DEPARTMENT: Regulatory Compliance Support	**POLICY DESCRIPTION:** BILLING - Referred Laboratory Testing
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SCOPE: All Company-affiliated hospitals performing and/or billing laboratory services. Specifically, the following departments:

Laboratory	Revenue Integrity
Administration	Shared Services Centers

PURPOSE: To establish guidelines for billing clinical laboratory tests referred to other laboratories in accordance with CMS guidelines.

DEFINITIONS:

Nonhospital patient (Specimen Only) – An individual who is neither an inpatient nor outpatient of the hospital furnishing the service. Nonhospital patients are individuals from whom a specimen has been taken and sent to the hospital for analysis and the patient does not receive hospital outpatient services on the same day. According to Medicare, if a Medicare patient receives hospital outpatient services on the same day as a specimen collection and laboratory test, then the Medicare patient is considered to be a registered hospital outpatient and cannot be considered to be a non-patient on that day for purposes of the specimen collection and laboratory test.

Referring Laboratory – A Medicare-approved laboratory that receives a specimen to be tested and that refers the specimen to another laboratory for performance of the laboratory test.

Reference Laboratory – A Medicare-enrolled laboratory that receives a specimen from another referring laboratory for testing and that actually performs the test.

POLICY: Clinical laboratory tests referred to another laboratory for testing will be billed in accordance with the guidelines outlined below.

1. **Anti-Markup Prohibition** - State law may limit the Referring Laboratory's (hospital-based or independent) ability to add to or otherwise mark-up the price of a laboratory service referred to a Reference laboratory and/or may require the Referring Laboratory to disclose to the patient and/or payor the identity of the Reference Laboratory and the amount Referring Laboratory paid for the laboratory service.

2. **Nonhospital patients (Specimen Only)** - When the hospital receives a specimen only and sends it to a reference laboratory, either the hospital may bill Medicare for the test under arrangements or the reference laboratory performing the test may bill Medicare, as long as both the hospital and reference lab do not bill. The hospital must have a contractual agreement with the reference laboratory outlining who will bill Medicare for the services.

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3. **Hospital Inpatients (including Inpatient Rehabilitation Facilities (IRF), Inpatient Psychiatric Facilities (IPF), and Long-Term Care Hospitals (LTCH)), Critical Access Hospitals and Outpatients -** When a specimen is obtained from an inpatient or outpatient of the hospital and is referred to another laboratory for testing, the hospital where the patient is an inpatient or outpatient may bill Medicare for laboratory services. In general, the lab date of service (DOS) is the date the specimen was collected, however, there are exceptions to this rule which may impact who bills for laboratory services. For example, if a test is ordered by the patient's physician at least 14 days following the date of the patient's discharge from the hospital, the date of service may be the date the test is performed and as a result the vendor laboratory may bill for the test. For complete guidance on the billing of laboratory services refer to the HCA Healthcare Laboratory Compliance Plan.

4. **End Stage Renal Disease (ESRD)** - Certain lab services are subject to Medicare ESRD Part B consolidated billing and are not separately payable when provided to Medicare ESRD beneficiaries by providers other than the renal dialysis facility. ESRD-related tests provided by hospital labs are billed to the dialysis facility and the dialysis facility will bill Medicare. When a hospital receives a specimen (non-hospital patient) from a Medicare ESRD patient and sends it to a reference laboratory for ESRD-related testing, the reference laboratory or the hospital may bill the dialysis facility.

5. **Skilled Nursing Facility (SNF)** - When a hospital provides laboratory services for a SNF patient, an arrangement should be in place outlining the process for billing laboratory services for Medicare and TRICARE patients

    a. Medicare & TRICARE Part A residents: Payment of laboratory services provided to residents of a skilled nursing facility (SNF) is included in the SNF Prospective Payment System (PPS) payment. When the hospital receives a specimen only from a SNF for a Medicare/TRICARE patient and sends it to a reference laboratory for testing, the hospital must bill the SNF and the SNF will bill Medicare/TRICARE for the laboratory service.
    b. Medicare Part B residents**:** If the hospital receives a specimen only from a SNF and sends it to a reference laboratory, the arrangement between the hospital and the SNF must specify who will bill Medicare for the laboratory service.

PROCEDURE

1. Hospital laboratory personnel must obtain and/or verify that documented CLIA (Clinical Laboratory Improvement Act) and/or CAP (College of American Pathologists), TJC (The Joint Commission), COLA (Commission On Laboratory Accreditation) certificate information is available for each testing specialty used by each reference laboratory identified as follows:
    a. Laboratory personnel must identify all tests in their chargemaster that are referred to another laboratory for testing.
    b. Laboratory personnel must identify the reference laboratory(s) that is utilized for each test.
2. When the hospital is responsible for billing referred laboratory services based on the guidelines outlined in this policy, the hospital must have a process in place to ensure the reference laboratory bills the hospital rather than Medicare/TRICARE.

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3. If the hospital will be billing for referred laboratory services, the following steps must be performed:
   a. Laboratory and/or hospital designated personnel must consult with Legal Operations Counsel to determine if State laws and/or statutes prohibit the marking up of laboratory services.
   b. If it is determined that such laws and/or statutes exist, the hospital must not charge any payer more than the charge billed by performing laboratory.
4. Laboratory and/or hospital designated personnel must educate all staff associates responsible for ordering, charging, or billing laboratory services on the contents of this policy.
5. The Facility Ethics and Compliance Committee (FECC) must review the laboratory's processes and arrangements on an annual basis for compliance with this policy.

The Facility Ethics and Compliance Committee is responsible for implementation and monitoring of this policy within the facility.

REFERENCES:

1. OIG Model Compliance Plan for Clinical Labs (March, 1997)
2. Medicare Benefit Policy Manual (CMS Pub. 100-2), Chapter 6
3. Medicare Claims Processing Manual (CMS Pub. 100-4), Chapter 16, Section 40