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## **Policy**

The purpose of this policy is to define the various methods by which The Johns Hopkins Hospital's Department of Pathology will monitor compliance with applicable Medicare and other government regulations regarding ordering and billing of tests and adherence to the Hospital's Billing Compliance Plan. All audits and monitoring activities will be conducted on an annual basis unless otherwise noted.

## **Procedure:**

### CLIA Enrollment


1. Pathology CGI office: Verify each laboratory has one or more CLIA certificates(q 2 yrs).
2. Review the expiration date on each CLIA certificate to ensure the certification is valid.
3. Review each test currently being performed in the laboratory to ensure the testing being performed falls within the category of testing permitted on the CLIA certificate.
4. Review the HCFA Performance Summary, which is issued by the laboratory proficiency-testing program, for each laboratory performing moderate or high complexity testing. Verify that proficiency testing status for each test performed is "Acceptable" by CLIA guidelines.
5. Document all findings.

### Requisition to Claim Audit

1. This procedure will be performed annually by Pathology dept, overseen by Internal Audits.
2. Obtain copies of ten patient test requisitions with associated lab reports and billing claim forms from the previous 12 months from selected laboratories.
3. For each requisition, determine whether:
  - a) Each test ordered was performed and billed.
  - b) A test was ordered and performed but not billed.
  - c) A test was ordered and billed but not performed.
  - d) A test was billed and performed without an order.
  - e) A test was performed without an order and was not billed.
  - f) A test was ordered but was not performed (specimen unsatisfactory, etc.) and not billed.
  - g) The wrong test was performed.
  - h) The wrong test was billed.
4. Document all findings.

### Medical Necessity

1. This procedure will be performed annually by Pathology dept; overseen by Internal Audits.
2. Obtain copies of ten patient test requisitions with associated billing claim forms and remittance advice from the previous 12 months from selected laboratories.
3. Examine each test order to determine whether there is an associated ICD-9

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- code in the patient's registration for the test(s) ordered.
4. Review the remittance advice for the claim associated with each requisition.
    - a) Determine whether any test was denied reimbursement for lack of Medical Necessity.
    - b) Determine whether any test was denied reimbursement as a noncovered screening procedure; and if an ABN was obtained.
  5. Determine whether an appropriate diagnosis was reported on the billing claim form.
  6. Determine whether any test requested with associated diagnosis coding, and if coding was changed prior to billing.
  7. Document all findings.


#### CPT Code Assignment

1. This procedure will be performed annually.
2. Obtain the current section of the JHH Control File which lists all of the Pathology Department's service codes, along with the assigned CPT-4 and UB92 revenue codes, a list of all panels and panel components, Medicare bulletins issued within the last year, the AMA's Physician's Current Procedural Terminology (CPT-4) manual, and the current reflex testing policy.
3. Review and document/revise any codes with the following issues:
  - a) The code is deleted or requires revision to a new CPT code.
  - b) The code does not accurately describe the testing performed.
  - c) The code is an "unlisted procedure" code. A specific analyte or method code should be used instead.
  - d) The code is not separately reportable or has no technical component.
  - e) The test is no longer performed.
  - f) An additional code is needed to report the service/test performed.
4. Document all findings.

#### Review of Documentation to Support Verbal Orders

Medicare states that "when telephone or verbal orders are used, they must be accepted only by personnel who are authorized to do so by the medical staff policies and procedures, consistent with federal and state law." Documentation verifying verbal orders must be signed or initialed by the ordering physician/practitioner within 30 days.

1. This procedure will be performed annually.
2. Obtain the laboratory verbal order request file or log.
3. Determine whether each verbal order and accompanying documentation is in compliance with the laboratory policy regarding verbal orders.
4. Determine whether written documentation to support verbal test orders is filed in a readily retrievable manner.
5. Document all findings.

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#### Review of Standing Orders

1. This procedure will be performed annually in conjunction with Dept. of Internal Audits.
2. Check ten recent standing orders to determine whether they contain the following: patient's name, physician signature, tests requested, diagnosis, effective date and duration of order.
3. Conduct a random review of the medical records containing standing orders. Select five standing orders.
4. Check laboratory accessioning logs for the orders pulled to determine whether testing has been performed pursuant to any standing order older than three days for in-patients or six months for outpatients.
5. Document all findings.

#### ICD-9-CM Code and Narrative Diagnosis Monitoring

1. This procedure will be performed annually and overseen by the Dept of Internal Audits.
2. Obtain copies of ten outpatient test orders with associated billing claim forms from the previous 12 months.
3. Examine each record to determine whether the physician has provided an ICD-9-CM code or narrative diagnosis.
4. Submit the records containing a narrative diagnosis to a certified coder for ICD-9-CM coding of the diagnosis provided.
5. Determine whether the ICD-9-CM code provided by the certified coder matches the ICD-9-CM code submitted to Medicare on the billing claim form.
6. Document all findings.