Reimbursement for Lipid Testing on the Cholestech LDX® System

Introduction

The federal Medicare health insurance program is administered by the Health Care Financing Administration (HCFA), which is part of the US Department of Health and Human Services. Medicare consists of two parts, A and B. Medicare Part A covers inpatient hospitalization costs, while Medicare Part B covers physician services and outpatient clinical laboratory tests. This technical bulletin contains important information for correctly submitting and receiving proper reimbursement from Medicare Part B for clinical laboratory testing performed using the Cholestech LDX System.

Medicare Reimbursement for Laboratory Testing

Before Medicare will pay for laboratory testing, three basic criteria must be met:

1. The service must be one that is covered by Medicare.

2. The Medicare patient must present with symptoms or indications of a disease or other medical problem.

3. The service must be reasonable and medically necessary.

Clinical laboratory testing reimbursement is based upon laboratory fee schedules issued by individual Medicare carriers. A *carrier* is a private insurance company or organization which has a contract with the federal government to process and monitor Part B claims in a given geographical area or state. Each carrier has a unique fee schedule that is based on the Consumer Price Index for that area or state. Reimbursement is also subject to National Fee Limitations (National Caps), defined as the maximum amount a carrier may pay for a given test. Therefore, the allowable reimbursement amount of a laboratory test varies with each state depending on the specific fee schedule in effect for that particular state. Criteria for reimbursement are reviewed and updated on an annual basis. Once the fee schedule has been determined, the reimbursement amount remains in effect for a year. In addition, laboratory tests must be billed on an assigned basis. This means that the *provider* (the person who provides the services covered by Medicare, i.e. a physician) must accept Medicare reimbursement as payment in full and may not bill the patient for any additional amounts.

HCFA 1500 Form

Completion of the HCFA 1500 form is required in order to receive reimbursement for clinical laboratory testing performed in your facility.

Required documentation includes:

- CLIA license number
- CPT code indicating the test performed
- ICD-9 diagnosis code describing the medical necessity for performing the test

It is easy to transpose numbers and place information in the incorrect box. Always carefully check over the form before it is submitted.

CLIA License Number

As of January 1, 1998, HCFA is requiring all facilities providing clinical laboratory services to include their CLIA identification number on all claims (paper and electronic) submitted for reimbursement.

- For paper claims the CLIA identification number should be entered in block #23 of the HCFA 1500 claim form.

- For electronic claims, the location of the CLIA identification number is dependent on the software version of the client's electronic filing system.

  - **NSF Versions 001.04, 002.00, and 003.011**
    Report CLIA number on Record FAO, Sequence 34, positions 164-178

  - **ANSI ASC X12 Version 30.32**
    Report CLIA number on line level 2-390 REF

  - **ANSI ASC X12 Versions 30.51 3B.00 and 30.51 3B.01**
    Report CLIA number on line level 2-470 REF

Providing HCFA with the facility's CLIA identification number serves two purposes. It allows HCFA to monitor the facility's CLIA license ensuring that they are certified to perform the test and that the tests were performed within the effective date of its CLIA certificate. If the CLIA identification number is not entered on each HCFA 1500 claim form submitted for reimbursement, the claim will be returned and not processed.

If you submit a CLIA waived certificate number and neglect to enter the QW at the end of the CPT code, reimbursement will be denied.

CPT Codes (Physicians' Current Procedural Terminology)

CPT codes are used to identify laboratory tests and procedures submitted to Medicare for payment. The procedure code is the most important part of a Medicare claim. The code you use determines what and if you will be reimbursed for any given test.

Calculated values such as LDL, VLDL, and TC/HDL ratio cannot be reimbursed by Medicare. If you are using the Cholestech LDX Analyzer, *be sure to include the QW at the end of the code to denote waived testing performed on the Cholestech LDX System.*

Diagnosis Codes ICD-9 (International Classification of Disease, 9th Revision)

ICD-9 codes are used to provide a mechanism for the facility to communicate the medical necessity for each test billed. These diagnosis codes must be compatible with the CPT code used. ICD-9 codes indicate why a test was performed, CPT codes identify which specific test was provided. In choosing an ICD-9 code, be as specific as possible, code the primary diagnosis first, followed by the secondary diagnosis, and so on. Lipid testing will not be covered if the only diagnosis code entered refers to diabetes. It is necessary to enter a code referring to an aspect of lipid metabolism disorder. It is recommended that codes referring to screening, unspecified or nonspecific testing not be used. Medical records are not required to be filed with the claim, but must substantiate the medical necessity if requested.

ICD-9 codes acceptable with the Cholestech LDX System include but are not limited to:

- 272.0 - Pure Hyperlipidemia
- 414.0 - Coronary Atherosclerosis

The LDX, when operated as waived system, uses the following codes. Note that when there are two options for coding, reimbursement will be the same amount regardless of which option is chosen.

Lipid Profile, waived procedure
(Total Cholesterol, HDL Cholesterol and Triglycerides)

Option A:	80061QW	Lipid Panel, waived procedure
or		
Option B:	82465QW	Total Cholesterol, waived method
	83718QW	HDL Cholesterol, waived method
	84478QW	Triglycerides, waived method

Lipid Profile and Glucose, waived procedure
(Total Cholesterol, HDL Cholesterol, Triglycerides and Glucose)

Option A:	80061QW	Lipid Panel, waived procedure
	82947QW	Glucose, quantitative, waived procedure
or		
Option B:	82465QW	Total Cholesterol, waived method
	83718QW	HDL Cholesterol, waived method
	84478QW	Triglycerides, waived method
	82947QW	Glucose, quantitative, waived procedure

Total Cholesterol, HDL Cholesterol and Triglycerides

82465QW	Total Cholesterol, waived method
83718QW	HDL Cholesterol, waived method
82947QW	Glucose, quantitative, waived procedure

Total Cholesterol, HDL Cholesterol

82465QW	Total Cholesterol, waived method
83718QW	HDL Cholesterol, waived method

Total Cholesterol and Glucose

82465QW	Total Cholesterol, waived method
82947QW	Glucose, quantitative, waived procedure

Total Cholesterol

82465QW	Total Cholesterol, waived method

Glucose

82947QW	Glucose, quantitative
82950QW	Glucose Post Dose (includes glucose)
82951QW	Glucose Tolerance Test (3 tests)
82952QW	Glucose Tolerance Test (each additional test beyond 3 tests)

Denials

Under provisions of the law, Medicare cannot pay for tests performed as routine screening or risk assessment. Screening refers to tests performed in the absence of signs, symptoms or other abnormalities requiring further evaluation. Risk factors, such as smoking or family history cannot, by themselves, be considered abnormalities of the patient and therefore are not eligible for Medicare reimbursement. Most medical necessity based payment denials arise from what the insurer believes is inappropriate use of a procedure or test for the reported diagnosis.

If your claim is denied:

- Refer to the Explanation of Medicare Benefits (EOB) to see the carrier's explanation of denial.
- Correct whatever deficiencies are stated and resubmit the claim.
- If the denial is incorrect, the claim should be resubmitted with an explanation.
- If the claim is still denied, an appeal may be filed.
- Contact your Regional Provider with any questions or additional information.

For further information, visit
http://www.hcfa.gov

To assist you with any further questions, please call Technical Service: 800-733-0404

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