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How Medicare Pays for Laboratory Tests

Medicare consists of two parts, A and B. Part A covers hospital inpatient costs and Part B covers most other healthcare services. The Medicare program is administered by the Center for Medicare and Medicaid Services, commonly called CMS.

Medicare Part A covers hospital inpatient's hospitalization costs. Part A is administered by Medicare Fiscal Intermediaries in each state. Hospitals are paid a fixed fee per patient based on Diagnosis Related Groups (DRGs). Laboratory tests performed for hospital inpatients are considered a part of the DRG payment.

Medicare Part B covers the cost of physician services, clinical laboratory tests and other medical services and supplies. Part B is administered by Medicare Carriers in each state. Most laboratory services are considered Part B services and paid for individually as identified by the appropriate CPT code.

Lab tests including electrophoresis procedures are paid from the **Laboratory Fee Schedule**. No co-payment is required for services on the Laboratory Fee Schedule. The provider receives the entire amount listed on the Laboratory Fee Schedule and the beneficiary pays nothing. Each Medicare carrier publishes a unique Laboratory Fee Schedule and adjusts payment levels annually as determined by Congress.

Physician services, including electrophoresis interpretation services, are paid from the **Physician Fee Schedule**. Co-payments of 20% are collected from the beneficiary for services on the Physician Fee Schedule. Thus, the actual payment received from Medicare is 80% of the Physician Fee Schedule amount.

Assignment of payment is required by Medicare for all lab tests. Providers must accept the Medicare reimbursement as payment in full for a laboratory test. Medicare patients may not be billed for any additional amounts.

Direct billing is also required for all Medicare-reimbursed laboratory tests. Tests must be billed directly to Medicare by the laboratory or physician performing the test. If an outside laboratory performs a test referred from a physician or another laboratory, only the reference laboratory may legally bill Medicare for the procedure unless the referring laboratory meets any one of the following three exceptions:

(1.) The referring lab is located in or is part of a rural hospital; or (2.) the referring

lab is wholly-owned by the reference lab or vice versa or both the referring lab and reference lab are wholly- owned by a third entity; or (3.) No more than 30% of the clinical diagnostic tests for which the referring laboratory RECEIVES REQUESTS annually are performed by another laboratory.

For the purpose of the 30% exception, each CPT code billed counts as one test. For example, when CPT code 80061 (lipid profile) is billed, it is counted as one test even though 3 tests are performed.

The above exceptions apply only to hospital non-patient specimens (that is, specimens from neither inpatients or outpatients) and independent laboratories, not physician laboratories or hospital outpatient specimens. Physicians may not bill for any Medicare specimens referred to other labs. Hospital outpatient Medicare specimens sent to reference labs must be directly billed by the hospital to their Medicare contractor. The hospital then pays the reference lab for performing the test. Hospital non-patient specimens (i.e.specimens drawn elsewhere and sent to the hospital for testing) may be billed by either the hospital or the reference laboratory if one of the above exceptions is satisfied.

The following examples illustrate how various providers must bill laboratory procedures to Medicare.

Example 1: A hospital laboratory serves surrounding physicians as a reference laboratory as well as performing laboratory tests for its own inpatients and outpatients.

Tests performed for Medicare inpatients are not billed. Payment for inpatient lab services is part of the DRG payment received from the hospital's Part A Medicare contractor

Tests performed for Medicare outpatients must be billed to the hospital's Part A Medicare contractor.

Tests performed on Medicare specimens received from outside physicians (non-patient specimens) are billed to the hospital's Medicare contractor. Physicians may not bill Medicare for such tests.

Example 2: A physician sends a Medicare specimen to an independent reference lab for protein electrophoresis.

Only the reference lab may bill Medicare for the procedure. However, the physician may bill private payers for reference laboratory services, if the payer does not have a contract with the reference laboratory preventing such an arrangement.

Example 3: A physician draws a specimen from a Medicare patient and performs a direct LDL test in his office lab and requests a lipid electrophoresis from an outside reference lab.

The physician must bill his/her Medicare contractor for the direct LDL that he performs.

The reference lab must bill its Medicare contractor for the lipid electrophoresis. The bill is always submitted to the contractor that processes claims for the state/area where the laboratory service is performed, thus two different Medicare contractors might be billed if the reference lab is in a different state than the physician.

Example 4: A hospital lab performs a protein electrophoresis for a Medicare outpatient and a pathologist provides an interpretation (as requested by the referring physician).

The hospital must bill its Medicare contractor for the lab procedure. The pathologist must bill his/her Medicare contractor for the interpretation.

Example 5: An independent reference laboratory performs a protein electrophoresis and interpretation by their pathologist for a Medicare patient as requested by a referring physician.

The laboratory bills its Medicare contractor for both the lab procedure and the interpretation.

Medicare Medical Necessity Requirements

For Medicare to pay for any laboratory test, the test must be medically reasonable and necessity. Diagnosis codes or narrative descriptions are used to document the medical necessity for tests performed. Medicare contractors can establish Local Coverage Determinations (LCDs) when they identify over-utilization or aberrant billing patterns for a particular test. These policies specify when Medicare covers a given CPT code and usually contain a list of covered ICD-9 (Diagnosis) codes.

Claims with non-covered diagnosis codes are denied as medically unnecessary. National Coverage Determinations (NCDs) are also used to define the medical necessity of laboratory tests. The only NCD applicable to electrophoretic assays is for lipids. See Lipids NCD.

Billing Patients for Denied Medicare Services

Medicare patients may be billed for services that are clearly not covered. For example, routine physicals or screening tests when there is no indication that the test is medically necessary. However, when a Medicare contractor is likely to deny payment because of medical necessity policy (either as stated in LMRP, NCD or upon examination of individual claims) the provider may not bill the patient unless the patient has been informed of their potential liability. If the provider fails to inform the patient of the liability before performing the test, the patient has no obligation to pay.

An Advance Beneficiary Notice or ABN is used to document that the patient knows that Medicare may not pay for a test and has agreed to pay the provider in the event payment is denied. Each ABN must be specific to the service provided and the reason that Medicare may not pay for the service. Blanket waivers for all Medicare patients are not allowed. If Medicare pays for the test, the physician must accept the fee schedule payment as full reimbursement. If Medicare denies payment, the physician can bill the patient for the test at his usual and customary rate and the patient is obligated to pay.

The CPT code modifier, -GA (Waiver of Liability Statement on file), is used to indicate that a provider has notified the Medicare patient that the test performed may not be reimbursed by Medicare and may be billed to the patient.

Standard CMS ABN forms (CMS-R-131) must be used. The forms may be printed on the back of laboratory requisitions, but may not be otherwise modified except for the customizable boxes.