Scope of this structured design:

California Medicaid (Medi-Cal) Professional Independent Laboratory DIagnosis Code Requirements

Medi-Cal (California Medicaid)
Pathology: Billing and Modifiers
Page updated: August 2020

This section includes information about the billing and reimbursement of pathology services.
Note: Only a provider with a Clinical Laboratory Improvement Amendments (CLIA) certificate and state license or registration appropriate to the level of tests performed may be reimbursed for clinical laboratory tests or examinations. Additional information and links to websites regarding licensing requirements are provided below.

Diagnosis Code Requirement

All claims for clinical laboratory tests or examinations (CPT® 80000 series codes) require an ICD-10-CM diagnosis code.
Providers may not submit the following non-specific diagnosis codes when ordering billing for laboratory procedures:
Z00.00, Z00.5, Z00.6, Z00.8, Z01.00, Z01.10, Z01.89, Z02.1, Z02.3

The exceptions are:

- CPT codes 86701 thru 86703. CPT codes 87389; 87390 and 87806 for HIV testing.
CPT code 81528 for colorectal cancer screening and HCPCS code G0499 for hepatitis B screening may be billed with any ICD-10-CM diagnosis code.
- CPT codes 86803 and 86804 may be billed with any ICD-10-CM code.

Non-specific Diagnosis Code list
Z00.00
Z00.5
Z00.6
Z00.8
Z01.00
Z01.10
Z01.89
Z02.1
Z02.3

Procedure Code exceptions List:
86701 - 86703
87389
87390
87806
81528
G0499
86803
86804

Acronyms:
CLUE = Claim line under evaluation
CUE = Claim under evaluation

ASSUMPTIONS:
Patient is eligible for Medi-cal
Patient is not dual eligible (Medicaid is primary insurance)

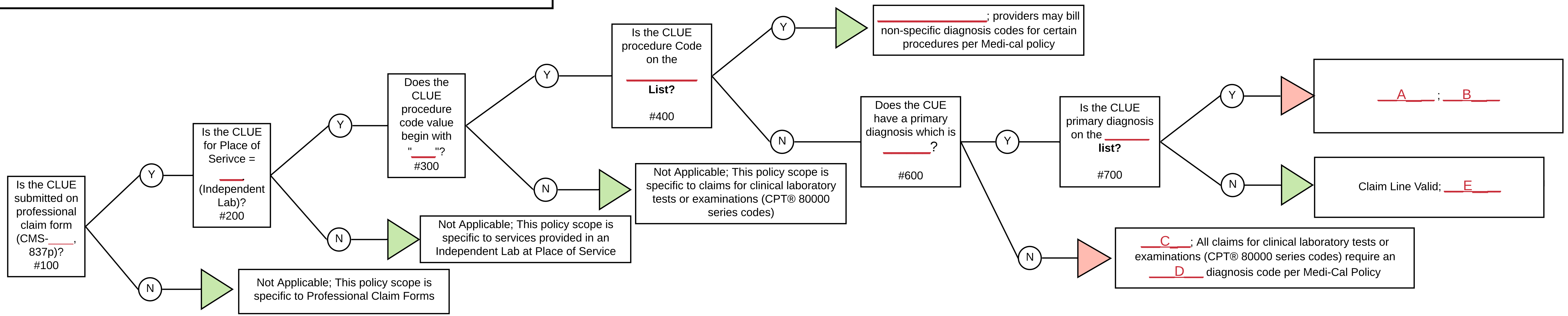
Valid Insight Tags for this Sample:

Not Applicable -This applies to "pre-requisite" nodes that eliminate claims that do not qualify for evaluation by the insight engine. For example, if an Insight Engine is specific to DME, then a pre-requisite node might say "Does the claim line have a procedure code that is in the DME table", if "No" then the insight might be "Not Applicable; This claim line is not for DME"

Claim Not Payable- If a node answer results in the rejection of an ***entire claim*** based on the policy interpretation, then this insight tag must precede the information

Claim Line Not Payable-If a node answer results in the rejection of the ***claim line under evaluation*** based on the policy interpretation, then this insight tag must precede the information

Claim Line Valid- Many insights within an insight engine do not find any issues with a claim or claim line. In these cases, this insight tag should be used, followed by the reason. For example, "Claim Line Valid; Modifier 59 override allows payment."



Is the CLUE submitted on professional claim form (CMS-____, 837p)? #100

Y

N

Not Applicable; This policy scope is specific to Professional Claim Forms

Is the CLUE for Place of Serivce = ____ (Independent Lab)? #200

Y

N

Not Applicable; This policy scope is specific to services provided in an Independent Lab at Place of Service

Does the CLUE procedure code value begin with "____"? #300

Y

N

Not Applicable; This policy scope is specific to claims for clinical laboratory tests or examinations (CPT® 80000 series codes)

Is the CLUE procedure Code on the ____ **List?** #400

Y

____; providers may bill non-specific diagnosis codes for certain procedures per Medi-cal policy

N

Does the CUE have a primary diagnosis which is ____? #600

Y

Is the CLUE primary diagnosis on the ____ **list?** #700

Y

___A___ ; ___B___

N

Claim Line Valid; ___E___

N

___C___; All claims for clinical laboratory tests or examinations (CPT® 80000 series codes) require an ____D___ diagnosis code per Medi-Cal Policy

Structured Designs

The decision tree is a graphical representation of the steps required to make a decision as to whether a claim or claim line was appropriately paid with respect to the policy being applied.

A binary decision tree is a structure based on a sequential decision process. Starting from the **root node**, a feature is evaluated and one of the two **branches** is selected. This procedure is repeated until a **leaf node** (decision or 'insight') is reached, which normally represents the most refined version of the data available.

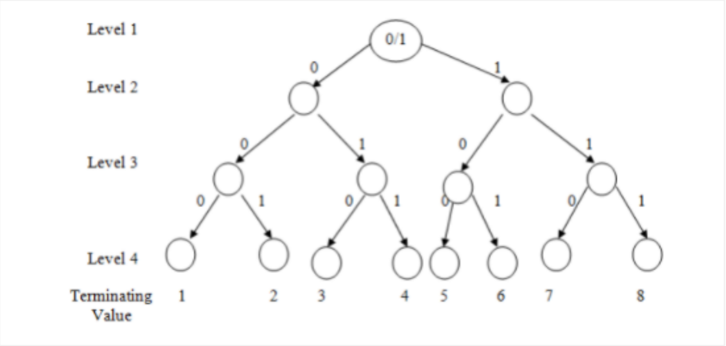


Figure 1. Generic decision tree concept. The decision tree starts with a root node at level 1, followed by branches (decisions) that link to internal nodes until an insight (leaf node) is revealed.

We take a healthcare policy from unstructured text and tease out the steps in the form of yes/no questions in a decision tree that represent the steps a person would take while auditing a claim for payment accuracy.

Mapping policy in such a way—provided appropriate data is available—allows for all possible paths of a policy to be accounted for, graphically. This visual representation can be translated into code in any programming language and leaves little room for misinterpretation. This is our **insight design**.

Some key features of this method for mapping policy include the following:

- ✓ A node MUST be a yes or no (binary) question
- ✓ Avoid using 'AND' statements inside of a node
- ✓ Nodes should be uniquely identifiable by a number, in the format of #[nodeId]—more on that in Section 5.3
- ✓ All logic should progress from the level of highest filtering to least, and the root node should ask the question that eliminates the most claims immediately
- ✓ If done correctly, each path through the tree results in a UNIQUE leaf node (insight)
- ✓ Consistent design using the standard shapes described in **Figure 4** below

Insight Text

Every **insight** in the decision tree has a unique path, so the insight text should be unique, even if it is tempting to just say 'Claim Line Not Payable' for any insight that results in a non-payable line. Since each path is unique, the more useful insight includes the unique statement as to why.

EXAMPLE

Claim Line Not Payable; **Emergency transport** code must be submitted with a corresponding mileage code with units greater than 0

vs.

Claim Line Not Payable; **Non-Emergency transport** code must be submitted with a corresponding mileage code with units greater than 0

While the logic behind each of these is nearly identical—except that one is for an emergency transport code and the other is not—one could be tempted to simply state 'Claim Not Payable; Transport code must be submitted with a corresponding mileage code with units greater than 0'. As you can see, while that is a true and accurate insight, it does not communicate the unique nature of the path.

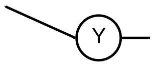
It isn't absolutely required that you use a truly unique insight; however, it is more informative for the person receiving this claim insight, as demonstrated in the example above. For this reason, you should aim for unique insight texts as much as possible.

Insight Engine Decision Tree Design - Standard Shapes (Figure 4)

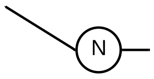
Yes-No Question

#Node

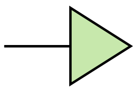
This is a node where you type in a clear yes/no question, such as "Does the claim line have a procedure code in the Extra Attendant Code List?"



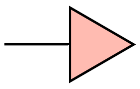
The Y (yes) connector simply helps easily identify the subsequent path is based on a YES answer from the previous node question.



The N (no) connector simply helps easily identify the subsequent path is based on a NO answer from the previous node question.



A green insight (terminal leaf) is typically used when the claim element being evaluated (line or header) on the branch has no errors or is otherwise not the "target." Examples: Insights associated with Insight tags of Not Applicable, Claim Line Valid



A Red insight (terminal leaf) is typically used when the claim element being evaluated (line or header) on the branch has an error or requires some action (manual review, change of claim line, contact provider, deny, etc). This is typically a "target" insight. Examlpes: Insights associated with insight tags of Claim Line Not Payable, Claim Not Payable, Recode Claim Line, Manual Review, Adjust Payment

[Insight Tag];This is a unique description associated with the insight

After each "Insight" shape (triangle) there should be insight text. This is the text that will tell the reviewer information about the claim or claim line that is being evaluated. Each insight needs to begin with the appropriate Insight Tag followed by a short but informative description as to why the claim has reached that particular terminal.

INSIGHT TAGS

There are a number of insight tags that are standard to our work. The content or text of each insight should be communicated as "[Insight Type], [Insight description]"

Current valid Insight Tags:

Not Applicable -This applies to "pre-requisite" nodes that eliminate claims that do not qualify for evaluation by the insight engine. For example, if an Insight Engine is specific to DME, then a pre-requisite node might say "Does the claim line have a procedure code that is in the DME table", if "No" then the insight might be "Not Applicable; This claim line is not for DME"

Claim Not Payable- If a node answer results in the rejection of an entire claim based on the policy interpretation, then this insight tag must precede the information

Claim Line Not Payable-If a node answer results in the rejection of the claim line under evaluation based on the policy interpretation, then this insight tag must precede the information

Recode Claim Line- If there is known information missing from a claim field based on policy (for example the maximum payable unit is 1, and there is a value of 2) then it is possible to call for a recode of the claim line to replace the value in the units field for that claim line.

Adjust Payment- If an insight engine is for pricing claims, and an insight results in a new allowed amount for payment (total claim or line), then it is appropriate to adjust payment in the appropriate claim response field.

Claim Line Valid- Many insights within an insight engine do not find any issues with a claim or claim line. In these cases, this insight tag should be used, followed by the reason. For example, "Claim Line Valid; Modifier 59 override allows payment."

Manual Review- Some policy requires that in certain circumstances that the payor review the claim to ensure that information that is not available to the automated system from claim data is present prior to payment. Other reasons that this tag might be used include the high probability that something is not paid correctly but research needs to be done, or a provider phone call needs to be made to verify, as the information is not available in the claim data.

Error- When a claim should never reach a certain path, but does, indicating that there is a problem with the engine design, reference data, or the engine code, and troubleshooting needs to occur. For example, if there should only be two choices for a field value (is indicator 1 or 0, and all data is supposed to be either 1 or 0), you would ask "Does this claim line per table X for the procedure code have indicator of 0?" > No, "Does this claim line per table X for the procedure code have indicator of 1" > No, then "Error, unknown indicator value