BILLING GUIDE

2020

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

LABORATORIES

mlabs.umich.edu
800.862.7284

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BILLING SERVICES

INTRODUCTION

Laboratory testing is one of the most challenging categories in medical billing. Numerous factors impact which party or parties are responsible for the reimbursement of tests or even different components of tests. The coverage of laboratory services can vary significantly from one insurance company to another, and even from one policy to another from the same payor. In addition, there are specific billing protocols required to seek reimbursement from Medicare or Medicaid.

MLabs is a comprehensive and cost competitive provider of reference laboratory services. We offer direct billing options to clients or referring institutions or to patients or their third-party payors.

We strive to bring the same level of professionalism and attention to detail to our approach to billing as we do to the extensive catalog of tests we offer. The policies detailed in this booklet are the result of years of experience helping patients, providers and insurers navigate the often complex, sometimes frustrating billing paperwork associated with lab testing.

A few important considerations

- Please indicate Client/Referring Institution or Patient/Insurance in the "Bill To" section of our 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 cannot honor requests for "professional courtesy".
- MLabs accepts a large majority of commercial insurance. Patients are responsible for co-pays, co-insurance and unmet deductibles as dictated by their insurance carriers.
- MLabs reserves the right to bill the client if our claim is denied by the patient's insurance carrier.

Find out more about MLabs at our website:
mlabs.umich.edu

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.

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

PLEASE MAKE CHECKS PAYABLE TO:
Regents of the University of Michigan

PLEASE SEND PAYMENTS TO:
Attention: Pathology Billing
Department of Pathology & Clinical Laboratories
2800 Plymouth Rd., Building 35
Ann Arbor MI 48109-2800

TAXPAYER ID NUMBER
38-6006309
(W-9 Form)

BILLING QUESTIONS
800.862.7284

INVOICE STATEMENTS

Clients have a choice of statement layouts that best meet their payment workflows: Separate HB and PB invoice statements or a Combined invoice statement.

- The Hospital Fee Billing Statement (HB) includes charges for clinical pathology testing, along with the technical components of flow cytometry, molecular diagnostics, special stains and immunohistochemical (IHC) stains.
- The Professional Fee Billing Statement (PB) includes charges for second opinion consultations and professional interpretations of clinical pathology testing, along with professional components of flow cytometry and molecular diagnostics. 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.
- Monthly invoice statements 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.
- The Combined Fee Billing Statement combines the HB and PB charges into one billing statement and includes the additional items of patient's date of birth and reason codes that indicate why charges are being billed to the client.

PATIENT / INSURANCE BILLING

MLabs bills the patient or the patient's insurance carrier directly for tests performed by MLabs provided we are able to do so successfully. Direct patient or third-party payors are billed according to the University of Michigan third-party payor fee schedule. Patients are billed for any copays or deductibles applied by the plan. Please advise 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 client at a discount rate. Examples of non-participating are non-Michigan Medicaid and non-Michigan HMO plans. We recommend the patients contact their insurance providers with any questions regarding benefits or services covered. Please refer to our Insurance List for participating and non-participating carriers.

Please refer to our **Insurance List** for participating and non-participating payors.

PATIENT BILLING REQUIREMENTS

In order for MLabs to bill a patient or a patient's insurance carrier, it is essential that complete patient demographics, insurance information and ICD-10 diagnosis codes be provided. **MLabs reserves the right to bill the client if this information is not provided or if the claim is denied.**

The following information is necessary and expected at the time the specimen is submitted in order for MLabs to successfully bill a third-party payor:

- Patient's full legal name as validated on a drivers license or state identification card.
- Patient's Social Security number (optional)
- Patient's sex
- Patient's date of birth
- Patient's primary phone number
- Patient's home address
- Parent or guardian's full name and date of birth if patient is under 18
- If patient has any commercial insurance, complete address and phone for each company
- Complete information for ALL relevant patient insurance policies (with priority ranking, group #, service codes, etc.)
- Referring physician & NPI
- All diagnosis (ICD-10) codes that support medical necessity
- Prior authorization number and/or copy of prior authorization (if applicable)
- 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)

MEDICARE BILLING

MEDICARE (CMS) LAW

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. See the chart below.

If a specimen was obtained in a private physician office (not billing under a facility tax ID), 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 or hospice).

MEDICARE 14-DAY RULE

SITE OF SPECIMEN COLLECTION	DATE SPECIMEN REMOVED FROM STORAGE	ORDER DATE	TEST	DATE OF SERVICE	MEDICARE BIILLING
Outpatient	N/A	<14 days after date of discharge	Molecular (CPT Codes 81200-81383, 81400-81408 and 81479) & Gene Sequencing Procedures (CPT Codes 81410-81471)	Test completed date	MLabs bills CMS
			All other tests	Specimen collection date	MLabs bills Hospital
		≥14 days after date of discharge	Molecular/GSPs	Test completed date	MLabs bills CMS
			All other tests	Specimen collection date	MLabs bills CMS
Inpatient	≤30 days from date of specimen collection	<14 days after date of discharge	All other tests	Specimen collection date	MLabs bills Hospital
		≥14 days after date of discharge	Molecular/GSPs	Test completed date	MLabs bills CMS
			All other tests	Specimen collection date	MLabs bills Hospital
	>30 days from date of specimen collection	Any	All other tests	Date specimen obtained from storage	MLabs bills CMS
Non-Hospital Patient	Any	Any	All tests	Test completed date	MLabs bills CMS
2nd Opinion Consults	N/A	N/A	Consults 88321, 88325	Date specimen receieved	See page 9 of the Billing Guidelines

MEDICARE BILLING (continued)

MLABS MEDICARE BILLING SCENARIOS

- 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 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 the 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 for additional special stains, MLabs will bill the professional fees directly to Medicare and will bill the technical charges to the client or referring facility commonly termed "split billing". (Note that split billing has not been implemented for Molecular Pathology or Flow Cytometry testing at this time).

MEDICARE BILLING (continued)

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, frequency, experimental testing, research-only testing or non-FDA approved procedures. The ABN document must contain the estimated 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; it does not apply to Medicare Advantage Plans.

MEDICAID BILLING

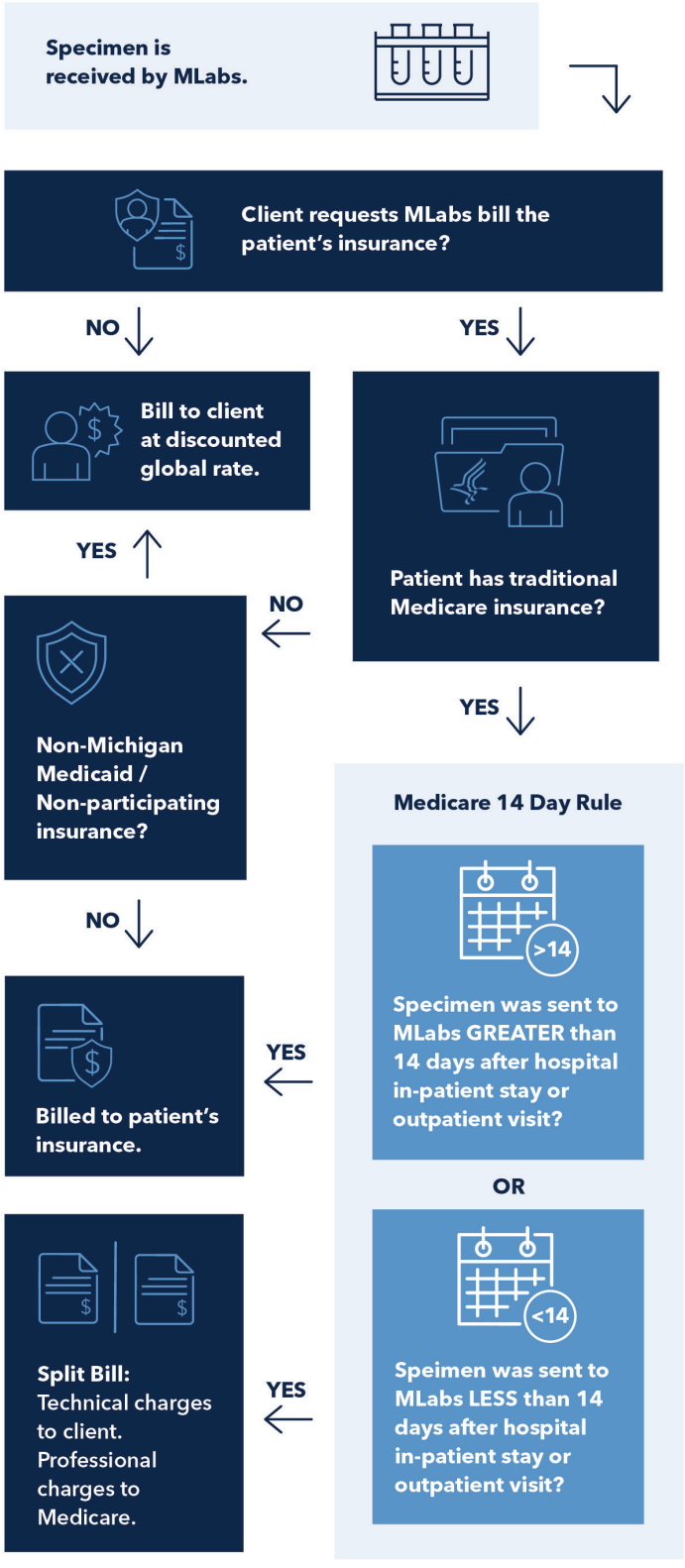
MLabs is a registered provider with Michigan Medicaid plans only. MLabs cannot bill any other State Medicaid Plans and will bill the client at a discounted rate when applicable. Providers ordering services for Michigan Medicaid patients, must be enrolled as a Michigan Medicaid provider. If it is determined that the patient is ineligible for Medicaid, he or she will be considered a self-pay patient and services will be billed to the client. Please note: Prior authorization is required for all molecular/genetic testing cases intended to be billed to a Medicaid plan.

CONSULTATION BILLING

MLabs' team of experts is happy to accept your most difficult cases for second opinion consultation. We are also happy to bill patient insurance for these services at your request. The diagram to the right is a decision tree that depicts how billing for consultations flows. MLabs participates with all major commercial payers as well as Medicare and Michigan Medicaid. Unfortunately, if your patient has an insurance we do not participate with, MLabs will be 'out of network' and unable to bill. This will result in the charges being billed to the client at a discounted rate. It's also important to note that consultation cases have both a technical and professional billing component, which can result in "split" billing following Medicare's 14 day rule. If the specimen is sent to MLabs less than 14 days after a hospital inpatient stay or outpatient visit, MLabs will bill the technical charges to the client and the professional charges to Medicare.

Our expert billing team is available to answer all of your billing questions.

CONSULT BILLING WORKFLOW



PRIOR AUTHORIZATION

Molecular testing is a valuable tool in the evaluation and personalized treatment of patients with malignancies and inherited conditions. Molecular tests may be ordered by the client, or may be generated as a result of a consultation.

Without a prior authorization, your patient's claim for services may be denied which could result in your patient receiving a significant bill.

Prior Authorization Documentation

Applying for a prior authorization requires an insurance company be provided with sufficient information to support the clinical need for the test.

All requests for molecular tests must be accompanied by:

- Molecular Diagnostic Clinical History form
- Most recent pathology report
- Relevant clinic encounter notes
- Medical genetics consultation notes (if applicable)

MLabs will submit a prior authorization request on behalf of you and your patient so that this testing can be authorized and performed without significant delay. If an insurance company requires the prior authorization to be submitted by the ordering physician, we will contact you.

PRIOR AUTHORIZATION

FREQUENTLY ASKED QUESTIONS

What is a prior authorization?

A prior authorization requirement, also known as a pre-authorization or pre-certification, is a clause in a health insurance policy that states that a patient must get permission from his or her health insurance company before receiving certain health care services, including specialized laboratory testing.

Which services have a prior authorization requirement?

Specialized laboratory testing that requires prior authorization can usually be found on the health plan's website or by contacting the health plan directly.

Who is responsible for obtaining prior authorization?

The physician who orders the testing is responsible for obtaining prior authorization for the specialized laboratory test. If the physician's office does not obtain the necessary prior authorization prior to the specialized laboratory testing, the patient will be responsible for paying for the testing. Based on the test ordered, that could result in a patient being billed thousands of dollars.

Can I, as the ordering physician, get the prior authorization myself?

Yes. In most cases, you can contact the health insurance company and complete the prior authorization process. This could include submitting the information via the insurance provider's website, completing or faxing the insurance provider's specific form, or providing the information over the phone.

Can MLabs get the prior authorization for me?

Yes. If you follow our Clinical History Instructional Guide to complete a Molecular Diagnostics Clinical History Form, we can attempt the process for you.

OTHER BILLING POLICIES

CANCELLATIONS

If a client must cancel a test order and the laboratory has not yet begun the test, it will be canceled at no charge. If the test is in process or results have already been analyzed, the results will be reported and the client or third-party payor will be 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 charges 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 payor. 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 at 800.862.7284.

OTHER BILLING POLICIES (continued)

ORDERING/REFERRING PHYSICIAN REQUIREMENTS

All insurance providers including the Centers for Medicare & Medicaid Services (CMS) require that the National Provider Identifier number (NPI) of the ordering clinician be submitted with claims for laboratory services. When ordering testing to be billed to Medicare, please verify that the ordering clinician has a current Medicare enrollment in the Medicare Provider Enrollment, Chain and Ownership System (PECOS). MLabs reserves the right to bill the client if a claim is denied by insurance due to errors in ordering or referring provider information. When testing is ordered by a physician assistant, nurse practitioner or midwife, the supervising physician's name and NPI are required.

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2800 Plymouth Rd, Building 35, Ann Arbor, MI 48109-2800
P: 800.862.7284 F: 734.936.0755
www.mlabs.umich.edu