Health Law Alert: New Medicaid Billing Rule Requiring Direct Billing for Independent Labs Set to Become Effective on October 1, 2015, Inconsistency with Medicare Rules Remains

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On August 27, 2015, the Minnesota Department of Human Services ("DHS") published changes to the laboratory and pathology section of its Minnesota Health Care Programs Provider Manual (the "Manual"). The new rules, which are slated to become effective on October 1, 2015, create an inconsistency between Medicaid and Medicare billing rules for independent clinical labs that have historically billed for services purchased from external reference labs.

Background

For many years, the Minnesota Medicaid program has permitted clinical lab tests to be purchased by a referring provider from a performing laboratory. The referring provider could then bill Medicaid for the clinical lab test. Likewise, hospitals could purchase clinical lab tests from a performing lab for their patients, with the hospital then receiving reimbursement from Medicaid for that work.

These rules were slightly different from the rules in the Medicare program. For non-hospital patients, Medicare has long provided that all tests reimbursable under the Clinical Laboratory Fee Schedule ("CLFS") are payable only to the lab that performed the test. There are several very technical exceptions to this rule, however, including one that permits certain referring labs to bill for up to 30% of the tests for which they receive requests annually that are performed by "reference labs" (i.e., a lab to which the referring lab sends specimens to perform the clinical lab test). Until January 1, 2014, hospitals could generally bill separately (under the CLFS) for tests performed for their outpatients. Even though most facility services provided to hospital outpatients are bundled into the outpatient prospective payment system ("OPPS") rate, clinical lab tests have been an exception to that rule ever since the OPPS became effective in 2000. Medicare changed this requirement effective January 1, 2014, however. While several exceptions exist, lab tests performed for hospital outpatients (either directly by the hospital or purchased under arrangement from another lab) are now generally packaged under the OPPS.

DHS Change

As of October 1, referring independent labs are no longer permitted to purchase tests from reference labs with the independent lab billing Medicaid for the test. Rather, the performing lab (i.e., the lab that performs tests referred to it by the referring lab) needs to bill for the test. Hospitals, however, will be able to continue to bill for clinical lab tests obtained under arrangement on behalf of their outpatients. According to the Manual, for tests performed on behalf of hospital outpatients, DHS can either pay the hospital or the lab performing tests on behalf of the hospital. Physician office labs cannot bill Medicaid for tests referred out to an external reference lab.

Beginning in the summer of 2014, DHS has published several versions of the Laboratory and Pathology section of the Manual governing the issue of billing for clinical lab tests performed by other parties. DHS has indicated in the Manual that these changes are being made "in conjunction with" the Medicaid statute. The federal regulation cited in support of this change is the Medicaid regulation governing reassignment. Earlier versions of the language finally adopted in the Manual would have gone further than the current restrictions and prohibited under arrangement relationships in which hospitals purchase clinical lab tests for their outpatients (and are reimbursed as part of the hospital rate). Under these earlier proposals, a lab rendering tests for hospital outpatients would be required to bill for the tests (as opposed to the hospital billing for the tests).

Implications for Providers

DHS' change has several implications for providers:

- Most critically, freestanding referring independent labs that have historically purchased tests for Medicaid beneficiaries from an external reference lab (with the referring lab billing for that test) will not be able to do that after October 1.
- Likewise, reference labs that in the past have sold tests (for Medicaid beneficiaries) to these referring labs (with the referring lab billing for that work) may lose business due to the change in the billing rules. These reference labs will need to consider enrolling in Medicaid (if they are not already enrolled) if they want to keep that work.
- For hospitals buying tests under arrangement, the Manual provides that DHS "can either" pay the hospital for the test or pay the performing lab for the test. This suggests the hospital and performing lab can agree between themselves on billing. However, the Manual also notes that DHS follows the OPPS rules on lab bundling. A hospital that elected to permit its performing lab to bill directly (for services provided to hospital outpatients) would need to evaluate how to operationalize this approach to ensure that no double payment occurs.
- The Medicaid rule is inconsistent with the Medicare rules governing billing for referred tests. This means labs that perform tests for both categories of beneficiaries will have competing standards that they need to meet. In addition, commercial payors (and prepaid Medical Assistance plans) may set their own rules

for billing. This potentially means that several different sets of billing requirements may need to be followed.

- In the section of the Manual permitting under arrangement relationships, DHS cites to the Medicaid regulation on reassignment. If the rules governing reassignment apply to clinical lab tests, an open question is whether other reassignment "exceptions" found in that regulation can also be used for those tests.

You can find a copy of DHS' new language in the Manual here.

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