

Lab Focus

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Sound bites. . . .

Change in Lactic Acid Specimen Requirements at Fairview-University Medical Center

Please note that in order to provide the most rapid testing, lactic acid will now be tested on heparinized plasma or whole blood.

Lactic Acid

Synonyms: Lactate

Turnaround Time: Performed and reported 24 hours/day.

Test Performed at: FUMC-U

Methodology: Lactate electrode

Specimen: Blood

Collection Volume: 1 mL.
(Minimum: 0.2 mL)

Container: Green (Li heparin) on ICE. (Plasma may be separated and stored at 2-8 C up to 24 hours.)

Alternate: Dry heparin syringe on ICE.

Collection: Collect without the use of a tourniquet or within 3 minutes of applying, but before releasing. Do not allow patient to clench/unclench hand; this builds up lactic acid.

Critical Range: Greater than 5.0 mmol/L

Reference Range: 0.7-2.1 mmol/L

Use: Identify lactic acidosis which characteristically presents as an increased anion gap metabolic acidosis.

Testing for Lactic Acid, CSF or Fluid are also available. Refer to the Laboratory Guide or Intranet site.

Reference Laboratory Selection

Individual physicians do not have the option of referring laboratory tests to specific reference laboratories. According to Joint Commission on Accreditation of Health Care Organizations (JCAHO) regulations, selection of reference laboratories is the responsibility of the executive medical staff. Following an evaluation by Fairview's system-wide Integrated Laboratory Services Committee (ILSC), the executive medical staff committees at all Fairview hospitals approved the ILSC recommended reference laboratories: ARUP Laboratories, located in Salt Lake City, Utah, and MedTox in St. Paul, Minn., for toxicology testing. A limited number of rare tests are referred to other predetermined, medical executive committee-approved laboratories, which generally offer only one or two highly specialized tests.

In addition to the accrediting organizations' rules, with the advent of a single laboratory information system and soon Fairview Clinical Information System (FCIS) order entry, the clinical laboratories at the different Fairview hospitals are not able to maintain multiple reference laboratory options, which may lead to incorrect testing.

Nevertheless, if there are compelling clinical reasons for a certain specimen or group of specimens, for example pediatric

patients or patients with a specific disease, the physician should contact the medical director of the most appropriate lab, or myself.

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Advance Beneficiary Notices and Medicare

This is the last in a series of articles that addresses the unique requirements associated with billing our Medicare population. This article pertains to the Advance Beneficiary Notice.

If Medicare denies reimbursement for medical necessity reasons their rules prohibit the laboratory or health care provider from billing the patient, unless an Advance Beneficiary Notice (ABN) or Patient Acknowledgment of Non-covered Services has been signed by the patient prior to the service. Without a signed ABN, the provider cannot bill the patient for any denied services. Medicare rules prohibit the provider from ignoring this process and absorbing the cost of denied testing. The ABN:

- Identifies patient date of service, laboratory test(s) to be performed, and likely reason for denial.
- Assures the patient understands he or she may be responsible for payment if the test is not considered to be medically necessary by Medicare.

- Allows the patient to make an informed decision whether or not to receive the service and pay for it out-of-pocket.

When the physician believes a test ordered may not be covered, the physician should ensure the patient is informed of this possibility and that the ABN is signed. The most common reasons for claim denial for laboratory tests are:

- Tests are ordered for screening purposes. Medicare regards screening tests as non-covered services under section 1862 of Title XVIII of the Social Security Act. Although an ABN is not required for screening tests, it can be a helpful communication tool to make the patient aware that the ordered testing will not be covered.
- Medical necessity, i.e., the ICD-9 code provided is not consistent with the local coverage decision (LCD) or national coverage determination (NCD). For information contained in these LCD/NCD policies, refer to the laboratory Web site at http://contentprod.fairview.org/fv/groups/public/documents/publishedweb/lmrp_c_061449.hcspT.
- Test frequency limitation is exceeded; e.g.:
 - Medicare only will reimburse four glycosylated hemoglobin tests per year, or one every 13 weeks.
 - A screening PSA is covered once annually for males over 50 years of age.
 - A screening pap smear is covered once every two years on females.

- Medicare considers the test to be experimental and for research or investigational use only; e.g., newly introduced tumor markers.

CMS has built specific steps into the ABN process:

- The patient must sign the ABN *before* the laboratory specimen is collected or *before* the test is performed.
- CMS has stated that an ABN should be discussed with the patient only when there is reason to believe that Medicare is likely to deny payment for service(s). CMS prohibits a practice called “blanket waiving” for all Medicare patients.
- If the patient chooses not to sign the ABN, the laboratory may decline to perform the test.

Carol Hill for the Laboratory Compliance Committee.