



**UNIVERSITY OF COLORADO
HOSPITAL**

Memorandum

Date: December 27, 2007

To: University of Colorado Hospital Physicians, Housestaff, Faculty, and Nursing Units

From: Ronald B. Lepoff, M.D.
Medical Director, Clinical Laboratory
Joan Coleman, M.B.A., MT (ASCP)
Administrative Director, Clinical Laboratory

Re: ANNUAL NOTICE OF CPT CODING CHANGES & MEDICAL NECESSITY

The AMA’s CPT Editorial Panel has made some changes and additions to CPT codes for 2008. These changes will directly affect the way our laboratory bills Medicare and other federal and state health care programs for these tests and may affect the amount of Medicare reimbursement we receive for each test.

Below is a discussion of specific changes affecting clinical laboratory tests. Please refer to the 2008 CPT Code Book for a complete listing of new, deleted and revised codes.

The 2008 Clinical Laboratory Fee Schedule can be accessed via the internet at http://www.cms.hhs.gov/ClinicalLabFeeSched/02_clinlab.asp#TopOfPage. The Medicaid reimbursement amount will be equal to or less than the Medicare reimbursement amount.

NEW CODES:

CPT/HCPCS Code	Descriptor	National Fee Cap
80047	Basic metabolic panel (Calcium, ionized) This panel must include the following: Calcium, ionized (82330); Carbon dioxide (82374); Chloride (82435); Creatinine (82565); Glucose (82947); Potassium (84132); Sodium (84295); Urea Nitrogen (BUN) (84520)	\$30.51
82610	Cystatin C	\$19.00
83993	Calprotectin, fecal	\$27.42
84704	Gonadotropin, chorionic (hCG); free beta chain	\$21.03
86356	Mononuclear cell antigen, quantitative (eg, flow cytometry), not otherwise specified, each antigen	\$37.41

CPT/HCPCS Code	Descriptor	National Fee Cap
86486	Skin test; unlisted antigen, each	\$10.31 (mean non-facility price from Physician Fee Schedule)
87500	Infectious agent detection by nucleic acid (DNA or RNA); vancomycin resistance (eg, enterococcus species van A, van B), amplified probe technique	\$49.04
87809	Infectious agent detection by immunoassay with direct optical observation; adenovirus	\$16.76
89322	Semen analysis; volume count, motility, and differential using strict morphologic criteria (eg, Kruger)	\$21.65
89331	Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)	\$27.37

REVISED CODES:

Reimbursement remains the same for these codes.

CPT/HCPCS Code	Descriptor (<i>changes indicated by underscore and strikethrough</i>)
80048	Basic metabolic panel (<u>Calcium, total</u>)
82272	Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, single specimen (eg, from digital rectal exam) <u>1-3 simultaneous determinations, performed for other than colorectal neoplasm screening</u>
83898	Molecular diagnostics; amplification, target, of patient nucleic acid, each nucleic acid sequence
83900	Molecular diagnostics; amplification, target, of patient nucleic acid, multiplex, first two nucleic acid sequences
83901 (add-on code)	Molecular diagnostics; amplification, target, of patient nucleic acid, multiplex, each additional nucleic acid sequence <u>beyond 2</u> (List separately in addition to code for primary procedure)
83908	Molecular diagnostics; signal amplification of patient nucleic acid <u>amplification, signal,</u> each nucleic acid sequence
86885	Antihuman globulin test (Coombs test); indirect, qualitative, each antiserum reagent red cell
86886	Antihuman globulin test (Coombs test); indirect, titer, each antiserum <u>antibody titer</u>

89320	Semen analysis; complete (volume, count, motility, and differential)
89321	Semen analysis; <u>sperm</u> presence and/ or motility of sperm, <u>if performed</u> (not including Huhner test)

DELETED CODES:

CPT/HCPCS Code	Descriptor
86586	Unlisted antigen, each

MEDICAL NECESSITY REQUIREMENT

Medicare will only pay for tests that meet the Medicare coverage criteria and are reasonable and necessary for treatment and diagnosis. **Medicare generally does not cover routine screening tests.**

Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) specify tests that have limited coverage under Medicare, list covered diagnosis codes for these tests, and may be viewed at <http://www.trailblazerhealth.com/coverage/index.asp>.

Physicians must provide ICD-9 codes or diagnoses with all outpatient laboratory requests to support medical necessity. Please note that the Clinical Laboratory requisitions are designed with this purpose in mind.

Note: Medicare will not cover services when a “rule-out” diagnosis is provided. Code the condition(s) to the highest degree of certainty for that encounter/visit, such as signs, symptoms, abnormal test results, exposure to communicable disease or other reasons for the visit.

When you order individual tests or any organ and disease oriented panels, please remember that for laboratories to bill Medicare, **each and every test, including each component of a panel, must be medically necessary** for the treatment or diagnosis of the particular patient being tested.

Reminder: A signed Advanced Beneficiary Notice (ABN) should be obtained **before service is rendered** from any outpatient for whom there is reasonable doubt that Medicare will provide coverage for specific lab tests or other services.

QUESTIONS?

Please do not hesitate to contact Karin Ingle, Administrative Lab Coordinator, at (720) 848-7059 if you have any questions about the changes for 2008.

For questions regarding appropriateness of tests, please contact our Clinical Consultants:

Chemistry, Transfusion Medicine	Lorne Holland, M.D.	720-848-7050
Microbiology	Nancy Madinger, M.D.	720-848-7047
Hematology	John Ryder, M.D.	720-848-7049
Virology/Molecular Diagnostics	Adriana Weinberg, M.D.	303-315-4624