s (Carrier Advisory Committee)
- Other third party payers: TAG’s (Technical Advisory Groups)
Correct coding is a key to financial and utilization review!

- In a fee-for-service system, all appropriate codes must be applied for accurate reimbursement.
- In a capitated system, documentation of all work performed is critical to determine if payment is adequate.
- In both payment systems, appropriate and non-fraudulent utilization of services may be tracked by procedure code.
- In both payment systems, appropriate codes account for work performed.
- In both payment systems, appropriate codes allow for utilization review for outcome and "P4P" purposes.

Correct coding documents the lab contribution to clinical care

- Validation of data collection for the HEDIS performance measure on Chlamydia screening in an MCO (Am J Manag Care, 2003, 9:583)
- Patterns of care received by Medicaid recipients with urinary tract infection (Pediatrics, 1995, 96: 638)

Keys to success

- First do good quality laboratory medicine
- Code for all you do and bill for all that you code
- Code and bill correctly and in compliance with the Office of Inspector General Guidance for Clinical Laboratories
- Know code defined billing rules and make appropriate process adjustments
- Do pre-claim review and monitor denials to identify problems
- Find solutions to the problems as a team

Laboratory Medicine: A National Status Report

- Spending 2.3% US and 2% Medicare
- YET drives 70+% of clinical decision making!
- 6.8b tests annually
- 2007 revenues $52b
- Clinical pathology 66%, $32b
- Anatomic and Cytology 23%, $11b
- Molecular and esoteric 8%, $4b
- More than 4000 tests available, 1162 reimbursed by Medicare, 500 performed regularly
- 1430 diseases detectable by genetic testing, 287 research only
- CLIA-certified labs >200,000 (POL 54%)
- Hospital based labs 55% of testing, 54% of revenue, $28.4b

http://www.futurelabmedicine.org/
Congressional Curbs on Medicare CLFS

CPI Updates
- 1985 (4.1%)
- 1987 (5.4%)
- 1989 (4.0%)
- 1990 (4.7%)
- 1991 (2.0%)
- 1992 (2.0%)
- 1993 (2.0%)
- 1994 (0.0%)
- 1995 (0.0%)
- 1996 (2.8%)
- 1997 (2.7%)
- 1998-2002 (0.0%)
- 2003 (1.1%)
- 2004-2008 (0.0%)
- 2009 (4.5%)

NLA
- 1996 (115%)
- 1998 (100%)
- 1999 (93%)
- 1995 (88%)
- 1994 (84%)
- 1995 (80%)
- 1996 (76%)
- 1998 (74%)
- 2001 (74% except codes set after 1-1-01, 100%)

Labs have steadily lost ground!
NIR, November 24, 2008

New reimbursement issues in 2008-2009
- Competitive bidding “killed” by MIPPA
- Medicare Part C may take hits
- ASCLS/CLMA initiative to use negotiated rulemaking to revise fee schedule
- AdvaMed efforts for demonstration project on molecular diagnostics
- Major efforts directed toward genetic testing
- Genentech FDA Citizen’s Petition to increase FDA oversight for LDTs
- New RAC efforts (Recovery Audit Contractors) in addition to CERT (Comprehensive Error Rate Testing)
- OIG eye on variation in laboratory payments

All issues require understanding of correct coding

The first step to successful reimbursement and credit for what you do is correct coding

Specific correct coding questions or concerns?
e-mail to vbaselski@utmem.edu
and I’ll try to work them into Part 2 next week!