MLabs will bill the client or referring institution or the patient's insurance carrier if appropriate and MLabs is able to do so successfully. Please indicate Client/Referring Institution or Patient/Insurance in the Bill To section of the test requisition form. If the patient has Medicare, please check the Medicare box and indicate if the patient was an In Patient, Out Patient, or Non Patient on the date of service. MLabs reserves the right to bill the client if our claim is denied by the patient's insurance carrier.

MLabs does not participate with non-Michigan Medicaid plans, except for the state of Ohio. The referring client is required to be active in the Michigan or Ohio Medicaid plan. If a client is not actively enrolled in the Michigan or Ohio Medicaid plan covering the patient, charges will be billed back to the referring client. Charges for patients with other than Michigan or Ohio Medicaid plans will be billed to the referring client.

MLabs cannot honor requests for "Professional Courtesy".

Patient Billing

MLabs will bill the patient or patient's insurance carrier directly for tests performed by MLabs provided we are able to do so successfully. Direct patient or third party payors will be billed according to the University of Michigan's patient or third party payor fee schedule. Patients will be billed for any copays or deductibles applied by the plan. Please advise your patients that they may receive a bill for laboratory services from the University of Michigan Health System.

If MLabs is a participating provider with the patient's health plan, out-of-pocket costs are usually limited to co-payments, co-insurances, and/or deductibles. If we are not participating with the health plan we will bill the insurance company, but any amounts unpaid by the plan are the patient's responsibility. We recommend that the patient contact the health plan with any questions regarding benefits or how services will be covered. Please refer to our Insurance List for participating and non-participating carriers.

It is expected that the client supply adequate patient and insurance information including demographics as well as ICD-10 diagnosis code **at the time the specimen is submitted**. The following information is necessary for MLabs to successfully bill the third party payer. MLabs reserves the right to bill the client if this information is not provided or if the claim is denied.

Required Billing Information:

- Patient's Full Name
- Patient's Social Security Number (optional)
- Patient's Sex
- Patient's Date of Birth
- Patient's Home Phone Number
- Patient's Home Address
- Parent or Guardian's Full Name and Date of Birth if patient is under 18
- All insurances the patient currently subscribes to and priority ranking (primary, secondary, etc.)
- If Patient has any commercial insurance, complete address for each company
- Complete information for each of the patient's insurances (Group #, Service Codes, etc.)
- Referring Physician
- Referring Physician NPI or UM doctor number
- Diagnosis (ICD-10) Code
- Prior authorization number and/or copy of prior authorization (if applicable)
- If Patient has Medicare, signed Advance Beneficiary Notice (ABN) (if applicable)

A "face sheet" or the MLabs Patient Demographics Form may be used to supply this information.

PECOS Enrollment: The Centers for Medicare & Medicaid Services (CMS) requires that the NPI of the ordering clinician be submitted to Medicare with claims for laboratory services. Medicare will deny claims for laboratory and pathology services if the ordering or referring provider is not in Medicare's enrollment records. When ordering testing to be billed to Medicare, please verify that the ordering clinician has a current Medicare enrollment record that contains his or her NPI. MLabs reserves the right to bill the client if a claim is denied by Medicare due to failed ordering or referring provider edits.

CHAMPS Enrollment: The Michigan Department of Community Health (MDCH) requires that the NPI of the ordering clinician be submitted to Michigan Medicaid with claims for laboratory services. Medicaid will deny claims for laboratory and pathology services if the ordering or referring provider is not enrolled in CHAMPS (Community Health Automated Medicaid Processing System). When ordering testing to be billed to Medicaid or a Medicaid managed care plan, please verify that the ordering clinician has a current CHAMPS enrollment record that contains his or her NPI. MLabs reserves the right to bill the client if a claim is denied by Medicaid due to failed ordering or referring provider edits.

Prior Authorizations: Prior authorization requirements for laboratory services vary by individual plan and policy. We recommend that the patient contact the health plan with any questions regarding benefits or how services will be covered. Note that most commercial insurance plans require prior authorization for genetic testing (including, but not limited to CPT code range 81105 – 81479). In most cases the prior authorization must be requested from the insurance plan by the ordering clinician. To obtain Blue Care Network (BCN) prior authorization contact Joint Venture Hospital Laboratories (JVHL) at 800-445-4979. MLabs reserves the right to bill the client if a claim is denied due to No Prior Authorization.

Advance Beneficiary Notice (ABN): A Medicare Advance Beneficiary Notice (ABN) signed by the patient is required when there is reason to believe payment of the claim may be denied by Medicare for any of the following reasons: screening, medical necessity (unpayable or no diagnosis provided), frequency, experimental testing, research-only testing or non-FDA approved procedures. The ABN document states the actual cost that the patient agrees to pay if Medicare does not pay for the testing. MLabs reserves the right to bill the client if a claim is denied by Medicare and no ABN was provided.

The **Department of Veteran's Affairs** (VA) is a nationwide system of health care services and benefits programs for America's Veterans. Any services provided outside of the VA Healthcare system (e.g., laboratory services provided by MLabs) must be preapproved. Care must be authorized on a VA Form 10-7079 Request for Outpatient Services or VA Form 10-7078 Authorization and Invoice for Medical and Hospital Services (for inpatient services). Requests for laboratory services not accompanied by a VA Authorization form will be billed to the referring client.

Split Billing

Beginning with dates of service on or after **April 1, 2014**, MLabs has implemented "split billing" of the professional and technical components of special stains associated with referral consultations for Medicare patients.

Under Medicare (CMS) law, MLabs cannot bill Medicare for technical charges if the date of service is less than 14 days after the patient was classified as a hospital inpatient or outpatient, or was an inpatient in a Skilled Nursing Facility (SNF) in a Medicare paid bed. If the specimen was obtained in a private physician office and there was no hospital visit on the date of service (patient is classified as a nonpatient) MLabs can bill Medicare directly for both technical and professional services (unless the patient was also in a SNF Medicare paid bed on the date of service).

For 2nd opinion consult cases, CPT 88321, Medicare inpatient or outpatient, MLabs will bill Medicare.

For 2nd opinion consult cases which are triaged to additional special stains, MLabs will bill the professional fees to Medicare and will bill the technical charges to the client; these charges will appear on the MLabs Hospital Fee Billing Statement.

Charges for non-Medicare patients billed to the client are at discounted global fees (including technical and professional services), which appear on the Professional Fee billing statement. Also note that split billing has not been implemented for Molecular Pathology or Flow Cytometry testing at this time.

Client Billing

MLabs will bill the referring facility directly. Each month, the client will receive two separate invoice statements from us. Charges for clinical pathology testing will appear on the MLabs Hospital Fee Billing Statement (invoice number begins with HB); charges for surgical pathology consultations and professional fees associated with some clinical pathology assays will be invoiced on the MLabs Professional Fee Billing Statement (invoice number begins with PB). Monthly invoice statements will include patient name, registration or medical record number (MRN), date of service, test name, test charge and CPT code. Payment terms are net 30 days.

Please send payments to: University of Michigan Health System
NCRC Building 520, Room 1194B
1600 Huron Parkway
Ann Arbor MI 48109-2800

MLabs Taxpayer Identification Number is 38-6006309 (W-9 Form).

CPT Coding

The billing party has sole responsibility for CPT coding. MLabs CPT recommendations are based on the American Medical Association (AMA) Current Procedural Terminology (CPT) manual. MLabs assumes no responsibility for billing errors due to reliance on the CPT codes listed in our Test Catalog or client invoice. If you have questions regarding the appropriate use of a code, please contact your local Medicare carrier.

Handling Charges

MLabs does not charge a handling fee for testing forwarded to another reference laboratory. However, for specimens forwarded to the Michigan Department of Community Health (MDCH) or Centers for Disease Control and Prevention (CDC) for which there is no charge for testing, MLabs does charge a small handling fee for processing and forwarding the specimen.

Charges for Inconclusive or Inadequate Samples

For Molecular Diagnostics assays, MLabs will charge for testing performed regardless of an inconclusive or inadequate sample result.

For Pap Test Cytology specimens deemed to be unsatisfactory there will be a charge for the technical component of the test.

Cancellations

If a client must cancel a test order, and the laboratory has not yet begun performing the test, it will be canceled at no charge. If the test is in process or already analyzed, the result will be reported and the client appropriately charged for the assay.

Repeat Determinations

If a test result seems inconsistent with a patient's clinical presentation and an error is suspected, the assay will be repeated, if possible, at no charge. Please contact MLabs Client Services.

Reflex Testing

Some tests require confirmation by another method or may have other tests reflexively performed in order to determine a final result. If a test is reflexed for further testing, additional CPT codes and charges for the added tests will be billed to the client or third party payer. Refer to the MLabs Reflex Testing Policy for a listing of tests that may include reflexive testing.