Part B Insider (Multispecialty) Coding Alert

Laboratory Coding: 83718 Reporting: Maximize Lipid Screening Pay

Acknowledge diagnosis restrictions to collect for lipid screening.

Medicare covers lipid screening, which could create a high test volume in your lab. That's why you need to know the ins and outs of coverage rules to make sure you're capturing all the pay you deserve.

Physicians may order any or all of the following tests to screen for cardiovascular disease, according to CMS:

- 82465 -- Cholesterol, serum or whole blood, total
- 83718 -- Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
- 84478 -- Triglycerides test.

These three tests comprise the lipid panel, so if the lab performs all three tests, you should report 80061 (Lipid panel) instead of the individual test codes. Medicare will pay for the individual tests when ordered separately, however. From a clinical standpoint, ordering the full panel makes sense. For instance, if a cholesterol test came back abnormal, the physician would need to know whether the HDL and, potentially, the low density lipoprotein (LDL) measurements were high or low to treat the patient.

Don't double dip calculated LDL: Although physicians may need to know LDL, and CPT provides a code for the test (83721, Lipoprotein, direct measurement; LDL cholesterol) you'll notice that it's not a covered test for screening because the lab typically calculates LDL from the other lipid fractions measured in a lipid panel, so you shouldn't separately charge for a calculated value. Although 83721 is not part of the screening coverage, Medicare may pay for direct-measure LDL as a diagnostic test under certain circumstances.

Use QW for waived labs: If you're a waived-status lab under the Clinical Laboratory Improvement Amendments (CLIA), don't forget to report the lipid tests 82465, 83718, 84478, or 80061 with modifier QW (CLIA waived test).

'No Symptoms' Means Screening

Medicare and other payers cover lipid screening blood tests for asymptomatic patients. That means that the beneficiary must have "no apparent signs or symptoms of cardiovasculardisease," according to the Guide to Medicare Preventive Services (www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf). When a patient has symptoms, the test becomes diagnostic rather than a screening.

Have an order: Make sure that the medical record documentation reflects that a physician or qualified nonphysician practitioner (NPP) ordered the test. Because lipid-test accuracy depends on patient fasting, you also need to document that the patient hasn't eaten for 12 hours prior to testing.

Look for These Diagnoses

Since the screening test is for asymptomatic patients, you won't have an ICD-9 condition or symptom code to show medical necessity for the test. Instead, the ordering physician should provide the lab with one of the following V codes when ordering lipid screening tests:

- V81.0 -- Special screening for ischemic heart disease
- V81.1 -- ... hypertension
- V81.2 -- ...other and unspecified cardiovascular conditions.

You may select more than one V code, but always indicate the primary reason the patient is receiving this service.

For instance: The patient has a family history of ischemic heart disease but is currently asymptomatic. No other family history is noted. In this case, you would report only V81.0, the special screening for ischemic heart disease. If the patient has multiple family history conditions, such as heart disease and hypertension, then you may select both relevant ICD-9 codes (V81.0 and V81.1). If you find no reason for the screening indicated in the chart, ask the physician why she ordered the screening.