PURPOSE:

To outline the procedure for billing services provided by reference laboratories

POLICY:

Laboratory services provided by reference laboratories will be billed in accordance with Medicare, Medi-Cal and other federally funded payor guidelines.

PROCEDURE:

1. Medicare requires direct billing of outpatient laboratory services by the laboratory performing the tests, except the hospital / laboratory must bill the federally funded payor for services, in the case of a clinical diagnostic laboratory test provided **under an arrangement** made by a hospital or rural primary care hospital with another laboratory. **Under an arrangement** is defined as a contractual agreement between a hospital / laboratory and a reference laboratory under which the hospital/laboratory will pay the reference laboratory for the test performed and the hospital/laboratory will be responsible for billing and collection activities.

2. Medicare requires direct billing of outpatient laboratory services by the laboratory performing the tests; however, reference laboratories, which send specimens to other laboratories for testing may bill for the tests if the reference laboratory meets certain criteria.

3. All tests that are referred to another laboratory for testing must be identified in the charge master. It is the responsibility of the Department of Pathology & Laboratory Medicine to submit a list of the tests to be provided by a new reference laboratory to the charge master coordinator in a timely manner.

4. Laboratory personnel must identify the reference laboratory(ies) that is (are) utilized for each test.

5. On an annual basis, the Laboratory must obtain, update and/or verify, and document CLIA (Clinical Laboratory Improvement Act), NPI # and/or CAP (College of American Pathologists) certificate information for each testing specialty provided by each reference laboratory identified in the previous step.

6. The department's Business Manager must determine if the reference laboratory is under arrangement to provide services for UCDHS.

   a. If reference laboratory is under arrangement, the hospital laboratory must bill for laboratory services.

   b. If the reference laboratory is not under arrangement, the hospital / laboratory must meet the 70/30 rule in order to bill Medicare for tests that are referred out. A hospital / laboratory may direct bill referred tests so long as no more than 30% of testing is referred out. To determine if the laboratory meets the 30% exception rule, review annual volumes of all referred tests and total tests performed, and calculate the percentage of tests referred by dividing the number of referred tests by the total test performed.

Example:	Total annual tests performed	=	100,000 tests
	Total annual referred tests performed	=	5,000 tests
	Percentage Referred tests	=	5,000/100,000x100=5%

7. Document the findings and retain records in accordance with the Administrative Policy #145.A, "Records and Material Retention."

8. If the laboratory refers **<u>more than 30%</u>** of its annual volume, the hospital / laboratory may no longer directly bill Medicare for those tests which are referred. The referring laboratory must then provide billing information to the reference laboratory with instructions that the reference laboratory direct bills.

9. Laboratory must educate all staff responsible for ordering, charging or billing laboratory services on the contents of this policy.

10. The department's Chief Administrative Officer and Business Manager must review the laboratory's arrangements with reference laboratories on an annual basis, and deviations from this policy must be documented and resolved.

REFERENCE:

Code of Federal Regulations, Title 42 CFR 411.1, Title 42 CFR 411 Subpart J.

PROCEDURE HISTORY:

Date	Written Revised By	Revision	Approved Date	Approved By
6/01	D. Brown	New	6/01	R. Green
8/01	D. Brown	Revision	8/01	R. Green
9/02	D. Brown	Annual Review	9/02	R. Green
10/03	D. Wright	Annual Review	10/03	R. Green
10/04	D. Wright	Revised	10/04	R. Green
9/05	D. Wright	Annual Review	9/05	R. Green
9/06	D. Wright	Annual Review	9/06	R. Green
09/07	C White	Annual Review	09/07	R. Green
8/08	C. White	Annual Review	08/08	L. Howell
8/09	C. White	Annual Review	8/09	L. Howell
08/10	C. White	Annual Review	8/10	L. Howell
11/12	E. Brennan	Revised: added payors to policy statement	11/12	L. Howell