Lab & Venipuncture

If it walks like a duck and quacks like a duck, it is probably a duck (or maybe not)

On November 22, 2013, CMS released MedLearn Matters Number MM8504 which clarified or issued new guidance on five (5) issues affecting rural health clinics. The billing process for venipuncture (HCPCS Code 36415) was one of the items that changed. In Chapter 16 of the Medicare Laboratory manual venipuncture is defined as “A specimen collection fee is allowed in circumstances such as drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization.”

Since 2001, laboratory services have not been covered by Medicare under the RHC program allowing RHCs to bill and be paid by Medicare for laboratory services in addition to their RHC covered services. Independent RHCs bill on the 1500 and are paid a fee for service and Provider-based RHCs bill using the hospital outpatient provider number on the appropriate bill type for their facility. MM8504 changes this treatment for venipuncture, and reads as follows, “When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report. This does not include venipuncture, which is included in the all-inclusive rate when furnished in the RHC or FQHC by an RHC or FQHC practitioner and as part of an RHC or FQHC visit.”

Venipuncture is now considered an “incident to” service provided by the RHC. Incident to is defined in Chapter 13 of the Medicare Benefits Manual as: “Services that are covered by Medicare but do not meet the requirements for a medically necessary visit with a RHC practitioner (e.g., blood pressure checks, allergy injections, prescriptions, nursing services, etc.) are considered incident to services.” Section 110 of the Chapter 13 includes an updated list of incident to services and Venipuncture is now listed. Here is an excerpt.

1. Drugs and biologicals that are not usually self-administered, and Medicare-covered preventive injectable drugs (e.g., influenza, pneumococcal); [sic] RHCs actually are not paid incident to as influenza and pneumococcal are paid in addition to the RHC rate
2. Venipuncture;
3. Bandages, gauze, oxygen, and other supplies; or….”

So what does this mean to your RHC? First, you need to stop billing venipunctures to Part B if you are an independent RHC and for provider-based RHC stop charging them using the outpatient provider number of the hospital. The charge (typically $10) for the venipuncture should now be included on the UB-04 of the RHC and would typically be rolled into the revenue code 0521. This will increase the charges for the patient and will create an additional co-payment of $2 to $3 per venipuncture for the Medicare beneficiary.

There is some question whether a RHC can charge for the venipuncture at all, but Chapter 13, Section 110 clearly states that incident to services may be charged. See the 2nd bullet point:

1. Services and supplies that are an integral, though incidental, part of the physician’s professional service:
2. Commonly rendered without charge or included in the RHC bill;
3. Commonly furnished in an outpatient clinic setting
4. Furnished under the physician’s direct supervision;
5. Furnished by a member of the RHC staff”

This will also create a billing nightmare for Venipunctures which are drawn on days where there is not an office visit (which is often the case).
Again quoting Chapter 13, “The cost of providing these services may be included on the cost report, but the provision of these services does not generate a billable visit. Incident to services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe.” (we often refer to this as the 30 day rule) RHCs with a cost per visit above the cap of $79.80 per visit will not receive any additional reimbursement for venipunctures. There are no special logs or a section of the cost report to recoup this cost in addition to the rate. (only bad debts, influenza, and pneumococcal are settled in addition to the rate)

Another nightmare will be the cost report. How will RHCs account for the portion of laboratory expense that relates to venipuncture which is now an allowable expense and the other laboratory expenses which are not? Time studies and cost tracking will have to be maintained to differentiate between the allowable and non-allowable portion.

Personally, I do not see the logic in this change. The Medicare beneficiary must pay a higher co-pay for a service that is listed on the laboratory fee schedule, the RHC will end up writing off a large portion of the venipunctures that do not occur on a day with an office visit, and are faced with an unnecessarily complex accounting and allocation process for the cost report. Hopefully common sense will prevail soon and this will be changed. Until then it looks like the old adage “if it walks like a duck and quacks like a duck, it is probably a duck.” has been proven wrong.

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