

Compliance

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Douglas County Hospital Laboratory (DCHL) abides by a compliance plan to adhere to all guidelines and regulations of federally funded health care programs. The laboratory intends that all dealings with patients, referring physicians, corporations, other health care providers, federal and state funded health care programs, and third party insurance providers are conducted with the highest level of integrity and in full compliance with all applicable laws, rules, and regulations. DCHL employees comply with all rules and regulations governing federally funded health care programs. They conduct themselves with high standards of honesty and integrity. All patients will be treated with respect, dignity, and compassion.

CPT Coding

Every effort is made to accurately code our laboratory procedures using the latest edition of Current Procedural Terminology (CPT) published by the American Medical Association. CPT codes listed are effective the date of printing and are subject to change. It is ultimately your responsibility to determine the correct CPT codes to use for billing. DCHL assumes no responsibility for billing errors due to reliance on the CPT codes listed in this catalog.

Medical Necessity

On recommendation from the Office of Inspector General (OIG), it is the policy of DCHL to only expect payment from federally funded health care programs for tests that meet reimbursement rules for those programs. We recognize that physicians must be able to order any tests, including screening tests, that they believe are appropriate for the treatment of their patients. However, Medicare will only pay for tests that meet their definition of “medical necessity” and they may deny payment for a test that the physician believes is appropriate but does not meet the Medicare definition of medical necessity. Claims will be paid only if the services are covered, reasonable, and necessary.

Federal law mandates that physicians provide medical necessity documentation for the tests they order. The OIG takes the position that a physician who orders medically unnecessary tests for which Medicare reimbursement is sought may be subject to civil penalties.

Medicare regulations require ordering physicians to include diagnostic information with every order for laboratory tests.

DCHL requires the use of ICD-9 codes rather than narrative diagnoses. Only diagnostic information from the physician can be used to submit claims.

If no diagnostic information is received, or if submitted information does not support medical necessity, DCHL will contact your facility via fax to obtain additional information. We will allow 5 working days for you to return the information. If there is no reply, the test(s) will be billed to your facility. If the returned diagnostic information still does not meet medical necessity edits, Medicare will not be billed; we will bill test(s) back to your facility. No credits will be honored. For other insurances, we will bill with the submitted information. If the patient has signed an Advanced Beneficiary Notice (ABN), please indicate on the DCHL test requisition (or attach a copy). In the event of a denial for medical necessity or frequency, the patient will be billed. If no ABN is on file, your facility will be billed. No credits will be honored.

The OIG specifically states **not** to:

- Use diagnostic information from earlier dates of service (other than appropriate standing orders)
- Create diagnostic information that has triggered reimbursement in the past
- Use computer programs that automatically insert ICD-9 codes without first receiving diagnosis information from the ordering physician
- Make up information for claim submission purposes

Billing for Panels

DCHL will bill federally funded programs for panel testing using the panel CPT codes. In other words, when panels are ordered, either by individual test codes or by panel codes, DCHL will submit claims using the panel codes (ie, “bundled”).

Local Coverage Determinations (LCD)/National Coverage Determinations (NCD)

Certain laboratory tests are subject to local and/or national medical review policies. Medicare will reimburse for these tests only with appropriate diagnosis codes which are delineated for each test. Some tests also have frequency limitations. DCHL must adhere to the LCD policies published by National Government Services (NGS), the Minnesota Medicare contractor. NCD policies are also in effect for a number of laboratory tests. Tests subject to the LCD or NCD policies are highlighted in red on the DCHL test requisitions.

Advance Beneficiary Notice (ABN)

An ABN or “waiver” is a written notice a provider gives a beneficiary when it is believed that Medicare probably or certainly will not pay for a service. The ABN allows the patient to make an informed decision on whether or not to receive the service for which he/she may have to pay out-of-pocket. To be acceptable, an ABN must be on the OMB-approved form [CMS-R-131](#). The ABN must clearly identify the particular service(s) that the provider believes will be denied and state the reason why payment will likely be denied. Beneficiaries should not be asked to sign a blank ABN, nor should an ABN be given unless there is genuine doubt regarding the likelihood of payment. Giving notice for all claims or services is not an acceptable practice.

Medicare Secondary Payor (MSP)

Medicare is not always the primary payor of a beneficiary’s health care bill. Medicare should be the secondary payor when the beneficiary can expect to receive payment from another insurance or benefit plan. Examples include: black lung, VA, worker’s compensation, working-spouse coverage, disability, end-stage renal disease, automobile/medical/no-fault insurance, and liability. To determine whether or not Medicare is the primary payor, providers must ask the Medicare beneficiary or their representative questions concerning their MSP status.