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Outpatient Hospital Laboratory Pass Through Billing

Applicable Lines of Business:

✓ Commercial - Health Maintenance Organization (HMO), Preferred Provider Option (PPO) and Point of Service (POS)
✓ Medicare Advantage - SecureCare HMO (includes the Dual Eligible Special Needs Plan [DSNP]) and SecureChoice PPO)
Mountain Health Trust (MHT) including WV Medicaid (Temporary Assistance for Needy Families [TANF], Expansion [WV Health Bridge] and Supplemental Security Income [SSI] populations) and West Virginia Children's Health Insurance Program (WVCHIP)
✓ Self-Funded/Administrative Services Only (ASO)
✓ West Virginia Public Insurance Agency (WV PEIA)

Applicable Claim Type:

Dental
✓ Facility
Pharmacy
Professional

Definitions:

Term	Definition
Billing laboratory	The laboratory that submits a bill or claim to an insurance carrier.
Centers for Medicare and Medicaid Services (CMS)	A federal agency that provides health coverage to more than 100 million people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.
Clinical Laboratory Improvement Amendments (CLIA) Certificate	CMS regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). The objective of the CLIA program is to ensure quality laboratory testing.
Independent laboratory	A laboratory that is not part of a hospital or hospital-based facility. Independent clinical labs perform tests or procedures to help

	diagnose and/or treat medical conditions.
Pass through billing	When a provider, such as a physician or hospital, pays a laboratory to perform their tests and then files the claims as though they had performed the tests themselves.
Physician office laboratory	A laboratory maintained by a physician or group of physicians for performing diagnostic tests in connection with the physician practice.
Reference laboratory	An independent referral or diagnostic facility that handles high volume routine and specialty testing on specimens it receives from other referring laboratories or care providers.
Referred clinical diagnostic laboratory service/test (also known as reference a test)	A service performed by one laboratory at the request of another laboratory.
Referring laboratory	A laboratory that refers a specimen to another laboratory for testing.

Policy Purpose:

The purpose of this policy is to address general payment guidelines related to outpatient hospital laboratory pass through billing by a provider to ensure fair and accurate payment of health care claims for covered services to avoid:

- Duplicate payments
- Over payments and subsequent recoupment
- Fraud, waste and abuse

This policy is also intended to ensure accurate member copay, deductible and coinsurance obligations for members under their health benefit plan in compliance with all state and federal laws, rules and regulations.

This policy applies to all outpatient hospital laboratory providers, including:

- Independent laboratories
- Reference laboratories
- Referring laboratories
- Hospitals
- Physicians
- Pathologists

Policy Description:

Although payment may generally be made to an independent clinical laboratory for those tests that it performs, payment may also be made to a laboratory for a test listed on the clinical laboratory fee schedule that it has referred to another laboratory.

Commercial, Medicare Advantage, Self-Funded/ ASO and WV PEIA Reimbursement Guidelines:

A referring laboratory may bill for clinical laboratory diagnostic tests listed on the clinical laboratory fee schedule that were performed by a reference laboratory.

Aligning with the Centers for Medicare and Medicaid Services (CMS), reference laboratories reporting laboratory services appended with modifier 90 are eligible for reimbursement.

Per CMS, payment may be made to the referring laboratory, but only if one of the following conditions are met:

1. It is in, or is part of, a rural hospital; or
2. It is wholly owned by the reference laboratory; or both it and the reference laboratory are wholly owned subsidiaries of the same entity; or
3. It refers no more than thirty (30) percent of the clinical laboratory tests annually to other laboratories, (not including referrals made under the wholly owned proviso, above).

Both the referring laboratory and the reference laboratory must be enrolled in Medicare to service THP's Medicare Advantage line of business (LOB).

Medicare Advantage Member Cost-Sharing:

Per CMS, member deductibles and coinsurance do not apply to clinical laboratory tests performed on a Medicare Advantage member by a physician or laboratory.

Commercial, Self-Funded/ASO and WV PEIA Cost-Sharing:

Applicable member cost-sharing (deductible, copay and coinsurance) will be applied to Commercial, Self-Funded/ASO and WV PEIA members.

Mountain Health Trust (MHT) Reimbursement Guidelines:

Outpatient hospital laboratory pass through billing is federally prohibited for the MHT LOB.

Billing Information and Guidelines:

A valid Federal Clinical Laboratory Improvement Amendments (CLIA) Certificate Identification number is required for reimbursement of clinical laboratory services reported on a CMS 1500 Health Insurance Claim Form or its electronic equivalent.

We only reimburse for laboratory services that you are certified to perform per your CLIA certificate.

You must not bill our members for any laboratory services for which you lack the applicable CLIA certification.

THP will not pay any amount greater than the amount the billing provider pays the rendering provider for the service.

The billing provider may not bill an amount greater than the amount the billing provider paid or will pay the rendering provider for the service.

The reimbursement amount is based upon the provider's contract with THP.

The billing laboratory, whether it is the referring laboratory or the reference laboratory, must submit its claim to THP.

When the billing laboratory is the referring laboratory it must:

- Identify the referred service as such by using modifier 90
    - It is fraudulent billing if modifier 90 is not included and billing is for a referenced test

- Identify the reference laboratory by specifying its CLIA number and address (i.e., the address where the test was performed).

Laboratory services billed with modifier 90 by a referring laboratory are reimbursable if a duplicate claim has not been received from an independent laboratory or reference laboratory.

If a reference laboratory and a non-reference laboratory provider submit duplicate laboratory services the first claim received by THP is processed and reimbursed.

Duplicate services are not reimbursable, unless one laboratory appends the appropriate repeat laboratory modifier (i.e., modifier 59, XE, XP, XS, XU, or 91) to the code(s) submitted.

According to the American Medical Association (AMA) and CMS, it is inappropriate to use modifier 76 or 77 to indicate repeat laboratory services.

Referring laboratory billing for referred and non-referred tests for the same member:

When the referring laboratory bills for both non-referred and referred tests for the same member, the provider may submit both non-referred and referred tests on one claim form.

A claim that contains both non-referred and referred tests for the same member must include the 90 modifier for the referred test.

If billing for services that have been referred to more than one laboratory for a member, the referring laboratory must submit a separate claim for each laboratory to which services were referred.

Referring laboratory billing the reference laboratory on a paper claim form:

When the referring laboratory is the billing laboratory, the reference laboratory's name and address must be reported in item 32 on the CMS-1500 paper claim form to show where the service (test) was actually performed.

The CLIA number of the reference laboratory shall be reported in item 23 on the CMS-1500 paper claim form.

Referring laboratory billing the reference laboratory electronically:

If the referring laboratory is billing electronically, the CLIA number of the **referring** laboratory is reported in:
X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4

If the referring laboratory is billing electronically, the CLIA number of the **reference** laboratory is reported in:
X12N 837 (HIPAA version) loop 2400, REF02. REF01 = F4

Providers ineligible to bill with modifier 90:

Non-reference laboratory physicians or Other Qualified Health Care Professionals reporting laboratory services with modifier 90 are not eligible for reimbursement.

Physicians or Other Qualified Health Care Professionals who own laboratory equipment (physician office laboratory) and perform laboratory testing report the laboratory service without appending modifier 90.

Reporting the place of service (POS) on the claim form:

Independent or reference laboratories should bill the place of service (POS) where the specimen was obtained.

For example:

- A sample taken at a physician's office and referred to the laboratory would be reported with POS 11.
- Report POS 81 if the independent or reference laboratory did the blood drawing in its own setting.

Reporting the date of service (DOS) on the claim form:

The date of service (DOS) on a claim for a laboratory test is the date the specimen was collected.

If the specimen was collected over 2 calendar days, the DOS must be the date the collection ended.

More billing information may be found in The Health Plan's Provider Manual located at healthplan.org "For Providers," "Resources."

References and Research Materials:

Examining Clinical Laboratory Services: A Review by the Healthcare Fraud Prevention Partnership. Healthcare Fraud Prevention Partnership. Available at: https://www.cms.gov/files/document/download-clinical-laboratory-services-white-paper.pdf

Pub. 100-04 Medicare Claims Processing. Department of Health & Human Services Centers for Medicare and Medicaid Services. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r85cp.pdf

Disclaimer:

This policy is intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry standard claims editing logic, benefit design and other factors are considered in developing payment policies. This policy is intended to serve as a guideline only and does not constitute medical advice, any guarantee of payment, plan pre-authorization, an explanation of benefits, or a contract. This policy does not govern whether a specific procedure is covered under any specific member plan or policy, nor is it intended to address every claim situation. The determination that any service, procedure, item, etc., is covered under a member's benefit plan shall not be construed as a determination that a provider will be reimbursed for services provided. Individual claims may be affected by other factors, including but not necessarily limited to state and federal laws and regulations, legislative mandates, provider contract terms, and THP's professional judgement. Reimbursement for any services shall be subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Unless otherwise noted within the policy, THP's policies apply to both participating and non-participating providers and facilities. THP reserves the right to review and revise these policies periodically as it deems necessary in its discretion, and it is subject to change or termination at any time by THP. THP has full and final discretionary authority for its interpretation and application. Accordingly, THP may use reasonable discretion in interpreting and applying this policy to health care services provided in any particular case.

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