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 follow the policies set forth in all applicable federal, state and local regulations in providing and billing for clinical laboratory services.

DEFINITIONS: Certain terms having specific definitions are used in this Policy, and these terms and definitions are as follows:

A. Laboratory means the Department of Onslow Memorial Hospital responsible for performing clinical diagnostic laboratory services on specimens using specialized equipment in a CLIA certified laboratory setting on a 24 hours a day, 7 days a week basis. Inpatient specimen collection is performed in the patient care units of the main hospital facility. Outpatient specimen collection and patient registration is performed at the Emergency Department of Onslow Memorial Hospital, the Main Laboratory outpatient area, or at the satellite location known as Onslow Diagnostics. For purposes of this policy, Laboratory means the main laboratory testing facility as well as outpatient specimen collection sites.

B. Hospital means the acute care hospital facility operated as Onslow Memorial Hospital, Inc.

PROCEDURE/GUIDELINES:

Types of Charges: Charges for laboratory services are handled in two ways: (1) Patient and/or Third Party Charging and (2) Client Billing Charging.

A. Patient and/or Third Party Charges.

1. Inpatients and Registered Outpatients: Individuals who are not already registered as patients of the Hospital and who present to the Laboratory with an order for laboratory services will be registered as Hospital outpatients.

Charges for laboratory services on all registered Hospital patients (whether inpatients or outpatients) are entered by Laboratory staff into the patient's account in the Hospital's main Electronic Health Record (EHR) system. When the test results for these

services are complete, the Laboratory technologist will enter and verify the results. For most Laboratory services, the results verification function immediately transfers information so that the results are available for viewing in the Hospital's EHR system and the charge for the laboratory service appears in the patient's account. Charges for Blood Bank, Microbiology and Anatomical Pathology services are processed in batch mode at 12 Midnight.

2. Unregistered Patients: Specimens collected offsite and received directly from physician offices through the hospital's outreach laboratory service are processed through a modified registration system that allows the specimens to proceed to analysis in a timely manner without compromising the specimen's integrity. The requests/orders are reviewed by the Laboratory office and "maintenance" is performed as needed. If any necessary information is missing from the request/order, Laboratory staff will contact the office of the ordering provider. The requisitions are then forwarded to the Hospital's Patient Financial Services Department for insurance processing and billing. Outreach laboratory services are billed according to the same fee schedule used for registered hospital patients.

The method of "Charge Posting" is rarely used in the Laboratory. Charge Posting may be used to enter the first time charges for tests prior to their inclusion in the Hospital's Charge Description Master (CDM).

B. Client Billing Charges. Some entities may make arrangements with the Hospital whereby the Laboratory will perform testing services for direct reimbursement from the requesting entity.

Requisitions/orders for laboratory services under a Client Billing arrangement will clearly indicate that the request is being made under the applicable Client Billing arrangement. Charges for these laboratory services are entered under the Client account and reference the specific patient for whom the service was provided.

Laboratory services provided under a Client Billing arrangement are billed on a monthly basis. A listing of all patients and their respective charges will be generated at the end of each calendar month and sent to PFS. PFS will prepare a cover sheet and bill the responsible Client accounts.

Client Billing arrangements are billed at either the Patient Fee Schedule rate or at a discount from the Patient Fee Schedule. A Client Billing arrangement may be established as a single discount applicable to all laboratory services on the Patient Fee Schedule, or the discount may vary from test to test; however, in no event will the discounted fee for a laboratory service be less than the Current Medicare Fee Schedule rate for that service.

Specific Rules:

A. Included in CDM: All clinical laboratory services performed by the Laboratory will be added to the Hospital's Charge Description Master (CDM). The most commonly ordered tests are included in the CDM. If a test is ordered that is not in the CDM, PFS is notified to hold the account open until the detailed test can be added to the CDM. Once the detailed test has been added to the CDM, it is resulted, charged and the hold is removed. The CDM is updated as bulletins dictate throughout the year and annually to ensure that the correct CPT code is being used.

B. Standing orders: The laboratory will only honor standing orders for up to one year from the date issued by the provider.

C. Calculations: The laboratory will not bill for any calculations.

D. 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 performed will not be billed.

E. Unperformed Tests: If a test is not performed (Specimen Quantity Not Sufficient (QNS), tests canceled, etc.), the Laboratory will not charge for that specimen.

F. 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 where it appears duplicate tests have been ordered. A second edit is made from the Hospital Computer to identify duplicate CPT4 codes. PFS or HIM sends edits to Lab Admin to get clarification on the edits and corrections needed.

G. 72 Hour Rule: Laboratory services provided in connection with a registered outpatient of the Hospital who is a Medicare beneficiary within72 hours prior to being admitted as an inpatient of the Hospital are not separately reimbursable; rather CMS considers those services as included in the DRG payment to the Hospital for the inpatient stay . The Hospital's Patient Financial Services Department will run special software to identify those laboratory services that must be rolled up into the Medicare inpatient claim.

H. DRG: The Laboratory will not bill separately for tests performed on Medicare inpatients. CMS considers reimbursement for these tests to be part of the DRG for the inpatient stay.

I. End State Renal Disease (ESRD) tests: ESRD tests that are included in the "composite rate" paid to providers of ESRD services will not be billed separately to Medicare. ESRD service providers who order composite tests must identify them, and they will be billed to the ESRD service provider that ordered the test.

J. 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.

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

K. Unbundling: When test panels and profiles are performed, if a specific code exists for a given combination of tests, that code must be used. Test panels should never be unbundled to obtain higher reimbursement if a single code exists that more accurately describes the test panel.

L. Medical Necessity: If a test is ordered for a Medicare Beneficiary and it does not meet "medical necessity," a properly executed Advanced Beneficiary Notice (ABN) is required. The Laboratory will evaluate all orders for laboratory services on Medicare beneficiaries for Medical Necessity when testing is ordered within the Meditech system and when appropriate, ensure that a properly executed ABN is in place prior to performing the laboratory service.

M. 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 staff will not give nor receive any benefits or incentives to/from providers in order to obtain referrals for laboratory services. Provided, however, the Laboratory may provide supplies used to collect specimens for testing by the Laboratory.

N. Archived Specimens and Add On Testing: Upon the request of a physician or medical provider, a test may be ordered on an archived specimen. Any add on testing ordered by the provider has the same Medical necessity requirements as other testing.

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