

May 20, 2005 CLMA Meeting Questions and Answers

I just received the following announcement. I am wondering if we can start submitting our claims with the .855 per mile rate & the P9604 @ \$ 8.55, since it is in effect for dates of service 1/1/2005 through 12/31/2005? Here is the announcement I received:

- Q1. On May 6, the Centers for Medicare and Medicaid Services published Transmittal 154, Change Request (CR) 3785 a one-time notification instructing contractors to correct payment for CPT codes P9603 and P9604 for clinical laboratory travel fees.

On November 5, 2004, CMS published a Recurring Update Notification - CR 3526 - with instructions regarding separate payable fees for traveling to collect specimens from nursing homes or homebound patients.

There are two codes used for billing travel: P9603, for a per mileage trip; or P9604, for a flat-rate trip where the average round trip is less than 20 miles. To bill either of these codes, the laboratory must document the number of specimens performed per trip for both Medicare and non-Medicare patients to calculate the Medicare prorated fee. Payments for both codes reflect personnel and transportation costs. The 2005 personnel payment rate is \$0.45 per mile.

CR 3526 listed the 2005 standard mileage rate for transportation costs as \$0.385 per mile, and the 2005 payment rate for P9603 as \$.835 per mile and for P9604 as \$8.35 for a flat-rate trip.

However, the standard mileage rate is now corrected to \$0.405 per mile. CR 3785 corrects the 2005 fee for code P9603 to \$0.855 per mile, and for code P9604 to \$8.55 per flat rate trip.

This correction is effective for dates of service from Jan. 1, 2005 through Dec. 31, 2005. Contractors will not retract payment for claims already paid nor retroactively pay claims. Contractors are instructed to adjust claims brought to their attention.

Although the effective date for CR 3785 is for dates of service on or after Jan. 1, 2005.

To read Transmittal 154, Change Request (CR) 3785, "Correction 2005 Clinical Laboratory Travel Fee (P9603 P9604)," please visit http://www.cms.hhs.gov/manuals/pm_trans/R154OTN.pdf.

- A#1. **Clinical laboratories and providers billing Medicare carriers for procedure codes P9603 and P9604 need to adjust their billing. Medicare carriers will not implement this change until July 5, 2005 as the related CR 3785 states. Carriers will not be doing automatic adjustments to these claims that were submitted prior to this date. We will adjust any claims that are brought to our attention. You may submit your claims with the adjusted rate; however, the system will pay the previous rate until July 5th, 2005.**

Q2. The guidelines for submitting claims on a Purchased Diagnostic Test requires that the CLIA number from the performing laboratory be included on the claim. Is there any edit, in the Medicare system, which will monitor when that other laboratory's CLIA number is submitted that the other laboratory is a Medicare provider?

A2. It is the responsibility of the laboratory to ensure that the other laboratory is a Medicare provider. When the billing laboratory is the referring laboratory it must identify the referred services as such by using the 90 modifier and Identify the reference laboratory (performing) by specifying its CLIA number in Item 23 or electronic equivalent and the address where the test was performed. This is a change request CR2193.

Q3. Are there new billing requirements soon to be in effect for rehabilitative services like Physical Therapy, Occupational Therapy, etc.? If so, are there any instructions available to comply with these new billing requirements? Currently at our facility when we bill for services, we document the time we start and stop the patient's treatment session, and then bill the number of units per each CPT code as appropriate. Example: Patient comes at 0900 and leaves at 0950. Patient is seen for exercise and ultrasound treatment. We bill two units of exercise and one unit of ultrasound treatment. Do we need to document the total minutes provided for each modality as well as the total time the patient was being treated?

A3. At this point there have not been any new physical therapy requirements released. In the example that was provided you indicated that you are billing 2 unit of exercise and 1 unit of ultrasound treatment. Going with the example, should a carrier request documentation, the documentation must substantiate the services that you are billing for. Based on the question, these are timed codes so the documentation should support the units of service.

Q4. We have received the following response from Stephanie WPS/Medicare Provider Outreach. Will WPS/Medicare be working to correct this so that all diagnosis are reviewed as outlined under HIPAA and the ANSI guidelines? We had to pay for special programming done on our Billing system to have all diagnosis codes reviewed to meet the HIPAA guidelines and now it appears that we will have to have it undone.

Your claims are hitting an edit in the system that is based on a National Coverage Determination (NCD). The edit looks at the primary diagnosis and if the diagnosis does not meet medical necessity, the system does not look at all reported diagnosis on the claim. For claims not tied to NCDs, if the primary diagnosis does not meet medical necessity, the system does look at all reported diagnosis on the claim. Therefore, for correct billing requirements, link the primary diagnosis for each procedure on the claim to the appropriate procedure code.

A4. WPS Medicare went to EDS with this problem. EDS is the contractor whom inputs all information for the NCDs for CMS. EDS is looking at this problem. There has been another contractor who also reported this problem. We are waiting for clarification from EDS as to this problem. WPS is not able to correct system problems in relationship to NCDs. At this point this is a system problem

not a change in processing procedures. Once we receive more information we will pass it along to everyone.

- Q5. "CLMA has found that there exists confusion within the laboratory community regarding whether or not it is appropriate to bill for testing labeled "research use only (RUO)" or "investigational use only (IUO)". Because of the potential compliance risks involved we are seeking clear answers to the following questions:
1. Is it incorrect to bill Medicare for RUO/IUO-based tests in all instances? Does the complexity level for which a lab is certified have any impact on the propriety of billing for RUO/IUO testing? CLIA section 493.17 seems to suggest that if a test is not FDA-approved, it is considered a "high complexity" test, leaving an inference that if labs in this category adhere to all other requirements, performance of diagnostic testing via RUO/IUO methods is not contrary to CLIA requirements.
 2. If it is improper to bill for RUO/IUO testing, can you provide us with a citation from Medicare manuals, SSA, CLIA or any regulatory source we can refer our members to that addresses this issue?
 3. Those who believe it is improper to bill Medicare for RUO/IUO testing assert that the beneficiary may be billed for the testing without an ABN. Is this true?
 4. If #3 above is true, what should labs do when the beneficiary demands the charges be billed to Medicare anyway ("demand bill")? CMS has no way of knowing the service is RUO/IUO-based and will likely pay for the testing.

A5. In order to respond, we need more information.

- Q6. MSP payment calculation. Please take the following example and display how the MSP payment would be calculated. In the MSP instructions at http://www.wpiscic.com/medicare/provider/msp_calc.shtml site, there are 3 ways necessary to review prior to determining how much the payment would be. Please illustrate how all 3 are applied. Please remember that laboratory services are paid 100% with no patient copay applicable (at least not for the services in the example).

CPT	Potential Charge Amount	Third Party Payment	Medicare Allowable	Amount Medicare would pay	Third Party Insurance Allowable Charge
P9604	\$ 3.54	\$ -	\$3.54	\$ 3.54	\$ -
G0001	\$ 10.00	\$ 8.40	\$ 3.00	\$ 3.00	\$ 11.20
80048	\$ 100.00	\$ 40.20	\$ 11.83	\$ 11.83	\$ 53.60
85025	\$ 45.00	\$ 32.49	\$ 10.86	\$ 10.86	\$ 43.31
81003	\$ 30.00	\$ 9.93			\$ 13.24

- A6. Medicare Part B has a formula to calculate what it should pay as the secondary payer. I am not aware of any other way to calculate a secondary payment. The web link sited in the question does not exist.

MSP Formula

1. Calculate the Medicare Reasonable Charge - deductible x .80 (This is the Medicare Allowed Amount)
2. Take the higher amount:
 - Medicare Reasonable Charge (allowed amount) **or**
 - Employer Allowed Amount (Primary Payer)

3. #2 - (less) the Employer Group Payment (Primary payment)
4. Pay the lower amount of #1 or #3.

Q7. Patients come to our draw station and request that we collect the specimen, prep it for shipping (sometimes spinning the specimen and splitting it, etc) then send it to another laboratory. We bill a 36415 for the blood collection, but since we are not the performing laboratory there is no test to bill. **Can we bill a handling fee to Medicare, 99001? Will this be reimbursed by Medicare? Is this a non-covered service that can be billed to the patient?**

A7. According to the Medicare Part B Communiqué- 2005 HCPCS update: The code 99001 is a B-code. It is bundled into another unspecified code.

Payments for covered services are always bundled into payment for other services not specified. There will be no relative value units (RVU) or payment amounts for these codes, and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident. Therefore, no separate payment can be made. Since it is a service that is bundled with a covered service, the patient cannot be billed for the service.