BILLING POLICY

Michigan Medicine Laboratories (MLabs) is a cost competitive provider of reference laboratory services. We offer both client and direct third party billing options.

MLabs will bill the client or referring institution or the patient or 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 Traditional Medicare, please indicate the patient’s status (inpatient, outpatient, or nonpatient) on the date of specimen collection. 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 or Third Party 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 Michigan Medicine.

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.

In order for MLabs to bill your patient or the patient’s insurance carrier, it is essential that complete patient and insurance information including demographics as well as ICD-10 diagnosis code are provided. For Medicare patients, it is important that the Medicare status of the patient on the date of specimen collection is provided. The following information is necessary and expected at the time the specimen is submitted for MLabs to successfully bill the third party payer. MLabs reserves the right to bill the client if this information is not provider 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)
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- If Patient has Medicare, signed Advance Beneficiary Notice (ABN) (if applicable)
- If Patient has Medicare, patient status on date of specimen collection (inpatient, outpatient, or nonpatient)

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 Health and Human Services (MDHHS) 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. Prior authorization for molecular testing (CPT code range 81105 – 81479) is required by many, but not all third party payors. When MLabs can bill the patient’s insurance directly for molecular testing, MLabs will submit prior authorization requests on behalf of our clients and patients. Effective September 4, 2018, in cases where MLabs will be submitting the prior authorization request and billing the patient’s insurance MLabs will require that all requests for molecular tests are accompanied by a Molecular Diagnostic Clinical History Form AND a recent pathology report, relevant clinic encounter notes, and/or medical genetics consultation. MLabs reserves the right to bill the client if required information is not provided and a claim is denied due to No Prior Authorization. See http://mlabs.umich.edu/client-services/prior-authorization/ for additional information regarding Prior Authorizations.

Traditional Medicare does not give prior authorization for services. Medicare Part B covers medically necessary clinical diagnostic laboratory services. Testing may or may not be covered depending on Medicare coverage rules for the particular test and diagnosis. The patient should be advised to contact Medicare with questions regarding their benefits and coverage. Medicare HMO or Advantage plans may require prior authorization; please check with the individual plan.

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. Note that the ABN is used for beneficiaries enrolled in Traditional Medicare and is explicitly not used for services provided under Medicare Advantage plans; these plans have their own rules regarding patient waivers.
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The Department of Veteran’s Affairs (VA)
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.

Medicare Date of Service Regulation (14 Day Rule)
The Centers for Medicare and Medicaid Services (CMS) regulation 42 CFR 414.510, also known as the “14 Day Rule”, specifies that the Date of Service (DOS) for either a clinical laboratory test or the technical or hospital component of pathology services is defined as follows:

GENERAL RULE
The general rule for the date of service (DOS) of a test performed on a laboratory specimen is the date that the specimen is collected (DOC).

ARCHIVED SPECIMEN
If the specimen was stored for more than 30 calendar days before testing, the DOS must be the date the specimen was obtained from storage (generally the Order Date). For second opinion consultations, Michigan Medicine (MLabs) uses the date the specimen is received (Order Date) as the DOS.

EXCEPTION
If a specimen was stored for less than or equal to 30 days, the DOS must be the date the test was performed (Result Date) if:

The test or service is ordered by the patient’s physician at least 14 days following the date of the patient’s discharge from the hospital;

- The specimen was collected while the patient was undergoing a hospital surgical procedure;
- It would be medically inappropriate to have collected the sample other than during a hospital stay; and
- The test or service was reasonable and medically necessary for treatment of an illness.

REVISED RULE
Effective January 1, 2018, Medicare added an exception to the DOS policy allowing the performing laboratory to bill Medicare directly for tier 1 and tier 2 molecular pathology tests (CPT code range 81105 - 81479) and advance diagnostic laboratory tests (ADLTs), which are excluded from the outpatient prospective payment system (OPPS) packaging policy. For these tests, the DOS must be the date the test was performed if the following criteria are met:

- The test was performed following a hospital outpatient’s discharge from the hospital outpatient department;
- The specimen was collected from the hospital outpatient during an encounter;
- It was medically appropriate to have collected the sample from the hospital outpatient during the hospital outpatient encounter;
- The results of the test do not guide treatment provided during the hospital outpatient encounter; and
- The test was reasonable and medically necessary for the treatment of an illness.

The revised rule does not apply to Medicare inpatients.
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Under Medicare (CMS) law, MLabs cannot bill Medicare for technical charges if the Order Date 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, except for molecular pathology testing (CPT code range 81105 - 81479) collected from a hospital outpatient (and meeting revised rule criteria listed above).

If the specimen was obtained in a private physician office and there was no hospital visit on the date of collection (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 collection).

MLabs Medicare Billing Scenarios (note MLabs Medicare billing policies apply only to Traditional Medicare and not to HMO or Advantage plans):

- Charges for laboratory testing on a specimen collected from a hospital inpatient or ordered within 14 days of discharge will be billed to the referring client or facility (considered part of the Medicare inpatient DRG payment to the hospital).
- Charges for laboratory testing on a specimen collected from a hospital outpatient or ordered within 14 days of the outpatient visit will be billed to the referring client or facility (considered part of the Medicare OPPS payment to the hospital).
- Exception: charges for laboratory testing which falls in the Molecular Pathology CPT code range or are ADLTs ordered on a specimen collected from a hospital outpatient will be billed directly to Medicare.
- Charges for laboratory testing on a specimen collected from a patient in a private physician office or at an MLabs blood draw site with no hospital visit on the date of collection (patient is classified as a nonpatient) will be billed directly to Medicare.
- Charges for professional services, e.g., second opinion consult cases CPT code 88321, will be billed directly to Medicare regardless of patient status (inpatient, outpatient, or nonpatient).
- Consultations may require addition of special stains and/or immunohistochemical (IHC) stains in order to render a diagnosis and in some cases may triage to molecular diagnostics testing. For second opinion consult cases from Medicare inpatients or outpatients which are triaged to additional special stains, MLabs will bill the professional fees directly to Medicare and will bill the technical charges to the client or referring facility. (Note that split billing has not been implemented for Molecular Pathology or Flow Cytometry testing at this time).

Client Billing

MLabs will bill the client or referring institution directly. Under a client bill arrangement, we bill all services to your facility at a discounted rate, except for Medicare outpatient molecular services which we bill directly to Medicare under the revised rule. If you choose to have MLabs bill your facility for these services we will do so, however, under the new rule you should not be billing Medicare for these services and therefore this is a potential added cost for you.

Each month, the client will receive two separate invoice statements:

- **HOSPITAL FEE BILLING STATEMENT (HB)** will include charges for clinical pathology testing and the technical components of flow cytometry, molecular diagnostics, special stains, and immunohistochemical (IHC) stains.
- **PROFESSIONAL FEE BILLING STATEMENT (PB)** will include charges for second opinion consultations and the professional components of flow cytometry, molecular diagnostics, and professional interpretations for clinical pathology testing. Charges for special stains performed for non-Medicare patients are billed to the client at discounted global fees (including technical and professional services), which appear on the Professional Fee billing statement.
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- Monthly invoice statements will include patient registration or medical record number (MRN), MLabs order or accession number, patient name, date of service, CDM or fee code (HB statement), test description, CPT code, quantity, fee and total charge amount.
- Payment terms are net 30 days.

Please send payments to: Attention:

Pathology Billing
Michigan Medicine Laboratories (MLabs)
2800 Plymouth Rd
Ann Arbor MI 48109-2800

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

Notification of statement errors or requests for adjustments must be communicated to MLabs within thirty (30) days of receipt of invoice or charges are considered to be acceptable as invoiced.

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.

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.

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.

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.

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. MiPS test and that you agree to pay whatever portion Medicare does not pay.