

UGS/WPS CLMA Meeting  
Madison, WI  
May 5, 2005  
10:00 AM

**Questions and Answers from UGS, LLC**

1. How will CMS change request 3681 affect-hospital lab blood products when billing for Medicare patients?

**A:** Wisconsin is a blood free state, which means providers do not purchase blood. Therefore, the guidelines in the *Medicare Claims Processing Manual*, Publication 100-4, Chapter 4, Section 231.1 applies. Access the website by going to [www.cms.hhs.gov/manuals](http://www.cms.hhs.gov/manuals) and select IOM manuals. The BL modifier indicated in the chapter does not apply. The following are the billing guidelines: Use revenue code 0390 (blood processing/storage) or 0399 (blood processing/storage; other processing and storage), along with the appropriate blood HCPCS code, the number of units transfused, and the line item of service (LIDOS). Processing and storage costs may include blood product collection, safety testing, retyping, pooling, irradiating, leukocyte reducing, freezing, and thawing blood products, along with the costs of blood delivery, monitoring, and storage. In general, such categories of processing costs are not patient-specific. There are specific blood HCPCS codes for blood products that have been processed in varying ways, and these codes intended to make payment for the variable resource costs of blood products that have been processed differently.

2. Please clarify, perhaps with reference to the Medicare manual or other source, the special Medicare billing status of a hospital-based reference lab relative to a non-hospital-based laboratory. My understanding is that a hospital-based reference lab must bill for all testing requests it processes, regardless of whether or not that test is actually performed in another laboratory. Example: Fort Healthcare Laboratory (FHC), a hospital-based laboratory, serves as a reference lab for surrounding clinics. FHC lab receives a requisition and specimens from one of these clinics to perform a CBC and an NMR profile. FHC lab performs the CBC on-site and bills Medicare for that testing, but forwards the NMR Profile to Liposcience Laboratory that exclusively performs that NMR profile. If the specimens received were obtained from a patient covered by Medicare, it is my understanding that FHC Lab, as a hospital-based lab, may not request that Liposcience Lab bill Medicare for the NMR Profile, whereas a free standing, non-hospital based reference lab under the same circumstances would be eligible to ask Liposcience Lab to bill for the testing performed for a Medicare patient. For the purpose of this example, please assume that FHC Lab performs 90% of all its testing volume in-house. The remaining 10% are sent out to other labs. Is my understanding correct?

**A:** Publication 100-4, Chapter 16, Section 40.3 states when a hospital obtains laboratory tests for outpatients under arrangements with clinical laboratories or other hospital laboratories, only the hospital can bill the arranged services. Your understanding is correct for hospital based laboratories. The guidelines for independent labs are in Publication 100-4, Chapter 16, Section 40.

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3. The guidelines for submitting claims on a purchased diagnostic test require that the CLIA number from the performing laboratory be included on the claim. Is there any edit, in the Medicare system that will monitor when that other laboratory's CLIA number is submitted when the other laboratory is a Medicare provider?

**A:** The Part A system doesn't have an edit in place to monitor the CLIA number.

4. Are there new billing requirements soon to be in effect for rehabilitative services like physical therapy or occupational therapy? Currently at our facility when we bill for services we document the time we start and stop patient's treatment session. Then, we 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?

**A:** For proper payment of Outpatient Part B therapy services, units must be correctly assigned to each CPT code. In order for medical review to confirm the accuracy of the unit assignment, the record must contain the specific time for each treatment. This can be documented by providing either the start and stop time for *each* treatment or the actual minutes spent in providing *each* treatment. Recently UGS made a change to the medical review additional development request (ADR) asking that this information be included in the response to the ADR. If the specific information regarding the treatment time for each timed code is not included in the response to the request, the treatment may be denied with the code **5BTBW: lack of documentation of minutes for each modality and procedure billed to support units billed. Medical subject to waiver denial type.**

5. Regarding 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](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 co-pay 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

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85025	\$ 45.00	\$ 32.49	\$ 10.86	\$ 10.86	\$ 43.31
81003	\$ 30.00	\$ 9.93			\$ 13.24

**A:** The MSP calculation and deduction is made at the claim level. After it is calculated, allocation is spread by line based on the ratio against the amount paid.

6. 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 Medicare reimburse this? Is this a non-covered service that may be billed to the patient?

**A:** HCPCS code 99001 is a non-allowable code for the OPPS. You may bill 36145 but the OPPS OCE will not make a payment if no other code is billed along with it. You may not bill the beneficiary for the service.

7. 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 investigation use only (IUO). Because of potential compliance issues involve we would like clarification to the following questions:

Is it incorrect to bill Medicare for RUO/IUO based tests in all instances? Does the complexity level for which CLIA section 493.17 seems to suggest that if a test is not FDA-approved, it is considered a “high-complexity” test performance of diagnostic testing via RUO/IUO methods is not contrary to CLIA requirements.

**A:** After speaking with the medical director of UGS, if the services were excluded then an ABN would not be necessary that is not the case here. If a provider feels the test is necessary, an ABN should be issued to the Medicare beneficiary with a full understanding of the cost etc, associated with the labs that are research only or investigational only. The test is for the purpose of research.

8. If it is improper to bill for RUO/IUO testing, can you provide us with a citation from Medicare manuals, SS CLIA, or any regulatory source we can refer our members to that address this issue?

**A:** Please refer to Publication 100-4, Chapter 30, Section 20.1.1 at [www.cms.hhs.gov/manuals](http://www.cms.hhs.gov/manuals)

- Click on IOM manuals
- Go to publication 100-4
- Find chapter 30 (click on the red bulls eye on the right hand side) and go to section 20.1.1
- Scroll to find the section indicated – **Note** the first bullet identifying 1862(a)(1) of the SSA.

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9. If it is improper to bill Medicare for RUO/IUO testing can will the beneficiary without an ABN?

**A:** As indicated in the answer to question 7 above, an ABN should be issued and explained thoroughly to the beneficiary before services are done.