



Billing Clinical Laboratory Services (A/B)

September 15, 2011



Proprietary and Confidential

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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1

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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2

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Acronyms



- AHCA Agency for Health Care Administration
- CBC Complete blood count profile
- CERT Comprehensive Error Rate Testing
- CLIA Clinical Laboratory Improvement Amendments
- CMS The Centers for Medicare & Medicaid Services
- FCSO First Coast Service Options
- LCD Local Coverage Determination
- MAC Medicare Administrative Contractor
- NCD National Coverage Determination
- NPI National Provider Identifier
- OIG Office of the Inspector General
- PECOS Provider Enrollment, Chain and Ownership System
- RARC Remittance Advice Remark Code
- PPMP Provider-Performance Microscopy Procedures

3

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Agenda Items



- Learning objectives
- Requisitions vs. orders
- Comprehensive Error Rate Testing (CERT) errors
- Ordering/referring provider
- Clinical Laboratory Improvement Amendments (CLIA)
- Medical Policies
- Billing laboratory services
- Model compliance plan
- Resources
- Summary

4

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Learning Objectives



- **At the conclusion of today' session, you will be able to**
 - Identify the difference between a requisition and an order
 - Understand the CMS signature requirements
 - Determine if ordering physicians are in PECOS
 - Determine the level of CLIA necessary for labs and how to determine the certification level
 - Identify lab National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
 - Describe billing issues with laboratories
 - Describe the elements of a model compliance program
 - Identify applicable laboratory resources

5

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Participant Questionnaires



Medifest 2011 Billing Clinical Laboratory Services (B)

Participant Questionnaire



Thank you for registering for **Billing Clinical Laboratory Services (B)** workshop at our 2011 Medifest Symposium. To ensure your specific needs are reflected in course content, please take a moment to respond to the following questions. All answers are confidential, and will only be used for the purpose of class design.

1. As stated in the course descriptor, this course is designed for Medicare Part B billing staff located in laboratories and physician's offices. What type of Medicare Part B provider do you work for (independent, facility or hospital-based laboratory; hospital; group practice; individual practice, etc.)?

2. Are you familiar with accessing the Clinical Laboratory Improvement Amendment (CLIA) laboratory demographics database?

3. What questions do you have for the facilitator relative to the program agenda outline listed below?

Program Agenda Outline

- Laboratory requisitions vs. orders
- Laboratory Comprehensive Error Rate Testing (CERT) errors
- Ordering/referring providers
- CLIA

6

WHEN EXPERIENCE COUNTS & QUALITY MATTERS



Requisitions and Orders

7

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Order vs. Requisition



What is an order?

- Communication from treating physician/practitioner requesting lab perform diagnostic laboratory test for beneficiary
- Written document signed by treating physician/practitioner hand-delivered, mailed, or faxed to treating facility
- Telephone call
- E-mail or other electronic means

What is a requisition?

- Actual paperwork (form) physician provides clinical diagnostic laboratory to identify test(s) to be performed

8

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Requisition Exercise



- What is incorrect on form?

9

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Comprehensive Error Rate Testing (CERT) Errors

10

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Five Categories of Errors

1. No documentation
2. Insufficient documentation
3. Medically unnecessary service
4. Incorrect coding
5. Other

11

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Insufficient Documentation



- To avoid “insufficient documentation” denials, providers should
 - Ensure medical records are documented based on policy
 - Submit correct and complete set of documentation to support services billed
 - Procure any necessary information from third party providers
 - Ensure legible identity and professional credentials of all who contributed to service or medical record is clear
 - Ensure Medicare signature guidelines are followed

12

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Increased Error Rates



- Missing evidence of treating physician's intent to order diagnostic tests
- Medical records from treating physician did not substantiate what was billed
- Missing or illegible signatures on medical record documentation

13

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Medically Unnecessary Services



- To avoid “medical necessity” denials, service should
 - Be provided according to Medicare coverage guidelines
 - Be appropriate in duration and frequency
 - Meet but not exceed patient’s medical need
 - Be non experimental or investigational
 - Be performed by qualified personnel in an appropriate setting
 - Be documented with all pertinent information

14

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Incorrect Coding



- To avoid “service incorrectly coded” denials, providers should
 - Refer to CPT and HCPCS manual to ensure you are billing appropriate code
 - Remind ordering physicians
 - Tests must be ordered by physician treating beneficiary
 - Intent to order CBC with or without WBC must be clearly stated in order

15

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Most Common CERT Error



- **Incorrect coding of**
 - CPT 85025 – Complete (CBC), automated (Hgb, RBC, WBC and platelet count) and automated differential WBC count
 - CPT 85027 – Complete (CBC) automated (CBC), automated (Hgb, RBC, WBC and platelet count)
- **Cause of CERT error**
 - Services billed as CPT 85025 however physician order indicated only CBC

16

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Review Requisition



- **What is the correct service to bill?**

17

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Ordering/Referring Providers

18

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Ordering/Referring Providers



- Doctor of Medicine or Osteopathy
- Dental Medicine
- Dental Surgery
- Podiatric Medicine
- Optometry
- Chiropractic Medicine
- Physician Assistant
- Certified Clinical Nurse Specialist
- Nurse Practitioner
- Clinical Psychologist
- Certified Nurse Midwife
- Clinical Social Worker

19

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Change Requests (CRs)

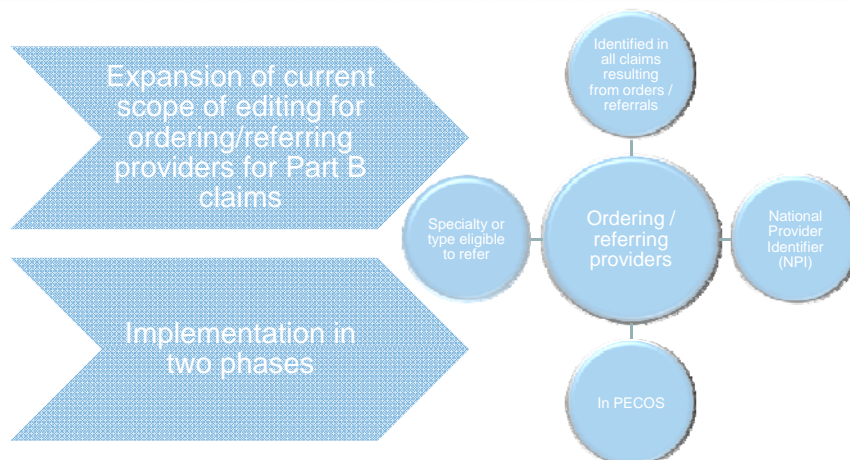


- **Special Edition Medicare Learning Network® (MLN) article SE1011**
 - Edits on the ordering/referring providers in Part B claims which encompasses
 - Change request 6417 – Editing for ordering/referring for Part B claims
 - Change request 6421 – Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
 - Change request 6696 – Ordering/referring providers who are not enrolled in Medicare

20

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Background CR 6417



21

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

CR 6417 – Phase 1



- **October 5, 2009, until ?**
 - End date to be announced
 - Item/service requiring ordering/referring does not contain ordering/referring on claim
 - Claim will be rejected
 - Ordering/referring is on claim
 - Ordering/referring verified is in PECOS and eligible to refer
 - If not in PECOS, Medicare searches in claims system
 - If not in PECOS or claims system
 - Claim continues to process
 - Provider/supplier receives warning message on Remittance Advice (RA)

22

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

CR 6417 – Phase 1



- Provider in PECOS and/or claims system but not of eligible specialty
 - Claim continues to process
 - Provider/supplier receives warning message on Remittance Advice (RA)
- Informational warning messages on RA
 - N264 – Missing/incomplete/invalid ordering physician provider name
 - N265 – Missing/incomplete/invalid ordering physician primary identifier
 - Provider not found in PECOS or claims system, or
 - Provider on master provider file but not of specialty eligible to order or refer

23

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

CR 6417 – Phase 2



- **No implementation date confirmed**
 - Item/service requiring ordering/referring does not contain ordering/referring on claim
 - Claim will be rejected
 - Ordering/referring not in PECOS and not in claims system
 - Claim will be rejected
 - Ordering/referring in PECOS or claims system but not of specialty to order/refer
 - Claim will be rejected

24

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Ordering/Referring Report



- **Avoid claim rejects or denials for referred / ordered services**
 - <http://www.cms.gov/MedicareProviderSupEnroll>
 - Access "Ordering/referring report"
 - Contains legal name and NPI of physicians and non-physician practitioners who
 - Are of a type/specialty legally eligible to order and refer in Medicare, and
 - Have current enrollment records in PECOS

25

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

RARC N264



- **Missing/incomplete/invalid ordering physician provider name**
 - Ensure first/last names submitted in appropriate fields on claim
 - Do not include MD, DO, Dr., Ph.D., etc
 - Hyphenated last names must be exactly as in PECOS or claims file
 - No middle name or initial
- **Paper claim**
 - In Item 17 of CMS-1500 claim form, place in order - first name followed by last name

26

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

RARC N265



- **Missing/incomplete/invalid ordering provider primary identifier**
 - Ensure you have verified enrollment in PECOS
 - Ordering/referring physician can only be an individual (type 1 NPI)
 - No group NPI
 - Ensure ordering/referring provider of a specialty eligible to order/refer

27

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

CR 6696



- Opt-out providers and
- Providers employed by government health care programs of specialty type otherwise eligible to refer
 - Physician or non-physician practitioner employed by
 - Department of Veterans Affairs (DVA)
 - Department of Defense (DOD) TRICARE program, or
 - Public Health Service (PHS)
- Must have a current enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS)
 - Complete all enrollment topics in Internet-based PECOS
 - Send FCSO a signed certification statement and cover letter stating provider is only enrolling to order and refer services

28

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Review Requisition



- Is the ordering provider in the list?

29

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

CLIA

30

What is CLIA?

- **Clinical Laboratory Improvement Amendments Act of 1988**
 - Established to ensure accuracy and reliability of patient test results
 - Laboratories must be certified based on the testing performed
 - Testing categorization
 - Waived
 - Virtually exempt from CLIA rules
 - Must adhere to manufacturer's instructions
 - Moderate complexity
 - High complexity

31

Five Types of Certificates



1. Certificate of Waiver
 - Perform only **waived** tests
2. Certificate for Provider-Performed Microscopy Procedures (PPMP)
 - Physician or practitioner performs no tests other than microscopy procedures
3. Certificate of Registration
 - Enables laboratory to conduct moderate or high complexity laboratory testing or both until survey conducted
4. Certificate of Compliance
 - Issued after inspection finds laboratory in compliance with CLIA

32

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Types of Certificates (Cont'd)



5. Certificate of Accreditation
 - Issued on basis of laboratory's accreditation by CMS approved accreditation organization

33

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Laboratory Certification



Must register by completing application

- May include State registration, as well
- Florida Agency for Health Care Administration (AHCA)
<http://ahca.myflorida.com>

Pay applicable fees

- Including State fees

Be surveyed (if applicable)

Become certified based on testing performed

34

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Laboratory Certification



- Determine laboratory certification
 - CMS Clinical Labs Center
(<http://www.cms.gov/center/clinical.asp>)
 - Select "CLIA" (<https://www.cms.gov/CLIA/>)
 - Access "Laboratory demographics lookup"
(https://www.cms.gov/CLIA/20_CLIA_Laboratory_Demographic_Information.asp)
 - Enter CLIA #, if available, or
 - Enter lab name and ZIP code

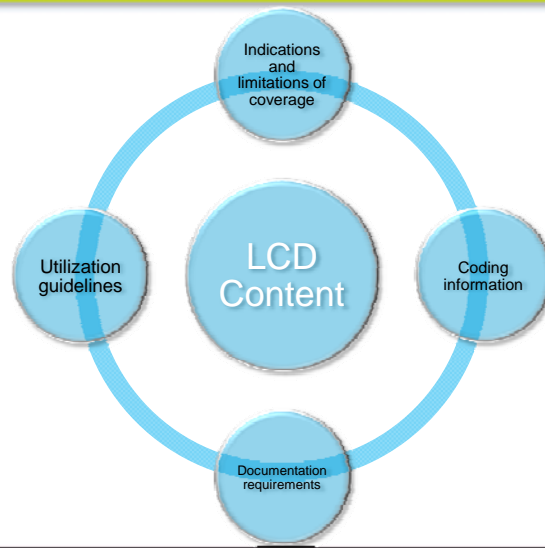
35

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Medical Policies

36

LCDs



37

■ Local Coverage Determinations

- Certain lab tests
- Procedures that depend on lab results
 - Access “LCD Lookup”
 - http://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp
 - Enter keyword, procedure code, or LCD ID#

38

■ National coverage determination

- Several lab tests have general guidelines
- Laboratory NCD index
 - <http://www.cms.gov/medicare-coverage-database/indexes/lab-ncd-index.aspx>

39

Billing Laboratory Services and Laboratory Claim Issues

40

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Laboratory Billing

- **Complete claims appropriately**
 - Ensure to have all patient information prior to billing claim
 - Claim should contain
 - Ordering/referring provider name and NPI
 - Item 17 and 17b or electronic equivalent
 - Procedure code
 - Applicable modifiers (ex. 'QW' for some waived tests, etc.)
 - Any additional information required
 - Item 19 or electronic claim comments
 - CLIA number (if applicable)
 - Item 23 or electronic equivalent

41

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Referred Lab Tests



- Lab may have to refer tests to another lab
 - Referring lab – Lab referring specimen to another lab
 - Reference lab – Lab performing the testing
- Referring lab bills Medicare in jurisdiction
 - Bills code with '90' modifier
 - Physicians will never use '90' modifier
 - Not authorized by Medicare
 - CO-172 denial received if inappropriate
 - Includes CLIA for reference lab
 - Includes physical billing location for reference lab, to properly price claim

42

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Overutilization



- **Certain labs have utilization guidelines defined**
 - Example: Preventive service labs
 - Refer to LCD or NCD
 - Physician should review prior to ordering lab
 - Advise the laboratory of potential overutilization via the order/requisition
 - Lab claim will deny
 - Claims will deny with PR 119
 - *Medicare does not pay for this many services*

43

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Repeat Tests



- If necessary to repeat tests:
 - Bill claim with modifier '91'
 - Same patient, same day procedure/service, by the same provider
 - Repeat lab test performed more than once on the same day
 - Example:
 - Patient undergoing chemotherapy for lung carcinoma has CBC with *automated platelet count* performed prior to receiving chemotherapy
 - Patient has very low platelet count, receives platelet transfusion
 - Automated platelet count is repeated after transfusion
 - 85027 (CBC with automated platelet count) and
 - 85049-91 (Repeat automated platelet count)

44

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Be Proactive



- What can you do to protect your business?
 - Educate staff on CMS regulations
 - Ensure to include order for services
 - If lab, ensure you receive order
 - Consider revising requisition forms to include a prompt for physician's name, date, and signature
 - Contact referring/ordering providers to make sure they're aware of regulations
 - Complete claims correctly
 - Include CLIA number when applicable
 - Submit complete medical documentation timely to contractors

45

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Model Compliance Program

46

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Compliance Program Benefits

- A well-designed compliance program can
 - Speed and optimize proper payment of claims
 - Minimize billing mistakes
 - Reduce chances an audit will be conducted by CMS or OIG
 - Avoid conflicts with self-referral and anti-kickback statutes
 - <http://oig.hhs.gov/fraud/docs/complianceguidance/cpcl.html>

47

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Compliance Program Guidance



- **Seven components**
 - Conduct internal monitoring and auditing
 - Implement compliance and practice standards
 - Designate a compliance officer or contact
 - Conduct appropriate training and education
 - Respond appropriately to detected offenses and develop corrective action
 - Develop open lines of communication
 - Enforce disciplinary standards through well-publicized guidelines

48

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Question & Answer Session



- **What questions do you have?**



49

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Additional Resources

50

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First Coast Service Options Inc.

medicare.fcso.com

medicareespanol.fcso.com

51

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FCSO Resources



- **Clinical laboratory specialty page**
 - <http://medicare.fcso.com/Landing/151248.asp>
- **Provider enrollment page**
 - Ordering/referring providers FAQs
 - <http://medicare.fcso.com/FAQs/178035.asp>
 - Provider enrollment tips and tutorials
 - http://medicare.fcso.com/PE_Tips_and_tutorials/
- **CERT Center**
 - <http://medicare.fcso.com/Landing/203608.asp>

52

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FCSO Resources (Cont'd)



- **Education**
 - <http://medicare.fcso.com/Landing/139820.asp>
 - Events calendar
 - Event resources
- **FCSO University**
 - <http://www.fcsouniversity.com>
 - Online learning

53

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Centers for Medicare & Medicaid Services

www.cms.gov

54

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CMS Resources

■ Laboratory resources

- CMS IOM Pub. 100-04 *Medicare Claims Processing Manual*, Chapter 16, Laboratory Services
 - <http://www.cms.gov/manuals/downloads/clm104c16.pdf>
- CMS IOM Pub. 100-02 *Medicare Benefit Policy Manual*, Chapter 15, Sec. 80.1
 - <http://www.cms.gov/manuals/Downloads/bp102c15.pdf>
- Clinical Labs Center
 - <http://www.cms.gov/center/clinical.asp>

55

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Summary of Today's Topics



- Today we have reviewed
 - Identifying the difference between a requisition and an order
 - Understanding CMS signature requirements
 - Determining if ordering physicians are in PECOS
 - Determining CLIA level necessary for labs and how to determine the certification level
 - Identifying lab National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
 - Describing laboratory billing issues
 - Describing elements of a model compliance program
 - Identifying applicable laboratory resources

56

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Thank You for Participating



- FCSO values your feedback
 - It is important that you complete the evaluation form and return it before leaving the class



57

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Brain Teaser

EXERCISE: 12 ways to a better you

This exercise is designed to test your skills at reading and following directions, as well as tease your brain. It should take approximately 2 minutes to finish.

Directions:

1. Before you begin, read everything on this page through carefully.
2. Print your name in the upper left-hand corner of this page.
3. Write today's date below your name in the upper left-hand corner.
4. As this is a Clinical Laboratory course, please indicate your CLIA in the upper right-hand corner of the page. If you are unsure of your CLIA number, write "XYZ" instead.
5. Below your CLIA number, indicate the approximate number of physicians your entity serves, in numerical form.
6. Write your birth date below today's date at the top of the page.
7. Add up all the numbers in your birth date.
Ex: June 28, 1972 is $6+2+8+1+9+7+2=35$
8. If the total from #7 above equals your age, ring the bell in the center of the table and continue to number 10.
9. If the total from #7 **does not** equal your age, stop the exercise here, put your pencil or pen down and stand up.
10. Add up all the numbers in today's date. If the number adds up to 21 or 55, put a smiley face at the top of your page and stop the exercise here. If not, continue on to number 11.

11. Put an "X" across the words "Brain Teaser" at the top of this page.

12. Now that you have read everything through carefully, perform only items 1, 2 and 3.