1001 Woodward Place NE
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www.tricore.org

TRICORE REFERENCE LABORATORIES

Main: 505-938-8888
Toll Free: 800-245-3296
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Annual Provider Notice
January 2019

Dear Provider/Client,

The Office of Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS) encourages clinical laboratories to educate providers regarding medical necessity and laboratory billing compliance. Please carefully review this summary of Medicare rules, billing guidelines and related laboratory policies and procedures.

Notice of regulatory and compliance information is often perceived as pro forma. However, as healthcare and its reimbursement become more complex, it is all the more important to be knowledgeable about the details. The following information is intended to help you understand and comply with the Centers for Medicare & Medicaid Services (CMS) requirements regarding medical necessity and laboratory billing compliance. Please carefully review this summary of Medicare rules, billing guidelines and related laboratory policies and procedures.

Medical Necessity

As a health care provider, you may order any test(s), including screening tests, which you believe are appropriate for the treatment of your patient. However, insurance claims submitted for laboratory services will only be paid by Medicare or other insurance payers if the service is "covered, reasonable, and necessary" as defined by payer-specific criteria, and based on the primary ICD-10 code supplied for each test ordered. The medical necessity of each test ordered must be documented in the patient's chart/medical record, signed by the ordering provider, and reflect any/all coding submitted on the lab order.

It is important to note that since the implementation of ICD-10, medical necessity coverage rules for lab testing have become more stringent by several payers. This is no longer a primarily Medicare focus. It is necessary for providers to be more aware of sending the most appropriate and specific diagnosis code that describes the patients' signs, symptoms or condition.

If the laboratory receives an order without any diagnosis information, or is unable to bill for testing performed because the coding supplied does not meet medical necessity requirements, we will attempt to contact the ordering provider to gather additional coding information that may have been documented in the patient's chart but was not noted on the original lab order. The laboratory will not assign diagnosis codes.

It is imperative that all diagnosis codes relevant to the patient's condition are provided with the order. Adding or changing a diagnosis code after a claim has been denied will be met with scrutiny by payers and TriCore will require documentation from the patient chart notes to support the change. To avoid the inconvenience and patient dissatisfaction, please provide all relevant information at the time of the order.

Valid Laboratory Orders/Requisitions

Laboratory testing must be ordered by a licensed provider or other individuals authorized by law. If your license has been revoked or suspended, you may no longer order or refer for laboratory testing. Providers must be enrolled in Medicare and Medicaid programs and of a provider type that is eligible to order testing for Medicare and Medicaid patients.

Effective January 6, 2014, CMS instructed the Medicare Administrative Contractors to turn on edits to deny claims for services ordered by providers who have not enrolled their National Provider Identifier (NPI) in the CMS internet based Provider Enrollment Chain and Ownership System (PECOS). PECOS does require periodic re-enrollment. Please be aware of your status and complete paperwork in a timely manner to avoid being disenrolled and losing the ability to order services for Medicare beneficiaries.

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Effective October 1, 2017, New Mexico Medical Assistance Division, Human Services Department began enforcement of required reporting of the referring/ordering provider on claims. In addition, all referring/ordering providers are required to be enrolled with the State of New Mexico Medicaid program and the Managed Care Organizations administering services to Centennial Care recipients. Please be aware of your status and complete paperwork in a timely manner to avoid losing the ability to order services for Medicaid recipients.

To ensure accurate testing, patient identification and timely reporting of lab results, lab orders must include the patient's full legal name, date of birth, reason for each test ordered (ICD-10), date and time of collection (if collected at the provider's office), source (when applicable) and the licensed ordering practitioner's name and address. Department of Health reportable tests will also require additional patient demographics including patient address.

Recurring orders or standing orders, are only acceptable in connection with extended treatment by the same ordering provider, and with the same diagnosis code(s). Recurring orders must include both the frequency and duration of the order, not to exceed 365 days from original order date. Claims for reimbursements are submitted only for tests which have been both ordered and performed.

If the laboratory receives a requisition with ambiguous orders subject to multiple interpretations, the ordering provider will be contacted to determine what test(s) are to be performed. Inadequate or unacceptable specimens will not be processed and no claim will be submitted.

Specimen Collection
For updates to test and collection information please refer to TriCore's website:
http://www.tricore.org/providers Under: ORDER TESTS use the TEST DIRECTORY SEARCH.

For testing accuracy, specimens must be labeled with a minimum of 2 unique identifiers, e.g., patient name and date of birth. If the specimen is collected in the provider's office, please attach a copy (front and back) of the patient's insurance card(s) to ensure proper billing. If incomplete insurance information is submitted, the patient may receive a bill.

Screening/Preventive/Routine Lab Orders
Medicare *does not* cover any lab testing for routine and/or screening purposes (asymptomatic). However, Medicare *does* cover some preventive lab tests (PSA, Glucose, Lipids, etc.) if ordered as required by Medicare. For preventive benefit information including test names, CPT codes, required ICD-10 codes and frequency limitations, please reference:
https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html

When laboratory testing is ordered for screening purposes, the patient should be advised that payment may be denied by Medicare or other insurance plans. Each lab test ordered for screening purposes must have the appropriate screening ICD-10 code.

Advance Beneficiary Notices (ABN)
Medicare can deny reimbursement for tests based upon absence of medical necessity, tests specified for investigational use only, tests ordered for routine screening (including tests ordered only as pre-operative screening), and when preventive services are ordered more frequently than screening benefits cover.
Clients can go to the TriCore Reference Laboratories website http://www.tricore.org/providers Scroll to: MEDICARE COMPLIANCE, COVERAGE DETERMINATIONS to review the Local Coverage Determinations or National Coverage Determinations.

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If a *non-covered* diagnosis is used, the patient must be *notified prior* to specimen collection and given the opportunity to sign the Advance Beneficiary Notice (ABN). The ABN must be completed for any Medicare patient where claim denial is suspected based on medical necessity or frequency limitations.

It is the responsibility of the ordering provider to obtain a properly completed ABN, if collecting specimens for testing from the Medicare beneficiary. Requesting the ABN on all Medicare beneficiaries is considered an unacceptable practice. For an ABN tutorial: https://med.noridianmedicare.com/web/jfb/topics/abn/abn-tutorial.

Providers can also go to TriCore's website http://www.tricore.org/providers Scroll to: DOWNLOADS/ABNs for an ABN form in English or Spanish and instructions on how to use it. Please send the completed form with the patient sample.

Organ/Disease Panels/Lab-Customized Panels
Review the components of any laboratory test panel, whether AMA, laboratory or client-developed (custom panel), and only order the panel when ALL the individual components of the panel are medically necessary as determined by specific ICD10 code(s) and documented in the patient's medical record/chart. If any component is not medically necessary, order only those individual tests that are.

Providers should review custom panels annually to ensure that they continue to reflect current testing needs and TriCore Reference Laboratories should be notified immediately of any changes.

Reflex Testing
Some lab tests may trigger additional reflex testing and additional charges based on laboratory policy that reflects standard of care or by request of the ordering provider. All procedures that contain a reflexive pathway are identified in TriCore's test directory, including criteria that will lead to these charges and the specific CPT code(s) used. See our website: http://www.tricore.org/providers Under: ORDER TESTS and use the TEST DIRECTORY SEARCH.

Preauthorization of Lab Orders
Preauthorization of certain lab testing, (i.e., any genetic testing [e.g., BRCA1/2, Oncotype DX® Breast Cancer Assay], cytogenetics, allergy testing, celiac testing, preservation of stem cells, etc.) may be required, as defined by the patient's insurance provider. Any preauthorization paperwork must be completed by the ordering provider's office prior to submission of any lab orders. Please include the preauthorization paperwork with the lab order, along with any related documentation.

CPT Code Updates
Providers may go to TriCore's website http://www.tricore.org/providers Scroll to: RESOURCES and use the MASTER COMPENDIUM.

PROVIDER PORTAL
TriCore's Provider Portal is a secure, web-based platform. To begin using TriCore's Provider Portal, send your request to portalrequests@tricore.org.

- Generate custom patient reports, whether you need a single result or a trend.
- Access longitudinal patient data, incorporating results for testing ordered by your practice and other facilities TriCore supports.
- Support your relationship with TriCore through live chat with agents, real time notifications, and management of your practice's exceptions.

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Inducements

Federal law prohibits offering or paying any remuneration – meaning anything of value – to induce the referral of tests that are covered by Medicare, Medicaid or other federal health care programs. Any form of kickback, payment or other remuneration that is intended to secure the referral of federal health care program testing business is strictly prohibited and should be reported to the TriCore Compliance hotline (1-844-276-2673).

TriCore will provide, as part of its services, such consumable items, devices or supplies to be used solely to collect, transport, process, and store specimens for testing by TriCore. Supply requests can be made to the Purchasing department at 505-938-8957 or send requests to supplies@tricore.org.

Other important information

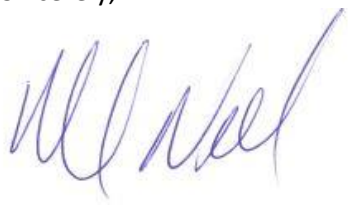
Provider or Client failure to provide sufficient information for TriCore to release a claim for processing may result in the services being directly billed to the ordering provider or Client.

Medicaid reimbursement will be equal to or less than the Medicare reimbursement amount. Medicare's Clinical Laboratory Fee Schedule (CLFS), including all CPT codes, can be found at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html.

The OIG/Department of Justice takes the position that an individual who knowingly causes a false claim to be submitted may be subject to sanctions or remedies available under civil, criminal and administrative law. The laboratory will not knowingly bill Medicare for lab testing that is non-covered, unreasonable and/or unnecessary.

Thank you for partnering with TriCore Reference Laboratories.

Sincerely,



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