

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



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Implementation Date: January 6, 2014

Update to 2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing

Provider Types Affected

This MLN Matters® Special Edition Article is intended for Outpatient Prospective Payment System (OPPS) providers submitting claims to Medicare A/B Medicare Administrative Contractors (MACs) for outpatient clinical diagnostic laboratory services to Medicare beneficiaries.

What You Need to Know

This article conveys updated requirements for Change Request (CR) 8572 which describes changes to the OPPS to be implemented in the January 2014 update. Make sure your billing staff is aware of these changes. This guidance updates the operational mechanism OPPS hospitals should use to bill Medicare on or after July 1, 2014, for outpatient clinical diagnostic laboratory tests (lab tests) furnished in CY 2014 that are eligible for separate payment under the Clinical Laboratory Fee Schedule (CLFS).

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Background

In the January 2014 update to the hospital OPPS (CR 8572 issued December 27, 2013), the Centers for Medicare & Medicaid Services (CMS) implemented a new policy under the CY 2014 OPPS final rule, providing packaged payment of outpatient lab tests (other than molecular pathology) under the OPPS rather than separate CLFS payment, effective for dates of service on or after January 1, 2014. In the Medicare claims system, packaged payment would apply to all lab tests (other than molecular pathology) billed by OPPS hospitals on a 013X Type of Bill (TOB) (Hospital Outpatient).

As per the OPPS final rule, CMS created very limited exceptions to the packaging policy and instructed hospitals to use the 014X TOB (Hospital Non-Patient) to obtain separate payment only in the following circumstances:

- (1) Non-patient (referred) specimen;
- (2) A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or
- (3) A hospital conducts outpatient lab tests that are clinically **unrelated** to other hospital outpatient services furnished the same day. "Unrelated" means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis.

In accordance with Medicare manual instructions, CMS assumed that a hospital functions as an independent laboratory in these circumstances. Therefore, hospitals could use the 014x bill used for "non-patients." In the absence of public comments indicating otherwise, CMS believed this was an appropriate use of the 014x TOB.

Since publication of the final rule and the January release of CR 8572, some hospitals expressed concern that submitting a 014x TOB in this manner may violate the Health Insurance Portability and Accountability Act. **The National Uniform Billing Committee (NUBC) definition approved in 2005 for the 014x TOB for billing of laboratory services provided to "Non-Patients," means referred specimen, where the patient is not present at the hospital.**

To alleviate this concern, for CY 2014 a new modifier will be used on the 013X TOB (instead of the 014X TOB) when non-referred lab tests are eligible for separate payment under the CLFS for exceptions (2) and (3) listed above. The 014x will only be used for non-patient (meaning referred) laboratory specimens (exception 1 above) and will not include this new modifier. The new modifier will be effective for claims received on or after July 1, 2014, and retroactive for dates of service on or after January 1, 2014. Please note that CMS views this new modifier as an immediate solution to hospitals' concern for CY 2014 and that we may evaluate better means to bill for laboratory services next year.

Additionally to alleviate concerns on what hospitals can do in the interim period until the new modifier is implemented on July 1, 2014, CMS, **at the request of the NUBC**, will continue to allow providers to utilize the 014x TOB during this interim period when a hospital seeks separate payment under any of the three exceptions listed above, as per the CY 2014 OPPS final rule. This will allow time for

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providers to make necessary system adjustments without having to hold claims until the July implementation.

It will continue to be the hospital's responsibility to determine when laboratory tests qualify to receive separate payment. Starting with claims received July 1, 2014, and after, when a hospital appends the new modifier to a laboratory service, the provider is attesting that exception (2) or (3) listed above is met. The requirement for all OPSS services to be submitted on a single 13x claim (other than recurring services) continues to apply. In addition, laboratory tests for molecular pathology tests described by CPT codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479 are not packaged in the OPSS and do not require the new modifier.

Note: Under the CY 2014 OPSS final rule, it is optional for OPSS hospitals to seek separate payment under the CLFS for a given outpatient lab test. To minimize administrative burden, OPSS hospitals are not required to distinguish related and unrelated outpatient lab tests, and may bill "unrelated" outpatient labs on the 013X TOB prior to July 1, 2014, or on the 013X TOB without the new modifier on or after July 1, 2014, to receive packaged payment under the OPSS. Hospitals are not required to reprocess any previously submitted claims.

The table below summarizes the billing discussed above.

Condition	Claims with Dates of Service on or after January 1, 2014, and received Prior to July 1, 2014	Claims with Dates of Service on or after January 1, 2014 Received on or after July 1, 2014
(1) Non-patient (referred) specimen;	TOB 14x	TOB 14x without the new modifier
(2) A hospital collects specimen and furnishes only the outpatient labs on a given date of service;	*TOB 14x	TOB 13x and the new modifier, effective January 1, 2014
(3) A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day	*TOB 14x	TOB 13x and the new modifier, effective January 1, 2014

*The 014X TOB does not provide differential CLFS payment rates for SCHs with qualified laboratories and other OPSS hospitals. See section below for further details.

Sole Community Hospitals (SCHs)

SCHs are paid under the OPSS. Therefore, the new OPSS packaging policies apply to SCHs as to other OPSS hospitals for laboratory and other services furnished on or after January 1, 2014. However, SCHs with qualified laboratories continue to be eligible for the 62 percent CLFS payment amount described in the "Medicare Claims Processing Manual" (Pub. 100-04 Chapter 16, Section 40.3) when they furnish outpatient lab tests that are separately payable under exceptions (2) or (3) listed above. The 014X TOB does not provide differential CLFS payment rates for SCHs with qualified laboratories and other OPSS hospitals. Qualified SCHs must submit a 013X TOB with the new

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modifier appended to separately payable outpatient lab services in order to obtain the 62 percent CLFS payment amount provided in current manual instructions. CMS recognizes that these providers may wish to cancel or adjust claims that are submitted without the new modifier prior to July 1, 2014, and submit a new 013x claim with the appended modifier after July 1, 2014, in order to receive corrected reimbursement or for other reasons when the new modifier is implemented in July.

CMS will be reviewing claims data for CY 2014 for potential inappropriate unbundling of laboratory services under the new OPSS packaging policy. As stated in the OPSS final rule, CMS does not expect changes in practice patterns under the new policy. Hospitals may not establish new scheduling patterns in order to provide laboratory services on separate dates of service from other hospital services for the purpose of receiving separate payment under the CLFS.

Billing Scenarios for the New Modifier (on or after July 1, 2014):

- 1) A patient goes to hospital and the hospital only collects the specimen and furnishes only laboratory services on that date of service. No other services are rendered on this date of service. It is generally appropriate to append the new modifier to the laboratory services (see example 2).
- 2) A beneficiary has a pre-surgery exam in a provider-based clinic for an outpatient cataract surgery that is scheduled in two weeks with the ophthalmologist. On the same day, while at the hospital the beneficiary goes to the hospital lab to have blood drawn for long-term psychiatric medication monitoring, by order of a community psychiatrist. In this situation, the hospital can use the new modifier to bill Medicare for separate payment under the CLFS of the lab test to monitor the patient's psychiatric medication level. However, any lab tests run by the hospital lab that day upon the order of the ophthalmologist or another physician in the ophthalmologist's group practice in preparation for the cataract surgery cannot be billed for separate payment.
- 3) The beneficiary in example 2 goes to the hospital lab to have blood drawn for long-term psychiatric medication monitoring, by order of a community psychiatrist, and has no other hospital services that day. The hospital can use the new modifier to bill Medicare for separate payment under the CLFS of the lab test to monitor the patient's psychiatric medication level.
- 4) The beneficiary in example 2 has the pre-surgery exam in the ophthalmologist's free-standing physician office. The ophthalmologist refers the beneficiary to the hospital lab located across the street for diagnostic lab tests in preparation for the upcoming outpatient surgery. The beneficiary has to immediately return to work and chooses to have the lab work done at the hospital 2 days later. The hospital can use the new modifier to bill Medicare for separate payment under the CLFS.
- 5) The beneficiary in example 3 goes to the hospital lab the same day to have the pre-surgical labs drawn. The hospital can use the new modifier to bill Medicare for separate payment under the CLFS.

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As a reminder, for claims received on or after July 1, 2014, OPPS providers are instructed to submit “specimen only” services on the 014x TOB. OPPS providers are instructed not to use the new modifier on 014x TOB.

Additional Information

To read the article related to CR 8572, go to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8572.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

News Flash - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- [MLN Matters® Article #MM8433](#), “Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season”
- [MLN Matters® Article #SE1336](#), “2013-2014 Influenza (Flu) Resources for Health Care Professionals”
- [HealthMap Vaccine Finder](#) - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community.

Free Resources can be downloaded from the CDC website including prescription-style tear-pads that will allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu. On the CDC order form, under “Programs”, select “Immunizations and Vaccines (Influenza/Flu)” for a list of flu related resources.

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