Pathology Coding – Doing It By The Numbers and Staying In Compliance

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Objectives

- Reassess recent CCI changes, MUEs, coding updates, and coding changes for laboratory and pathology services in 2012.
- Discuss coverage policies and determinations that demonstrate trends for coding and reimbursement.
- Describe current status of implementing new molecular codes for 2012.
- Briefly discuss current compliance trends that raise or demonstrate compliance risks.

New Codes for 2012

- 86386 Nuclear Matrix Protein 22 (NMP22), qualitative
  - Tumor marker for bladder cancer
    - Detects a protein during cell death
  - POC procedure
  - No longer use CPT 86316 (IA other antigen, quant.)
  - CMS crosswalk to 82487 (chromatography, paper, 1-dimensional, NOS)
  - NLA $22.47 (preliminary)

New Codes for 2012

- 87389 HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result
  - POC procedure for both antigens
    - Multiple platforms exist
  - EIA section of CPT
  - CMS crosswalk to 87390 (HIV-1) plus ½ of 86703 (HIV-1/2 antibody)
  - NLA $34.48 (preliminary)

New Codes for 2012

- October Editorial Meeting
- Consider adding code for Galectin-3 assay
  - Galectins are a family of soluble β-galactoside-binding lectins
  - Play important regulatory roles in inflammation, immunologic response, and cancer
  - Galectin-3 has been the most widely-studied for its role in the promotion of fibrosis
  - Clinical evidence indicates an effect of galectin-3 in chronic heart failure

CMS Reconsideration Requests

- G0434 Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter
  - Request separate code for moderate complexity
    - Four times the allowable ($81.88)
  - No description change
  - No payment change
  - NLA $20.47 stands as before

CMS Reconsideration Requests

- G0435 Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening
  - No description change
  - No payment change
  - NLA $16.88 stands as before
  - Consider changing the descriptor to state "Infectious agent antibody detection by rapid antibody test, HIV-1/HIV-2, oral screening"

CMS Reconsideration Requests

- 83861 Microfluidic analysis utilizing an integrated collection and analysis device; tear osmolarity
  - No crosswalk change (CPT 83909 – separation & ID by high resolution technique such as capillary EP)
  - No payment change
  - NLA $23.58 stands as before

CMS Reconsideration Requests

- 86481 Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon producing T-cells in cell suspension
  - Previous crosswalk 86480 (TB cell mediated immunity)
  - Current NLA $87.22
  - Crosswalk to 86480 plus 83520 (IA quant., NOS)
  - NLA $105.44 (preliminary)

CMS Reconsideration Requests

- 87906 Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, other region (e.g., integrase, fusion)
  - NLA $181.14
  - No crosswalk change (50% of CPT 87901 – HIV-1 RT + protease)
  - No payment change
  - NLA $181.14 stands as before

Current CPT Codes

88387 Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg a single lymph)

Current CPT Codes

- Do not report 88387 for tissue preparation for microbiologic cultures or flow cytometric studies
- Do not report 88387 in conjunction with 88388, 88329 – 88334
- Reimbursed under the MPFS

Current CPT Codes

- +88388 Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint intraoperative consultation, or frozen section, each tissue preparation: (eg a single lymph node) (List separately in addition to code for primary procedure)

Current CPT Codes

- Use 88388 in conjunction with 88329 – 88334
- Reimbursed under the MPFS

CPT 88387

- Question whether can bill each lymph node if two nodes were included in the same block
  - Be cautious about doing so
  - Real issue is documenting that two separate tissues were included in the same block
    - If clearly documented, both specimens/nodes my be separately billable
    - Must be handled separately and use sterile technique as described by the AMA.

CPT 88387, Cont.

- Description for the code does state "...each tissue preparation (eg, a single lymph node)." Thus, it is key to document the separate handling for the specimens in the same block
- Suggest documentation occur in the pathology report that will be placed in the medical record
- Medicare reimbursement simulates $42 for a global service
- Payers may differ in recognition of the code and/or units of service
- A pathologist must participate in the procedure

New CPT for 2011

- 88363 Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)
  - Review of archived sample to select blocks most appropriate for molecular study
  - Does not include microdissection or molecular interpretation

CPT 88363, Cont.

- Includes:
  - Retrieve previously diagnosed case specimens
  - Select appropriate specimens for testing
  - Determination that specimen contains cancer cells
  - Estimate if the content of tumor cells present
    - % of tumor nuclei present in specimen

Correct Coding Initiative (CCI)

- According to CMS
  - "The annual updated version of the National Correct Coding Initiative Policy Manual for Medicare Services will be effective January 1, 2012 rather than October 1, 2011. This manual will be posted on the NCCI website on or around December 1, 2011."
  - These may be found at www.cms.gov
  - Column 1 Column 2 changes
  - Medically exclusive edits
  - It is important to review these changes compared to the last update (7/1/11)
  - Changes may impact budgetary planning for 2012

Medically Unlikely Edits (MUEs)

- These edits cap the units of service for a code used in reporting services provided and billed
- Medicare utilizes these edits in auditing claims for payment
- MUEs of "1" for Medicare include:
  - CPT 80500, 80502, 83912, 88187-88189, 88291, 88323-25, 88384-86
- CPT 88172-73 have MUE of 3; 88177 has MUE of 2
- Molecular MUEs are unpublished

Coverage Policy Trends

- On Increase
- Other payers follow Medicare
- New example:
  - Trailblazer Health and BV testing: LCD, 2936, for Infectious Disease Molecular Diagnostic Testing
  - "When services billed with codes 87480, 87510 and 87660 are performed using one specimen for a test kit regardless of the number of medically necessary tests, only bill one unit of service using code 87797." ($28.22)

Palmetto Draft LCDs

- Non-Standardized Organ and Disease Oriented Panels
- "This is a non-coverage policy for all non-standardized organ or disease-oriented panels that meet the following criteria:
  - Non-FDA cleared laboratory developed tests (LDTs)
  - Tests performed or marketed by a sole source, hospital or reference laboratory
  - Tests that have not received a specific AMA CPT code
  - Tests that have not obtained an NCD, or a coverage determination from Palmetto GBA (LCD or article)
  - Tests that require multiple CPT codes in order to submit a claim for a single assay/test"

Non-Standardized Organ and Disease Oriented Panels, Cont.

- "Only the standard procedure reporting manuals CPT and HCPCS may generate test panel definitions. According to CPT coding instructions, if no specific code exists for a provided service, the appropriate unlisted procedure/service must be reported. Panels defined and developed by an individual lab or manufacturer must be reported with the appropriate unlisted service and follow the published Palmetto GBA review process."
- "Services reported with multiple codes and a single and/or multiple units of service to represent a single test panel are considered investigational and therefore, not a covered service."

Non-Standardized Organ and Disease Oriented Panels, Cont.

- "Palmetto GBA will apply the following payment rules:
  - Test panels submitted and paid that have NOT been reviewed and approved through the Palmetto GBA mandated process are considered investigational and will be subject to overpayment collection.
  - Approved test panels will be effective for dates of service on and after the approval date. Dates of service prior to the approval effective date will be subject to denial and overpayment collection.
  - Unapproved panels will be subject to denial and overpayment collection."

Palmetto Draft LCDs

- Molecular Diagnostic Tests
- "This policy confirms 'non-coverage' for all molecular diagnostic tests that are not explicitly covered by a National Coverage Determination (NCD), a Local Coverage Determination (LCD) or coverage article published by Palmetto GBA.
- For the purposes of this policy, Palmetto GBA defines MDT as a single test (often with multiple components) that delivers one result and involves nucleic acids (DNA/RNA), proteins, enzymes and/or other metabolite detection. Most test results rely upon an algorithm or other form of data/evaluation derivation."

Molecular Diagnostic Tests LCD, Cont.

- "In addition to this definition, this non-coverage policy applies to all tests that:
  - Are Non-FDA cleared laboratory developed tests (LDTs, or
  - Are performed or marketed by a sole source, hospital or reference laboratory, or
  - Have not received a specific AMA CPT code, or
  - Have not obtained an NCD or a coverage determination from Palmetto GBA (LCD or article)"

Molecular Diagnostic Tests LCD, Cont.

- "According to the AMA CPT instructions, when a rendered procedure or service does not match the published description, providers should use a Not Otherwise Classified (NOC) code (84999, 85999, 86849, and 87999). All MDT services correctly billed with an NOC code must be reviewed to assess if the service meets Medicare's reasonable and necessary requirement. Palmetto GBA will only cover and reimburse MDTs that demonstrate analytical and clinical validity, and clinical utility.

Molecular Diagnostic Tests LCD, Cont.

- MDTs have been incorrectly reported for reimbursement with the following codes:
  - method-based or "stacking" codes (83890 - 83914)
  - array codes (88384-88386)
  - cytogenetic codes
  - combinations of method-based codes and serology-based codes
  - combinations of method-based codes and anatomic pathology codes "

Molecular Diagnostic Tests LCD, Cont.

- "Until Palmetto GBA has determined an MDT meets Medicare's reasonable and necessary requirement, the MDT will be considered investigational and therefore, not a covered service. Palmetto GBA understands concerns about delays in coverage reviews, and is working with CMS to address this through a standardized, transparent coverage review process previously released over the past 18 months and through increasing reviewing capacity."

Molecular Diagnostic Tests LCD, Cont.

- "Palmetto GBA will apply the following payment rules to MDTs:
  - Tests submitted and paid that have NOT been reviewed and approved through the Palmetto GBA mandated process are considered investigational and will be denied.
  - Approved tests will be effective for dates of service on and after the approval date of a 'coverage' determination. Dates of service prior to the approval effective date will be subject to this non-coverage policy."

Future Molecular CPT Changes

- Group focused on higher frequency tests
- Has proposed codes which address greater than 90% of medically useful molecular testing currently being performed
- Services identified by CPT codes will include all analytical services performed in the test (eg, cell lysis, nucleic acid stabilization, extraction, digestion, amplification, detection and interpretation)
- "Robust" granularity in the code descriptors to better allow providers and payers to communicate the tests that are actually performed

Future Molecular CPT Changes

- The initial set of these codes will be published in the *CPT® 2012* book
- MPCW continues to construct codes for less common analytes and more complex analyses
- "It is anticipated that the current "stacking code" method of reporting molecular pathology services will be deleted upon conclusion of the workgroup's activities."

Draft of Molecular Changes

- Affect coding for:
  - Molecular assays
  - Genetics
  - Histocompatability
- Not affect:
  - Molecular microbiology
  - Most cytogenetic assays
- Two tiers of coding
  - Nucleic acid testing

Draft of Molecular Changes

- Tier 1
  - Most commonly performed tests
  - Assigned an analyte specific code
  - Category I code – CPT
- Tier 2
  - Less commonly performed tests
  - Assigned to 1 of 9 resource level codes
    - Level of resources required
    - Level of interpretation

Draft of Molecular Changes

- Tier I and 2 coding replace CPT 83890 – 83914
- The molecular code series will remain for analyses that are not captured by the tier codes
  - Anticipated to be retired in 2013
- Human Genome Organization approved names for variations in genes:
  - Germline/constitutional disorders
  - Somatic/neoplastic disorders
  - HLA alleles and antigenic differences

Draft of Molecular Changes

- Category 1/Tier 1
  - UOS expected to be 1
  - Proteins or diseases commonly associated with genes are listed as examples in the code descriptor and are not a complete representation of all conditions in which the gene may be indicated
  - Codes for gene variants assume all variants would be tested and any not listed would not be separately billed
  - Full gene sequencing should not be used when assessing the presence of variants unless the variant is stated in the descriptor

Draft of Molecular Changes

- Category 1, cont.
- Procedures required prior to cell lysis may be reported separately
  - Ex. Microdissection
- Results that require interpretation by a physician or "other qualified health care professional"
  - -26 modifier works with the analyte specific code
- Analyses are qualitative unless noted otherwise

Draft of Molecular Changes

- Category 1 Codes
  - 78 new analyte specific codes are expected
  - Another 14 new codes are expected for HLA
  - Placeholder coding currently indicated
- Examples:
  - 81210 BRAF (v-raf murine sarcoma viral oncogene homolog B1) (e.g., colon cancer), gene analysis, V600E variant

Draft of Molecular Changes

- Category I Examples, cont:
- 81206 BCR/ABL1 (t(9;22)) (e.g., chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative
- 81207 minor breakpoint, qualitative or quantitative
- 81208 other breakpoint, qualitative or quantitative

Draft of Molecular Changes

- Category I Examples, cont:
  - 81228 Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (e.g., Bacterial Artificial Chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)
  - 81229 interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities

Draft of Molecular Changes

- Tier 2 Codes
- Parenthetical examples listed are not all-inclusive:
  - 81400 Molecular pathology procedure, Level 1 (e.g., identification of single germline variant [e.g., SNP] by techniques such as restriction enzyme digestion or melt curve analysis)
  - 81401 Molecular pathology procedure, Level 2 (e.g., 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)

Draft of Molecular Changes

- Tier 2 Examples, cont:
  - 81402 Molecular pathology procedure, Level 3 (e.g., >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)
  - 81403 Molecular pathology procedure, Level 4 (e.g., analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)

Draft of Molecular Changes

- Tier 2 Examples, cont:
  - 81404 Molecular pathology procedure, Level 5 (e.g., analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)

Draft of Molecular Changes

- Tier 2 Examples, cont:
  - 81405 Molecular pathology procedure, Level 6 (e.g., analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)
  - 81306 Molecular pathology procedure, Level 7 (e.g., analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)

Draft of Molecular Changes

- Tier 2 Examples, cont:
  - 81407 Molecular pathology procedure, Level 8 (e.g., analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)
  - 81408 Molecular pathology procedure, Level 9 (e.g., analysis of >50 exons in a single gene by DNA sequence analysis)

Molecular Coding

- New codes likely published in2012
- Not recognized by Medicare as not discussed in public meeting and no reimbursement established
- No decision of which fee schedule employed
  - CLFS: Slight increase anticipated
  - MPFS: Co-pay applies
  - RUCs have discussed RVUs
  - Payer variances may exist for coding
- Eradicate "stacking" by 2013

Current Environment

- Intense government scrutiny by a variety of auditing and quality review entities
- Ability of CMS to rapidly respond to new issues in billing and coding, Stark and Anti-kickback and other laws and regulations that affect claims payment and recoupment
- New tools to penalize and punish violating companies and individuals
- Serious national economic problems and the resulting deficit hearing's focus on cutting healthcare costs

Intense Government Scrutiny

- Budget issues create political and legislative landscape to justify cost cutting measures, many of which affect labs in a variety of ways
- Levinson testimony before Congress on July 28, 2011 concerning fraud and abuse issues
- Constant review and revision of the various program integrity subcontractors (RAC, CERT and other entities) to ensure they are doing what they're supposed to be doing

Levinson Testimony

- "Fraud is a serious problem requiring a serious response"
- "the majority of health care providers are honest and well-intentioned"
  - Purposefully billing for services never provided
  - Purposely billing for services that are not medically necessary
  - Billing for a higher level of service than was provided
  - Misreporting cost or other information to increase payments
  - Paying or receiving kickbacks
  - Illegal or improper marketing of products
  - Providing substandard or poor quality care
  - Stealing providers' or beneficiaries' identities

Waste, Fraud and Abuse

- CMS estimates that 10.5% of fee for service claims paid in FY 2010 did not meet program guidelines
- Government considers these "errors in payment" found through its error testing audits like CERT and RAC audits
- Main reasons:
  - Insufficient documentation
  - Miscoded claims
  - Medically unnecessary services

CMS Integrity Contractors

- **Medicare Administrative Contractors (MAC)**
- Medicare Secondary Payer Recovery Contractor (MSPRC)
- Zone Program Integrity Contractors (ZPICs)
- Qualified Independent Contractors (QICs)
- Quality Improvement Organization (QIO)
- **Recovery Audit Contractors (RACs)**
- **Comprehensive Error Rate Testing auditors (CERT)**
- **Medicaid Integrity Contractors (MIC)**

Collaborative Effort

- "Collaboration and innovation are essential in the fight against health care fraud"
- Many new CMS integrity contractors to supplement the MACs
- HIPAA of 1996 established the Health Care Fraud and Abuse Control (HCFAC) Program
  - Return on investment in this program is $6.80 returned for every $1.00 spent
  - $4 billion in FY 2010, $18 billion since 1997
- May 20th, 2009 HHS Secretary and Attorney General announced creation of Health Care Fraud Prevention and Enforcement Action Team (HEAT)

HEAT

- Assembles resources from different government agencies and enhances partnerships between agencies
- "Strike Forces are designed to identify and investigate fraud, and prosecute the perpetrators quickly "
- Strike Force teams are composed of dedicated prosecutors from DOJ and U.S. Attorneys Offices and Special Agents from OIG; the Federal Bureau of Investigation (FBI); and, in some cases, State and local law enforcement agencies

HEAT

- Enforcement teams are supported by data analysts and program experts
- Teams use data to identify suspicious billing patterns as they occur
- OIG created a team of data experts composed of OIG special agents, statisticians, programmers, and auditors
- Have decreased the time from start of investigation to prosecution by approximately half

HEAT TEAM ACTION AGAINST SMALL PHARMACY IN NEW YORK

Mom and Pop pharmacy commits $3 million dollar fraud against Medicare program

Discovered because *data showed that they billed as much as larger pharmacies in the surrounding area*

Demonstrates that even smaller providers are found and prosecuted using these sophisticated data analysis techniques

ACA Enhancements to Program Integrity

- Increased funding for new technology and "boots on the ground"
- More robust enrollment screening and more intense payment oversight for new providers
- Enrollment "moratoria" when the Secretary identifies fraud "hot spots,"
- Heightened disclosure and transparency requirements

Other Enforcement Tools

- Authority to suspend payments pending investigation of "credible" allegations
- Changes to the False Claims Act, the Federal anti-kickback statute, OIG's administrative authorities, and the Federal Sentencing Guidelines to allow more effective prosecution and stiffer penalties
- Enlist providers in the fight by requiring compliance programs

FERA of 2009 and ACA

- Significantly expanded the scope and applicability of the Federal False Claims Act (FCA) and made sure that sufficient resources are available
- Ensures that the FCA is applicable to Medicaid and Medicare Advantage Plans
- Changed the Antikickback law so that no proof of a specific intent to defraud is required
- Extends liability for overpayments making them an FCA violation if not promptly retuned
- FERA and ACA significantly changes the consequences of any violations of laws and regulation

Reporting and Returning Overpayments

- If a person has received an overpayment, the person "shall"
  - Report and return the overpayment
  - Report means a written statement of the reason for the overpayment
  - Report shall be to the "Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address"
- The deadline for returning and reporting is 60 days from the date the overpayment is identified or the date a cost report (if applicable) is due
- Failure to report and refund by the 60 day deadline constitutes an actionable violation of law (an obligation) so, missing the deadline turns a simple error and refund into a potential FCA violation
- Key is when does the 60 day clock start running.

Penalties For FCA Violations

- If not refunded in 60 days it becomes an "obligation" and is potentially an FCA violation
- Treble damages which means refunding of 3 times the overpayment
- Per claim fines that range from $5,500 to $11,500 regardless of the amount of the overpayment and dependent on the exact circumstances on a case by case basis
- It only takes 87 claims at $11,500 per claim to reach $1 million

Permissive Exclusion Authority

- No program payment may be made for any item or service that an excluded person or entity furnishes, orders, or prescribes
- Entities cannot employ excluded individuals
- OIG weighs fraud risk against considerations like access to care
  - Some entities cannot be excluded because they are too big or are a sole provider, etc.
- Discretionary exclusion allows the government to exclude individuals and executives of companies
  - Are excluded as "responsible corporate officers"

Predictive Modeling

- Data analysis tools designed to analyze claims data to prevent payments based on the risk that the claim is likely improper
- Uses "Innovative risk-scoring technology" to detect improper claims before they are paid
- Uses a wide range of data to generate each risk score, such as claims data, complaints to the Medicare hot line, and law enforcement information
- CMS would thoroughly test the technology to ensure it provided a low rate of false positives and did not disrupt legitimate providers

Most Important

- Your compliance program should keep you in the realm of the contractor and out of the realm of the investigator or prosecutor
- This means
- Prevent, Detect, Refund and Correct
  - Rather than
- Discover, Disclose, Settle and CIA
- Auditing and monitoring is now the most important element of your compliance program

Current Government Audits and Reviews

- CBC and Differential
  - Some contractors are auditing for orders for "CBC" that do not specifically order a differential and requiring refund if the lab performed one
- Direct measure LDL
  - Some contractors are using a section in the Correct Coding Initiative Manual (CCI), Chapter 10 that says that a direct measure LDL is only necessary if the Triglyceride is greater than 400 mg/dl to seek refunds from labs that are doing the direct measure LDL routinely

Current Government Audits and Reviews

- Billing errors related to Urinalysis testing versus Urinalysis testing that includes a microscopic examination
  - Involves CPT codes 81001 and 81003 for automated dipstick testing with or without microscopy
  - If the physician orders a "Urinalysis" (UA), 81003 but does not specifically indicate that a microscopic be performed (81001), the lab may not bill for the microscopic even if it performs it
- Comment in a MAC report concerning "common billing errors for labs" found in CERT audits

CERT Audit Results

HCPCS/Reviewer Error

- 88304 - Insufficient documentation

Reviewer Comments

- Submitted includes the Pathology Report from 08/24/2010. The operative report documents the plaque removed, and the "loose debris" from the carotid artery that would support medical necessity. Missing are the physician's orders or documented intent to order the Level III Tissue exam

CERT Audit Results

HCPCS/Reviewer Error

- 86900 86901 Insufficient documentation

Reviewer Comments

- Disagree per SSA 1862(a)(1)(A), 42 CFR 410.32, PUB 100-02, Chapter15 80-80.1, 80.6.1 and PUB 100-04 Chapter 16 10-10. No progress note or documentation submitted to support medical necessity. Submitted electronic lab requisition and lab results.

CERT Audit Results

HCPCS/Reviewer Error

- 36415 Medically unnecessary service or treatment

Reviewer Comments

- Disagree per SSA 1862(a)(1)(A), PUB100-2 Chapter 16 Â§180, 42 CFR 410.32(a), and PUB 100-2, Chapter 15 Â§ 80.6.1. Missing medical necessity for any laboratory testing that would require the performance of Venipuncture on the billed date of service.

CERT Audit Results

HCPCS/Reviewer Error

- 36415 Medically unnecessary service or treatment

Reviewer Comments

- Billed laboratory test is not medically necessary for lack of the verification of the treating physician's order; therefore, the venipuncture is not reasonable and necessary. Received acceptable electronic order and results, but no documentation submitted to support medical necessity for the billed test. Requested documentation from the billing and ordering provider and received duplicate documentation from tech stop and no response from MRS Call. Missing progress notes with medical necessity to support billed services.

CERT Audit Results

HCPCS/Reviewer Error	Reviewer Comments
85025 Service incorrectly coded	Billed for DOS 11/04/2010 is CBC with automated differential. Missing the physician order or documentation of intent of ordering the billed CBC with Diff. Physician's intent is for CBC only. Received an unsigned requisition form and the results. Also received a progress note that documents a CBC only. There is no documentation that supports the physician intent or plan to order the billed differential. Change code from 85025 to 85027 - CBC, automated (Hgb, Hct, RBC, WBC, platelet count).

CERT Audit Results

HCPCS/Reviewer Error

Reviewer Comments

- 85610 Insufficient documentation

  - Disagree per SSA 1833 (e) and 42 CFR 410.32 (d) (2) (i) which states that "The physician who orders the service must maintain documentation of medical necessity in the beneficiary's medical record." Billed CPT 85610- Prothrombin Time for billed Date of Service 12/06/2010. Received acceptable electronic order and results, but no documentation submitted to support medical necessity for the billed test. Requested documentation from the billing and ordering provider and received duplicate documentation from tech stop and no response from MRS Call. Missing progress notes with medical necessity to support billed services.

CERT Audit Results

HCPCS/Reviewer Error

- 86704 Insufficient documentation

Reviewer Comments

- Missing documentation to support physician order or documented intent and the medical necessity of diagnostic testing. Submitted documentation includes lab test report, signature log, illegible screen shots, and copy of lab standing orders. Insufficient documentation for lab (total hepatitis B core antibody) for billed date of service 12/8/2010

CERT Audit Results

HCPCS/Reviewer Error

Reviewer Comments

- 81002 Insufficient documentation

  - PUB 100-02 Ch 15, Â§ 80.6.1 that defines an order and requires an order from the treating physician for all dx tests to be considered R & N. Missing physician order or documented intent to perform the diagnostic tests and documentation of medical necessity for urinalysis and measurement of post- voiding residual urine for billed date of service 12/14/2010. Received results and office visit note that does not mention physician intent or plan to order the billed service(s). Requested additional documentation and received attestation statement and unsigned surgical note but no valid orders to support billed services from MRS Call and tech stop.

RAC Additional Documentation Limit (ADR)

- Notice published on August 15th on CMS website for the Recovery Audit Program
- Updates the limits on the documentation requests that RACs can make of providers
- There is a limit on the number of additional documentation requests (ADRs) that a Recovery Audit Contractor (RAC) can request per campus
  - The limit (per campus) is calculated at 1% of all prior calendar year claims that were submitted, divided by eight
  - The update clarifies that for small providers whose calculation results in a number less that 35, the RAC may request 35
- The RAC can request this number every 45 days

Other Topics of Interest

- ICD-10 Preparation and Implementation
- Provider Enrollment Revalidation
- Patient Direct Access to Lab Results
- New ABN Form
- ICD-9 Changes
- Direct to Consumer Genetic Tests
- Co-pay
- Final Reimbursement Levels

Discussion

Thank you for your courtesy!

Diana & Chris