Medicare will continue to increase its efforts to cut spending through aggressive review of claims and the use of new fraud and abuse regulations. Providers must be especially careful to provide correct procedure codes that define precisely what services have been provided and accurate diagnosis codes that link those procedures or tests to an appropriate diagnosis. Medicare reimbursement rules for clinical laboratory procedures are explained, including the proper use of procedure and diagnosis codes. Coding and payment for new automated test panels are discussed, as well as the economic consequences of using smaller panels. Medicare coverage requirements, including medical necessity, are described, as well as the proper use of advance beneficiary notices and the Medicare appeals process.

Medicare Payment for Clinical Laboratory Services

Medicare consists of two parts: Medicare Part A covers inpatient hospitalization costs, once the annual deductible has been met, for almost everyone age 65 and older plus the permanently disabled and those with chronic renal disease. Coverage under Part A is automatic. Payment for inpatient care in most hospitals is based on a fixed fee determined for each diagnosis (diagnosis-related groups, DRGs). DRGs are not applied to physician services. Laboratory tests performed for Medicare inpatients are considered a part of the DRG payment. Medicare Part B covers physician services, outpatient clinical laboratory, and x-ray tests for eligible persons along with other medical services and supplies not covered under Part A. Part B is voluntary; however, most who are eligible sign up. There is an annual deductible and a 20% co-payment for all Part B services except outpatient clinical laboratory services.

Most clinical laboratory procedures are paid from laboratory fee schedules issued by individual Medicare carriers. Medicare carriers are contractors, usually large insurance companies, who administer Part B Medicare services in each state. There are 57 carriers, including one for each state and territory plus two in California and three in New York. All physician services, including pathology services not included in the laboratory fee schedule, are paid according to the Physician Fee Schedule. Unlike the laboratory fee schedule, under this schedule co-payments of 20% are collected from the beneficiary so that the actual payment received from Medicare for a given procedure is 80% of the Physician Fee Schedule amount.

Before Medicare pays for any test or diagnostic service, two basic criteria must be met: (a) the service must be covered by Medicare, and (b) the service must be medically necessary and indicated. Once these two criteria are met, Medicare pays for most clinical laboratory tests based on the applicable Laboratory Fee Schedule. Each carrier publishes a unique laboratory fee schedule and adjusts payment levels as determined by Congress during the annual budget process. Updates, when granted, are effective January 1st.

NATIONAL FEE LIMITATIONS

National caps apply to most laboratory tests. These caps define the maximum amount a carrier may pay for a given test. The 1998 National Limitation amounts for any given test are based on 74% of the median amount listed on all carriers’ fee schedules for a particular laboratory test. National caps were reduced from 76% to 74% effective January 1, 1998, resulting in a reduction of 2.63% for most clinical laboratory tests.

Fee schedules may be adjusted only by statutory changes approved by Congress. When the fee schedule is

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1 Nonstandard abbreviations: DRG, diagnosis-related group; CPT, Physicians’ Current Procedural Terminology; HCFA, Health Care Financing Administration; HCPCS, Health Care Financing Administration, Common Procedural Coding System; AMA, American Medical Association; AST, aspartate transaminase; SGOT, serum glutamic-oxaloacetic transaminase; GGT, gamma glutamyltransferase; BUN, blood urea nitrogen; ALT, alanine aminotransferase; SGPT, serum glutamic-pyruvic transaminase; HDL-C, HDL-cholesterol; LDL-C, LDL-cholesterol; ICD-9, International Classification of Diseases; and ABN, Advance Beneficiary Notice.

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adjusted by a given percentage, national caps are adjusted up or down by the same amount. Medicare payment for clinical laboratory tests is always the lowest of the fee schedule, the national cap, or the actual amount billed. The changes shown in Table 1 have been made to laboratory fees since 1984, when the Laboratory Fee Schedule was established. The dollar amounts at the right-hand side of Table 1 show the effect of fee schedule changes on a test that was reimbursed at $10.00 in 1984.

Certain clinical diagnosis procedures listed in the Pathology and Laboratory sections of the Physicians' Current Procedural Terminology (CPT) (1) are not considered a part of the laboratory fee schedule. The procedures listed below are paid from the Physician Fee Schedule at 80% of the amount listed on that fee schedule. The beneficiary is responsible for the remaining 20% once the annual deductible has been met. These procedures are not subject to national limitations:

- Clinical pathology consultations
- Bone marrow smears and biopsy
- Blood bank physician services
- Skin tests
- Anatomical and surgical pathology services
- Duodenal and gastric intubation
- Sputum and sweat collection

Medicare tests must be billed on an assigned basis. This means that the provider must accept the Medicare reimbursement as payment in full for any covered laboratory test. Medicare patients may not be billed for any additional amounts for covered tests. (See below for policies regarding tests that are not covered by Medicare). Medicare patients may be billed for non-covered services. The mandatory assignment requirement for laboratory tests applies regardless of whether the physician is participating (accepts assignment for all Medicare services) or non-participating (does not accept assignment for all Medicare services).

Direct billing is also required for all Medicare-reimbursed laboratory tests. Tests must be billed directly to Medicare by the laboratory or physician performing the tests. If an outside laboratory performs a test on a referral from a physician, only the reference laboratory may legally bill Medicare for the procedure.

However, hospitals and reference laboratories that send specimens to other laboratories may bill Medicare for tests performed by the other laboratories if the referring laboratory meets any one of the following three exceptions:

(a) The referring laboratory is located in or is part of a rural hospital;
(b) The referring laboratory is wholly owned by the reference laboratory, or the referring laboratory wholly owns the reference laboratory, or both referring laboratory and reference laboratory are wholly owned by a third entity; or
(c) No more than 30% of the clinical diagnostic tests for which a laboratory receives requests annually are performed by another laboratory other than an ownership-related laboratory.

For the purpose of the 30% exception, each CPT code billed counts as one test. For example, when CPT code 80054 is billed, it is counted as one test although 12 tests are performed.

### The Health Care Financing Administration Common Procedure Coding System

Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) codes were created as a common coding system to be used nationally for processing Medicare claims. HCPCS codes must be used when preparing claims for Medicare and Medicaid patients. The HCPCS system consists of the following three levels:

- Level I, which constitutes the major part of the system, is the CPT coding system. For most claims submitted, the CPT code is all that is required.
- Level II, National HCPCS Codes, begin with a letter (A–V) and are followed by four numbers. Most of these codes are used for describing supplies and do not apply to laboratory and pathology procedures. These codes are the same throughout the US.
- Level III, Local or Intermediary HCPCS codes, begin with W–Z or S and are followed by four digits. These codes are established by local Medicare carriers and are seldom used.

When code levels overlap, local codes have top priority, national codes second, and CPT codes lowest priority.

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**Table 1. Changes in the Medicare laboratory fee schedule.**

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984</td>
<td>Payment established for each laboratory procedure</td>
<td>$10.00</td>
</tr>
<tr>
<td>1985</td>
<td>4.1% increase in all fees</td>
<td>$10.41</td>
</tr>
<tr>
<td>1986</td>
<td>National limitations imposed at 115% of median</td>
<td>$10.41</td>
</tr>
<tr>
<td>1987</td>
<td>5.4% increase in all fees</td>
<td>$10.97</td>
</tr>
<tr>
<td>1988</td>
<td>Caps reduced to 100% of median</td>
<td>$9.54</td>
</tr>
<tr>
<td>1989</td>
<td>4% increase in all fees</td>
<td>$9.92</td>
</tr>
<tr>
<td>1990</td>
<td>4.7% increase in all fees; caps reduced to 93% of median</td>
<td>$9.66</td>
</tr>
<tr>
<td>1991</td>
<td>2% increase in all fees; caps reduced to 88% of median</td>
<td>$9.32</td>
</tr>
<tr>
<td>1992</td>
<td>2% increase in all fees</td>
<td>$9.51</td>
</tr>
<tr>
<td>1993</td>
<td>2% increase in all fees</td>
<td>$9.70</td>
</tr>
<tr>
<td>1994</td>
<td>Caps reduced to 84% of median</td>
<td>$9.26</td>
</tr>
<tr>
<td>1995</td>
<td>Caps reduced to 80% of median</td>
<td>$8.82</td>
</tr>
<tr>
<td>1996</td>
<td>2.7 increase in all fees; caps reduced to 76% of median</td>
<td>$8.56</td>
</tr>
<tr>
<td>1997</td>
<td>2.6% increase in all fees</td>
<td>$8.78</td>
</tr>
<tr>
<td>1998</td>
<td>Caps reduced to 74% of median (2.63% reduction)</td>
<td>$8.55</td>
</tr>
</tbody>
</table>
CPT CODES
The procedure code is one of the most important parts of a Medicare claim. The code used determines what and if a laboratory will be paid for any given test or procedure. Use of CPT codes for submitting Medicare claims became mandatory in 1987. Most other insurance companies and third party payers also use these codes to identify what medical procedures have been performed in the course of any episode of illness or medical treatment.

CPT codes are revised and published annually by the American Medical Association (AMA). Of the >7000 procedures listed, ~950 apply to clinical laboratory tests and pathology services. The official AMA-published CPT manual together with its comprehensive cross index should always be used as the primary tool when searching for a particular procedure or test.

Many payers interpret and apply coding rules in unique and sometimes arbitrary ways. The only way to assure full reimbursement for any given procedure is to regularly review claims payments. The success of a coding strategy can be verified only by submitting claims, monitoring the payments received, and comparing the amounts actually paid to the Medicare fee schedules.

Laboratory tests are listed in the CPT by a common procedure name followed by additional information that describes the method, specimen source, or other details. The common procedure name is not repeated when used with more than one code. Care must be taken in reading individual entries to refer back to the common name that precedes the semicolon and to see if any subheadings apply more specifically to the test being coded than the principal code.

PROCEDURE CODE MODIFIERS
Procedure code modifiers are two-digit codes added to the basic five-digit CPT code. Modifiers are used to describe unusual circumstances or to provide additional information regarding a test or procedure. HCFA has created the following additional modifiers which may be used in submitting Medicare claims.

-GA, waiver of liability statement on file. This modifier is used to indicate that the provider has notified a Medicare patient that the test performed may not be reimbursed by Medicare and may be billed to the patient. Situation-specific waivers of liability must be obtained by a provider and signed by the patient if the patient is to be billed for tests or other services not covered by Medicare.

-GB, distinct procedural service. This modifier is used to indicate that a procedure or service is distinct or separate from other service(s) performed on the same day. For example, performance of a follow-up test after obtaining an abnormal result from a more general clinical test.

-QP, individually ordered automated test or panel. This modifier is used to indicate that automated chemistry tests or panels containing only automated chemistry tests were ordered individually and as such are not subject to medical necessity documentation requirements.

-QW, CLIA waived category test. This modifier is used to indicate a CLIA-waived procedure was used.

-QR, repeat clinical diagnostic lab test performed on the same day to obtain subsequent reportable test value(s) (separate specimens taken in separate encounters). This modifier is used when it is necessary to obtain multiple results in the course of treatment, for example, concentrations of drugs or hormones during treatment or challenge tests. This modifier is not to be used when codes are available that describe the series of results, e.g., glucose tolerance.

When a modifier is employed, additional information should be provided to support its use. In most cases, use of the modifier alone will not guarantee appropriate reimbursement. Modifiers are to be used sparingly. It is better to use a more specific primary code (with no accompanying description) to describe what was done.

Medicare Coding Rules for Clinical Laboratory Services
When coding individual clinical laboratory procedures, the following coding rules apply:

(a) Select the name of the procedure that most accurately identifies the service being performed. The listing of a procedure under a particular specialty in the CPT does not restrict its use to that specific specialty.

(b) When a procedure for a specific analyte is not listed, use the method code that most accurately identifies the procedure used. As a last resort, use an unlisted service code (those ending in 99) plus appropriate description of the procedure.

(c) Procedures that include multiple tests may not be “unbundled” into component procedures. Unbundling is considered an abusive practice by Medicare.

(d) Multiple codes may be used to describe a single panel or profile so long as the unbundling rule is not violated.

(e) Unless otherwise specified, laboratory procedures are assumed to be quantitative.

Additional coding rules apply to test panels and profiles. If a specific code exists for a given combination of tests, that code must be used. It is considered billing fraud to unbundle a test panel to obtain higher reimbursement if a single code exists that more accurately describes the test panel.

Specimen Collection Codes
Specimen collection codes are used to identify phlebotomy and other services required to obtain body fluids or tissue for laboratory analysis. Medicare and most other
payers allow a separate specimen collection charge for drawing or collecting specimens by venipuncture or catheterization whether the specimen is processed on site or referred to another laboratory for analysis. Only one collection fee is allowed for each patient encounter, even when multiple specimens may be collected. When a series of specimens is collected for a single test (for example, glucose tolerance), the series is treated as a single encounter. For non-Medicare claims, the following CPT code is used:

36415 ROUTINE VENIPUNCTURE OR FINGER/HEEL/EAR STICK for collection of specimen(s)

For Medicare claims the following HCPCS code is used:

G0001 ROUTINE VENIPUNCTURE FOR COLLECTION OF SPECIMEN

This code is used to avoid confusion over the inclusion of finger/heel/ear stick specimens in code 36415. Code G0001 must be used for all Medicare venipunctures (and urine collections by catheterization).

Physician laboratories may charge for specimen collection only when (a) it is accepted and prevailing practice among physicians in the locality to make a separate charge for drawing or collecting a specimen, and (b) it is the customary practice of the physician performing such a service to bill separately for specimen collection. In other words, physicians may collect the $3.00 Medicare venipuncture fee only if they also charge other payers for blood draws.

Specimen collection fees are also paid when it is medically necessary for a laboratory technician to draw a specimen from either a nursing home or homebound patient. The technician must personally draw the specimen. When a laboratory performs the specimen collection, it may receive payment both for the draw and the associated travel to obtain the specimen(s) for testing. Payment may be made to the laboratory even if the nursing facility has on-duty personnel qualified to perform the specimen collection. When the nursing home performs the specimen collection, it may receive payment only for the draw. Specimen collection performed by nursing home personnel for patients covered under Medicare Part A is paid for as part of the payment to the facility for its reasonable costs, not on the basis of the specimen collection fee.

The $3.00 Medicare specimen collection fee does not apply to non-routine venipuncture or arterial punctures. Arterial punctures for blood gas testing should be coded as CPT 36600 (arterial puncture, withdrawal of blood for diagnosis). Non-routine venipunctures, such as those common to pediatrics and those performed in atypical vein sites, should be coded using cardiovascular codes, 36400-36410 or 36420-36425. Medicare reimbursement for these procedures is paid from the Physicians’ Medicare Fee Schedule rather than the Medicare Laboratory Fee Schedule.

A code for 24-h urine specimens (81050, volume measurement for timed collection, each) was added in 1993 and is used whenever a volumetric measure of urine is required to report a test result.

**Travel Allowance Codes**

Travel allowance codes are used to identify estimated travel costs when collecting a specimen from a nursing home or homebound patient. A separate fee is payable to cover transportation and expenses for trained personnel who travel to a nursing home or homebound patient to collect a sample. This allowance is made only when a specimen collection fee would be payable. No travel allowance is made when the technician merely performs a messenger service to pick up a specimen drawn by a physician or nursing home personnel. Furthermore, the travel allowance may not be paid to a physician unless the trip to the homebound or nursing home patient was solely for the purpose of drawing a specimen.

HCPCS codes used for travel allowances for Medicare claims are as follows:

P9603 TRAVEL ALLOWANCE-ONE WAY: in connection with medically necessary laboratory specimen collection drawn from homebound or nursing home patient, prorated as miles actually traveled (carrier allowance on per mile basis); or

P9604 TRAVEL ALLOWANCE-ONE WAY: in connection with medically necessary laboratory specimen collection drawn from homebound or nursing home patient, prorated as a trip charge (carrier allowance on flat fee basis).

**Drug Testing Codes**

The following codes are to be used for qualitative instrumental methods:

80100 DRUG SCREEN: multiple classes, each procedure

80101 DRUG SCREEN: single class, each procedure

80102 DRUG CONFIRMATION: each procedure

Quantitative assays should be coded using the appropriate method code or 83520 (immunoassay, other than antibody or infectious agent antigen, quantitative, not otherwise specified).

CPT code 80100 or 80101 is used for the initial screen, depending on whether the method detects multiple classes or a single class of drugs. Each confirmatory identification procedure is coded separately using 80102. These codes may be used in addition to the codes listed in the Therapeutic Drug Assay section of the CPT if the drug(s) determined qualitatively is subsequently quantified.

For example, an overdose of phenobarbital is suspected after obtaining a positive result for a urine screen...
for barbiturates. A quantitative serum assay for phenobarbital is then performed. Coding would be as follows:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80101</td>
<td>DRUG SCREEN: single class (Barbiturates)</td>
</tr>
<tr>
<td>80184</td>
<td>PHENOBARBITAL</td>
</tr>
</tbody>
</table>

**Evocative/Suppression Testing**

Evocative/suppression testing codes (CPT 80400 through 80440) are used when evocative or suppressive agents are administered, and the subsequent patient response relative to baseline values is measured. These codes are used only for the laboratory component of the overall test. Physician administration of evocative or suppressive agent is reported using the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90780</td>
<td>INFUSION FOR THERAPY/DIAGNOSIS: administered by physician or under direct supervision of physician up to 1 h</td>
</tr>
<tr>
<td>90781</td>
<td>INFUSION FOR THERAPY/DIAGNOSIS: administered by physician or under direct supervision of physician, each additional hour, up to 8 h</td>
</tr>
<tr>
<td>90782</td>
<td>THERAPEUTIC OR DIAGNOSTIC INJECTION: subcutaneous or intramuscular</td>
</tr>
<tr>
<td>90783</td>
<td>THERAPEUTIC OR DIAGNOSTIC INJECTION: intraarterial</td>
</tr>
<tr>
<td>90784</td>
<td>THERAPEUTIC OR DIAGNOSTIC INJECTION: intravenous</td>
</tr>
</tbody>
</table>

Supplies and drugs used in performing evocative/suppression panels are reported using CPT code 99070 (supplies and materials provided by physician over and above those usually included with the office visit or other services rendered). Appropriate evaluation and management codes may be used to report physician attendance and monitoring. Prolonged physician care codes may be used if appropriate, but not for prolonged infusions reported under CPT codes 90780 and 90781.

**Allergy Testing**

Allergen-specific IgE determinations are coded using the following two codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>86003</td>
<td>ALLERGEN-SPECIFIC IgE: quantitative semi-quantitative, each allergen</td>
</tr>
<tr>
<td>86005</td>
<td>ALLERGEN-SPECIFIC IgE: qualitative, multiallergen screen (dipstick or disk)</td>
</tr>
</tbody>
</table>

CPT code 86003 should be submitted for each allergen determined.

Other allergy testing is described under the Medicine section of the CPT using the following codes (954004-95078). These codes are not part of the laboratory fee schedule and are paid from the Physician Fee Schedule.

**SCRATCH, PUNCTURE, AND PRICK TESTS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>95004</td>
<td>PERCUTANEOUS TESTS: with allergenic extracts, immediate type reaction, specify number of tests</td>
</tr>
<tr>
<td>95010</td>
<td>PERCUTANEOUS TESTS: sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, specify number of tests</td>
</tr>
</tbody>
</table>

**INTRADERMAL TESTS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>95015</td>
<td>INTRACUTANEOUS TESTS: sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, specify number of tests</td>
</tr>
<tr>
<td>95024</td>
<td>INTRACUTANEOUS TESTS: with allergenic extracts, immediate type reaction, specify number of tests</td>
</tr>
<tr>
<td>95028</td>
<td>INTRACUTANEOUS TESTS: with allergenic extracts, delayed type reaction, including reading, specify number of tests</td>
</tr>
</tbody>
</table>

**OTHER TESTS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>95027</td>
<td>SKIN END POINT</td>
</tr>
<tr>
<td>95044</td>
<td>PATCH OR APPLICATION TEST(S): specify number of tests</td>
</tr>
<tr>
<td>95052</td>
<td>PHOTO PATCH TEST(S): specify number of tests</td>
</tr>
<tr>
<td>95056</td>
<td>PHOTO TESTS</td>
</tr>
<tr>
<td>95060</td>
<td>OPHTHALMIC MUCOUS MEMBRANE TESTS</td>
</tr>
<tr>
<td>95065</td>
<td>DIRECT NASAL MUCOUS MEMBRANE TEST</td>
</tr>
<tr>
<td>95070</td>
<td>INHALATION BRONCHIAL CHALLENGE TESTING: with histamine, methacholine, or similar compounds</td>
</tr>
<tr>
<td>95071</td>
<td>INHALATION BRONCHIAL CHALLENGE TESTING: with antigens or gases, specify</td>
</tr>
<tr>
<td>95075</td>
<td>INGESTION CHALLENGE TEST</td>
</tr>
<tr>
<td>85078</td>
<td>PROVOCATIVE TESTING: (for example, Rinkel test)</td>
</tr>
</tbody>
</table>

CPT codes for percutaneous (scratch, puncture, or prick), intracutaneous (intradermal), and patch tests include test performance, evaluation, and correlation with the patient’s history, physical examination, and other observations. The number of tests should be dependent upon history, physical findings, and clinical judgment. All patients should not receive the same number or type of sensitivity tests.

**Molecular Diagnostics Procedures**

Molecular diagnostics procedures are coded by procedure rather than analyte using the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>83890</td>
<td>MOLECULAR DIAGNOSTICS: molecular isolation or extraction</td>
</tr>
</tbody>
</table>

Clinical Chemistry 44, No. 8, 1998 1717
New antigen-specific codes are now used to describe infectious agent antigen detection and quantification using molecular diagnostic procedures (see New Codes for 1998 below).

**Antibody Identification Codes**

Antibody identification codes are organized together in the Immunology section of the CPT (codes 86602 through 86804). These procedures must be coded as precisely as possible. When multiple tests are performed to detect antibodies to a specific organism or class of immunoglobulin, each assay is to be coded separately.

For example, if antibodies to Coxsackie A and B viruses are determined using two separate assays, the following codes would be used:

86658 ANTIBODY: Enterovirus (Coxsackie A)
86658 ANTIBODY: Enterovirus (Coxsackie B)

If the IgM immunoglobulin class was subsequently determined for each type of virus, the same code would be used two more times:

86658 ANTIBODY: Enterovirus (Coxsackie A, IgM)
86658 ANTIBODY: Enterovirus (Coxsackie B, IgM)

When a specific antibody is not listed, one of the following general purpose codes or the appropriate method code should be used:

86790 ANTIBODY: virus, not listed elsewhere
86671 ANTIBODY: fungus, not listed elsewhere
86609 ANTIBODY: bacterium, not listed elsewhere

Identification of antibodies to antigens other than viruses, fungi, or bacteria are coded by method rather than analyte. For example, an immunofluorescent titer for Trichinella antibodies (a parasite) would be coded as:

86256 FLUORESCENT ANTIBODY: titer, each antibody

**CLIA 1988 Waived Test Codes**

CLIA 1988 waived test codes have been assigned to the following simple tests commonly performed in physician offices and other locations. These tests are not subject to many of the regulatory requirements of the Clinical Laboratory Improvement Act of 1988.

80061QW LIPID PANEL
81001QW URINALYSIS: automated dipstick, with microscopy
81002QW URINALYSIS: automated dipstick without microscopy
82044QW MICROALBUMIN: urine, semiquantitative (reagent strip)
82273QW OCCULT BLOOD: other sources, qualitative
82465QW CHOLESTEROL: serum, total
82947QW GLUCOSE: quantitative
82950QW GLUCOSE, POST GLUCOSE DOSE: including glucose
82951QW GLUCOSE TOLERANCE TEST: 3 specimens including glucose
82952QW GLUCOSE TOLERANCE TEST: each additional specimen beyond 3
82985QW GLYCATED PROTEIN
83718QW LIPOPROTEIN, HDL CHOLESTEROL: direct measurement
83986QW pH BODY FLUID: except blood
84478QW TRIGLYCERIDES
85013QW SPUN MICROHEMATOCRIT
85014QW BLOOD COUNT, HEMATOCCRIT: other than spun
85018QW BLOOD COUNT, HEMOGLOBIN
85610QW PROTHROMBIN TIME
86318QW IMMUNOASSAY FOR INFECTIOUS AGENT ANTIBODY: qualitative, one step
8588QW STREPTOCOCCUS: direct screen
87072QW CULTURE OR DIRECT BACTERIAL ID: each organism, by commercial kit, other than urine

Rather than continue to create new codes for each CLIA-waived product approved by the Food and Drug Administration, HCFA has chosen to use a modifier (QW) to designate waived tests. Payment, in general is the same as for the non-waived version of the same test. The following waived procedures are included in the 1998 laboratory fee schedule:
Unlisted Procedure Codes
When a specific analyte is not listed in the CPT, an unlisted procedure code may be used. However, these codes should be used only as a last resort because many payers will require additional “development” or explanation of why the test was performed. No Medicare fee schedule amounts are published for these codes.

Method Codes
When a specific test analyte can not be found in the CPT, a method code may be used to define the test performed. Such codes may be used only when a more specific code is not available.

Changes in the 1998 CPT
The following new codes have been added to the laboratory section of the 1998 CPT.

MISCELLANEOUS LABORATORY PROCEDURES
80201 TOPIRAMATE
83019 H. PYLORI BREATH TEST: (including drug and breath sample collection kit)
84512 TROPONIN: qualitative
86148 ANTI-PHOSPHATIDYLSEERINE: (Phospholipid)
86361 T CELLS: absolute CD4 count

AUTOMATED TEST PANELS
80049 BASIC METABOLIC PANEL
80054 COMPREHENSIVE METABOLIC PANEL
80051 ELECTROLYTE PANEL

Coding rules and medical necessity documentation requirements for automated tests and automated test panels are discussed under New Automated Multichannel Tests.

HEPATITIS TESTS
86704 HEPATITIS B CORE ANTIBODY: IgG and IgM
86705 HEPATITIS B CORE ANTIBODY: IgM
86706 HEPATITIS B SURFACE ANTIBODY
86707 HEPATITIS B e ANTIBODY
86708 HEPATITIS A ANTIBODY: IgG and IgM
86709 HEPATITIS A ANTIBODY: IgM
86803 HEPATITIS C ANTIBODY
86804 HEPATITIS C ANTIBODY: confirmatory test

INFECTIOUS AGENT ANTIGENS
An extensive new section covering the detection and quantification of infection agent antigens by various methods has been added under "Microbiology" in the Laboratory section of the CPT. These codes replace the following general method codes, which have been deleted.

86313 IMMUNOASSAY FOR INFECTIOUS AGENT ANTIGEN: qualitative, multiple-step method
86315 IMMUNOASSAY FOR INFECTIOUS AGENT ANTIGEN: qualitative, single-step method

The new codes are organized under the following seven methods:

(a) detection by direct fluorescent antibody technique;
(b) detection by enzyme immunoassay technique, qualitative or semiquantitative multitest method;
(c) detection by enzyme immunoassay technique, qualitative or semiquantitative, single-step method;
(d) detection by nucleic acid (DNA or RNA), direct probe technique;
(e) detection by nucleic acid (DNA or RNA), amplified probe technique;
(f) detection by nucleic acid (DNA or RNA), quantification; and
(g) detection by immunoassay with direct optical observation.

The following individual CPT codes have been assigned to specific infectious agents under each method category. A general purpose code for unspecified agents is also included for each method.

INFECTIOUS AGENT ANTIGEN DETECTION BY DIRECT FLUORESCENT ANTIBODY TECHNIQUE: qualitative or semiquantitative, multitest method

87260 Adenovirus
87265 Bordetella pertussis or parapertussis
87270 Chlamydia trachomatis
87272 Cryptosporidium/giardia
87274 Herpes simplex virus
87276 Influenza A virus
87278 Legionella pneumophila
87280 Respiratory syncytial virus
87285 Treponema pallidum
87290 Varicella zoster
87299 Not otherwise specified

INFECTIOUS AGENT ANTIGEN DETECTION BY ENZYME IMMUNOASSAY TECHNIQUE, qualitative or semiquantitative, multitest method

87301 Adenovirus enteric types 40/41
87320 Chlamydia trachomatis
87324 Clostridium difficile toxin A
87328 Cryptosporidium/giardia
87332 Cytomegalovirus
87335 Escherichia coli 0157
87340 Hepatitis B surface antigen
87350 Hepatitis Be antigen
87380 Hepatitis: delta agent
87385 Histoplasma capsulatum
87390 HIV-1
87391 HIV-2
INFECTIOUS AGENT DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL OBSERVATION

A new series of CPT codes for antigen detection by nucleic acid (DNA or RNA) techniques has been created for the following infectious agents. Each infectious agent detection is classified as either by direct probe technique, amplified probe technique, or quantification.

**Embryo Preparation and Transfer Codes**

The following new codes are now available:

- 89251 CULTURE AND FERTILIZATION OF OOCYTE(S): with coculture of embryos
- 89252 ASSISTED OOCYTE FERTILIZATION: microtechnique
- 89253 ASSISTED EMBRYO HATCHING: microtechniques
- 89254 OOCYTE IDENTIFICATION FROM FOLLICULAR FLUID
- 89255 PREPARATION OF EMBRYO FOR TRANSFER
- 89256 PREPARATION OF CRYOPRESERVED EMBRYOS FOR TRANSFER
- 89257 SPERM IDENTIFICATION FROM ASPIRATION: other than seminal fluid
- 89258 CRYOPRESERVATION: embryo
- 89259 CRYOPRESERVATION: sperm
- 89260 SPERM ISOLATION: simple prep, for insemination or diagnosis with semen analysis
- 89261 SPERM ISOLATION: complex prep, for insemination or diagnosis with semen analysis

**Organ- or Disease-oriented Panels**

When the following organ- or disease-oriented panel codes are used, all included tests must be performed. Medicare reimbursement for these panels is equal to the sum of the fee schedule amounts of the individual tests included. Medicare does not consider the general Health Panel (80050) and the Obstetric Panel (80055) to be covered services.

- 80049 BASIC METABOLIC PANEL: new automated test panel
- 80050 GENERAL HEALTH PANEL: not reimbursed by Medicare
- 80051 ELECTROLYTE PANEL: new automated test panel
- 80054 COMPREHENSIVE METABOLIC PANEL: new automated test panel
- 80055 OBSTETRIC PANEL: not reimbursed by Medicare
- 80058 HEPATIC FUNCTION PANEL: new automated test panel
- 80059 HEPATITIS PANEL
- 80061 LIPID PANEL
- 80072 ARTHRITIS PANEL
- 80090 TORCH ANTIBODY PANEL
- 80091 THYROID PANEL
- 80092 THYROID PANEL WITH THYROID-STIMULATING HORMONE

**Use of the New Automated Test Panels**

The 1998 CPT contains four new “clinically relevant” test panels, which are designed to replace automated, multichannel test codes 80002 through 80019 and HCPCS
codes G0058 through G0060, which have been deleted. These new panels are as follows:

80049 BASIC METABOLIC PANEL: (the following 7 tests must be performed to use this code)

<table>
<thead>
<tr>
<th>Test</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbon dioxide</td>
<td>Potassium</td>
</tr>
<tr>
<td>Chloride</td>
<td>Sodium</td>
</tr>
<tr>
<td>Creatinine</td>
<td>Urea nitrogen (BUN)</td>
</tr>
<tr>
<td>Glucose</td>
<td></td>
</tr>
</tbody>
</table>

80054 COMPREHENSIVE METABOLIC PANEL: (the following 12 tests must be performed to use this code)

<table>
<thead>
<tr>
<th>Test</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albumin</td>
<td>Protein</td>
</tr>
<tr>
<td>Bilirubin, total</td>
<td>Sodium</td>
</tr>
<tr>
<td>Calcium</td>
<td>Aspartate aminotransferase (AST)</td>
</tr>
<tr>
<td>Chloride</td>
<td>Serum glutamic-oxaloacetic transaminase (SGOT)</td>
</tr>
<tr>
<td>Creatinine</td>
<td>Urea nitrogen (BUN)</td>
</tr>
<tr>
<td>Glucose</td>
<td></td>
</tr>
</tbody>
</table>

80051 ELECTROLYTE PANEL: (the following 4 tests must be performed to use this code)

<table>
<thead>
<tr>
<th>Test</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbon dioxide</td>
<td>Potassium</td>
</tr>
<tr>
<td>Chloride</td>
<td>Sodium</td>
</tr>
</tbody>
</table>

80058 HEPATIC FUNCTION PANEL: (the following 6 tests must be performed to use this code)

<table>
<thead>
<tr>
<th>Test</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albumin</td>
<td>Alanine aminotransferase (ALT)</td>
</tr>
<tr>
<td>Bilirubin, total</td>
<td>Serum glutamic-pyruvic transaminase (SGPT)</td>
</tr>
<tr>
<td>Bilirubin, direct</td>
<td></td>
</tr>
<tr>
<td>Alkaline phosphatase</td>
<td></td>
</tr>
<tr>
<td>AST, SGOT</td>
<td></td>
</tr>
</tbody>
</table>

This panel is the same as the already existing Hepatic Function Panel except that direct bilirubin has been added so that six rather than five tests are now included.

Although the automated multichannel test codes have been deleted from the CPT, the former list of automated multichannel tests has been retained by HCFA for use in pricing these tests. The following assays are classified as automated, multichannel tests:

<table>
<thead>
<tr>
<th>Test</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albumin</td>
<td>Lactate dehydrogenase</td>
</tr>
<tr>
<td>Bilirubin, direct</td>
<td>Phosphatase, alkaline</td>
</tr>
<tr>
<td>Bilirubin, total</td>
<td>Phosphorus</td>
</tr>
<tr>
<td>Calcium</td>
<td>Protein, total</td>
</tr>
<tr>
<td>Chlorides</td>
<td>Sodium</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>AST, SGOT</td>
</tr>
<tr>
<td>Creatine kinase</td>
<td>ALT, SGPT</td>
</tr>
<tr>
<td>Creatinine</td>
<td>Triglycerides</td>
</tr>
<tr>
<td>Gamma glutamyl-</td>
<td>Urea nitrogen (BUN)</td>
</tr>
<tr>
<td>transferase (GGT)</td>
<td>Uric acid</td>
</tr>
<tr>
<td>Glucose</td>
<td></td>
</tr>
</tbody>
</table>

The new Medicare coding rules for automated, multichannel tests are effective January 1, 1998.

Under the old rules, all automated multichannel tests were to be bundled into the corresponding CPT code for the total number of automated multichannel tests performed. With the demise of the automated multichannel test codes from the CPT, Medicare has adopted the following new coding rules, which no longer require bundling of these tests.

Tests on Medicare’s uniform list of automated procedures may be billed using:

(a) the new panel codes;
(b) organ/disease panel codes that contain automated multichannel tests;
(c) individual automated test codes; or
(d) any combination of new automated test panels, organ/disease panels, and/or individual automated multichannel test codes.

This new policy means that it is now impossible to improperly unbundle automated multichannel because any combination of individual tests and panels that contain automated, multichannel tests are to be accepted by Medicare Carriers.

**Medicare Payment Policy for Automated, Multichannel Tests**

Medicare has retained the automated, multichannel fee schedule for reimbursement purposes. Last year’s fees have been updated to yield the 1998 fee schedule (Table 2) for automated, multichannel tests.

Reimbursement for the new automated, multichannel test panel codes is based on the number of automated tests in each panel.

<table>
<thead>
<tr>
<th>Code</th>
<th>Panel</th>
<th>Paid the same as</th>
<th>1998 National Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>80049</td>
<td>Basic metabolic panel</td>
<td>ATP07</td>
<td>$11.29</td>
</tr>
<tr>
<td>80051</td>
<td>Electrolytes panel</td>
<td>ATP04</td>
<td>$ 9.69</td>
</tr>
<tr>
<td>80058</td>
<td>Hepatic function panel A</td>
<td>ATP05</td>
<td>$10.81</td>
</tr>
<tr>
<td>80054</td>
<td>Comprehensive metabolic panel</td>
<td>ATP12</td>
<td>$12.48</td>
</tr>
</tbody>
</table>

Medicare carriers have been instructed by HCFA to pay for all combinations of new and existing automated, multichannel test panels and single automated tests starting January 1, 1998, according to the following rules.

Carriers are to:

Step 1: Unbundle each panel into automated and non-automated tests;

---

Because total and direct bilirubin are coded using the same CPT code (82251), HCFA has chosen to count the CPT codes rather than the number of tests and pay this six-test panel as though it contained only five tests. The old Hepatic Function Panel (80058) included bilirubin (total or direct), which when coded separately is 82250. The new Hepatic Function Panel includes bilirubin (total and direct), which when coded separately is 82251.
Step 2: Eliminate all duplicate tests resulting from overlapping panel test compositions;  
Step 3: Rebundle all remaining automated tests together and pay according to the updated automated,  
multichannel fee schedule (see above); and  
Step 4: Pay all nonautomated tests individually based on the applicable laboratory fee schedule.

Although carriers have been instructed to install edits to accomplish the proper rebundling and payment for unbundled claims, it remains to be seen how accurate their reimbursement will be. It would be wise to monitor payments and Explanation of Benefits summaries for all automated tests and panels to ensure that payments are correct. If a carrier does not reimburse correctly for the tests submitted and overpays and the provider does not refund an overpayment, Medicare at a later date may accuse the provider of making a False Claim. Likewise, if the carrier underpays, the provider needs to refile the claim to receive proper payment. Thus, it would be wise to monitor all payments and promptly refund or refile to make sure that no liability is incurred for overpayments and that no payments are less than they should be.

### Table 2. 1998 Medicare reimbursement for automated multichannel tests.

<table>
<thead>
<tr>
<th>Number of tests performed</th>
<th>Payment code*</th>
<th>1998 Medicare payment limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ATP01</td>
<td>$ 7.20</td>
</tr>
<tr>
<td>2</td>
<td>ATP02</td>
<td>$ 7.20</td>
</tr>
<tr>
<td>3</td>
<td>ATP03</td>
<td>$ 9.18</td>
</tr>
<tr>
<td>4</td>
<td>ATP04</td>
<td>$ 9.69</td>
</tr>
<tr>
<td>5</td>
<td>ATP05</td>
<td>$10.81</td>
</tr>
<tr>
<td>6</td>
<td>ATP06</td>
<td>$10.84</td>
</tr>
<tr>
<td>7</td>
<td>ATP07</td>
<td>$11.29</td>
</tr>
<tr>
<td>8</td>
<td>ATP08</td>
<td>$11.70</td>
</tr>
<tr>
<td>9</td>
<td>ATP09</td>
<td>$12.00</td>
</tr>
<tr>
<td>10</td>
<td>ATP10</td>
<td>$12.00</td>
</tr>
<tr>
<td>11</td>
<td>ATP11</td>
<td>$12.21</td>
</tr>
<tr>
<td>12</td>
<td>ATP12</td>
<td>$12.47</td>
</tr>
<tr>
<td>13</td>
<td>ATP16</td>
<td>$14.61</td>
</tr>
<tr>
<td>14</td>
<td>ATP16</td>
<td>$14.61</td>
</tr>
<tr>
<td>15</td>
<td>ATP16</td>
<td>$14.61</td>
</tr>
<tr>
<td>16</td>
<td>ATP16</td>
<td>$14.61</td>
</tr>
<tr>
<td>17</td>
<td>ATP18</td>
<td>$14.71</td>
</tr>
<tr>
<td>18</td>
<td>ATP18</td>
<td>$14.71</td>
</tr>
<tr>
<td>19</td>
<td>ATP19</td>
<td>$15.28</td>
</tr>
<tr>
<td>20</td>
<td>ATP20</td>
<td>$15.77</td>
</tr>
<tr>
<td>21</td>
<td>ATP21</td>
<td>$16.27</td>
</tr>
<tr>
<td>22</td>
<td>ATP22</td>
<td>$16.77</td>
</tr>
</tbody>
</table>

*These payment codes are used by HCFA as an internal reference when determining payment. They are not to be used to submit claims for automated tests. Claims submitted using these codes will be denied.

### Example I: electrolytes plus bun and creatinine

**Tests performed**
- Carbon dioxide
- Chloride
- Potassium
- Sodium
- BUN
- Creatinine

**Coding options**
- **Option A**
  - 80051 Electrolyte Panel (4 automated tests)
  - 84520 BUN
  - 82565 Creatinine
- **Option B**
  - 82374 Carbon dioxide
  - 82435 Chloride
  - 84232 Potassium
  - 84295 Sodium
  - 84520 BUN
  - 82565 Creatinine

**Medicare payment policy**
- Carrier pays for six tests
- ATP06 = $10.84

### Example II: customized liver panel

**Tests performed**
- Albumin
- Direct bilirubin
- Alkaline phosphatase
- ALT
- AST
- GGT

**Coding options**
- 80051 Albumin
- 82250 Direct bilirubin
- 84075 Alkaline phosphatase
- 84460 ALT
- 84450 AST
- 82977 GGT

**Medicare payment policy**
- Carrier pays for six automated tests
- ATP06 = $10.84
Medical Necessity Rules for Automated Multichannel Tests

Payment will be made only for tests, including automated multichannel tests, that meet Medicare coverage rules. Tests are considered covered by Medicare if the beneficiary is eligible and presents with indications of a disease or other clinical problem. For example, screening or preventive care tests are not covered except in specific cases determined by Congress.

Starting January 1, 1998, annual mammograms (annually after age 40) and screening pelvic exams (every 3 years) will be covered, as well as annual fecal occult blood tests (beginning at age 50). As of July 1, 1998, coverage begins for expanded diabetes self-management training and bone mass measurement. Coverage for prostate cancer screening using prostate-specific antigen and a digital rectal examination begins January 1, 2000.

Medicare requires a diagnosis code (ICD-9) (2) for all laboratory tests as a means of verifying medical necessity.

Carriers have been instructed to review claims for patterns of high utilization of profiles with large numbers of tests and, if documentation (i.e., patient records and chart notes) does not support Medicare coverage, to recoup payments made in the past. Such actions can also put a provider at risk of prosecution by the Medicare Office of Inspector General under the False Claims Act for submission of medically unnecessary claims.

However, HCFA has stated that for automated, multichannel tests only: “When a physician orders automated tests on a test-by-test basis, that is, not as a part of a custom panel, each of the tests is to be considered medically necessary.”

When more than one automated, multichannel test is ordered individually, documentation supporting the medical necessity for every individual test is not required. In other words, a single valid medically necessary diagnosis can be used for all automated, multichannel tests.

---

**Example III: single automated and nonautomated tests**

<table>
<thead>
<tr>
<th>Tests performed</th>
<th>Coding options</th>
<th>Medicare payment policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potassium</td>
<td>84132 Potassium</td>
<td>Carrier pays for five</td>
</tr>
<tr>
<td>Glucose</td>
<td>82497 Glucose</td>
<td>automated tests plus</td>
</tr>
<tr>
<td>Creatinine</td>
<td>82565 Creatinine</td>
<td>thyroxine (T&lt;sub&gt;4&lt;/sub&gt;)</td>
</tr>
<tr>
<td>BUN</td>
<td>84520 BUN</td>
<td></td>
</tr>
<tr>
<td>Cholesterol</td>
<td>80061 Cholesterol</td>
<td>ATP05 $10.81</td>
</tr>
<tr>
<td>Thyroxine (T&lt;sub&gt;4&lt;/sub&gt;)</td>
<td>84436 Thyroxine (T&lt;sub&gt;4&lt;/sub&gt;)</td>
<td></td>
</tr>
</tbody>
</table>

---

**Example IV: lipid panel with direct LDL**

<table>
<thead>
<tr>
<th>Tests performed</th>
<th>Coding options</th>
<th>Medicare payment policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol</td>
<td>80061 Lipid Panel</td>
<td>Carrier pays for two</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>83721 LDL-cholesterol</td>
<td>automated tests plus</td>
</tr>
<tr>
<td>HDL-cholesterol</td>
<td>(direct measurement)</td>
<td>HDL-C and LDL-C</td>
</tr>
<tr>
<td>LDL-cholesterol</td>
<td>Option B</td>
<td></td>
</tr>
<tr>
<td>(LDL-C)</td>
<td>82465 Cholesterol</td>
<td>ATP02 $12.00</td>
</tr>
<tr>
<td></td>
<td>84478 Triglycerides</td>
<td>LDL-C $13.18</td>
</tr>
<tr>
<td></td>
<td>83718 HDL-cholesterol</td>
<td>HDL-C $11.31</td>
</tr>
<tr>
<td></td>
<td>(direct measurement)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>83721 LDL-cholesterol</td>
<td></td>
</tr>
</tbody>
</table>

Total: $36.49

---

**Example V: custom chemistry profile (chem 14)**

<table>
<thead>
<tr>
<th>Tests performed</th>
<th>Coding options</th>
<th>Medicare payment policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALT</td>
<td>84460 ALT</td>
<td>Carrier pays for 13</td>
</tr>
<tr>
<td>AST</td>
<td>84450 AST</td>
<td>automated tests</td>
</tr>
<tr>
<td>Total bilirubin</td>
<td>82250 Total or direct bilirubin</td>
<td>ATP16 = $14.61</td>
</tr>
<tr>
<td>Calcium</td>
<td>82310 Calcium</td>
<td></td>
</tr>
<tr>
<td>Cholesterol</td>
<td>83721 Cholesterol</td>
<td></td>
</tr>
<tr>
<td>Creatinine</td>
<td>82665 Creatinine</td>
<td></td>
</tr>
<tr>
<td>GGT</td>
<td>82977 GGT</td>
<td></td>
</tr>
<tr>
<td>Glucose</td>
<td>82947 Glucose</td>
<td></td>
</tr>
<tr>
<td>Alkaline</td>
<td>84075 Alkaline phosphatase</td>
<td></td>
</tr>
<tr>
<td>PhD</td>
<td>84155 Total protein</td>
<td></td>
</tr>
<tr>
<td>Total protein</td>
<td>84478 Triglycerides</td>
<td></td>
</tr>
<tr>
<td>BUN</td>
<td>84520 BUN</td>
<td></td>
</tr>
<tr>
<td>Potassium</td>
<td>84599 Uric acid</td>
<td></td>
</tr>
</tbody>
</table>

ATP05 $10.81
T<sub>4</sub> $9.50
Total $20.31
ordered and performed on the same date of service so long as the tests are ordered individually by the physician.

HCFA has also stated that the new automated, multichannel test panels as well as organ and disease panels are to be considered to be individual tests for medical necessity documentation purposes.

A special **QP modifier** is used to indicate that automated, multichannel tests were individually ordered and as such are not subject to individual documentation of medical necessity.

**Example**

Carbon dioxide, chloride, potassium, sodium, BUN, and creatinine are ordered on the same date of service.

If ordered as and billed as:
- Electrolyte Plus Profile, 80059
- Electrolyte Panel, 84520
- Creatinine, 82565

Documentation of medical necessity is required for each of the six tests performed.

If ordered as:
- Electrolyte Panel, 80059
- BUN, 84520
- Creatinine, 82565

and billed as:
- Electrolyte Panel, 80059QP
- BUN, 84520QP
- Creatinine, 82565QP

Medical necessity is assumed and only one diagnosis code is required for all of the tests (unless local medical review policy requires specific ICD-9 codes for these tests).

If ordered as:
- Carbon dioxide
- Chloride
- Potassium
- Sodium
- BUN
- Creatinine

and billed as:
- Carbon dioxide, 82374QP
- Chloride, 82435QP
- Potassium, 84132QP
- Sodium, 84295QP
- BUN, 84520QP
- Creatinine, 82565QP

Medical necessity is also assumed, and only one diagnosis code is required for all of the tests (unless local medical review policy requires specific ICD-9 codes for these tests). Note that this panel cannot be coded as a Liver panel, 80058, because it does not include direct bilirubin.

A number of tests commonly included in chemistry profiles or general health panels do not appear on the automated multichannel chemistry list in the CPT. For example:

- Amylase
- Magnesium
- Lipase
- Ferritin
- Iron
- TIBC
- HDL-cholesterol
- Apolipoproteins

These tests can be submitted to Medicare for individual payment. Because the average reimbursement level per test for automated tests is lower than the individual payment for each test, panel reimbursement increases dramatically when nonautomated tests are added to the panel and billed separately. Medical necessity is always required when such “add-on” tests are performed. If appropriate diagnosis codes are not submitted showing the necessity for performing such tests, payment may be denied by Medicare.

**Local Medical Review Policy**

Local medical review policy dictates the coverage for clinical laboratory tests in regard to medical necessity issues. The local medical review policy typically includes:

- Indications and limitations of coverage
- Covered ICD-9 codes
- Reasons for non-coverage
- Non-covered ICD-9 codes
- Documentation requirements

Local medical review policy may be published for a single assay, disease, or group of tests. Most policies connect with a single CPT code, but some apply to a group of related codes. Applicable CPT codes are cited at the beginning of each policy.

**Medical Necessity Enforcement and Penalties**

Providers can be exposed to serious legal consequences when Medicare pays for services that are later found to be medically unnecessary. Until recently, such overpayments were treated as recovery actions by the carrier and subject only to the amount of the overpayment plus interest. However, as Congress and HCFA seek ways to reduce Medicare growth, increased attention is being paid to fines and penalties as a way to both save money and generate new revenue, which can be used to finance further investigations and increase program compliance.

During the past several years, the Justice Department and HCFA’s Office of Inspector General have relied more and more on the False Claims Act to seek significant penalties and settlements in cases involving improper coding, medical necessity issues, and unbundling violations. The False Claims Act can be used to prosecute any person who knowingly presents a false or fraudulent claim for payment to the US Government. In 1986, the Act was amended to provide that “no proof of specific intent to defraud is required” and to include imposition of treble damages plus a penalty of not less than $5000 or more than $10,000 for each claim submitted.

The Health Insurance and Accountability Act of 1996 (Public Law 104-191) also includes a number of important amendments to the Civil Monetary Penalties Law regarding penalties for filing medically unnecessary claims to any federally funded health care program, including the following specific new offenses:
• Medical necessity offenses: “submission of a claim which a person knows or should know is for a medical item or service which is not medically necessary”
• Upcoding offenses: “a pattern or practice of presenting a claim based on a code which the person knows or should have known will result in greater payment than appropriate”

The penalties for the above offenses include fines of $2000 to $10 000 per line item (CPT Code) and treble the amount claimed. In addition, bounties of up to 10% of fines or recovered funds can be granted to virtually anyone (patients, employees, and others) who reports allegations of fraud or abuse or sanctionable offenses.

Billing Medicare Patients for Services That May be Denied

Medicare patients may be billed for services that are clearly not covered. For example, routine physicals or screening tests such as total cholesterol or when there is no indication that the test is medically necessary. However, when a Medicare carrier is likely to deny payment because of medical necessity policy (either as stated in their written Medical Review Policy or upon examination of individual claims), the patient must be informed and consent to pay for the service before it is performed. Otherwise, the patient has no obligation to pay for the test.

An Advance Beneficiary Notice (ABN; sometimes called a patient waiver form) is used to document that the patient is aware that Medicare may not pay and has agreed to pay the provider in the event payment is denied. Each ABN must be specific to the service provided and the reason that Medicare may not pay for the service. Blanket waivers for all Medicare patients are not allowed.

The CPT code modifier, -GA (Waiver of Liability Statement on file), is used to indicate that the provider has notified the Medicare patient that the test performed may not be reimbursed by Medicare and may be billed to the patient.

An ABN (Waiver of Liability) must:

(a) be in writing;
(b) be obtained prior to the beneficiary receiving the service;
(c) clearly identify the particular service;
(d) state that the provider believes Medicare is likely to deny payment for the service;
(e) give the reason(s) that the provider believes that Medicare is likely to deny payment for the specific service; and
(f) include the beneficiary’s signature and date.

Routine notices to beneficiaries that do nothing more than state that Medicare denial of payment is possible, or that the provider never knows whether Medicare will pay for a service, will not be considered acceptable evidence of advance notice. Unacceptable practices include (a) giving notice for all claims or services; (b) failing to list the specific reason or rationale for likely denial; and (c) failing to state the particular service which Medicare is likely to deny.

The sample ABN shown meets the statutory requirements as outlined above.

Limiting Liability Relative to Medical Necessity Issues

The following actions should be useful in dealing with the new medical necessity rules:

(a) Initiate educational programs for physicians and laboratory staff so that both understand what is required in terms of medical necessity documentation.
(b) Note any local Medicare carrier policy regarding medical necessity published in Medicare bulletins and disseminate to both laboratory personnel and physicians.
(c) Make sure that the source of ICD-9 codes can be documented and traced to the ordering physician.
(d) Review all laboratory requisitions to make sure they comply with Medicare medical necessity rules. All automated tests should be ordered individually unless the selected tests constitute one of the new organ/disease-oriented panels listed in the 1998 CPT.
(e) Make sure you have all current medical necessity policy from your carrier.
(f) Create educational materials that help physicians select the correct ICD-9 codes. For example, lists of ICD-9 codes that relate to particular tests or CPT codes.
(g) Institute a compliance program that ensures the education of all personnel involved in coding and billing Medicare tests, which includes education, periodic third party review, and punitive measures for individuals who do not follow the rules.

How to Appeal Medicare Denials

Medicare denials of payment based on medical necessity that are believed to be incorrect or clinically inappropriate may be appealed using the process outlined below. Statutory exclusions, i.e., services defined as non-payable under Medicare law, cannot be appealed. For example, denials based on any of the following reasons may be contested using the appeals process:

(a) the test or procedure is not medically necessary (whether or not based on carrier medical review policy);
(b) inappropriate coding practice;
(c) the test is not recognized as generally accepted medical practice by carrier;
(d) an assay is arbitrarily defined as screening test; or
(e) the test is considered a “research” procedure.
Denial of payment for the following services, which are never covered by Medicare, may not be appealed:

(a) screening tests for asymptomatic patients;
(b) routine physicals;
(c) most preventive care; and
(d) patient-requested tests that the physician knows, or should know, do not meet the Medicare carrier’s medical necessity criteria.

The amount paid for any given procedure, as defined on the carrier fee schedule, may not be appealed because these fees are set and can be modified in most cases only by Congress.

STEP 1: Within 6 months of receiving an Explanation of Benefits form, laboratories have the right to request a review by an employee not involved in the original determination. This step requires requesting a review of attached denial(s) and the reason the claim(s) should be paid; this can be done with HCFA form 1964. The carrier must acknowledge the request within 45 days, and the response must come from someone not involved in the original payment determination.

STEP 2: If the result of the carrier review is still unsatisfactory, and the amount in question is at least $100, laboratories may request a fair hearing within 6 months of an adverse review determination.

A detailed letter or HCFA form 1965 should be used. The hearing may be in person or via phone, or can rely only on submitted documents. The carrier must acknowledge the request within 45 days and arrange for the date and time of the hearing. This step provides the opportunity to present the case in person, usually to the Medical Review office and his/her staff.

STEP 3: If the matter is not resolved by the Fair Hearing, and the amount in question is at least $500, one may request a hearing by an administrative law judge within 60 days of an adverse fair hearing determination. The administrative law judge is bound only by Medicare law and regulations, not HCFA’s administrative directives to carriers or any individual carrier’s interpretation of HCFA policy. The hearing may be in person or via phone. Unsatisfactory determinations by an administrative law judge can be appealed to US District Court for amounts over $1000.

Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862(a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary under Medicare program standards, Medicare will deny payment for that service.

I believe that, in your case, Medicare is likely to deny payment for the following service(s) for the reason(s) stated below:

Date of Service ______

Procedure or Service:

________________________

Reason for likely Medicare denial:

________________________

I have been notified by my provider that he/she believes in my case Medicare is likely to deny payment for the service(s) identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Beneficiary Signature ___________________________ Date ___________
Conclusions
Medicare will continue to increase its efforts to cut spending through aggressive review of claims and use of the many new fraud and abuse regulations passed by Congress in the 1998 Balanced Budget Act and other legislation. Providers and clinical laboratories must be especially careful to provide correct procedure (CPT) codes, which define precisely what services have been provided, and accurate diagnosis (ICD-9) codes, which link those procedures or tests to an appropriate diagnosis. Ignorance will not be accepted as an excuse by Medicare for improperly filed or documented claims. All coding practices should be reviewed at least annually and documented as part of a written laboratory compliance plan for maximum protection from recoupment actions and false claims liability in the future.

References