Billing Guidelines

1. Medicare reimburses the laboratory according to a fee schedule. The **Medicare Laboratory fee schedule** amounts are available on the www.palmettogba.com web site under ‘Providers’.

2. **Medicaid reimbursement** for tests will be equal to or less than Medicare reimbursement.

3. **Charges for calculations** derived from other test results are not submitted for billing. The reporting of such calculations as a part of the test results does not affect any claims for reimbursement to federal or privately funded health care programs.

4. **Panel Charging**
   a. If one of the **AMA panels** is ordered, it will be billed by the panel CPT code only.
   b. If there are **overlapping panels**, efforts will be made to order panels and/or individual tests to assure there is not duplicate billing.
   c. If **individual panel tests** are ordered that do not include all tests within the panel, Palmetto Health will bill them individually. If these are tests included in the CMS automated profile list, Medicare will bundle them and pay according to the CMS automated profile reimbursement fee schedule.

5. **Medical Necessity**:
   a. If your office sends a Medicare limited coverage test to one of our facilities, please review the test for medical necessity. If it does not meet medical necessity guidelines, it is important that you have the patient sign an ABN and send it with the test. If this is not done, we cannot bill the patient. If this occurs with frequency, we may have to bill your office for the corresponding tests.
   b. If the diagnosis, sign or symptom does not support medical necessity guidelines for a test(s) ordered by the physician or authorized person, we will ask the patient to sign an Advanced Beneficiary Notice (ABN) to inform the patient of their financial responsibility for the test requested. If we do not obtain a valid ABN when the test(s) do not meet medical necessity guidelines, we will bill the test in the non-covered field showing that we performed the test and apply an appropriate modifier showing we did not obtain an ABN when applicable.

6. **Screening Tests**:
   a. If the test(s) requested is a screening test (absence of signs, symptoms, complaints) for a Medicare beneficiary, we will bill Medicare for a denial and then bill the patient for the full service as Medicare does not pay for screening except for Medicare allowed laboratory screening tests (pap smears, PSA, cardiovascular, diabetes, HIV and fecal occult blood screening).

7. **Correct Coding Edits/Medically Unlikely Edits**:
   a. There are some tests that Medicare and other payers do not allow to be ordered together. Some situations require a modifier if it was performed on a separate draw time or different site/specimen within one calendar day. In other situations, some tests can never be ordered on the same date of service (Example: CMP and BMP; T4 Free and T4 Total). If this occurs we would have to write off one of the tests as we cannot bill the payer or the patient for these tests.

b. Medicare instituted Medically Unlikely Edits (MUE) in place where two or more of the same tests cannot be ordered within one calendar day. These cannot be billed to Medicare or the patient. When we see that this occurs with frequency, we will contact your office in order to discourage future occurrences.

8. **Duplicate Billing:** Medicare does not pay for duplicate testing unless it is a separate draw/separate site and medically necessary. Please review the section on panel ordering. If there are overlapping panels or a separate test ordered that is included in a panel ordered for the same draw, we cannot bill the payer.