

Did you know?

Facts about Medicare's Reimbursement for Clinical Laboratory Testing:

Composite Rate & Other ESRD Billing Rules

Laboratory testing included in Medicare's composite rate has remained unchanged since 1983. Composite rate testing must be billed by Spectra to the dialysis clinic.

Testing upon admission is subject to Medicare's billing rules for ESRD patients. Additional lab orders must be medically necessary in order for Spectra to be reimbursed.

A renal diagnosis (e.g., 585.6) may be used for tests ordered within composite rate frequencies but is not required. It is always the best practice to use the most specific diagnosis for all lab orders.

Medicare adopted the CDC recommendations for hepatitis testing for patients initiating treatment in a dialysis clinic. The appropriateness of future hepatitis testing depends on the patient's serologic status.

The 50/50 rule provides that if 50% or more of the Automated Multi-Channel Chemistry (AMCC) tests performed are composite rate tests, none of the AMCC tests are billable to Medicare.

It is unlikely that a monthly lab draw will pass the 50/50 rule since 50% or more of the AMCC tests are typically included in the composite rate.

Spectra counts all AMCC tests ordered and applies the 50/50 rule to determine whether a claim is submitted to Medicare.

Coverage & Screening Tests

Medicare generally only pays for services which are reasonable and necessary for the diagnosis of illness or injury.

Screening tests will be covered only when statutorily approved (e.g., annual PSA testing for men > age 50).

Generally, laboratory tests ordered with a V code from the ICD-9 code set will not be covered by Medicare if the diagnosis code description signifies screening (e.g., V73.89, screening for other specified viral disease).

Medicare Coverage Policies (NCD/LCD) & Correct Coding

National Coverage Determinations (NCDs) were established for 23 frequently ordered laboratory services in 2002 to improve uniformity in Medicare Coverage Policies.

Local Medicare Carriers still retain the authority to impose Local Coverage Determinations (LCDs) for laboratory services not currently subject to an NCD.

Medicare Coverage Policies applicable to Spectra Laboratories in either Rockleigh or Fremont may be found in the book entitled 'Clinical Lab Test Coding'.

Medicare will deny claims where ICD-9 codes do not support medical necessity in accordance with Medicare Coverage Policies. Physicians may furnish additional medical documentation, supported by the medical record, that would allow Spectra to resubmit claims for payment. Updating future test orders in your clinical system, where appropriate, may eliminate reports you receive for recurring coding issues.

Correct Coding Initiative (CCI) Edits adopted by Medicare are used to deny claims for certain tests that should not be reasonably performed in conjunction with another test (e.g., UIBC payment denied if ordered with transferrin).

Curious Facts about Medicare Lab Reimbursement

Spectra submits claims for only 7.5% of the total number of AMCC tests ordered each year after application of Medicare's ESRD billing rules.

The Medicare Modernization Act of 2003 included a 5-year payment freeze for clinical lab services, which continues through 2008.

Over the last ten years, clinical lab testing fees have received the lowest cumulative payment update among all major Medicare provider types (hospitals, physicians, etc.).



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