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A systematic approach to billing laboratory services – the legal framework: Supplement and update to the article in J Lab Med 2014; 38(4):179–205

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Abstract: Our article “A systematic approach to billing laboratory services – the legal framework” [Rathenberg et al., *J Lab Med* 2014;38(4):179–205] reviewed all relevant aspects of billing laboratory services. Here we provide supplementary information due to further legal advancements based on the German health-care law, with emphasis on specialist outpatient care (*Ambulante spezialfachärztliche Versorgung* [ASV]) and selective contracts and complexes of services. In addition, we focus on occupational medicine as well as billing in connection with hospital emergency departments.

Keywords: fee billing; medical laboratory services; medical reimbursement; medical tariff.

List of abbreviations: ASV, Outpatient specialist care; ASV-AV, agreement in accordance with Section 116b para 6 sentence 12 SGB (Social Code) V regarding the form and content of the billing procedure and the necessary forms for outpatient specialist care. EBM, uniform rating scale; GOÄ, fee schedule for doctors; HzV, medical care centered on family physicians; KV, Association of Statutory Health Insurance Physicians; MVZ, medical care center.

1 Outpatient specialist care (ASV) according to Section 116b SGB V

With respect to outpatient specialist care (ASV), our review article “Systematic approach to billing laboratory services – the legal framework”¹ has thus far been limited to the statement that Section 116b SGB V regulates ASV services “for example, at hospitals” and that the laboratory² to which services are outsourced must issue an invoice to the hospital.³ The current 2-year periods in accordance with Section 116b para. 8 SGB V and the related decision-making processes at hospitals eligible under the former Section 116b SGB V regarding their future participation in ASV, however, require an update to this topic, particularly from the point of view of the laboratory. The changes to the legal framework that have brought about the current situation are summarized herein below, as are the consequences for the billing of lab services.

1.1 Changes in legal framework

The new version of Section 116b SGB V⁴ created the services sector under ASV, where in addition to the hospitals

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¹ Rathenberg/Ivandic/Wohlfart, Systematik der korrekten Laborberechnung – rechtliche Rahmenbedingungen, *J Lab Med* 2014;38(4): 179–205.

² The term “laboratory”, or “lab”, is used frequently in this article to enhance the readability of the text, and refers to medical service providers (e.g. specialist doctors of laboratory medicine, microbiology, human genetics or pathology), who can be organized in a wide range of constellations.

³ cf. Rathenberg/Ivandic/Wohlfart, Systematik der korrekten Laborberechnung – rechtliche Rahmenbedingungen, *J Lab Med* 2014;38(4): 179–205. => *ibid.* Section 3.5 (pp. 196 et seq.) and Table 7 (p. 202).

⁴ By the Act to improve care structures within the system of statutory health insurance (GKV-VStG dated 22.12.2011).

that had already been eligible under the former Section 116b SGB V, service providers were now also eligible to participate in panel-doctor-based medical care, that is, panel doctors, medical care centers (MVZ), authorized physicians and facilities. ASV comprises, in accordance with Section 116b para. 1 SGB V, the diagnosis and treatment of complex, difficult-to-treat diseases that require special qualifications, interdisciplinary collaboration and special equipment depending on the disease. More detailed regulations on ASV can be found – as provided for in Section 116b paragraph 4 SGB V – in the directive of the Federal Joint Committee on outpatient specialist care according to Section 116b SGB V⁵ (“ASV Directive”), whose schedules specify the diseases covered by ASV and define the scope of treatment. To date, four of these schedules have been adopted: on tuberculosis,⁶ on gastrointestinal tumors,⁷ on gynecological tumors⁸ and on Marfan’s syndrome.⁹ Other schedules – for example, concerning rheumatism and heart failure – will follow.

To date, numerous hospitals still have privileges for outpatient treatment according to Section 116b SGB V (old version) based on a state provision in accordance with Section 116b para. 2 SGB V (old version). The new Section 116b para. 8 SGB V provides that those provisions of the federal state will continue to be valid until their repeal by the state. This repeal must occur no later than 2 years after entry into force of the directive resolution of the Joint Federal Committee regarding the respective disease. For ASV in connection with tuberculosis, for example, the state provisions will therefore have to be repealed by 23.04.2016, but may be repealed sooner as well. For hospitals providing outpatient care under the former regulations, this now raises the question whether they will be able to participate in ASV and meet the legal requirements in the future.

1.2 Requirements for participation in ASV

The ASV-eligible parties defined in Section 2 para. 1 of the ASV Directive (service providers that are part of panel doctor care and hospitals licensed under Section 108 SGB V) can participate in ASV if and where they meet the

personnel, material and organizational requirements for the individual diseases under the ASV Directive and the respective directive resolutions. The key requirements are presented below.

1.2.1 Interdisciplinary cooperation

ASV regularly requires cooperation within an interdisciplinary team (Section 3 para. 1 ASV Directive), which can be ensured in different ways:

If a service provider can meet the requirement of interdisciplinary cooperation itself, that is, in-house, it will not have to enter into a cooperation with an external service provider – except for cases involving care for patients with severe progressions of oncological conditions.¹⁰ This is true, for example, of hospitals that offer all necessary disciplines.

If a service provider cannot ensure interdisciplinary cooperation in-house, it may join forces with various service providers (which must be ASV-eligible) to meet jointly the requirements for individual diseases under the directive resolutions of the Federal Joint Committee. This type of **service cooperation** is not mandatory, but can help obtain an ASV authorization if the interdisciplinary cooperation requirement is met in this way (cf. Section 1 para. 1 sentence 2 ASV Directive). This service cooperation can span sectors (between the hospital and panel doctors) or take place within a care sector (e.g. between two hospitals or between two panel-doctor facilities).

In deviation thereof, **ASV cooperation** requires an intersectoral association for the care of patients with severe progressions of oncological conditions (Section 116b para. 4 sentence 10 SGB V, Section 10 para. 1 sentence 2 ASV Directive). An exception from this cooperation requirement can be granted under Section 116b para. 4 sentence 11 SGB V only if an ASV-relevant catchment area does not have a suitable cooperation partner or if a service provider, despite serious efforts, fails to find a willing and/or suitable cooperation partner within a period of at least 2 months.

In summary, therefore, this means that the care for patients with severe progressions of oncological conditions always requires intersectoral ASV cooperation, and that in all circumstances regulated thus far the service provider may ensure interdisciplinary cooperation in-house or join forces with one or several external cooperation partners to meet this requirement. For reasons of legal

⁵ As published on 21.03.2013, as amended on 20.02.2014.

⁶ “Tuberculosis and atypical mycobacteriosis”, decision of 19.12.2013, entered into force on 24.04.2014.

⁷ “Gastrointestinal tumors and tumors of the abdominal cavity”, decision of 20.02.2014, entered into force on 26.07.2014.

⁸ “Gynecological tumors”, decision of 22.01.2015, not yet in force.

⁹ “Marfan’s syndrome”, decision of 22.01.2015, not yet in force.

¹⁰ cf. explanations on ASV cooperation.

certainly, all these arrangements should be supported by written cooperation agreements.

1.2.2 Composition of the interdisciplinary team

The interdisciplinary team responsible for interdisciplinary cooperation consists of a team leader, a core team and specialist doctors that can be called upon in real time in case of medical emergency (Section 3 para. 2 sentence 1 ASV Directive). The qualification requirements for all team members as well as the material and organizational requirements are subject to the respective schedules of the ASV Directive. Table 1 shows the functions that the laboratory can perform in the context of the interdisciplinary team with respect to the schedules of the ASV Directive adopted to date. Furthermore, the team members must have a billing authorization in at least one of the two sectors, which also contains the services to be billed under ASV.¹¹

1.2.3 Notification procedure

In addition to meeting specific material and personnel requirements, participation in ASV also requires the implementation of a notification procedure. Under Section 2 para. 1 ASV Directive, service providers must report their meeting all requirements under the ASV Directive to the state committee in charge of the notification procedure. Generally, there are forms available for this, which can be ordered from the statutory health insurance associations or downloaded from their websites. The service provider will be authorized to participate in ASV 2 months after its notification has been received, unless the state committee informs the provider within such period of time that it has failed to meet the requirements for ASV participation (Section 116b para. 2 sentence 4 SGB V). It is further stated there that the period is “suspended” if the state committee demands additional information or statements. The question whether this represents a suspension or interruption in the period in legal terms has been answered in different ways in the literature. On the one hand, one opinion is that the 2-month period starts anew after receipt of the documentation requested.¹² On the other hand, referring to the intention of the legislator and waiving the conventional

approval procedure for accelerating participation in ASV, it is believed that the 2-month period, once commenced, will merely be extended by the time span it takes to submit the documentation requested.¹³ Given this lack of clarity with respect to the period, it is recommended that the service provider should obtain a certificate about its ASV eligibility prior to the provision of services, even though a formal approval is not really necessary.

1.3 Relevance of changes in law to the laboratory

In view of the changed legal framework, it is not only the hospitals (still) authorized under the former Section 116b SGB V that must decide whether and, if so, how and with what cooperation partners they can meet the requirements for future ASV participation. Laboratories, too, are faced with the decision as to whether they want to participate in ASV and how they can go about ensuring the applicable requirements. As Table 1 shows, for them, depending on the respective schedule of the ASV Directive, it is possible to participate as part of the core team or as a consulting physician. To regulate and prove cooperation to the state committee, cooperation agreements must be entered into that should reflect the content of services as well as the cooperation arrangement (regarding place of activity, billing, etc.). As for the place of performance, it should be noted that members of the core team must generally perform specialist medical services at the place of activity of the team management or at specific times at least 1 day a week at the place of activity of the team management. Only services tied to non-portable equipment as well as the preparation and examination of sample material taken from patients are excluded in this context. However, the place of performance for services to be performed **directly** on patients must be at an appropriate distance (as a rule, 30 min) from the place of activity of the team management – both for core team members and consulting physicians (Section 3 para. 2 sentence 4 et seq. ASV Directive).

1.4 Referral and settlement of services under ASV

Rules regarding referrals in the ASV context are specified, in particular, in Section 2 para. 4 and Section 8

¹¹ See also: Roters, Die Richtlinien des Gemeinsamen Bundesausschusses zur Ambulanten Spezialfachärztlichen Versorgung, GesR 8/2014, 456 (457) for further information.

¹² Hess, Kasseler Kommentar zum Sozialversicherungsrecht, § 116b marginal note 17.

¹³ cf. also Hahne, Ambulante spezialfachärztliche Versorgung (ASV) in der anwaltlichen Beratung niedergelassener Ärzte, GesR 8/2014, 463 (464).

ASV Directive. According to Section 2 para. 4 sentence 1 ASV Directive, there is no referral requirement between members of the core team. Consulting physicians perform their services, according to Section 2 para. 4 sentence 1 ASV Directive, in line with the respective treatment scope on referral (definition or indication order). All other details on the referral of laboratory services in connection with ASV are shown in Table 1. A distinction must be made, however, between the core team pursuant to Section 3 para. 2 sentence 2 ASV Directive and the interdisciplinary ASV team (consisting of team management, core team and consulting physicians).

The services under ASV will be reimbursed directly by the health insurance under Section 116b para. 6 sentence 1 SGB V. Panel doctors, however, may instruct the statutory health insurance association to handle the billing of these services against reimbursement of expenses. Until a separate billing system has been introduced under Section 116b para. 6 SGB V, billing will have to be done on the basis of the uniform rating scale¹⁴ (EBM). Services and examinations allowed in the ASV context, but not implemented in EBM, can be identified by pseudo codes (uniform across the country) and submitted for billing until such time as they have been incorporated into EBM (chapter 50).¹⁵ Because there are no corresponding EBM codes, service codes from the fee schedule for physicians (“GOÄ”) are applied in this exception. The services must be indicated in the ASV invoice and identified by the ASV team number. The GOÄ codes used as pseudo codes are entered in the IT system in the field “Non-Personnel Expenses Designation” (field ID 5011), and the prices in the field “Material Costs in Cents” (field ID 5012). Payment is made according to fees set for ASV under GOÄ (laboratory: factor 1.0). Excluded from the provision are ASV services that are also included in the oncology agreement.¹⁶ Until they are included in EBM, they will be reimbursed according to the regional flat rates as per Schedule 2 of the oncology agreement.

Section 2 para. 1 sentence 3 ASV Directive provides that each service provider (no matter whether as team leader, core team member or consulting physician) remains ASV eligible and performs his/her ASV services independently within the context of the cooperation, which is why invoices to the health insurance or via

instructions to the respective statutory health insurance association must also be settled separately by each ASV-eligible provider. There is no internal compensation and/or settlement between ASV cooperation partners.

One exception is the settlement of laboratory services that hospitals with an ASV authorization under Section 116b SGB V (old version) request from the lab. As before, and as illustrated in our review article, the lab must settle these services with the hospital. As soon as the provisions of hospitals under Section 116b SGB V (old version) have been repealed by the states, this settlement approach will be abandoned, and only the aforementioned ASV provisions will apply.

2 Complex of services codes

2.1 Differentiation of general conditions

Our article has given various examples of the billing and settlement of laboratory tests in connection with services subject to a complex of services codes and/or service complexes in general.¹⁷ Apart from the general conditions already described there, we believe a further differentiation of the key service complexes in the area of statutory health insurance (GKV) is necessary, as is a compilation of the information that should be as definitive as possible.

Generally, doctors are reimbursed a flat fee for a services complex, with which all individual services contained in the complex service code are compensated. This means that these individual services cannot be billed and settled again outside the settlement via complex service codes. Consequently, the doctor who bills the complex service code must reimburse the laboratory for services that he/she does not perform or cannot perform and therefore orders these services from the lab. Such services complexes in connection with laboratory services are found in the context of so-called selective agreements, but also, indirectly, in EBM – often they are not apparent as such at first sight.

Since the laboratory, which only acts upon a referral, cannot know itself whether the lab services ordered concern such services complexes, making sure that the consulting physician orders the services correctly is key. Unfortunately, the general conditions for such compensation by complex service codes change at irregular intervals, particularly for selective agreements. What

¹⁴ As amended with effect from 01.04.2015.

¹⁵ cf. Schedule 5 of the agreement under Section 116b para. 6 sentence 12 SGB V regarding the form and content of the billing procedure as well as the required forms for outpatient specialist care (ASV-AV), which entered into force on 01.10.2014 and applies to invoice submissions from 01.01.2015.

¹⁶ Schedule 7 of the German Federal Master Agreement with Physicians.

¹⁷ cf. Rathenberg/Ivandic/Wohlfart, Systematik der korrekten Labrabrechnung – rechtliche Rahmenbedingungen, J Lab Med 2014; 38(4): 179–205. => ibid. Section 3.8 (p. 197).

is more, this also affects primarily groups of physicians that order lab tests. Therefore, the following examples can only describe the basic system, but do not relieve the requesting doctor – as part of his/her request, which is always indication-based – of the regular need to ask whether and, if so, when lab services are already included in the services complex to be performed and billed by him/her.

2.2 Compensation by service codes for selective agreements

Probably the most prominent example of selective agreements may be the medical care centered on family physicians (“HzV”) under Section 73b SGB V. The family physician participating in such a selective agreement is paid for each patient registered under such agreement a flat fee, with which he/she must cover the various services. The services contained in the flat fee and thus paid are listed in the respective “range of codes” attached to the selective agreement. Among other things, these include laboratory services that the doctor can perform in his/her own practice (services under Section MI GOÄ) or procure from a private group laboratory (services under Section MII GOÄ) and/or from a specialist laboratory (services under Sections MIII and MIV GOÄ). If the doctor performs lab services himself/herself, or procures them from a private group laboratory, he/she will have to cover the costs incurred with the flat fee under the selective agreement.

Since the “ranges of codes” of selective agreements contain some services that are classified as basic laboratory services in EBM under chapter 32.2, while in GOÄ they are deemed specialist lab services under Section MIII, this oftentimes creates the problem that these services cannot be procured from a panel-doctor or a private group laboratory. This is so because a panel-doctor group lab requires direct billing to the health insurance (KV) and because a separate settlement at the expense of KV that exceeds the flat fee is not allowed under HzV agreements, while a private group lab can only perform services under Section MII GOÄ. As a result, these services can only be referred to a specialist lab as a specialist lab service under Section MIII GOÄ; that lab, then, bills the doctor.¹⁸

¹⁸ At this point, one must mention a pending case before the Social Court of Mainz (S 8 KA 244/14) regarding the question of whether the HzV compensation system causes a factual referral and settlement ban at the expense of laboratory physicians. Still, the exclusion of separate

Overall, the number of existing selective agreements that also include laboratory services – even if one were to limit oneself only to HzV agreements – is already quite extensive. In light of this, we have compiled an exemplary list of lab services in Table 2, which are part of the (German public health insurance company) AOK family physician contracts in force as of March 2015.

The differences in the AOK ranges of codes show that each selective agreement must be checked for lab services included and their proper requisitioning in order to avoid subsequent recourses or reclaims in connection with the settlement of remuneration under collective agreements.

2.3 Compensation by service codes under EBM

There are also various service complexes in EBM. These include lab services for

- Nephrology (dialysis);
- Reproductive medicine (in-vitro fertilization, IVF);
- Gastroenterology (colonoscopy);
- Obstetrics (maternity guidelines);
- Preoperative care;
- Cardiac catheter examination.

The lab tests contained in these service complexes are summarized in Tables 3A–F. Based on the assignment in the respective EBM service legend, the following distinctions are made there:

- Mandatory => these services must have been performed;
- Optional => these services may be performed, but are then paid;
- Billing exclusion => these services are not reimbursable in conjunction with the complex code or service complex;
- Mentioned in the Federal Joint Committee directive.

Here, too, and for any further EBM service complexes, attention must be paid to the correct requisitioning by the treating, ordering physician as well as the correct billing to the requester by the commissioned lab performing the services.

compensation for the lab services contained in the range of codes creates for the doctor participating in the HzV agreement an obligation to bear the costs. The doctor can merely refer the lab services as private services and must cover the costs incurred with his/her flat fee.

3 Occupational medicine

At this point, our previous explanations¹⁹ refer only to the constellation where the occupational physician or company doctor works as part of an employment relationship with the company or performs his/her services independently on the basis of a fee agreement and settles with the company **outside the GOÄ** (for example, based on flat fees or budgets). It is only in these cases that a laboratory can invoice specialist lab services under Sections MIII and MIV of GOÄ to the requesting occupational physician or company doctor.

But where the occupational physician or company doctor settles his/her own services with the company **on the basis of GOÄ**, he/she cannot, given the Federal Court decision dated 25.01.2012 (Ref.: 1 StR 45/11), procure any services from the lab under Sections MIII and MIV of GOÄ and bill these as his/her own services. In this case, he/she may only request the lab services, and the lab must then bill the company (that is, the payer) for the services. However, the settlement conditions between the lab and the company are freely negotiable.

It is therefore crucial against this background that the occupational physician or company doctor inform the laboratory whether he/she settles accounts as part of GOÄ or outside the GOÄ framework. This may be done by way of an agreement between the requester and the lab, or may be noted on the lab order form in individual cases. If the laboratory does not know the billing method of the requester, the lab should settle directly with the company to avoid legal risks.

4 Billing hospital/emergency room

This part serves to deepen one's understanding of the individual billing constellations in connection with hospital emergency rooms, as well as to point out billing-relevant trends. Following up on our review article,²⁰ we have generally identified the following billing options for laboratory services that a hospital emergency room orders for patients with statutory health insurance.

¹⁹ cf. Rathenberg/Ivandic/Wohlfart, Systematik der korrekten Laborabrechnung – rechtliche Rahmenbedingungen, J Lab Med 2014;38(4):179–205. => ibid. Section 3.10 (p. 199).

²⁰ cf. Rathenberg/Ivandic/Wohlfart, Systematik der korrekten Laborabrechnung – rechtliche Rahmenbedingungen, J Lab Med 2014;38(4):179–205. => ibid. Section 3.12 (pp. 200 et seq.) and Table 7 (p. 201): (Case 11/11a).

4.1 Laboratory as an operational unit of the hospital

If the laboratory is an integral part of the hospital's operations, the lab services must be settled by the hospital directly with the competent panel doctors' association in a manner previously agreed between the hospital and the association.

4.2 Laboratory as an outsourced external operation without separate license

If the laboratory is an external operation outsourced from the hospital that does not have its own license for panel-doctor care, the hospital will be billed by the laboratory performing the services for lab services requested via a hospital-specific order form. The hospital then usually settles the services with the panel doctors' association in accordance with a method previously agreed between the hospital and the association.

4.3 Laboratory as an outsourced external operation with separate license

If the laboratory is an external operation outsourced from the hospital that has its own license for panel-doctor care (e.g. MVZ with panel-doctor license), the laboratory will settle lab services directly with the competent panel doctors' association following a referral by the emergency room on the basis of the Model 10 form.

Since basic lab services are often performed by the hospital's own, on-site laboratory, while specialist lab services are procured from an external specialist laboratory, such cases create mixed constellations that fall in between the billing options described.

4.4 Scope of billable emergency services

Regarding the question of the billable scope of emergency services, the Federal Social Court decided on 12.12.2012 (Ref.: B 6 KA 5/12 R) that lab tests on blood alcohol content and on C-reactive protein are not generally part of emergency services, because they usually are not medically indicated or useful in primary care.

In light of this, and from the perspective of emergency rooms and/or hospitals, it might be useful to clarify with the competent panel doctors' association the services that can be settled as part of emergency care, and to what extent.

Table 1: Outpatient specialist care (ASV): ASV team.

Directive	Function of the laboratory (individual practice, group practice/ BAG, MVZ, etc.) with the composition of the ASV team					Referral to the laboratory within ASV team ^{a,b}		Referral from ASV team to laboratory outside ASV team ^a	
	Decision date	Entry into effect	Team management	Core team ^b	Consulting physicians	Model 10 Model 10A	Model 10 Model 10A	Model 10 Model 10A	Lab settlement with
Tuberculosis and atypical mycobacteriosis	12/19/2013	4/24/2014	Not possible	Specialist Doctor of microbiology, virology and infectious disease epidemiology	Specialist Doctor of laboratory medicine	ASV team number instead of BSNR ASV code "1" in line 6, form position 30 (space must be included in pos. 29)	BSNR		KV (KK) ^c
Oncological diseases – cancer group 1: gastrointestinal tumors and tumors of the abdominal cavity	2/20/2014	7/26/2014	Not possible	Not possible	Specialist Doctor of human genetics Specialist Doctor of laboratory medicine Specialist Doctor of pathology				
Oncological diseases – cancer group 2: gynecological tumors	1/22/2015	Pending	Not possible	Not possible	Specialist Doctor of human genetics Specialist Doctor of laboratory medicine Specialist Doctor of pathology				
Marfan's syndrome	1/22/2015	Pending	Not possible	Not possible	Specialist Doctor of human genetics Specialist Doctor of laboratory medicine				
More to come...	...	...							

^aKBV-requirement catalog "Formularbedruckung" (form printing) dated 11.04.2014 (BSNR, establishment number). ^bNo referral required within core team. ^cContract medical providers will prefer settlement with the panel doctors' association over settlement with the health insurance companies (which is also an option).

Table 2: Complex numbers range GP-centered care (HzV).

		KV District:	Baden Württemberg	Bavaria	Berlin and Brandenburg	Hesse	North Rhine	Westfalen- Lippe
		Health Insurance:	AOK	AOK	AOK	AOK	AOK	AOK
		Contract:	AOK_Baden- Württemberg ^c	AOK_ Bavaria ^d	AOK	AOK_Hesse	AOK Rhineland/ Hamburg, Arbitration Agreements_ North Rhine	AOK
		Last update:	2/13/2015	2/6/2015	2/18/2015	2/13/2015	2/13/2015	3/13/2015
		Entry into force:	11/26/2014	10/1/2013	1/1/2014	1/1/2015	10/1/2013	10/1/2013
		GOÄ classification ^b X means 'contained in range of codes'						
EBM-GOP	GOP designation	Request => from ^a	Bill => to					
01708	Lab tests, usually newborn screening, subject to authorization	Specialist laboratory	Sender	X	X	X	X	X
01734	Tests on blood in stool under Section D. III. of early cancer detection policy, incl. cost	Own practice or specialist lab	Sender	X	X	X	X	X
01826	Cytological examination of one or more smears	Specialist laboratory	Sender	X	X	X	X	X
01827	Microscopic examination of the native smear	Specialist laboratory	Sender	X	X	X	X	X
02401	H2 breath test, incl. cost	Specialist laboratory	Sender	X	X	X	X	X
31010	Preoperative preparation for outpatient and GP procedures on neonates, infants, toddlers and children	Private group lab or specialist laboratory (concerns entire EBM 32)	Sender	X	X	X	X	X
31011	Preoperative preparation for outpatient and GP procedures on adolescents and adults up to the age of 40	Private group lab or specialist laboratory (concerns entire EBM 32)	Sender	X	X	X	X	X
31012	Preparation for surgery in ambulatory and GP procedures on patients after the age of 40, under the age of 60	Private group lab or specialist laboratory (concerns entire EBM 32)	Sender	X	X	X	X	X

Table 2 (continued)

31013	Preparation for surgery in ambulatory and GP procedures on patients after the age of 60	Private group lab or specialist laboratory (concerns entire EBM 32)	Sender	MI to MIV possible	X	X	X	X	X
32001	Economic provision and/or instigation of services of Chapter 32 (on some points)	Is disregarded, unless services are referred outside the range of numbers	Is disregarded, unless services are referred outside the range of numbers	X	X	X	X	X	X
32025	Glucose	Own practice		If performed at doctor's practice	X	X	X	X	X
32026	TPZ (thromboplastin time)	Own practice		If performed at doctor's practice	X	X	X	X	X
32027	D-dimer	Own practice		if performed at doctor's practice	X	X	X	X	X
32030	Preliminary examination	Own practice or specialist lab	Sender	MI or MIII (no private group lab possible)	X	X	X	X	X
32031	Urine microscopy	Own practice or specialist lab	Sender	MI or MIII (no private group lab possible)	X	X	X	X	X
32032	PH value	Specialist laboratory	Sender	MIII (no private group lab possible)	X	X	X	X	X
32035	Erythrocyte count	Own practice or standard blood count from private group lab	Sender	MI if done at doctor's practice or MII	X	X	X	X	X
32036	Leukocyte count	Own practice or standard blood count from private group lab	Sender	If performed at doctor's practice, otherwise private group lab	X	X	X	X	X
32037	Platelet count	Own practice or standard blood count from private group lab	Sender	If performed at doctor's practice, otherwise private group lab	X	X	X	X	X

Table 2 (continued)

KV District:		Baden Württemberg	Bavaria	Berlin and Brandenburg	Hesse	North Rhine	Westfalen- Lippe
Health Insurance:		AOK	AOK	AOK	AOK	AOK	AOK
Contract:		AOK_Baden- Württemberg ^c	AOK_ Bavaria ^d	AOK Northeast and IKK Brandenburg and Berlin	AOK_Hesse	AOK_Rhineland/ Hamburg, Arbitration Agreements_ North Rhine	AOK Northwest
Last update:		2/13/2015	2/6/2015	2/18/2015	2/13/2015	2/13/2015	3/13/2015
Entry into force:		11/26/2014	10/1/2013	1/1/2014	1/1/2015	10/1/2013	10/1/2013
EBM-GOP	GOP designation	Request => from ^a	Bill => to	GOÄ classification ^b X means 'contained in range of codes'			
32038	Hemoglobin	Own practice or standard blood count from private group lab	Sender	X	X	X	X
32039	Hematocrit	Own practice or standard blood count from private group lab	Sender	X	X	X	X
32040	Blood in stool	Specialist laboratory	Sender	X	X	X	X
32041	Albumin in stool, qualitative	Specialist laboratory	Sender	X	X	X	X
32042	BSR	Specialist laboratory	Sender	X	X	X	X
32045	Microscopic examination of body material	Specialist laboratory	Sender	X	X	X	X
32046	Fetal hemoglobin in red blood cells	Specialist laboratory	Sender	X	X	X	X
32047	Reticulocyte count	Private group lab	Sender	X	X	X	X
32050	Microscopic examination by Gram stain	Specialist laboratory	Sender	X	X	X	X
32051	Differential blood count	Specialist laboratory	Sender	X	X	X	X

Table 2 (continued)

32052	Ingredients in 24-hour urine, quantitatively	Specialist laboratory	Sender	MIII (no private group lab possible)	X	X	X	X
32055	Determining the concentration of a drug	Specialist laboratory	Sender	MIII (no private group lab possible)	X	X	X	X
32056	Total protein	Private group lab	Sender		X	X	X	X
32057	Glucose	Private group lab	Sender		X	X only for 01732	X	X
32058	Total bilirubin	Private group lab	Sender		X	X	X	X
32059	Bilirubin direct	Private group lab	Sender		X	X	X	X
32060	Total cholesterol	Private group lab	Sender		X	X only for 01732	X	X
32061	HDL cholesterol	Private group lab	Sender		X	X only for 01732	X	X
32062	LDL cholesterol	Private group lab	Sender		X	X only for 01732	X	X
32063	Triglycerides	Private group lab	Sender		X	X only for 01732	X	X
32064	Uric acid	Private group lab	Sender		X	X only for 01732	X	X
32065	Urea	Private group lab	Sender		X	X	X	X
32066	Creatinine (Jaffe method)	Private group lab	Sender		X	X only for 01732	X	X
32067	Creatinine, enzymatically	Private group lab	Sender	Private group lab, usually only the Jaffe method	X	X only for 01732	X	X
32068	Alkaline phosphatase	Private group lab	Sender		X	X	X	X
32069	GOT	Private group lab	Sender		X	X	X	X
32070	GPT	Private group lab	Sender		X	X	X	X
32071	Gamma-GT	Private group lab	Sender		X	X	X	X
32072	Alpha-amylase	Private group lab	Sender		X	X	X	X
32073	Lipase	Private group lab	Sender		X	X	X	X

Table 2 (continued)

32092	CK-MB	Private group lab	Private group lab to sender	X	X	X	X
32094	HbA1c, HbA1c	Private group lab	Private group lab to sender	X	X	X	X
32097	BNP and/or NT-Pro-BNP	Own practice or specialist lab	Sender	MIII (no private group lab possible)	X		
32101	TSH	Specialist laboratory	Sender	MIII (no private group lab possible)	X	X	X
32103	IgA	Private group lab	Sender	X	X	X	X
32104	IgG	Private group lab	Sender	X	X	X	X
32105	IgM	Private group lab	Sender	X	X	X	X
32106	Transferrin	Private group lab	Sender	X	X	X	X
32107	Serum electrophoresis	Private group lab	Sender	X	X	X	X
32110	Bleeding time (standardized)	Specialist laboratory	Sender	MIII (no private group lab possible)	X	X	X
32111		Specialist laboratory	Sender	MIII (no private group lab possible)	X		X
32112	PTT	Private group lab	Sender	X	X	X	X
32113	Prothrombin time, plasma	Private group lab	Sender	X	X	X	X
32114	Prothrombin time, capillary blood	Private group lab	Sender	X	X	X	X
32115	Thrombin time	Private group lab	Sender	X	X	X	X
32116	Fibrinogen	Specialist laboratory	Sender	MIII (no private group lab possible)	X	X	X
32117	Fibrin monomers, fission products (qual.)	Specialist laboratory	Sender	MIII (no private group lab possible)	X	X	X
32120	Mechanized blood count, reticulocyte count	Private group lab	Sender	X	X	X	X
32121	Differential blood count	Private group lab	Sender	X	X	X	X
32122	Mechanized complete blood count	Private group lab	Sender	X	X	X	X
32123	Surcharge for subsequent microscopic differentiation	Specialist laboratory	Sender	MI or MIII (no private group lab possible)	X	X	X

Table 2 (continued)

KV District:		Baden Württemberg	Bavaria	Berlin and Brandenburg	Hesse	North Rhine	Westfalen- Lippe
Health Insurance:		AOK	AOK	AOK	AOK	AOK	AOK
Contract:		AOK_Baden- Württemberg ^c	AOK_ Bavaria ^d	AOK Northeast and IKK Brandenburg and Berlin	AOK_Hesse	AOK Rhineland/ Hamburg, Arbitration Agreements, North Rhine	AOK Northwest
Last update:		2/13/2015	2/6/2015	2/18/2015	2/13/2015	2/13/2015	3/13/2015
Entry into force:		11/26/2014	10/1/2013	1/1/2014	1/1/2015	10/1/2013	10/1/2013
EBM-GOP	GOP designation	Request => from ^a		Bill => to	GOÄ classification ^b		
32124	Determination of endogenous creatinine clearance	Private group lab	Sender	Sender	X	X	X
32125	Preoperative laboratory diagnostics: Erythrocytes, leukocytes, platelets, hemoglobin, hematocrit, potassium, blood glucose, creatinine, GGT	Private group lab	Sender	Sender	X	X	X
32150	Immunological detection of troponin I and/or troponin T on prefabricated reagent carrier with acute coronary syndrome (ACS), including, if necessary, equipment-based quantitative evaluation	Specialist laboratory	Sender	Sender	X		
32212	Quantitative determination of the individual factors of the coagulation system, applies to the tariff positions 32210-32227, fibrin monomers, fibrin and/or fibrinogen degradation products, e.g. D-dimers	Specialist laboratory	Sender	Sender	X		

Table 2 (continued)

32232	Quantitative chemical or physical analysis, applies to the tariff positions 32230-32236, 32240 and 32242-32246 and 32248, lactate	Specialist laboratory	Sender	MIII (no private group lab possible)	X	
32880	Preliminary testing for protein, glucose, erythrocytes, leukocytes and nitrite in the urine (no. 32030), laboratory flat fee for tests related to the fee schedule position 01732	Own practice or specialist lab	Sender	MI or MIII (no private group lab possible)	X	X only for 01732
32881	Lab flat fee for tests in connection with the provision of fee schedule position 01732 (health check)	Private group lab	Sender		X	X only for 01732
32882	Lab flat fee for tests in connection with the provision of fee schedule position 01732 (health check)	Private group lab	Sender		X	X only for 01732

^aIt should be checked on a case-by-case basis which MII lab services can be provided by the respective private group laboratory. ^bThis is a description of the lab test classification for the GOÄ chapter. Some services of Chapter 32.2 EBM do not correspond to Chapter M II GOÄ and therefore cannot be procured from a private group laboratory. ^cPreliminary remark on the range of codes: BNP (32097), troponin qual. (32150), D-dimers (32212) and lactate (32232) marked as Section 73c-services: "Such services for insured patients registered with the AOK specialist doctor program cannot be settled by the family physician or any other doctor of the same BAG/MVZ with the KV. If the service is performed by the family physician or in his/her BAG/MVZ, it will generally be deemed paid through the flat fees under the present agreement. ^dPrinciple no. 5 of the preliminary remark on the HzV range of codes in effect from 01.10.2013, as amended by the 3rd interim agreement dated 02.10.2013. "All laboratory services are not part of this HzV agreement and must be settled via the KVB. Further laboratory services in connection with the services of health check (01732) and preoperative family physician care (2003) are part of the respective flat fee and are therefore deemed paid. These laboratory services are to be settled via a private card. In connection with 01732, the practice has to perform or purchase the following lab codes: 32057, 32060, 32061, 32062, 32063, 32064, 32066, 32067, 32880, 32881, 32882".

Table 3A: Complex code range EBM, dialysis.

EBM chapter		III.a		III.b	
EBM section		4.5.4.		13.3.6.	
EBM-GOP, EBM-range		Preamble		Preamble	
Description		Fee schedule positions of pediatric nephrology and dialysis		Fee schedule positions of nephrology and dialysis	
Remark		No. 6: As long as the patient undergoes dialysis or LDL apheresis treatment, the fee schedule positions 32038, 32039, 32065, 32066 or 32067, 32068, 32081, 32082, 32083, 32086 and 32112 cannot be billed either by the doctor performing the dialysis or LDL apheresis or the doctor to whom these services are assigned. This additionally applies to the fee schedule position 04565, as it does to fee schedule position 32036.		No. 5: As long as the patient undergoes dialysis or LDL apheresis treatment, the fee schedule positions 32038, 32039, 32065, 32066 or 32067, 32068, 32081, 32082, 32083, 32086 and 32112 cannot be billed either by the doctor performing the dialysis or LDL apheresis or the doctor to whom these services are assigned. This additionally applies to the fee schedule position 13611, as it does to fee schedule position 32036.	
EBM-GOP, EBM-range	GOP designation	Request => from ^a	Bill => to	GOÄ assignment	X means that this has been paid as part of the complex compensation, and cannot be settled together with the services complex
32036	Leukocyte count	Own practice or standard blood count from private group lab	Sender	If performed at doctor's practice, otherwise private group lab	X
32038	Hemoglobin	Own practice or standard blood count from private group lab	Sender	If performed at doctor's practice, otherwise private group lab	X

Table 3A (continued)

32039	Hematocrit	Own practice or standard blood count from private group lab	Sender	If performed at doctor's practice, otherwise private group lab	X	X
32065	Urea	Private group lab	Sender		X	X
32066	Creatinine (Jaffe method)	Private group lab	Sender		X	X
32067	Creatinine, enzymatically	Private group lab	Sender	Private group lab, usually the Jaffe method	X	X
32068	Alkaline phosphatase	Private group lab	Sender		X	X
32081	Potassium	Private group lab	Sender		X	X
32082	Calcium	Private group lab	Sender		X	X
32083	Sodium	Private group lab	Sender		X	X
32086	Phosphorus, inorganic	Private group lab	Sender		X	X
32112	PTT	Private group lab	Sender		X	X

^{a)}It should be checked on a case-by-case basis which MII lab services can be provided by the respective private group laboratory.

Table 3D: Complex code range EBM, gynecology.

EBM chapter		II	
EBM section		1.7.4.	
EBM-GOP, EBM-range		01770	
Description		Care of pregnant women according to maternity guidelines	
Remark		According to Section 2. b) and 4. Maternity Guidelines in conjunction with Cologne comments for EBM	
EBM-GOP, EBM-range		Optional service content: Immunological pregnancy tests	
Request => from ^a		Bill => to	
Request => from ^a		GOÄ assignment	
Request => from ^a		X means that this has been paid as part of the complex compensation, and cannot be settled together with the services complex	
32035	Erythrocyte count	Own practice or specialist lab	Sender
32038	Hemoglobin	Own practice or specialist lab	Sender
32030	Preliminary examination (protein, sugar in the urine)	Own practice or specialist lab	Sender
32031	Microscopic examination of the urine for morphological components	Own practice or specialist lab	Sender
32120	Mechanized blood count, reticulocyte count	Private group lab	Sender
32132	Immunological pregnancy tests	Specialist laboratory	Sender
32352	Chorionic gonadotropin (HCG and/or β -HCG)	Specialist laboratory	Sender

^aIt should be checked on a case-by-case basis which MII lab services can be provided by the respective private group laboratory.

Table 3E: Complex code range EBM, preoperative care.

EBM chapter		IV					
EBM section		31.1.2.				32.2.5.	
EBM-GOP, EBM-range		31010		31011		31012	
Description		Preparation for surgery in neonates, infants, toddlers and children up to age 12		Preoperative preparation for procedures on adolescents and adults up to the age of 40		Preparation for surgery for procedures on patients after the age of 40	
Remark		Optional service content: Laboratory tests (Nos. 32101, 32125 and/or 32110–32116) Billing exclusion on day of treatment: Chap. 32		Optional service content: Laboratory tests (Nos. 32101, 32125 and/or 32110–32116) Billing exclusion on day of treatment: Chap. 32		Optional service content: Laboratory tests (Nos. 32101, 32125 and/or 32110–32116) Billing exclusion on day of treatment: Chap. 32	
EBM-GOP, EBM-range		Request => from*		Bill => to		GOÄ assignment	
32035	Erythrocyte count	Own practice or standard blood count from private group lab	Sender	If performed at doctor's practice, otherwise private group lab			X, billing exclusion
32036	Leukocyte count	Own practice or standard blood count from private group lab	Sender	If performed at doctor's practice, otherwise private group lab			X, billing exclusion
32037	Platelet count	Own practice or standard blood count from private group lab	Sender	If performed at doctor's practice, otherwise private group lab			X, billing exclusion
32038	Hemoglobin	Own practice or standard blood count from private group lab	Sender	If performed at doctor's practice, otherwise private group lab			X, billing exclusion
32039	Hematocrit	Own practice or standard blood count from private group lab	Sender	If performed at doctor's practice, otherwise private group lab			X, billing exclusion
32047	Reticulocyte count	Private group lab	Sender				X, billing exclusion
32057	Glucose	Private group lab	Sender				X, billing exclusion

X means that this has been paid as part of the complex compensation, and cannot be settled together with the services complex

Table 3E (continued)

32066	Creatinine (Jaffe method)	Private group lab	Sender							X, billing exclusion
32067	Creatinine, enzymatically	Private group lab	Sender	Private group lab, usually the Jaffe method						X, billing exclusion
32071	Gamma-GT	Private group lab	Sender							X, billing exclusion
32081	Potassium	Private group lab	Sender							X, billing exclusion
32101	TSH	Specialist laboratory	Sender	MIII, no private group lab possible	X, optional				X, optional	X, optional
32110	Bleeding time (standardized)	Specialist laboratory	Sender	MIII, no private group lab possible	X, optional				X, optional	X, mandatory
32111	Recalcification time	Specialist laboratory	Sender	MIII, no private group lab possible	X, optional				X, optional	X, mandatory
32112	PTT	Private group lab	Sender		X, optional				X, optional	X, mandatory
32113	Prothrombin time, plasma	Private group lab	Sender		X, optional				X, optional	X, mandatory
32114	Prothrombin time, capillary blood	Private group lab	Sender		X, optional				X, optional	X, mandatory
32115	Thrombin time	Private group lab	Sender		X, optional				X, optional	X, mandatory
32116	Fibrinogen	Specialist laboratory	Sender	MIII, no private group lab possible	X, optional				X, optional	X, mandatory
32120	Mechanized blood count, reticulocyte count	Private group lab	Sender							X, billing exclusion
32122	Mechanized complete blood count	Private group lab	Sender							X, billing exclusion
32125	Preoperative laboratory diagnostics	Private group lab	Sender		X, optional				X, optional	X, mandatory
Chap. 32 EBM	Laboratory medicine, molecular genetics and molecular pathology	Private group lab or specialist laboratory	Sender		X, billing exclusion	X, billing exclusion			X, billing exclusion	X, billing exclusion
Chap. 32.2 EBM	General laboratory tests	Private group lab or specialist laboratory	Sender							X, optional

¹¹It should be checked on a case-by-case basis which MII lab services can be provided by the respective private group laboratory.

Table 3F: Complex code range EBM, cardiac catheter.

EBM chapter					IV
EBM section					34.2.9.
EBM-GOP, EBM-range					34291
Description					Cardiac catheter examination with coronary angiography
Remark					Optional service content: Coagulation test(s) (e.g. activated clotting time); Billing exclusion in the same session: Chap. 32
EBM-GOP, EBM-range	GOP designation	Request => from ^a	Bill => to	GOÄ assignment	X means that this has been paid as part of the complex compensation, and cannot be settled together with the services complex
32110	Bleeding time (standardized)	Specialist laboratory	Sender	MIII, no private group lab possible	X, optional
32111	Recalcification time	Specialist laboratory	Sender	MIII, no private group lab possible	X, optional
32112	PTT	Private group lab	Sender		X, optional
32113	Prothrombin time, plasma	Private group lab	Sender		X, optional
32114	Prothrombin time, capillary blood	Private group lab	Sender		X, optional
32115	Thrombin time	Private group lab	Sender		X, optional
32116	Fibrinogen	Specialist laboratory	Sender	MIII, no private group lab possible	X, optional
32117	Fibrin monomers, fission products (qual.)	Specialist laboratory	Sender	MIII, no private group lab possible	X, optional
Chap. 32 EBM	Laboratory Medicine, Molecular Genetics and Molecular Pathology	Private group lab or specialist laboratory	Sender		X, billing exclusion

^aIt should be checked on a case-by-case basis which MII lab services can be provided by the respective private group laboratory.

Legal sources and references

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2. Uniform rating scale, as amended with effect from 01.04.2015.
3. Social Code Book V, dated 20.12.1988, as amended by the Act of 15.04.2015.
4. Federal master agreement with doctors, as amended on 01.01.2015.
5. Directive by the Federal Joint Committee on specialist outpatient medical treatment under Section 116b SGB V, as published on 21.03.2013, as amended on 20.02.2014.
6. "Tuberculosis and atypical mycobacteriosis", decision of 19.12.2013, entered into force on 24.04.2014.
7. "Gastrointestinal tumors and tumors of the abdominal cavity", decision of 02.20.2014, entered into force on 26.07.2014.
8. "Gynecological tumors", decision of 22.01.2015, not yet in force.
9. "Marfan's syndrome", decision of 22.01.2015, not yet in force.
10. Kasseler Kommentar zum Sozialversicherungsrecht, last update: 01.12.2014, Verlag C.H. Beck München.
11. Schedule 5 of the agreement under Section 116b para. 6 sentence 12 SGB V regarding the form and content of the billing procedure as well as the required forms for outpatient specialist care (ASV-AV), which entered into force on 01.10.2014.

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