Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Upgrade Your Lab Coding Knowledge With 5 Expert Tips

Do you know all the rules for modifiers -91 and -QW?

If you can't figure out when to report a lipid panel and an LDL cholesterol measurement on the same claim, you're not alone.

Lab test frequency limits, modifiers and bundling edits are enough to make any coder feel like a mad scientist. Prevent laboratory service claims denials with these five expert tips on the toughest lab coding issues.

1. Use Modifier -91 For Same-Day Series

When your physician performs the same lab test multiple times, you should apply modifier -91 (Repeat clinical diagnostic laboratory test) only if the repeat test is for the same patient on the same day. And these repeat tests must be physician-ordered repeats, says **Joan Logue, BS, MT-ASCP**, principal with **Health Systems Concepts Inc.** in Longwood, FL.

Example: The physician orders a hemoglobin series 83020 (Hemoglobin fractionation and quantitation; electrophoresis [e.g., A2, S, C, and or F]) for a patient suffering from bleeding to monitor the patient's condition. The physician orders one test at 8 a.m., another test at noon and a third test at 4 p.m. Because the tests are physician-ordered, you may code the procedure three times, appending modifier -91 to the second and third tests codes.

Pitfall: You many not append -91 when the code descriptor mentions repeat testing, warns Logue. For example, if your laboratory performs three glucose tolerance tests - 82951 (Glucose; tolerance test [GTT}, three specimens [includes glucose]) - you can report 82951 only once, says Logue.

Watch out: You also cannot use modifier -91 to bill for repeat tests the physician performed to confirm results, or because of laboratory testing problems, says Logue.

2. Don't Waive Without -QW

In addition to -91, modifier -QW (CLIA- waived test) is the other modifier offices with labs need to be concerned with. The Clinical Laboratory Improvement Amendments (CLIA) classify different levels of in-office laboratories for quality assurance purposes. Offices that have a "waived" lab (a lab with a certificate of waiver) must perform and report only CLIA-waived tests with modifier -QW to indicate the lab status, says **William Dettwyler, MT-AMT**, a coding analyst and president of **Codus Medicus,** a laboratory coding consulting firm in Salem, OR.

If CLIA classifies a test as moderate or high complexity, a waived laboratory must send the test order to an outside laboratory qualified to perform those tests.

Example: Many pregnancy test kits are CLIA-waived if you perform them on urine, but are moderate complexity if you perform them on serum. An office with a CLIA-waived laboratory should report **CPT 81025** (Urine pregnancy test, by visual color comparison methods) with modifier -QW. But if the physician orders a serum test, you must send the sample to an outside laboratory qualified to perform moderate complexity tests.

Editor's note: For a listing of Medicare's CLIA-waived tests, go to www.cms.hhs.gov/clia/waivetbl.pdf.

3. Hit The Right Code Every Time For Venipuncture

Targeting the right code for a blood draw is easy with Medicare because there is only one code available: 36415 (Collection of venous blood, by venipuncture). You should no longer be using G0001 (Routine venipuncture for collection of specimens); CMS deleted this code for venipuncture in 2005, notes Logue (for more information on this deletion, see CMS Transmittal 363, Change Request 3526).

Although the code for veni- puncture changed, the Medicare status of 36416 (Collection of capillary blood specimen [e.g., finger, heel, ear stick]) remains the same - not payable.

Note: Don't forget that you may bill 36415 only once per 24-hour period, points out Logue.

If your physician draws the blood sample because there is no assistant, don't be tempted to report 36410 (Veinpuncture, age 3 years old or older, necessitating physician's skill [separate procedure], for diagnostic or therapeutic purposes [not to be used for routine veinpuncture]), cautions **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CHBME,** president of **Cash Flow Solutions, Inc**. in Brick, NJ. You should only report 36410 when the skill level required to draw the blood is above that of a physician's assistant.

Example: An IV drug user needs to have blood drawn. Because his arm veins are deteriorated, the physician has to draw blood from the neck or the veins in between the fingers - a task the assistant doesn't normally perform. If you charge for 36410, be sure to indicate in the chart specifically why the physician had to draw the blood, adds Cobuzzi.

4. Prove Your License To Unbundle Lipid Panels

Coders often want to use modifier -59 (Distinct procedural service) in order to report both 80061 (Lipid panel) and 83721 (Liopoprotein, direct measurement; direct measurement, LDL cholesterol). But the National Correct Coding Initiative (NCCI) bundles 83721 into 80061. You may break the bundle with modifier -59 and report both codes, but only under special circumstances.

Use -59 when: Normally a laboratory can calculate LDL levels for the lipid panel indirectly by using the Friedewald formula, rather than running a separate test. Indirect LDL calculation isn't very accurate, however, once triglyceride levels go above a certain level, says Dettwyler.

CMS does not clearly define what constitutes a high triglyceride level, but some carrier policies do have a set level above which a lab may perform a direct measurement. For example, in its lipid profile/cholesterol testing policy, **Empire Medicare** of New Jersey states you should measure the LDL directly if triglyceride levels exceed 250 mg/dl (check with your carrier as to what it considers elevated). So if the patient's triglyceride level is above the carrier's set threshold, you may break the NCCI bundle and bill for both the direct LDL measurement and the lipid panel. Be sure to append modifier -59 to 83721 to indicate the separate test was required because of the elevated triglyceride level, Dettwyler explains.

Having documentation of the patient's elevated triglyceride level is very important, Dettwyler warns. If an audit shows you have been billing for 83721 when levels are below the specified threshold, you may have to repay Medicare.

5. Take Control of Thyroid Testing

Thyroid test coding can get tricky because of Medicare's testing restrictions and because there's no thyroid panel code so you must report all tests individually.

Know the limits on free thyroxine: Medicare limits thyroid testing to twice a year in stable patients. But Medicare will allow more frequent testing if documentation proves a patient has symptoms of hyperthyroidism (242.9x) or hypothyroidism (244.x), or if the patient is undergoing altered thyroid therapy.

The five thyroid tests you may commonly encounter are:

1. 84443 (Thyroid stimulating hormone [TSH])

2. 84436 (Thyroxine; total) [Often ordered as FT4, Free T4, or FTI]
3. 84439 (Thyroxine; free) [also known as T4 or TT4]
4. 84479 (Thyroid hormone [T3 or T4] uptake or thyroid hormone binding ratio[THBR])
5. 84480 (Triiodothyronine T3; total [TT-3])

Beware this bundle: Under the NCCI edits, you may bill for 84436 and 84479 together and get paid for both. However, you may not bill 84439 in addition to either 84436 or 84479, says Dettwyler. NCCI includes 84439 in 84436 and 84479 - and these edits have a modifier indicator of "0," which means you may not unbundle and bill for both tests separately with modifier -59, he explains.