

CMS Reminder & Updates:

Date of Service

The final rule also modifies the laboratory date of service for specimens. Under rules in effect in 2006, if the date of service (DOS) was during a hospital stay, the laboratory test would be bundled with the inpatient services and paid under the DRG rules. This affected tests on specimens taken during surgery. CMS met with lab groups and, as a result, modified their policy to accommodate the special situations presented by cancer recurrence assays and chemotherapy sensitivity assays.

CMS's primary concern was to clearly separate the outpatient or non-patient testing from the inpatient treatment or hospital stay. Under the final rule, for all specimens retrieved from storage for additional tests other than chemotherapy sensitivity, less than 30 days after collection, the DOS equals test performance date only if:

- The test is ordered at least 14 days after hospital discharge;
- The specimen was collected during a hospital surgery;
- It would be medically inappropriate to otherwise collect the specimen;
- Test results do not relate to the hospital stay; and
- The test is reasonable and necessary.

Chemotherapy sensitivity tests performed on live tissue are unique because the tissue must be cultured, not otherwise stored, to preserve it for testing. The decision to preserve the tissue must be made at surgery. So, for these tests, the DOS is the date the test is performed if:

- The decision of what specific chemotherapeutic agents to test is made 14 days after discharge;
- The specimen is collected during a hospital surgery;
- It would be medically inappropriate to otherwise collect the specimen;
- Test results do not relate to the hospital stay; and
- The test is reasonable and necessary.

Processing of Diagnosis on Claims – Linking Changes for Part B Providers

The ANSI 837P 4010 allows a maximum of eight diagnosis codes to be reported for each claim. In processing the claim under the format established by HIPAA, the Multi-Carrier System (MCS) applies the first four diagnosis codes on the claim. The remaining diagnosis codes are not used in the payment determination for Medicare.

The clinical laboratory negotiated rule making committee agreed that Medicare would consider all diagnosis codes reported in the processing of claims for clinical laboratory services. Until now, the enforcement of this requirement was generally done manually, but this process has not always worked effectively, notes the Center for Medicare & Medicaid Services (CMS) in a transmittal issued October 27 (Transmittal 1095, Change Request 4276).

The transmittal implements the negotiated rule making agreement to automatically consider all diagnosis codes reported. The change request also requires the MCS to process all diagnosis information submitted on the approved HIPAA claim format for all other types of claims. Generally, paper claims should have only four diagnoses. If more are reported, MCS should capture up to the maximum allowed by the ANSI 837 40101 claim format.

Effective for claims processed July 1, 2007, and later, the carrier standard system shall capture and process up to eight diagnosis codes reported on a claim, says the transmittal. For claims processed July 1 and later, the Common Working File (CWF) shall accept all diagnosis codes reported by the MCS to CWF. Within 45 days of the implementation of the coding changes effective on July 1, 2007, the carriers shall make the appropriate updates to their edits and audits to read all diagnosis codes reported on the claim.