

 HAWAII HEALTH SYSTEMS C O R P O R A T I O N <i>"Touching Lives Everyday"</i> Policies and Procedures	Quality Through Compliance	Policy No.: FIN 0518
		Revision No.: N/A
Subject: Laboratory Hematology Procedures	Issued by: Corporate Compliance Committee	Effective Date: September 15, 2000
	Approved by: Thomas M. Driskill, Jr. President & CEO	Supersedes Policy: N/A Page: 1 of 4

I. PURPOSE: To bill hematology services in accordance with Medicare, Medicaid, and other federally funded payor requirements. Hematology services must not be "unbundled" (i.e., the use of two or more CPT billing codes in lieu of one inclusive code), double billed, or improperly submitted (i.e., for tests not ordered, for tests not medically necessary, etc.).

II. POLICY: Hematology procedures, which include three or more components must not be "unbundled" into individual procedures. Only one hematology panel per outpatient per date of service for federally funded programs may be billed. Hematology services billed to a federally funded program must be based on a written order and be medically necessary.

III. PROCEDURE: The following steps must be performed to bill hematology services in accordance with Medicare and other federally funded programs. It is the responsibility of the Chief Financial Office at each facility to assure adherence to this procedure.

A. Implementation:

1. Laboratory personnel review Medicare Regulations to guarantee that the proper CPT code is assigned. The recommendations are given to Hilo Data Processing who then enter the changes into the chargemaster. Clinical labs does not have access to the hospital's chargemaster and related Laboratory and Order Entry masterfiles/dictionaries.

a. Lab identifies CPT/HCPC codes as defined below and attach revenue code 305 in accordance with the UB-92 Manual for hematology components and panels. Hilo Data Processing makes changes to the chargemaster.

1) Components:

- a) 85007 Manual differential, WBC count
- b) 85009 Buffy coat differential, WBC count
- c) 85013 Spun hematocrit
- d) 85014 Hematocrit - not spun
- e) 85018 Hemoglobin
- f) 85041 RBC

2) **85048 WBC**

- a) 85595 Platelet, automated count

3) **Panels:**

- a) 85021 Hemogram, automated (RBC, WBC, Hgb, Hct, and indices only)
- b) 85022 Hemogram, automated, and manual differential WBC count (CBC)
- c) 85023 Hemogram and platelet count, automated, and manual differential WBC count (CBC)
- d) 85024 Hemogram and platelet count, automated, and automated partial differential WBC count (CBC)
- e) 85025 Hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
- f) 85027 Hemogram and platelet count, automated
- g) 85031 Blood count; hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices)

- b. Three or more components must be bundled to the appropriate panel therefore, remove charge explosions from hematology panels which contain three or more components. Two or less components may be ordered as a “panel”, but must be billed as individual components, such as H & H (Hemoglobin and Hematocrit).

2. Business office personnel must establish edits in the electronic billing system which:

- a. Prevent billing more than one hematology panel, per outpatient per date of service for federally funded programs.
 - b. Bundle components to the panel level when three or more components are charged on the same patient on the same date of service.
3. All staff/physicians responsible for ordering, charging, or billing laboratory services will be educated on the contents of this policy.
4. Mechanisms must be established and implemented in order for business office personnel to identify intermediary interpretations, which vary from the interpretations in this policy. Specific intermediary documentation related to the variance(s) must be obtained and faxed to the Regional Compliance Officer who will work with the Corporate Compliance Officer.

B. Daily:

- 1. It is recommended but not required that laboratory personnel review daily charge reports (e.g., Ancillary Charge Report, NPR charge reports, etc.) to monitor compliance with this policy as follows:
 - a. No duplicate hematology components are billed to federally funded programs.
 - b. Only one hematology panel is billed per outpatient per date of service for federally funded programs.

- c. Three or more hematology components must be bundled to the appropriate panel defined as follows:

<u>85021</u>	<u>85022</u>	<u>85023</u>	<u>85024</u>	<u>85025</u>	<u>85027</u>	<u>85031</u>
	85007	85007	85007	85007		85007
85009	85009	85009	85009	85009		85009
85013(14)	85013(14)	85013(14)	85013(14)	85013(14)	85013(14)	85013
85018	85018	85018	85018	85018	85018	85018
85041	85041	85041	85041	85041	85041	85041
85048	85048	85048	85048	85048	85048	85048
		85595	85595	85595	85595	85595

Any exceptions noted on the daily charge reports should be corrected on the individual patient accounts. This will guarantee that the accounts receivable system remains updated with actual billing data.

2. Business office personnel must review electronic billing edit/error reports daily and perform the following:
 - a. Eliminate duplicate hematology procedures for all federally funded payors.
 - b. Bundle hematology components into the appropriate panel when three or more are billed.
 - c. Identify presence of more than one hematology panel and eliminate the least comprehensive.
 - d. Modify number of units and related charges in the electronic billing vendor system to reflect the appropriate charge and CPT for the panel being billed.
 - e. It is recommended but not required to modify the number of units and related charges in the accounts receivable system to match the corrected claim in electronic billing system.

(Note: Utilize ancillary charge codes rather than correcting claims with adjustment codes. Corrections made subsequent to final bill should be processed through the patient accounting system late charge cycles.)

This will validate that the accounts receivable system remains updated with actual billing data.

C. Examples:

1. a) Doctor orders CBC with differential.
- b) The CBC is performed on a automated system and you report complete CBC with platelet, indices, and auto differential.
- c) **BILL:** CPT code 85025 (Automated Hemogram with platelet and auto differential).

2. a) Doctor orders CBC no differential (Hemogram).
b) You report results, some of which are abnormal.
c) Doctor then orders complete CBC with differential on the same sample.
d) You report CBC, platelet, indices, and differential (performed on automated system).
e) **BILL:** CPT code 85025 (Automated Hemogram with Platelet and auto differential).
3. a) Doctor orders CBC with differential.
b) You perform test on an automated system that includes indices and platelets.
c) You perform a spun hematocrit to confirm a discrepancy between the hemoglobin and hematocrit values.
d) **BILL:** CPT code 85025 (Automated Hemogram with platelet and auto differential).
4. a) Doctor orders Hemoglobin and Hematocrit and a White Blood Count.
b) You perform these three tests on an automated system.
c) **BILL:** CPT code 85021 (Automated Hemogram)
5. a) Doctor orders a CBC with differential.
b) You perform this on an automated system. (85025)
c) Manual differential is performed due to abnormal values. (85007)
d) You report CBC, platelet, indices, and manual differential results.
e) **BILL:** CPT code 85023 (Automated Hemogram with Platelet and manual differential).

D. Special Considerations:

1. **DO NOT CHARGE FOR** services reported as a result of a calculation. This includes CPT 85029 and 85030. CPT codes 85029 and 85030 have been deleted in the CPT 1999 Manual.
2. **DO NOT CHARGE FOR** both manual and automated differential on the same patient for the same date of service.

E. Definitions:

Encounter: Each date of service.