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TECHNICAL BULLETIN
JANUARY 2023

NEW ENTERIC PATHOGEN PANEL OFFERRED – EFFECTIVE JANUARY 1, 2023

On 04/17/2022, Medicare issued a coverage determination for expanded pathogen (>5 pathogens) profiles. After this date CPT code 87506 was only covered for Places of Service (POS) 19, 21, 22, 23 or if ordered by an infectious disease specialist. In response to this revision, Physicians Laboratory has developed a new test that is available effective January 1, 2023.

Test # 10317

Enteric Pathogens Mini Panel by PCR – Client Price $100.00

Includes Campylobacter, Salmonella, Shigella, Shiga Toxin-1, Shiga Toxin-2

CPT 87505

Please note that the following profiles will still be available; however, neither panel is routinely covered by insurance. For this reason, these tests will only be ordered if the patient prepays, pre-authorization is obtained, a signed ABN is submitted, or if the charges are billed back to the client facility. Please refer to Medicare coverage policy A58761 for additional information regarding these CPT Codes.

8446 Enteric Pathogen Panel by PCR (CPT 87506)

8384 Gastrointestinal Pathogen Panel (CPT 87507)

UNSATISFACTORY PAPS – HPV TESTING

As a reminder, due to manufacturer guidelines, HPV's will not be performed on Unsatisfactory ThinPrep® pap smears that are acellular or which have insufficient cellularity. An HPV order should **NOT BE ADDED** to a ThinPrep® pap smear that has been resulted out as such. In these scenarios, a negative HPV test could be falsely negative; it is unknown if the negative HPV result is due to lack of virus or lack of cells.

There will be a statement on the report which states "This specimen has not been forwarded for HPV testing due to manufacturer recommendations regarding specimens which are acellular or which have insufficient squamous cellularity." It will replace the comment "This specimen has been forwarded for HPV testing per clinician" on those pap smear orders that are either ACOG (ages 30-65) or Reflex HPV Any Diagnosis, including those ordered with Reflex to 16/18. The patient's insurance will not be billed for this initial unsatisfactory Pap smear.

PERIPHERAL SMEAR ~ PATHOLOGIST REVIEW (TEST 3957) NON-COVERED SERVICE ON OUTPATIENTS

CPT 85060 Blood Smear Interpretation by Physician with Written Report
This code/test is non-covered for outpatients. If a physician desires to order this test in an outpatient setting, they may opt to have the charges billed back to their facility or they can collect an ABN so that the charges can be billed to the patient once we receive a denial from the insurance.

EFFECTIVE JANUARY 9, 2023 – TEST 1606 LIPID PANEL W/REFLEX TO DIRECT LDL

Test 1606 will no longer automatically include a Direct LDL. Due to payer restrictions, the Lipid Panel will now only reflex to the Direct LDL when the Triglyceride level is greater than 400 mg/dL and less than 3000 mg/dL.

TEST #8223 – THIOPURINE METHYLTRANSFERASE, RBC – EFFECTIVE JANUARY 1, 2023

TPMT, RBC is performed at ARUP test #92066. Effective January 1, 2023, the CPT code for this test changed from 82657 to 84433. Please update this test in your records.

OPTUM VA INSURANCE ALWAYS REQUIRES PREAUTH PRIOR TO SUBMISSION

Please note that Optum VA requires preauthorization for all laboratory testing. If preauthorization is not obtained, Optum will not pay for testing and the laboratory cannot bill the patient for these services. Please include the pre-authorization documentation with the order so that we can include this on the claim.

VITAMIN D TESTING – BCBS REQUIRES PREAUTHORIZATION

Please note that BCBS requires preauthorization for Vitamin D testing. Additionally, the majority of payers have become extremely restrictive regarding payment for this test. Physicians Laboratory will not perform Vitamin D testing on BCBS patients without evidence of preauthorization or a signed ABN. A link to BCBS of Nebraska policies and procedures is provided in this bulletin for your reference.

PRIMARY AND SECONDARY DIAGNOSIS CODES

Please be cognizant of the order of diagnosis codes that are placed on the requisition. Secondary diagnosis codes can only be utilized if a primary diagnosis code is provided in the first position. The most prevalent examples include pregnancy diagnosis codes. Codes that specify the gestation of a patient cannot be primary.

Common Examples of Secondary Codes (These cannot be used as Primary):

- Z3A Weeks of Gestation of Pregnancy
  - Code first obstetric condition or encounter for delivery
    - Ex: Z34.0 Encounter for supervision of normal first pregnancy
- D63.1 Anemia in chronic kidney disease
  - Code first underlying chronic kidney disease N18.-
- N77.1 Vaginitis, vulvitis, and vulvovaginitis in diseases classified elsewhere
  - Code first underlying disease, such as: pinworm (B80)

BILLING REMINDERS:

- Insurance Changes: Please provide accurate insurance that is provided at the time of the patient's visit. Many patients change insurance plans at the beginning of the year and we need this updated information in order to bill correctly for services. This includes the correct subscriber (person who carries the insurance), their DOB, and the correct policy (member number or identification number) and group numbers.
- Diagnosis Codes: Correct diagnosis codes are a necessity. Please ensure diagnosis codes are provided on every order as this is required to bill insurance. Additionally, diagnosis codes must meet medical necessity. If the diagnosis code does not meet medical necessity, then a signed ABN must be submitted with the order. There are several online resources available in order to determine whether a code is covered by insurance. Most private insurance companies follow Medicare guidelines; however, you should consult their coverage policies prior to submission:
  - Medicare Local Coverage Determinations
    https://www.wpsgha.com/wps/portal/mac/site/policies/guides-and-resources/lcds-and-coverage-articles
  - Medicare National Coverage Determination
    http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10.html
  - PhysLab Medical Necessity Validation
    https://physlab.com/providers/resources.html
  - Blue Cross Blue Shield of Nebraska Policies and Procedures
    https://medicalpolicy.nebraskablue.com/home
  - United Healthcare Policies and Procedures
    https://www.uhcprovider.com/en/policies-protocols.html

- Correct provider: In order to bill insurance, a provider must be indicated on the order. If the patient has Medicare, a PECOS enrolled physician must order the tests. Refer to the following website to determine whether a provider is Medicare approved https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/order-and-referring.
- Select the appropriate billing directives on the order.
  - Client Bill – Charges are billed back to your facility.
  - Insurance Bill – Charges are billed to the patient's insurance.
  - Patient Bill – Charges are billed directly to the patient (not to insurance).

When the billing information on the order is missing, inaccurate, or the diagnosis provided does not meet medical necessity, the billing team will fax requests to your office weekly. This information is needed to get the claim out in a timely manner. Please make sure these requests are faxed back with the correct information within one week.

BILLING CONTACTS

Paityn Bybee (Primary Contact for all Client Billing Requests)
Client Manager
Email: pbybee@physlab.com
Phone: 402-738-5074
Fax: 402-932-5136

Theresa Watson
Billing Manager
twatson@physlab.com
Phone: 402-933-5436
Fax: 402-738-5015

Billing Administrator / Compliance
Jamie Loch
Email: jloch@physlab.com
Phone: 402-933-5729
Fax: 402-738-5015

ADD ON TESTING – PLEASE NOTIFY CLIENT SERVICES

We strongly encourage you to contact Client Services with add-on testing or other requests. This ensures you are assisted more efficiently and that your request is handled accurately. Faxed requests may not be received or could be routed to the incorrect laboratory/department. This significantly delays response time. When you do need to fax information to Client Services, Processing, or elsewhere, please direct your documents to the appropriate departmental fax.

Client Service Fax Omaha: (402)884-8610
Clinical Processing/Sendouts Fax Omaha: (402)738-5076
Client Service Fax Lincoln: (402)488-6941
Billing Fax Omaha: (402)738-5015

PHYSICIANS LABORATORY ONLINE RESOURCES – VISIT PHYSLAB.COM

The following resources are available on our website:

Test Directory — This includes all of the tests we offer along with specimen requirements, stability, CPT codes, etc.

Online Results — If your providers or clinical staff would like the ability to view results online, please go to resources and under Forms – Click on Web Access Request Form. Once you complete this information, our IT department will reach out within 24 hours to provide your user ID and password.

Supplies — To order supplies, please go to our website and click on the order supplies button on the right-hand side of the screen. Your order will automatically be sent to our supply department and ensures timely fulfillment of your request.

Billing — There are several billing resources available on our website. Click on the resources button and look under Forms to find:
ABN Forms Medicare English/Spanish
ABN Form Commercial
Monthly Invoice Adjustment Form
Medical Necessity Validation Tool

CAP / CLIA Certificates — Select About Us at the top of the screen and click on Certifications. This will allow you to print out the certificates for your records.

Antibiograms — Select the Resources button. Scroll to the bottom of the screen. Click on the appropriate antibiogram.

Technical Bulletins — A link to the most recent technical bulletins will be included under the Resources Button.