

PUBLICATION

CMS 'Packages' Clinical Laboratory Tests Into Outpatient Prospective Payment System [Ober|Kaler]

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Hospitals Lose Right to Bill Separately for Laboratory Tests for Outpatients

As part of its calendar year 2014 hospital outpatient prospective payment system (OPPS) policy changes, the Centers for Medicare & Medicaid Services (CMS) adopted a policy that "packages" certain clinical laboratory tests provided to hospital outpatients into OPPS (other than certain excluded molecular pathology tests). [Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Final rule with comment period and final rules, 78 Fed. Reg. 74826 \(Dec. 10, 2013\)](#) CMS stated that laboratory tests would be packaged when they were considered integral, ancillary, supportive, dependent, or adjunctive to a primary service or services provided in the hospital outpatient setting. A laboratory test that was packaged would be paid for by Medicare only as part of OPPS. A laboratory test that was not packaged would continue to be paid separately based on the Medicare clinical laboratory fee schedule (CLFS).

Notwithstanding the complicated description of tests that would be packaged, CMS adopted a simple approach to determining which laboratory tests will be packaged for OPPS payment. Under the new payment policy, a laboratory test will be packaged when (1) it is provided on the same date of service as the primary service and (2) it was ordered by the same practitioner who ordered the primary service. By contrast, a laboratory test will not be packaged if it is the only service provided to a Medicare beneficiary on the date of service. Additionally, a laboratory test that is performed on the same date of service as the primary service will not be packaged if it is ordered for a different purpose than the primary service and is ordered by a practitioner who is different from the practitioner who ordered the primary service.

The final rule illustrates the new payment policy using two examples. According to CMS, if a Medicare beneficiary was scheduled for eye surgery by an ophthalmologist, but on the same date of service received unrelated laboratory tests that had been ordered by his or her cardiologist, the laboratory tests would not be packaged. As a result, the hospital would receive separate payment for those tests under the CLFS. By contrast, if the ophthalmologist ordered laboratory tests as a part of preoperative testing and the tests were performed on the same date of service as the eye procedure, then payment for the laboratory tests would be packaged into the payment for the surgical procedure under OPPS.

In order to implement this arrangement, CMS has revised the use of type of bill (TOB) 13x and 14x. Previously, bill type 13x was used for outpatient diagnostic testing services. Bill type 14x was used for laboratory tests performed on a laboratory specimen for a non-patient. Under the new payment policy, laboratory tests that are packaged into OPPS must be billed on a 13x claim with the primary service. A laboratory test that is not packaged should be billed on a 14x claim. According to CMS, it will be the hospital's responsibility to determine when to separately bill laboratory tests on the 14x. CMS stated that it planned to issue revised contractor instructions for billing for these laboratory tests in January 2014, and to install related claims processing edits.

The new payment policy applies only to services to Medicare beneficiaries who are hospital outpatients. Although CMS indicated that it has included the cost of laboratory tests in determining payments for hospital

outpatient services, hospitals can expect a likely reduction in Medicare payments for clinical laboratory tests furnished to their outpatients.

Ober|Kaler Comments

It is important for every hospital to implement procedures that reflect the new payment policy. The hospital's procedures should cover tests for hospital outpatients that are performed by the hospital laboratory directly and such laboratory tests that may be referred to a reference laboratory. Hospitals should be aware that Medicare contractors may be actively looking for improper arrangements that are intended to circumvent the new payment policy and to avoid the claims processing edit that will be put in place.

Hospitals and other providers of clinical laboratory services should monitor Medicare payments to insure that they receive the payments to which they are due. CMS acknowledged that an edit put in place to prevent payment of the technical component (TC) of pathology services with the same date of service as an outpatient hospital service incorrectly denied TC claims that had a place of service other than the hospital. Hospitals and laboratories should remain alert for similar glitches that result in the improper denial of payment claims.