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Lab Coding and Billing

by Roberta Buell, M.B.A.

Q *Why is Medicare so particular about laboratory coding and billing?*
A Medicare is concerned about overutilization of laboratory testing. All physicians order laboratory testing, whether or not they charge directly for the tests. As a result, millions of dollars are spent on these services. There is a belief among HCFA/Medicare carriers that payments to physician offices and independent labs are often excessive. Thus, Medicare has targeted these areas: bundling and lack of medical necessity. A physician or laboratory caught doing either of these can be subject to fraud and abuse penalties.

Q *What are the most problematic areas of laboratory billing?*
A More than likely you will run into problems in one of two major areas: "bundling" (sometimes also known as "unbundling") and "lack of medical necessity." Bundling is the arrangement of several groups of codes together in order to bill a higher code. Bundling mostly applies to chemistry panels. For example, a physician orders a glucose and potassium test for a patient; however, the testing equipment may report as many as sixteen laboratory tests at once. Problems arise when a reimbursement claim mistakenly bills for more tests than were ordered. Staff should ensure that there are no discrepancies between the physician order and the reimbursement claim.

"Lack of medical necessity" involves a test deemed unreasonable or unnecessary based on the patient's condition or chart documentation. A primary concern in this area is billing for tests that are in fact screening for a diagnosis like hypercholesterolemia in the absence of symptoms. Remember, Medicare will not pay for screening.

Q *How can I bill for laboratory services correctly?*
A Diagnosis coding is key. Regularly scan your carrier's bulletins for its diagnosis guidelines for chemistry tests and complete blood counts (CBCs). If the patient's diagnosis code does not meet these guidelines, you might check to see if you could use V58.1 (encounter for chemotherapy) for your chemotherapy patients. In many areas, this code is an allowed diagnosis for blood counts and chemistries.

Q *What chart documentation justifies laboratory testing?*
A The following items should be documented in the chart:
- *A test order.* A separate order must be made for the specific tests performed. For example, an order for a CHEM-16 or an SMAC-12 would not be reimbursed because a code no longer exists for those tests. Physicians should learn the new terminology for chemistry panels; otherwise they should order tests individually or check them off an order sheet.
- *Documentation of a reason for the test.* Most cancer patients have legitimate grounds for these services. However, if the test is performed in the absence of a diagnosis or an "accepted" (by the carrier) diagnosis, the patient should sign an Advanced Beneficiary Notice (ABN) and pay for the test. Bill only for diagnoses documented in the patient chart.
- *Results of the test.* This information proves that the test was actually performed. The results may be written or printed.

Q *What lab patterns would trigger a Medicare audit?*
A If your billing exceeds other oncologists in the area, or if you are billing for more expensive tests than other oncologists in your area, you might attract the attention of Medicare auditors, particularly if the tests are performed in a physician-owned laboratory.

Q *What's new in laboratory coding for 1999?*
A These coding changes will be effective immediately for Medicare. (Some carriers may have already implemented these changes, but they will be effective for all by April 1, 1999.)
- *Bilirubins.* The hepatic function panel (80058) now has six tests as opposed to five.
- *Lab panels.* Carbon dioxide, "bicarb" (82374), has now been added to the chem panels and bilirubin direct (80054) has been subtracted.
- *Reticulocytes.* Blood count, reticulocytes (85046), has been added as a single test.
- *Indices.* The most notable change for oncologists is the deletion of indices 85029-85030.
- *Modifier-QC.* This modifier must still be used for CLIA-waivered tests.

Have a coding question? You can e-mail your questions to Ms. Buell at codemistress@documedics.com. Or, you may submit your questions in writing to Ms. Buell c/o *Oncology Issues* at 11600 Nebel Street Suite 201, Rockville MD 20852-2557. Fax: 301-770-1949.

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