

Top Reimbursement Questions For BD GeneOhm™ Assays

Medicare

1. Q. Can I bill Medicare separately for lab tests versus other procedures performed?

A. It depends on the nature of the test and the status of the patient. First, the Medicare statute allows for Medicare to reimburse only for “items and services that are ‘reasonable and necessary’ for the diagnosis and treatment of illness or injury.” For inpatients, coverage and payment for all lab tests performed during the patient’s stay are included in the DRG payment; therefore, tests on inpatients should not be separately billed. For outpatients and non-patients (testing performed by a hospital lab on patients who are not registered as either inpatients or outpatients), Medicare covers all lab tests deemed to be reasonable and necessary and separately pays for most of them through the clinical laboratory fee schedule.

2. Q. What criteria establish which Medicare patients are inpatients for testing purposes?

*A. All testing performed on the day of admission, during the inpatient stay, and each of the 3 full days **prior** to the day of admission is included in the DRG payment. Thus, if a patient is admitted at any time on a Monday, any testing performed at any time on the previous Friday, Saturday, or Sunday would be included in the DRG payment and not be separately billable. In this scenario, testing performed on or before the previous Thursday would be potentially eligible for outpatient or non-patient status and separate billing through the clinical laboratory fee schedule.*

3. Q. How do I know if Medicare considers this testing reasonable and necessary?

*A. For patients at risk of developing an infection, a doctor may feel that the test is medically necessary to ensure the patient’s health during surgery. While this clinical decision is not binding on Medicare, the program may defer to physician decision-making, especially when available guidelines such as, *The Society of Thoracic Surgeons Practice Guideline Series: Antibiotic Prophylaxis in Cardiac Surgery, Part II: Antibiotic Choice*¹ and the *Society for Healthcare Epidemiology of America Guideline for Preventing Nosocomial Transmission of Multidrug-Resistant Strains of Staphylococcus aureus and Enterococcus*², support the intervention and a non-coverage policy is not in effect. You should contact your local Medicare contractor to find out what specific policies are in force in your region.*

¹ <http://ats.ctsnetjournals.org/cgi/content/full/83/4/1569>

² Infection Control and Hospital Epidemiology, May 2003; 24: 362-386.

Commercial/Private Payors

4. Q. From a private payor perspective, which patients are eligible for reimbursement under CPT codes?

A. The payment depends in part on the kind of policy the patient has (indemnity, managed care, etc.) and in part on the payment mechanism established between the insurer and the service provider through contract, if any (negotiated fee-for-service, DRG, per diem, case rates, capitation, etc.). Under DRGs, per diems, capitation, and case rates, separate payment for lab services may or may not be available. Contact your individual payors to determine their specific payment mechanisms and policies. (This applies to both outpatients and inpatients).

5. Q. Are outpatients with commercial insurance that receive MRSA or S. aureus surveillance testing eligible for reimbursement if they are a high risk patient?

A. Payment for outpatient testing is covered according to a payor's medical policy. Again, individual physician decision-making regarding medical necessity is typically important, but the payor has the final say. Please notify your BD representative if you become aware that a particular payor does not cover the test.

6. Q. What is the definition of a patient that is admitted for "observation" and is still considered outpatient?

A. It varies from payor to payor, but the majority of the time it is a patient explicitly admitted to observational status for up to 24 to 48 hours. Patients admitted to observational status are typically treated as outpatients during the period they are being observed for testing coverage determinations.

7. Q. Can patients admitted for observation be eligible for reimbursement under CPT codes?

A. Typically, yes; however, payment for outpatient testing is covered according to a payor's medical policy. Again, individual physician decision-making regarding medical necessity is usually important, but the payor has the final say. Please notify your BD representative if you become aware that a particular payor does not cover the test.

8. Q. The new BD GeneOhm™ StaphSR assay simultaneously identifies MRSA and MSSA, can we bill for both organisms using a single test?

A. According to instructions in the CPT 2008 Professional Edition manual that precede the primary source "infectious agent antigen detection" section, where applicable codes for MRSA and MSSA by nucleic acid amplified probe technique are found, the coder is directed as follows: "When separate results are reported for different species or strain of organisms, each result should be coded separately." This same publication goes on to clarify in the following additional instruction: "For assays that detect methicillin resistance and identify Staphylococcus aureus using a single nucleic acid sequence, use 87641."³ In other words, if only a single nucleic acid sequence is used to detect both MRSA and MSSA, then only 87641 would be reported. The BD GeneOhm™ StaphSR assay detects MRSA via the proprietary junction region at the insertion site of the

³ CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved.

SCCmec cassette in *S. aureus*, and detects MSSA via the separate *nuc* gene. Thus, this assay meets the CPT criteria for providing separate results using multiple (2) nucleic acid sequences and may be properly coded with codes 87640 and 87641. However, individual payer policies may vary from CPT directions. You should consult with payers in your area to confirm their policies.

9. Q. ACOG and the CDC recommend screening pregnant patients at 35 - 37 weeks for Group B Strep (GBS) using culture (sensitivity of 85%); can I get reimbursed using the BD GeneOhm StrepB assay?

A. The BD GeneOhm StrepB assay sensitivity exceeds the 2002 CDC recommendation (minimum sensitivity of 85%)⁴ at a sensitivity of 94%⁵. *Medical coverage policy varies from payor to payor for this testing. You should consult with your payors to determine their specific policies regarding PCR-based GBS tests. Please notify your BD representative if you become aware that a particular payor does not cover the test.*

Performance of BD GeneOhm™ Strep B vs. Intrapartum Culture⁶

<u>Method</u>	<u>Sensitivity</u>	<u>Specificity</u>
BD GeneOhm Strep B	94.0%	95.9%
<u>Antenartum Culture</u>	54.3%	97.0%

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⁴ <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5111a1.htm>

⁵ Davies et al., CID 2004 vol. 39 pages 1129-1135

⁶ Davies et al., CID 2004 vol. 39 pages 1129-1135