Billing Information

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This section provides instructions on how to process a patient and fill out a requisition form in a step by step format. It is imperative to recognize the importance of each section because not only does it affect the accuracy and turn-around-time of the patient's results, but it also ensures that the patient billing information submitted is correct, valid and acceptable to Foundation Laboratory (FL).

There are 4 sections on a requisition form that must be filled out prior to sending the specimen to the main laboratory for testing.

A. Patient Billing Information
B. Patient Demographic Information
C. Client / Ordering Physician Information
D. Documenting Tests and/or Panels requests

Patient Billing Information

The patient billing information is the 1st section you must complete when processing a patient. Each step must be followed for each and every visit the patient makes to FL for laboratory services. You must adhere to the steps listed below before accepting a patient for a blood draw:

#1- Determine if the patient's health insurance plan is accepted by FL.
#2 - Verify patient's eligibility.
#3 - Copy the Insurance card (FRONT and BACK).
#4 - Provide a Diagnosis / ICD-9 codes

1. *Determining if the patient's health insurance plan is accepted by FL* is the most important step in this process. There are several Bill types you may encounter while dealing with patients and it is your responsibility to determine if you should accept the patient or not. Bill types may include:
   - Third Party Insurance Carriers
   - Medi-cal
   - Medicare
   - Medi-Medi
   - Workmen's Compensation
   - Patient
   - Client/Physician

a. **Third Party Insurance**: Patients that have health insurance are enrolled in some type of managed care plan. The most common types of managed care plans are HMOs and PPOs. Therefore, you must first determine if the patient has an HMO or PPO health plan and then verify if FL is a contracted provider. Please contact our Billing Department for a complete list of our contracted PPO and HMO Insurance carriers.

i. PPO is a Preferred Provider Organization and usually has 3 types of health benefits for their members.

1. *In-Network*: PPO health plans contract with a large group of doctors, hospitals, clinics, and other health care providers such as laboratories. This group of contracted health care providers is known as the health plan's "in-network" providers. By using an "in-network" provider, members of a PPO health plan are less liable financially at the time of service.
2. *Out-of-Network*: In some types of PPO plans, the member may be required to receive all their health care services from an "in-network". However, in other PPO plans, members may be able to receive health care services from a "out-of-network" provider, who are not part of the contracted or "in-network" group. But members utilizing an "out-of-network" provider are more liable financially at the time of service.
3. *POS:* The least common of PPO plans is the POS or the Point of Service plan. This plan combines the features of an HMO and a PPO plan. The member primarily has an HMO plan, however they may chose to use "in-network" provider for an additional cost for laboratory services. Patients should be aware when using "in-network" benefits that they have "self referred" themselves to utilize Foundation Laboratory.

ii. HMO: HMO (Health Maintenance Organization) health plans are managed by a small group of providers, sometimes called an IPA or Independent Physician Association. A member must elect a primary care physician (PCP) within that small group of providers, who will be responsible for managing and coordinating all basic necessities for their healthcare. The most important difference between an HMO and a PPO plan is that the healthcare provider must be contracted with the IPA or managed group. Please note: FL will not be compensated if you accept a HMO patient that does *not* belong to a contracted IPA group. **Therefore, it is your responsibility to ensure that only contracted HMO patients are processed and sent to our facility.**

b. **Medi-cal**: Low income patients that need health insurance may apply to the State or Federal funded programs to receive health care services. You must be familiar with the types of programs Medi-cal offers and any restrictions that they may entail. The following are the types of Medi-cal programs:

i. Straight Medi-cal or fee-for-service: All laboratory services are covered only if deemed necessary by the ordering physician. Diagnoses are required.
ii. Pregnancy Related Coverage: All laboratory orders are covered ONLY if the diagnoses reflects that the patient is pregnant or post-partum. Specific diagnoses are required.
iii. Family Planning, Access, Care and Treatment (FPACT): This health plan provides pregnancy prevention services, including contraceptives, for those females and males who are at risk of unintended pregnancies. Services are limited to a few laboratory tests. Please contact our Billing Department for the complete list of tests and diagnoses allowed under the FPACT plan. Please note: if the ordering physician has ordered tests and/or panels not included in the list, the client may be charged for those non-covered services. Specific S-codes are required.
iv. Presumptive Eligibility (PE): This is a temporary health plan that the State offers patients that believe that they are pregnant and do not have any other health plan. Once a pregnancy is substantiated, patients typically apply for Straight Medi-cal or Pregnancy Related Medi-cal, retroactively. Services are only limited to a few laboratory tests. Please contact Billing Department for the complete list of tests. Please note: if the ordering physician has ordered tests and/or panels not included in the list, the patient must be notified that they must contact our Billing Department once they have been assigned with a Straight Medi-cal or Pregnancy Related Medi-cal number or they may be responsible for the non-covered tests under PE. Otherwise, the client will be responsible for the non-covered services. Specific diagnoses are required.
v. Medi-cal Managed Care or HMO: Services are only covered when utilizing a contracted HMO provider. Please contact our Billing Department for the complete list of contracted managed IPA groups or HMO plans. **Please note, it is your responsibility to ensure that only contracted HMO patients are processed and sent to our facility.**

c. **Medicare**: Medicare is health insurance for people age 65 or older and under 65 with certain disabilities. Medicare has a Part A Hospital Insurance and a Part B Medical Insurance that determines what services are covered for each member. A patient must have Part B Medical Insurance to cover laboratory services. Furthermore, there are important guidelines written for Medicare Part B patients that you must adhere to after verifying patient's eligibility status (refer to A-2-c and A-2-d). Those guidelines are as follows:

i. You must verify that the ordered test(s) and/or component(s) within a panel do not violate any frequency or medical necessity issues stipulated by Medicare's Limited Coverage Policies and Guidelines. To help identify those tests, the shaded areas on our requisition form indicate the tests with limited coverage that require specific diagnosis and the * following each test indicates that frequency rules apply for

coverage. However, it does not include all the tests; therefore you must contact our Billing Department for a *complete* summary of Medicare's Limited Coverage Policies. This summary includes the list of individual tests that Medicare deemed "limited" and require specific diagnosis or ICD-9 code(s). If the ordered test(s) and/or component(s) within a panel are NOT on that list, you may proceed to verify patient's eligibility. If the ordered test(s) and/or component(s) within a panel are on that listed, you must adhere to the following step.

ii. You must provide a diagnosis or ICD-9 code(s) that is covered under the Medicare Limited Coverage Policies. However a covered diagnosis or ICD-9 code does not guarantee payment. Please refer to following step.

iii. You must refer to the Medicare's Limited Coverage Policies and Guidelines to substantiate any frequency issues. For example: a TSH is a limited coverage test and has a frequency limitation that states that TSH testing may be covered up to two times a year. Therefore, even if the appropriate covered diagnosis or ICD-9 code(s) are provided by the ordering physician, if the patient has had a TSH test more than two times in one year, Medicare will deny payment. Therefore, you must always adhere to following last step.

iv. Must have the patient sign the Advanced Beneficiary Notice (ABN) located on the back of our requisition form, which explains that if Medicare does not cover any of the tests ordered by the physician, Foundation Laboratory will bill the patient at Medicare rates. Please contact our Billing Department for pricing.

d. **Medi-Medi**: Patients with both Medicare and Medi-cal benefits are considered Medi-Medi. These patients follow each Billtype the same way as mentioned above. The only difference is that Medicare is usually the patient's primary coverage and Medi-cal is secondary.

e. **Workmen's Compensation**: Patients with Workmen's Compensation claims require the Employer's Name, Claim Number, Date of Injury (DOI), Adjuster Name, and the Claims's address and telephone number in order to provide laboratory services.

f. **Patient**: The patient is responsible for all charges related to laboratory services. You may contact our Billing Department for patient pricing or fee schedules. In addition, it is important to notify patients of additional charges that may incur after analysis or testing. Those tests and/or panels are indicated with "Δ" on the requisition form. For example, if a client orders a urine culture and sensitivity, you must charge the patient for the urine culture and inform the patient if the culture is positive an additional charge will be billed to the patient for the sensitivity study performed on the urine specimen.

Payments may be accepted at our Patient Service Centers, by mail or at our website www.foundationlaboratory.com.

g. **<u>Client/Physician</u>**: The Client or Physician is responsible for all charges related to laboratory services.

2. *Verify patient's eligibility:*

Once you have determined that the patient's health plan is acceptable, you must verify the <u>patient's eligibility</u>. This means you ***MUST*** verify that the patient has an active status *with* covered benefits for laboratory services. The following section provides the steps necessary to check a patient's eligibility for each Billtype.

a. **<u>Third Party Insurance</u>**: Verifying a patient's eligibility status with a Third Party Insurance company involves a few steps. Although most of the pertinent information needed to verify patient eligibility is located on the patient's insurance card, you must still ask the patient for additional information.

   i. You must collect the following information before contacting the insurance company for eligibility:
      1. Patient's Name
      2. Patient's Date of Birth
      3. Subscriber/Insured ID# located on the insurance ID card
         a. If none, provide SSN#
      4. Group # located on the insurance ID card
      5. Subscriber/Insured relationship to patient
         a. If subscriber/insured is not the patient, you must provide the Subscriber's name, Date of Birth and relationship to the patient.

   ii. Next you must contact the insurance company for eligibility. The telephone number is located on the insurance ID card. You must verify the following information:
      1. Effective Date and Termination Date
      2. Verify if the patient has a PPO or HMO plan
         a. If a PPO plan, please verify if FL is a contracted provider. You may contact our Billing Department for further assistance.
         b. If a HMO plan, first you must verify the IPA group or contracted laboratory required by the patient's HMO plan. You may contact our Billing Department for further assistance.
      3. Claims Address
         a. If HMO, you must verify if the FL is contracted provider. Please contact our Billing Department.

b. **<u>Medi-cal</u>**: There are several ways you can verify if the patient is eligible for Medi-cal. Please contact our Billing Department for assistance.

c. **<u>Medicare</u>**: There are several ways you can verify if the patient is eligible for Medicare Part B benefits. Please contact our Billing Department for assistance. Once you have

established the patient's eligibility status, you must adhere to Medicare's guidelines listed in Section A-1- c: i-iv.

d. **Medi-Medi**: You must follow Medicare or Medi-cal eligibility verifications procedures.

e. **Workmen's Compensation**: If the Payor is the actual Employer of the patient, you must contact the Employer to verify if the claim will be directly paid by them.

f. **Patient**: No verification required.

g. **Client/Physician**: No verification required.

3. *Copy the Insurance Card:*
Please copy both the FRONT and BACK sides of the patient's health insurance card for all Bill types (if applicable), and attach it to the requisition form.

4. *Diagnosis/ ICD-9:*
The diagnosis or the ICD-9 code is an extremely important aspect of billing. Without a diagnosis or ICD-9 code, FL cannot bill any health insurance plan or send out the specimen to our reference laboratory. Please make sure that codes are legible and valid.

Patient Demographic Information

A blue or black pen must be used when filling out a requisition form. It is extremely important that all the information must be legible, accurate and current.
There are two types of patients; a New Patient and an Existing Patient. You must adhere to the following guidelines regarding BOTH scenarios.

a. Last Name, First name:
You must verify the spelling of the patient's name with an ID card - either the Health Insurance card or Driver's License. Please note: the patient's name must match the name as it appears on the health insurance card (whether the patient is the Subscriber or the Insured on the health plan).

b. Date of Birth (DOB):
You must write the date in numerical text, for example: 3/17/1988.

c. Sex:
You must indicate "M" for male and "F" for female.

d. Telephone Number:
You must always indicate the area code with the telephone number.

e. Address:
   You must verify the address with an ID card.

f. Social Security Number (SSN#):
   If patient's SSN# is not on the Health Insurance card, please request it from the patient. The SSN# will be used as the Patient ID#.

g. Chart Number:
   This is used for any information the ordering physician wants to appear on the test result. For example: the patient's Chart number or telephone number. Please note: if the ordering physician wants the phone number to appear on the result you must duplicate that same information in both the Telephone number and Chart Number areas.

h. Date Collected:
   You must document the current date, also known as the Date of Service (DOS).

i. Time Collected:
   You must document the current time.

j. Fasting/Non-Fasting:
   You must document if the patient has been fasting or not, which means if the patient has had anything to eat for more than 8 hours or not.

k. Billing Information:
   You must indicate the patient's Bill type from list on the right hand side of the requisition form. All Medicare patients must sign the ABN on the back of the requisition form.

Client / Ordering Physician Information

The Client and Physician information are located on the upper right hand side of the requisition form. The upper section pertains to the Client information and directly below it is where the Ordering Physician is documented. It is extremely important that every requisition form is submitted with ID # for both the Client and Ordering Physician. Please note: both the Client and Ordering Physician may have the same ID# or different ID#. Please contact our Client Services Department if you do not have the appropriate ID numbers or if you encounter one of the following scenarios.

a. Pre-printed requisition forms
   If the Client information is already pre-printed on the requisition form, any corresponding physicians pertaining to that Client should also be pre-printed either on the top or bottom of the requisition form with their ID#. If not contact our Client Services Department for the ID#.

b. Non-Preprinted requisition forms

If the Client and Ordering Physician's name and ID# are not pre-printed on a FL requisition form, you must contact Client Service Department to obtain the Client and Ordering Physician ID#. If that information is not on file, please provide the following information:

1. Client's full name
2. Ordering Physician's first and last name
3. Address
4. Telephone
5. Fax
6. NPI number
7. CA license
8. UPIN (if applicable)

Finally, it is important to document "New Client" on top of the requisition form.

Ordering Tests / Panels

After verifying that the patient is eligible for laboratory services with Foundation Laboratory, and documenting the Patient Demographic information, the last step when preparing a requisition form is to clearly identify all the test and/or panels ordered by the physician. Using pre-printed requisition forms allow our physicians to simply mark or check off the appropriate test and/or panel needed. However, if a test and/or panel is not included on the requisition form, please note that every order must be **valid** and **legible**; otherwise there may be delay in processing the specimen. Please feel free to contact our Client Services Department for any assistance prior to specimen collection.