

**Clinical Laboratory Management Association (CLMA)
Wisconsin Physicians Service/United Government Services Meeting
January 12, 2006
10:00 AM –12 Noon**

WPS

1. *WPS Policy ALG-001 establishes medical necessity criteria for Allergy Testing and Allergy Immunotherapy. Included in this policy is a statement that leukocyte cytotoxic testing has no or limited evidence of validity and is non-covered. The CPT codes referenced appear in section J and include 86021, 86022, and 86023. The latter two CPT codes actually represent the AMA coding description for **platelet** antibodies and autoantibodies. Platelet antibody testing is often performed by ELISA technology to diagnose and manage autoimmune thrombocytopenic purpura and heparin-induced thrombocytopenia. These conditions can be fatal and require prompt diagnosis. Were these codes representing platelet antibody testing meant to be included in this policy? If so, are there no medical conditions in which WPS will cover the testing? (Note: This was sent to Ann Kelly on about 10/25/2005. She may have already done some research on this issue.)*

Answer: Spoke with the policy department, and procedure 86022 and 86023 have been removed from this policy. This update has been published in the December 2005 Communiqué.

2. *Scenario: A large healthcare organization owns several clinic each with their own laboratories and applicable individual CLIA licenses as well as a hospital with a hospital based laboratory. Many times a patient will be at a clinic and a request will be made for laboratory tests. Some of the tests from the same collection will be performed by the Physician Office Laboratory (POL), some will be referred on to the Hospital based laboratory. How should these tests be billed?*
 - a. *POL bills for it's tests and Hospital based laboratory bills for their own tests? (Result is patient has two accounts one at the POL & one at the Hospital and the patient may receive two bills in the end)*
 - b. *Hospital based laboratory bills with split claims based upon CLIA number and location of testing? (Result patient has two billing accounts; one for the non-lab clinic services and one hospital account for all of the hospital and clinic lab services)*
 - c. *POL bills with split claims based upon CLIA number and location of testing? (Result patient has only one clinic billing account with all services rendered at clinic and from Hospital lab.)*

Policy References:

1. *CMS Manual System - Pub. 100-04 Medicare Claims Processing CR3090*

Trans 85 (See attached)

*According to CMS Transmittal 85 - Change Request 3090 – Publication 100-4.
Section I. General Information*

A. Policy:

Although Medicare payment may generally be made to an independent clinical laboratory only for those tests that it performs, payment may also be made to a laboratory for a test that is on the clinical laboratory fee schedule that it has referred to another laboratory, provided the referring laboratory meets one of the following three conditions.

** It is located in, or is part of, a rural hospital*

** It is wholly-owned by the reference laboratory: or both it and the reference laboratory are wholly-owned subsidiaries of the same entity; or*

** It refers no more than 30 percent of the clinical laboratory tests annually to other laboratories, (not including referrals made under the wholly-owned proviso, above).*

The billing laboratory, whether it is the referring laboratory or the reference laboratory, must submit its claim to the carrier in which it is enrolled by reason of having a physical presence.

When the billing laboratory is the referring laboratory it must:

** Identify the referred service as such by use of the modifier 90, and*

** Identify the reference laboratory by specifying its CLIA number and address (i.e., the address where the test was actually performed).*

Answer: Based on the senior listed above the POL has two options, they may submit the claim for the services they perform and the reference lab may submit their own charges (letter A above), or the POL may submit the charges for the services that they performed themselves and for the services that they referred out to the hospital lab with a 90 modifier (answer C listed above). When the POL opts for the latter, the POL must meet the referring/reference conditions, all CLIA, and address requirements for claim filing.

- 3. Please define Specialty Code 69, independently billing clinical laboratories as referenced in CR 3090. How do Physician Office Laboratories, Hospital based laboratories, and independent reference laboratories fit into or out of this specialty code?*

Answer: A specialty 69 independently billing clinical laboratory is defined in the Medicare Claims Processing Manual, Chapter 16, Section 10.1 as an independent laboratory:

"Independent Laboratory" - An independent laboratory is one that is independent both of an attending or consulting physician's office and of a hospital that meets at least the requirements to qualify as an emergency hospital as defined in §1861(e) of the Social Security Act (the Act.) (See the Medicare Benefits Policy Manual, Chapter 15, for detailed discussion.)

Attending and consulting physicians' office laboratories and hospital-based laboratories are not specialty 69 independently billing clinical laboratories. An independent reference laboratory is a specialty 69 laboratory if it is independent of an attending or consulting physician's office and independent of a hospital as described above.

4. *When an independent laboratory sends phlebotomists to draw patients in a nursing homes, assisted living facility or at home should they be collecting an MSP questionnaire?*

Answer: In situations when there is a face-to-face encounter with the beneficiary, contractors shall instruct hospitals and independent labs that they are required to collect MSP information from the beneficiary when billing for lab services.

5. *What is the Medicare reimbursement for CPT code 88380 (Microdissection)? I cannot find it on either the lab or physician fee schedule. Are there billing restrictions on this code?*

Answer: Procedure code 88380 is a Status C on the Relative Value File. Procedure Codes with status C are carrier priced. Carrier priced procedures are taken on a case by case basis.

6. *The AMA has created a new CPT code for occult blood detection 82272. Since Medicare pays for an annual occult blood screening, how should providers submit this service when it's performed for a screening reason? At this time, there isn't a matching HCPCS G code for CPT 82272. Will Medicare pay annually for CPT 82272 with a screening ICD-9 code?*

Answer: We have not received any info from CMS instructing us to pay for 82272 when used for screening purposes. No new instructions were received. 82272 would not be paid using a screening diagnosis. G0107 should be used for Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations.

7. *The genetic modifier appendix of the 2006 CPT book was greatly expanded. Are there any initiatives for Medicare to begin requiring their use on claims?*

Answer: At this time, Medicare has not received any directives from CMS to use these modifiers. Claims with these modifiers if submitted will deny as unprocessable.

8. *What instructions should we, as indirect providers of services, give to beneficiaries who are inappropriately classified as deceased in the Medicare files? Are there specific contact numbers we can provide? We have had the beneficiaries correct with social security only to have the next claim submitted be denied as 'patient is deceased'.*

Answer: Medicare has about 3 files in which it receives information from. When a beneficiary corrects one file, the other file(s) must also be updated. We have received instructions to have beneficiaries contact the local SSA office as well. Beneficiaries will need to tell the SSA office their Medicare claims are denying due to this incorrect information. The SSA office will have to file a request to have Medicare files updated.

9. *When we receive a CO109 Medicare reject--Claim not covered by payer/contractor--(Skilled Nursing Facility) Should we refund at that time? We have been informed by Medicare that when a CO109 generated then a re-coupment is also automatically issued for previously paid charges. At what point should we initiate a refund if we haven't seen the recoupment?*

Answer: When providers receive a remittance notice indicating that the claim that a previously paid claim is now overpaid due to a SNF stay, providers are encouraged to send the money back with the adjusted ICN. When CWF receives a claim for a SNF it sends over a report prompting a mass adjustment of all services for that patient that consolidated billing. Our system is unable to automatically send the re-coupment letter.

10. *Please provide a list of the CPT codes that Medicare classifies as Automated Multi-Channel Chemistry (AMCC) Tests. They are referenced in Med learn Matters number MM3890, CR Transmittal 598, cr request 3890 released on June 27, 2005*

Answer: Medicare does not differ in classification of AMCC tests. If you have examples of a test that we classify differently, please provide claim examples. We are unable to provide a listing of all AMCC tests. If you would like a listing of these procedures you may make this request through Freedom of Information.

11. *CR 3630 (the CR related to MM3630) that described the temporary change in instructions. CR 3630 was issued in late December 2004, and states it is effective "until further notice." Is there any information regarding "until further notice?"*

Answer: Change Request 3961 issued on July 29, 2005 indicates the current payment policy will continue. Providers continue to report purchased diagnostic tests to the local carrier.