Duplicative Laboratory Billing in Wisconsin

What Is Duplicative Laboratory Billing?

Duplicate billing occurs in laboratory claims when a provider billed the global service at the same time that they (or another provider) billed for either the technical or professional component of the same service.

What Is a TC Modifier (Technical Component)?

Some laboratory services have both professional and technical components. If a provider performs only one component of the service, they may only be paid for that component. Wisconsin Medicaid allows the use of the "TC" modifier to identify the performance of only the technical component for these services.
(Wis. Admin. Code § DHS 106.02(9)(e))

What Is a 26 Modifier (Professional Component)?

Some laboratory services have both professional and technical components. If a provider performs only one component of the service, they may only be paid for that component. Wisconsin Medicaid allows the use of the "26" modifier to identify the performance of only the professional component for these services.
(Wis. Admin. Code § DHS 106.02(9)(e))

What Is a Global Service?

When the same provider performs both the technical and professional components of a single laboratory service, that provider may bill a global service. Global services do not have any component-specific modifiers attached to them.

OIG addresses this common billing error through audits and provider self-audits. Possible outcomes include, but are not limited to, technical assistance, recoupment, sanction, and termination.

What Is Medicaid Waste?

Waste is the squandering of money or resources. Claims billed in error are considered waste. Most overpayments that are identified through the Office of the Inspector General's (OIG) audits and provider self-audits are considered waste because they are usually unintentional.

What Are the Documentation Requirements?

Laboratory, diagnostic, radiology, and imaging test services are required to have a prescriber order or prescription. If a provider bills either the global service of the procedure code with "26" modifier, a written report must be produced and maintained in the recipient's medical record to support the professional component.
Wis. Admin. Code § DHS 107.02(2m)(a)12

New Program Integrity Strategy: OIG Provider Self-Audit Letter Campaigns:

1. OIG reviews data and identifies providers who appear to have committed this particular billing error.
2. OIG sends the providers a report detailing the errant claims and a letter requesting the provider conduct a self-audit of the included claims.
3. The provider reviews the report and identifies which claims were billed in error and returns the report to OIG.
4. OIG validates the report and sends a final letter with the identified overpayment.
5. The providers return the identified overpayment to OIG.
6. The self-audit is closed and providers are encouraged to self-audit any claims not included in the sample provided by OIG.
7. Providers who do not respond are flagged for further review including a potential audit.
8. Non-compliant providers may also be referred to the Department of Justice Medicaid Fraud Control and Elder Abuse Unit if fraud is suspected.

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