

Laboratory Services

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A laboratory is defined as any facility that performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention or the treatment of or impairment of disease, or for the assessment of health.

LABORATORY CODES

Panel Codes

The American Medical Association (AMA) CPT Board approved automated laboratory panels that comprise specific automated tests frequently performed in conjunction with one another. They were developed to facilitate ordering of common groupings of tests (refer to the 1998 CPT book). Panel codes that replaced CPT codes 80002-8-19 and HCPCS codes G0058 through G0060 are as follows (for additional panels, refer to the CPT book):

80048 Basic metabolic panel

This panel must include the following:

- Calcium (82310)
- Carbon dioxide (82374)
- Chloride (82435)
- Creatinine (82565)
- Glucose (82947)
- Potassium (84132)
- Sodium (84295)
- Urea nitrogen (BUN) (84520)

80051 Electrolyte panel

This panel must include the following:

- Carbon dioxide (82374)
- Chloride (82435)
- Potassium (84132)
- Sodium (84295)

80053 Comprehensive metabolic panel

This panel must include the following:

- Albumin (82040)
- Bilirubin, total (82247)
- Calcium (82310)
- Carbon dioxide (82374)
- Chloride (82435)
- Creatinine (82565)
- Glucose (82947)
- Phosphatase, alkaline (84075)
- Potassium (84132)
- Protein, total (84155)
- Sodium (84295)
- Transferase, alanine amino (ALT)(SGPT)(84460)
- Transferase, aspartate amino (AST)(SGOT)(84450)
- Urea nitrogen (BUN)(84520)

When all of the medically necessary tests ordered match a grouping, bill the appropriate panel. Unnecessary tests must not be added in order to match a panel. When the tests ordered do not group into a panel code, bill each test separately.

Individual Laboratory Codes

Listed below are 22 tests that can be billed separately when they do not match to codes 80048, 80051 or 80053:

82040	Albumin	84075	Phosphatase, Alkaline
82250	Bilirubin, Direct or Total	84100	Phosphorus
82551	Bilirubin, Total and Direct	84132	Potassium
82310	Calcium	84155	Protein Total
82374	Carbon Dioxide Content	84295	Sodium
84450	Transaminase, Glutamix Oxa Oacetic (SGOT)	84478	Triglycerides
82435	Chlorides	84520	Urea nitrogen (BUN)
84460	Transaminase, Glutamic Pyruvic (SGPT)	84550	Uric acid
82465	Cholesterol		
82550	CPK (Creative Phosphoskinase)		
82565	Creatinine		
82947	Glucose (Sugar, Fasting Blood)		
82977	GGT (Gamma Glutamyl) (Transpeptidase)		
83615	Lactic Dehydrogenase (LDH)		

These sample HCFA-1500 claims illustrate the proper way to bill for individual automated lab tests when the combination of automated tests does not match an automated panel code. A sample Remittance and Status Advice (RA) follows each claim.

The first claim

Date (s) of service MM/DD/CCYY MM/DD/CCYY		Place of Service	Type of service	Procedures, Services, supplies CPT	Diagnosis Code	Charges	Days or units	EPSDT
05/02/2000	05/02/2000	11	3	84450		7.14	1	
05/02/2000	05/02/2000	11	3	84460		7.18	1	
05/02/2000	05/02/2000	11	3	84550		7.14	1	
05/02/2000	05/02/2000	11	3	84075		7.15	1	
05/02/2000	05/02/2000	11	3	82977		9.95	1	
05/02/2000	05/02/2000	11	3	84132		6.35	1	
						Total Charge		
						44.91		

Sample RA for first claim

NAME RECIPIENT ID	SERVICE DATES	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	Total Billed	Non Allowed	Total Allowed	Payable Cutback	Payable Charge	Other Deducted Charges	Paid Amount	Explanat ion Codes
PAID CLAIMS MEDICAL											
GOODMAN KRISTIN 242598966S	CO=41 RCC=		CLAIM NUMBER =1020001812033052NCXIX MEDREC=35221								
	05022000 05022000	1	3 84450								
	05022000 05022000	1	3 84460	7.14	0.00	9.39	0.00	0.00	0.00	9.39	99
	05022000 05022000	1	3 84550	7.18	7.18	0.00	0.00	0.00	0.00	0.00	2954
	05022000 05022000	1	3 84075	7.14	7.14	0.00	0.00	0.00	0.00	0.00	2954
	05022000 05022000	1	3 82977	7.15	7.15	0.00	0.00	0.00	0.00	0.00	2954
	05022000 05022000	1	3 84132	9.95	9.95	0.00	0.00	0.00	0.00	0.00	2954
	05022000 05022000	1	PTLIB= COPAY=0.00 TPL=	6.35	6.35	0.00	0.00	0.00	0.00	0.00	2954

Total payment for all of the lab tests are listed on the first lab detail of the RA. The RA will list each automated test billed with EOB 2954: "Reimbursement for this lab service was made on a previously paid detail. Reimbursement is determined by the number of automated tests billed. Payment is reflected on the first detail." The total reimbursement for the six automated lab tests billed is \$ 9.39.

If the provider later discovers that all the automated tests performed on that date of service were not included on the first claim, another claim may be submitted for the other automated lab tests as follows:

Second claim

Date (s) of service MM/DD/CCYY MM/DD/CCYY		Place of Service	Type of service	Procedures, Services, supplies CPT	Diagnosis Code	Charges	Days or units	EPSDT
05/02/2000	05/02/2000	11	3	84100		6.56	1	
						Total Charge 6.56		

Second RA

NAME RECIPIENT ID	SERVICE DATES	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	Total Billed	Non Allowe d	Total Allowed	Payable Cutback	Payable Charge	Other Deducted Charges	Paid Amount	Explanation Codes
			PAID CLAIMS MEDICAL								
SMITH MARY 123456789S	CO=41 RCC= 05022000 05022000	1	CLAIM NUMBER =1020002000000000NCXIX MEDREC=35221 3 84100 PTLIB= COPAY=0.00 TPL=	6.56	5.04	1.52	00	1.52	00	1.52	2955

HCFA mandates that the total amount paid for individual laboratory procedure codes not exceed the maximum fee allowed for lab panel fees. Reimbursement for automated lab tests is based on the total number of lab tests performed and not on the fee for each individual automated lab test.

Maximum reimbursement based on the number of tests is:

Number of tests	Reimbursement Rate (effective 4/1/00)
2	\$7.20
3	\$9.18
4 to 6	\$9.39
7 to 12	\$10.91
13 to 16	\$11.49
17 to 18	\$13.69
19 or more	\$14.69

PATHOLOGY SERVICES

The N.C. Medicaid program has aligned reimbursement criteria for pathology services to be consistent with Medicare reimbursement criteria.

Type of Service

Physician pathology services have both a technical modifier, TC and professional modifier, 26, component. When physician pathology codes listed below are performed in a hospital setting, the physician must bill only for the professional component by using modifier 26 in block 24D of the HCFA-1500 claim form. The hospital will receive reimbursement for only the technical component.

When a physician pathology service is performed in an independent laboratory, the complete procedure must be billed either by billing the professional component using modifier 26 plus the technical component, modifier TC, in block 24 of the HCFA-1500 claim form, or by billing the complete procedure with no modifier in block 24D. Reimbursement is the same for either billing option; neither can exceed the allowance for the complete procedure.

- No modifier denotes the billing of the complete procedure when the provider performs both the technical and professional components.
- Modifier 26 is the professional component. The professional component involves the supervision and interpretation of the CPT procedure. The provider using modifier 26 must prepare a written report that includes findings, relevant clinical issues, and, if appropriate, comparative data. This documentation must be retained in the patient's medical records for a period of not less than five years.
- Modifier TC is the technical component. The technical component charges are usually institutional charges such as equipment or cutting of slide.

Certain diagnostic tests have codes defining a complete procedure. Other tests have codes that define a professional and an associated technical component of the test. Do not bill modifier TC with a procedure code that describes the technical component of the procedure in the code definition. For example, code 93041, *Rhythm ECG, one to three leads, tracing only without interpretation and report*, cannot be billed with modifier TC. Do not bill modifier 26 with a procedure code that describes the professional component of the procedure in the code definition. For example, code 93010, *Electrocardiogram, routine ECG with at least 12 leads, interpretation and report only*, cannot be billed with modifier 26.

Changes to Billing for Pap Smears

The following policy changes were effective with date of service June 1, 2000 when billing pap smears:

Physician Interpretation Procedure Code and Billing Information

CPT 88141 is the only code that physicians may use to bill the **physician interpretation** of a Pap smear. Code 88141 has no components; therefore it must be billed without a modifier. For dates of service June 1, 2000 and after, code 88141 appended with modifier 26 will be denied. Hospitals billing for the physician interpretation should bill 88141 on the HCFA-1500 claim form using the hospital's professional provider number.

Technical Pap Smear Component Procedure Codes and Billing Information

The technical procedure codes are listed below. The provider rendering the technical service must choose a technical procedure code from one of the following methods:

Thin Layer	Non-Bethesda	Bethesda	Not Specified
88142	88150	88164	88147
88143	88152	88165	88148
88144	88153	88166	
88145	88154	88167	

Laboratories and physicians: Bill the technical component procedure code without a modifier on the HCFA-1500 claim form.

Hospitals: Bill the technical component procedure code, without a modifier, using **Revenue Code (RC) 311** on the UB-92 claim form.

BILLING REQUIREMENTS AND LIMITATIONS

Venipuncture and Specimen Collection

Medicaid reimburses for venipuncture specimen collection fee, code G0001, only to the provider who extracted the specimen. The provider billing for this collection fee must be sending the lab work outside his office to be performed. One collection fee is allowed for each recipient, regardless of the number of specimens drawn.

Pap Smears

As mentioned earlier, Medicaid covers three types of pap smears. However, these codes should not be used for collection of specimen. The collection of the pap smear is incident to the office visit and no separate fee is allowed. Physicians who do not perform the laboratory test should not bill for the pap smear. Only the provider who actually performs the laboratory test should bill. Medicaid does not recognize purchased service arrangements.

Handling Fee

Medicaid does not reimburse for handling or conveyance of specimen.

Laboratory Examination Diagnosis

Medicaid does not reimburse for the generic diagnosis code V726, laboratory examination. Claims will deny with an EOB stating: "An ICD-9 CM diagnosis code supporting the medical necessity of this service must be submitted on the claim. Refile with the appropriate diagnosis code."

Laboratory claims are subject to the same billing limitations as other providers. If an independent lab submits a claim with a diagnosis related to an abortion, hysterectomy or sterilization procedure performed on a Medicaid recipient, all federal guidelines must be met before any related claim can be paid. When the appropriate consent statement does not meet federally mandated requirements or is not on file at EDS, all related claims will deny.

Laboratories can contact either the attending physician's billing office or EDS Provider Services to determine if the consent statement has been filed.

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)

Definition

Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988, which established minimum quality standards for all laboratory testing to ensure high quality patient testing regardless of laboratory location.

Types

There are three categories of testing based on complexity of the testing method: Waived tests; moderate complexity, including the subcategory of Provider Performed Microscopy (PPM); and high complexity. Based on the complexity of the testing performed, CLIA specifies regulations for quality control, quality assurance, patient test management, personnel, inspections, and proficiency testing to assure accurate and reliable testing.

Requirements

Laboratories must obtain certification, pay applicable fees and comply with regulations regarding proficiency testing, personnel, inspections, patient test management, quality control, and quality assurance. The Health Care Financing Administration (HCFA) has undertaken an initiative to monitor CLIA compliance for physician office laboratories (POLs) as well as independent laboratories.

Medicaid requires all laboratories to have their CLIA certification number on file to receive reimbursement for any laboratory procedures. Physicians are reminded that they may only bill for those tests for which they are certified.

Providers may contact EDS Provider Services at 1-800-688-6696 or 919-851-8888 to verify that their CLIA certification number is on file. Complete and return the form below to place your CLIA certification number on file with Medicaid. You must include a copy of your CLIA certificate with a copy of this form. Mail form and certificate to the address listed below.

EDS Provider Enrollment Unit
P.O. Box 300009
Raleigh, North Carolina 27622

CLIA Certification Information Number

Provider Name _____ Provider Number _____

Street Address _____

City _____

State _____

Zip Code _____

Phone Number _____

Contact Person _____

CLIA Number _____

To correct the CLIA certification information, contact the CLIA state agency from which the CLIA certification was obtained.

In North Carolina:

CLIA Certification
PO Box 29530
Raleigh, North Carolina 27626-0530
(919) 733-3032

In states other than North Carolina:

Contact EDS Provider Services at 1-800-688-6696 for a CLIA representative

To update CLIA information for Medicaid, submit a copy of the correct current CLIA certificate with CLIA form to:

EDS Provider Enrollment Unit
P.O. Box 300009
Raleigh, North Carolina 27622