Program Memorandum Carriers/Intermediaries

Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS)

Transmittal AB-02-030 **Date: MARCH 5, 2002**

CHANGE REQUEST 1998

SUBJECT: Administrative Policies Related to Processing Claims for Clinical Diagnostic Laboratory Services

Scope: This Program Memorandum (PM) implements the administrative policies for clinical diagnostic laboratory services under Medicare Part B as found in the Preamble of the final regulation published in the **Federal Register** on November 23, 2001, 66 FR 58788. We will issue subsequent instructions implementing those administrative policies requiring systems changes.

Background: Section 4554(b)(1) of the Balanced Budget Act (BBA), Public Law 105-33 mandated the use of a negotiated rulemaking committee to develop national coverage and administrative policies for clinical diagnostic laboratory services payable under Part B of Medicare. BBA required that these national policies be designed to promote program integrity and national uniformity and simplify administrative requirements with respect to clinical diagnostic laboratory services payable under Part B.

The Committee for the Negotiated Rulemaking for Laboratory Services recommended several administrative procedures. This PM implements those administrative polices and provides clarifications as needed.

Policy: The administrative policies discussed herein apply to every diagnostic clinical laboratory service that is payable under Medicare Part B. Neither the place where the service was performed, nor the type of contractor that will process the request for payment has any effect on the applicability of these policies. A service done in a hospital laboratory, independent laboratory, physician/practitioner office laboratory or other type of CLIA approved laboratory service is subject to these administrative policies.

The treating physician must be the physician who orders any clinical diagnostic laboratory service.

Implementation:

A. Limitation on Number of Diagnosis Codes

- Until implementation of the Health Insurance Portability and Accountability Act (HIPAA) requirement to accept eight or more diagnosis codes, some Medicare contractors may not have the capability to accept eight or more diagnosis codes in the diagnosis section of the claim. Advise your physicians and diagnostic clinical laboratories that any diagnosis code in excess of your capacity may be coded in a narrative field.

- When you choose to manually review a laboratory claim, use information from all diagnosis codes, including those in the narrative field, to make your review decision.

B. Diagnosis and Procedure Codes Matching

- If you choose to perform manual prepay review (routine or complex) of a service and the laboratory has submitted multiple diagnosis codes, you must examine all submitted diagnosis codes when making a coverage or coding determination.

- For claims submitted to carriers, the best way for laboratories to indicate that a service is noncovered is to use the GY modifier to indicate a service is statutorily excluded or the GZ modifier to indicate a service is expected to be denied as not reasonable and necessary. A less preferable method is for a laboratory to submit a separate claim for the procedure that is not covered by Medicare, e.g. where the diagnosis code and procedure code do not correspond as required by the National Coverage Decision (NCD).

- For bills submitted to intermediaries, the provider must bill all services on the same day on a single claim unless they bill using condition codes 20 or 21.

C. Ordering Practitioner

- Any of the administrative policies that relate to the individual who orders the service applies to a physician or a non-physician practitioner qualified under 42CFR410.32(a)(3) to order diagnostic services.

- Ordering practitioners include non-physician practitioners such as clinical nurse specialists, clinical psychologists, clinical social workers, nurse midwives, nurse practitioners, and physician assistants who furnish services that would be physician services if furnished by a physician and who work within the scope of their authority under State law and within the scope of the Medicare statutory benefit.

D. Multiple Services

- There are two CPT modifiers that identify multiple services for the same beneficiary on the same day. These modifiers are not interchangeable. The more frequently used modifier should be the '91'. Each has a specific use as described below.

  - Modifier '59' indicates distinct procedural services.

    The modifier '59' is appropriate to report multiple service submissions by a clinical laboratory for the same beneficiary on the same day. These situations usually involve microbiology where samples or cultures are taken from a patient from different anatomical sites or different wounds, use the same CPT code, and then are tested the same day.

  - Modifier '91' indicates repeat clinical diagnostic laboratory services.

    If an ordering physician requests a laboratory test that requires that several of the same services (CPT code) be performed for the same beneficiary on the same day, the laboratory should use modifier "91" to indicate that multiple clinical diagnostic laboratory tests were done on the same day.

    Example: An arterial blood sample is drawn from a patient at three different intervals on the same day, and the blood testing is performed three times that same day, the CPT code 82803 – Gas, blood, any combination of pH, PCO2, PO2, CO2, HCO3 (including calculated 01 saturation). The laboratory should report the CPT code on the line item and code the modifier '91' after the CPT code. The information would appear as "82803 91" on the line item.

Using either modifier does not relieve the laboratory of the responsibility to supply medical necessity documentation if you request it.

E. Narrative Diagnosis

- When required by local medical review policy (LMRP) or NCD, a laboratory that submits electronic claims must use ICD-9-CM codes rather than narrative descriptions. A laboratory that submits paper claims may use narrative descriptions.

- If a laboratory receives a requisition with a narrative description rather than an ICD-9-CM as the diagnosis, the laboratory may translate that narrative to the appropriate ICD-9-CM diagnosis code. The narrative does not have to exactly match the description of the submitted ICD-9-CM. The laboratory must maintain the requisition with the translated narrative description and submit it you upon request.

- If the ordering physician submits an ICD-9-CM code on the requisition, the laboratory must use that code unless there is a reason to question the ordering physician to change the code. The laboratory must receive and maintain the documentation to alter the claim. The documentation may be written information from the ordering physician or a written note documenting the telephone call with the ordering physician. A faxed copy of the documentation is acceptable. The laboratory must maintain the documentation and submit it to you upon request.

F. Documentation Requirements

- The ordering physician must maintain documentation of medical necessity in the beneficiary's medical record.

- The laboratory must maintain the documentation that it receives from the ordering physician and must ensure that the information listed on the claim accurately reflects the documentation it received from the ordering physician.

- The laboratory may request additional diagnostic and other medical information from the physician to document that the services it bills are reasonable and necessary. If the laboratory requests additional documentation, it must request material relevant to the medical necessity of the specific service(s), taking into consideration current rules and regulations on patient confidentiality.

- If a claim selected for manual prepayment or postpayment review (including routine or complex) contains additional documentation simultaneously submitted with the claim, you must review the documentation before denying the claim. **Exception:** You may deny without reviewing attached or simultaneously submitted documentation when clear policy serves as the basis for denial.

G. Utilization Parameters (Frequency Screens)

The final rule for Negotiated Rulemaking for Laboratory Services requires that you not use frequency screens that result in a frequency based denial unless information published by CMS or its contractors includes an indication of the frequency that is generally considered reasonable utilization for Medicare purposes.

During any type of MR-directed review (prepay or postpay; automated, routine or complex), you shall not deny services that exceed utilization parameters, unless clear policy serves as the basis for the denial.

Of course, you may always deny claims based on obvious typographical errors (e.g., 10,000 blood cultures for the same beneficiary on the same day), and in situations where you sent an additional documentation request (ADR) letter and reviewed the ADR response but the ADR response failed to support the coverage or coding of the claim, or where no timely response is received in response to an ADR letter. These types of denials are not considered utilization denials.

NOTE: The term "clear policy" means a statute, NCD, coverage provision in an interpretive manual, or LMRP specifies the circumstances under which a service will always be considered non-covered or incorrectly coded. Clear policy that will be used as the basis for frequency denials must contain utilization guidelines that you consider acceptable for coverage. Definitions of utilization guidelines and parameters can be found in PIM Chapter 1, §2.5.

H. Signature on Requisition Form

Medicare does not require the signature of the ordering physician on a laboratory service requisition. While the signature of a physician on a requisition is one way of documenting that the treating physician ordered the service, it is not the only permissible way of documenting that the service has been ordered. For example, the physician may document the ordering of specific services in the patient's medical record.

I. Provider Education

Include this information in your next scheduled newsletter. Update your website with this information.

The *effective date* for this PM is February 23, 2002.

The *implementation date* for this PM is April 18, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after February 23, 2003.

Contact Dolores Crujeiras (410) 786-7169 for questions related to claims processing issues, and Dan Schwartz (410) 786-4197 for questions related to medical review issues.