

ORGANIZATION POLICY

POLICY: Handling Charges for Laboratory Tests

POLICY NUMBER: 1220

OBJECTIVE:

To provide guidance and information on handling the charges for laboratory tests.

POLICY:

The Laboratory will charge for only lawfully requested tests and follow the policies set forth in the federal, state and local regulations.

PROCEDURE/GUIDELINES:

Types of Charges:

Laboratory charges are of two types: Patient and/or Third Party Charging and Account Bill Charging. The first is carried out through a combination of the Hospital's computer system interfaced to the Laboratory's computer system and the later is carried out only through the Laboratory's computer system

Patient and/or Third Party Charging.

Out Patients and Inpatients: Patients who present themselves are registered and their tests are ordered in the Hospital computer system. This information is transferred to the Laboratory computer system via an interface. When the test results are completed by the testing method, the technologist enters and verifies the results. For most of the Laboratory results, this verification function immediately sends the results across the interface to the Hospital system. The results are available for viewing in the Hospital computer system and the test is charged. However, the tests results for Blood Bank, Microbiology and Anatomical Pathology are charged in batch mode at 12 Midnight.

The method of "Charge Posting" is rarely used in the Laboratory. Charge Posting may be used to enter the first time charges of a newly built test.

Non Patients: Specimens that are received through the Outreach Service will be registered through a modified registration system. This system allows the specimens to proceed to analysis without compromising the specimen's integrity. The requests are reviewed by the Laboratory office and "maintenanced" as needed. Missing information is obtained from the doctor's office if necessary. The "maintenanced" requisitions are further processed for insurance information entry by the Registration Department. The charging is as the same for the tests is the same as for out patients and inpatients.

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Specific Rules:

- o All Laboratory tests are built in the Charge Description Master (CDM). Most tests are built and entered into the CDM prior to being ordered. If a test is ordered and it has not been built in the CDM, an “Unresultable Test” is ordered to hold the account open until the detailed test can be built. Once the detailed test has been built, it is resultated, charged and the “Unresultable Test” is deleted. The CDM is updated as bulletins dictate through out the year and annually to ensure that the correct CPT4 code is being used.
- o Standing orders: The laboratory will only honor standing orders no longer than one year.
- o Calculations: The laboratory will not bill for any calculations.
- o Billing of Repeated Tests: Tests that are repeated because the specimen was inadequate, the initial testing was performed on an incorrect specimen or an incorrect test was order will not be billed.
- o Charging for Unperformed Tests: If a test is ordered and not performed (Specimen Quantity Not Sufficient (QNS), tests canceled, etc), the Laboratory will not charge for that specimen.
- o Duplicate Tests on One Order: When the same test is ordered more than once on the same requisition, the Laboratory software will “duplicate” out the excess tests. The Laboratory staff will also take care to evaluate any situation that there may appear to have duplicate tests. A second edit is made from the Hospital Computer to identify duplicate CPT4 codes. The Data Systems Coordinator reviews these edits and makes corrections as needed.
- o 72 Hour Rule: Tests ordered on an outpatient 72 hours before an inpatient admission will not be billed separately. Patient Financial Services will run special software to identify these incidents.
- o DRG: The laboratory will not charge separately for tests ordered on Medicare inpatients. These tests will be part of the DRG.
- o End State Renal Disease (ESRD) tests: ESRD tests that are included in the “composite rate” will not be billed separately to Medicare. Composite tests will be identified and billed to the ESRD complex that ordered the test.
- o Lab to Lab Referral: Medicare permits a testing lab to bill a referring lab and the referring lab to bill Medicare if one of the following criteria applies

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- o The test-performing lab is a subsidiary, parent or sibling corporate relation of the test-referring lab.
- o The test-referring lab is a hospital lab; or
- o The test-referring lab refers no more than 30% of the tests for which it receives orders to another lab for testing.

- o **Unbundling:** The Laboratory will use only AMA recommended Panels. These panels will not be exploded and billed separately.

- o **Medical Necessity:** Billing Medicare beneficiaries for medically unnecessary test without a properly executed Advanced Beneficiary Notice (ABN) is considered a violation. The Laboratory will evaluate all Medicare orders for Medical Necessity through the Pathways Compliance Program or through the hard cover manual system.

- o **Kickbacks:** The law prohibits the provision or receipt of financial benefits to induce referrals of laboratory testing services provided on behalf of Medicare (and Medicaid) beneficiaries. The Laboratory will provide only supplies to collect specimens that are received by the laboratory.

- o **Archived Specimens:** Upon the request of a physician or medical provider, a test may be ordered on an archived specimen. If the specimen is older than 24 hours, obtain the Archive Specimen Form, register the patient and order the test.

Account Bill Charging:

Some physician's offices may arrange for an Account Billing whereby the physician's office is billed for the laboratory tests once a month.

Arrangements for billing may be at 100% of the Patient Fee Schedule or at a discount from the Patient Fee Schedule. The discount schedule may vary from test to test; however, the discounted fee will not be lower than the Current Medicare Fee Schedule

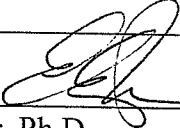
- In the Laboratory computer, the tests are ordered for a patient but under a client or physician account.
- A listing of all patients and their respective charges will be generated after the end of the month and this list is sent to Accounting. Accounting will provide a cover sheet and bill the clients.

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EFFECTIVE DATE: July 2004

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APPROVED BY: _____

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