



Coding *and* Payment Guide for Laboratory Services

*An essential coding, billing and reimbursement resource
for laboratory and pathology services*

2016

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of the HCPCS Level II codes and the quarterly updates to this code set may be found at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html.

Non-Medicare acceptance of HCPCS Level II codes is idiosyncratic. Providers should check with the payer before billing these codes.

Claim Forms

Institutional (facility) providers use the UB-04 claim form, also known as the CMS-1450, or the electronic 837I format to file a Medicare Part A claim to Medicare contractors.

Noninstitutional providers and suppliers (private practice or other health care providers offices) use the CMS-1500 form or the 837P electronic format to submit claims to Medicare contractors for Medicare Part B-covered services. Medicare Part A coverage includes inpatient hospital, skilled nursing facilities (SNF), hospice, and home health. Medicare Part B coverage provides payment for medical supplies, physician, and outpatient services.

Not all services rendered by a facility are inpatient services. Providers working in facilities routinely render services on an outpatient basis. Outpatient services are provided in settings that include rehabilitation centers, certified outpatient rehabilitation facilities, SNFs, and hospitals. Outpatient and partial hospitalization facility claims might be submitted on either a CMS-1500 or UB-04, depending on the payer.

For professional component billing, most claims are filed using ICD-9-CM diagnosis codes to indicate the reason for the service, CPT codes to identify the service provided, and HCPCS Level II codes to report supplies on the CMS-1500 paper claim or the 837P electronic format.

A step-by-step guide for completing the CMS-1500 and UB-04 claim forms and an explanation of the claims filing process can be found in the claims processing section of this *Coding and Payment Guide*.

Contents and Format of This Guide

The chapters following this introduction provide information regarding the reimbursement process, documentation, and claim completion, respectively.

The fifth chapter, "Procedure Codes for Laboratory Services," contains a numeric listing of procedure codes. Each page identifies the information associated with that procedure including an explanation of the service, coding tips, associated diagnoses, related terms, and CMS internet-only manual (IOM) references that identify any official references found in the CMS Online Manual System. The full excerpt from the CMS Online Manual System pertaining to the reference is provided in the Medicare official regulatory information chapter. The full excerpt from the CMS Online Manual System pertaining to the reference is provided in the Medicare official regulatory information appendix. The full text of all of the IOMs may be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>. The procedure code pages also have a list of codes from the official *Centers for Medicare and Medicaid Services National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive or mutually exclusive procedures and should not be reported separately. Please note that

the CCI edits will be updated quarterly and posted on Optum's website at <http://www.optumcoding.com/cciedits>. Finally, all relative value information relevant to the code is listed at the bottom of the page.

Please note that this list of associated ICD-9-CM codes is not all inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

Glossary and CLIA-Waived Tests

The final section consists of:

- A glossary of coding, billing and, clinical terms applicable to laboratory and pathology
- A listing of the tests granted waived status under the Clinical Laboratory Improvements Amendment (CLIA)

Laboratory Cross-Coder

In addition you will find with this book a CD containing up-to-date CPT laboratory codes linked to the ICD-9-CM and HCPCS coding systems.

Some CPT codes are omitted from the listing because consistent and reliable cross-links are almost impossible to establish. Unlisted procedures are an obvious example. Certain types of add-on codes also are treated somewhat differently.

The laboratory cross coder information presents the most likely scenarios as derived from clinical information sources and federal national coverage determinations (NCD). However, the laboratory cross coder information is not a substitute for ICD-9-CM, or any other medical coding reference, and users are urged to regularly consult all available sources. The absence of any specific code does not necessarily indicate that its association to the base procedure is inappropriate. Likewise, the inclusion of a code does not guarantee coverage.

How to Use This Guide

The chapters: "The Reimbursement Process," "Documentation—An Overview," and "Claims Processing" may be read in their entirety and/or used as references. When using this *Coding and Payment Guide* for code assignment, follow these important steps to improve accuracy and experience fewer overlooked diagnoses and services:

- **Step 1.** Carefully read the medical record documentation that describes the patient's diagnosis and the service provided. Remember, more than one diagnosis or service may be documented.
- **Step 2.** Locate the main term for the procedure or service documented in the CPT index. This will identify the procedure code that may be used to report this service.
- **Step 3.** Locate the procedure code in the chapter titled "Procedure Codes." Read the explanation and determine if that is the procedure performed and supported by the medical record documentation. The Terms to Know section may be used ensure appropriate code assignment.

80047

80047 Basic metabolic panel (Calcium, ionized)

Explanation

A basic metabolic panel with ionized calcium includes the following tests: calcium (ionized) (82330), carbon dioxide (82374), chloride (82435), creatinine (82565), glucose (82947), potassium (84132), sodium (84295), and urea nitrogen (BUN) (84520). Blood specimen is obtained by venipuncture. See the specific codes for additional information about the listed tests.

Coding Tips

Report organ or disease-oriented panel codes only when each panel component in the panel definition is performed. The assignment of organ or disease oriented panel codes is optional for most non-Medicare payers. You may assign an organ or disease panel code or opt to report each individual assay code. Medicare guidelines state that if all tests of a CPT defined panel are performed, the provider may bill the panel code or the individual component test codes. The panel codes may be used when the tests are ordered as that panel or if the individual component tests of a panel are ordered separately. According to CPT guidelines, do not report two or more organ or disease-oriented panels when any of the same tests are performed in each panel and the panels are performed from the same patient collection. When a group of tests overlap two or more panels, report the panel that has the greatest number of tests allowing the definition of that panel to be met and then report the remaining tests using the appropriate individual test codes. This test may be performed using a CLIA-waived test system. Laboratories with a CLIA-waived certificate must report this code with modifier QW CLIA-waived test. See appendix 1 for CLIA-waived kits and test systems. An ionized calcium basic metabolic panel should not be billed in addition to a comprehensive metabolic panel (80053). Venipuncture is separately reportable. For collection of venous blood by venipuncture, see code 36415. When venipuncture on a patient 3 years of age or older requires the skill of a physician or other qualified health care provider, see code 36410. For venipuncture on a patient younger than 3 years of age performed by a physician or other qualified health care provider, see codes 36400-36406. Most third-party payers and state scope of work exclude the use of a code requiring a physician or other qualified health care provider, by a phlebotomist, or other unlicensed clinical staff.

Terms To Know

CLIA. Clinical Laboratory Improvement Amendments. Requirements set in 1988, CLIA imposes varying levels of federal regulations on clinical procedures. Few laboratories, including those in physician offices, are exempt. Adopted by Medicare and Medicaid, CLIA regulations redefine laboratory testing in regard to laboratory certification and accreditation, proficiency testing, quality assurance, personnel standards, and program administration.

laboratory. Facility for the virological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of or the assessment of the health of human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities that only collect or prepare specimens (or both) or act only as a mailing service and do not perform tests are not considered laboratories.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-2,11,20.2; 100-2,11,30.2.2; 100-2,15,80.1; 100-4,16,40.6.1; 100-4,16,70.8; 100-4,16,100.6

	Work Value	Non-Fac PE	Fac PE	Malpractice	Non-Fac Total	Fac Total
80047.....	0.00	0.00	0.00	0.00	0.00	0.00

Appendix 1. CLIA Waived Tests

TESTS GRANTED WAIVED STATUS UNDER CLIA

<u>CPT CODE(S)</u>	<u>TEST NAME</u>	<u>MANUFACTURER</u>	<u>USE</u>
81002	Dipstick or tablet reagent urinalysis – non-automated for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen	Various	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
81025	Urine pregnancy tests by visual color comparison	Various	Diagnosis of pregnancy
82270 82272 (Contact your Medicare carrier for claims instructions.)	Fecal occult blood	Various	Detection of blood in feces from whatever cause, benign or malignant (colorectal cancer screening)
82962	Blood glucose by glucose monitoring devices cleared by the FDA for home use	Various	Monitoring of blood glucose levels
83026	Hemoglobin by copper sulfate – non-automated	Various	Monitors hemoglobin level in blood
84830	Ovulation tests by visual color comparison for human luteinizing hormone	Various	Detection of ovulation (optimal for conception)
85013	Blood count; spun microhematocrit	Various	Screen for anemia
85651	Erythrocyte sedimentation rate – non-automated	Various	Non-specific screening test for inflammatory activity, increased for majority of infections, and most cases of carcinoma and leukemia