

DEPARTMENT: Regulatory Compliance Support	POLICY DESCRIPTION: BILLING – Hematology Procedures, Urinalysis Procedures, and Organ or Disease-Oriented Panels
PAGE: 1 of 3	REPLACES POLICY DATED: 5/1/17
EFFECTIVE DATE: February 1, 2024	REFERENCE NUMBER: REGS.LAB.026
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All HCA Healthcare -affiliated hospitals performing and/or billing laboratory services. Specifically, the following departments:

Administration	Shared Service Centers
Laboratory Personnel	Billing Staff
Revenue Integrity	Ancillary/Nursing

PURPOSE: To establish guidance for billing hematology procedures, urinalysis procedures, and organ or disease-oriented panels in accordance with Medicare, Medicaid, and other federally-funded payer requirements.

POLICY:

Hematology procedures, urinalysis procedures, and organ or disease-oriented panels and component tests billed to a federally-funded program must be based on a documented physician or advanced practice professional (APP) order and be medically necessary. Laboratory tests which include multiple tests must not be “unbundled” into component procedures. Laboratory test components will be bundled to the most appropriate comprehensive procedure (or panel) level based upon the tests ordered and performed:

- Chemistry components will be bundled to the appropriate Centers for Medicare & Medicaid Services (CMS)-approved organ or disease-oriented panels, unless the payer has provided written documentation regarding the acceptance of other American Medical Association defined organ or disease-oriented panels.
- Hematology components will be bundled to the appropriate comprehensive hematology procedure.
- Urinalysis components will be bundled to the appropriate comprehensive urinalysis procedure.

Repeated laboratory tests, including repeated components of comprehensive procedures (or panels):

- Must **not** be billed when tests are rerun to confirm initial results due to testing problems with specimens or equipment or for any other reason when a normal, one-time, reportable result is all that is required.
- Must **not** be billed when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing).
- Must **not** be billed when performed from the same specimen collection.
- May be billed when the tests are performed on the same specimen type from a subsequent collection and are medically necessary, which is indicated by appending modifier 91 to the

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HCPCS/CPT code for the repeated test. Modifier 91 may only be used, when in the course of treating a patient, it is necessary to repeat the same laboratory test on the same day to obtain subsequent test results. If a payer does not recognize or accept modifier 91 and the payer has not provided specific billing guidance for repeated laboratory tests, these tests may not be billed.

- May be billed when the repeated chemistry tests are performed on different specimen types and are medically necessary, which is indicated by appending modifier 59. If a payer does not recognize or accept modifier 59 and the payer has not provided specific billing guidance for repeated laboratory tests, these tests may not be billed.

Laboratory tests must be billed in accordance with the HCA Healthcare Laboratory Billing Compliance Plan and the Company Standard Laboratory Chargemaster. In addition, laboratory tests must be billed in compliance with CMS established Medically Unlikely Edits (MUE) and National Correct Coding Initiative (NCCI) edits.

PROCEDURE:

The following steps must be performed when billing hematology, urinalysis, and organ or disease-oriented panels to Medicare, Medicaid, and other federally-funded payers.

1. Laboratory Director and Shared Service Center (SSC) Chargemaster personnel must review and verify applicable entries are present in the facility chargemaster and appropriately tied to the related Laboratory and Order Entry masterfiles/dictionaries in accordance with the Company Standard Laboratory Chargemaster and the HCA Healthcare Laboratory Billing Compliance Plan.
2. Laboratory and SSC personnel must review and follow the additional information and billing requirements for this policy in the HCA Healthcare Laboratory Billing Compliance Plan.
3. SSC personnel must establish processes for working with the laboratory department to discuss issues and resolve identified trends.
4. Billing Edits have been implemented to assist in billing hematology, urinalysis, and organ or disease-oriented panels in accordance with this policy. SSC personnel must establish processes for resolving these edits in accordance with this policy and the HCA Healthcare Laboratory Billing Compliance Plan.
5. Laboratory Director and applicable SSC Directors must educate all staff associates responsible for ordering, charging, or billing laboratory services on the contents of this policy.

MONITORING

The billing edits established to facilitate compliance with this policy and affected claims will be periodically reviewed by Regulatory Compliance Support, Parallon and/or Shared Service Centers.



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REFERENCES:

1. Medicare Claims Processing Manual, Chapter 16, Section 90
2. AMA CPT Assistant, Summer 1993 Pages: 14-15
3. AMA CPT Assistant, January 1998 Pages: 7-8
4. AMA CPT Assistant, July 2003 Page: 7
5. Current Year Clinical Lab Fee Schedule
6. Medicare National Correct Coding Initiative Policy Manual
7. American Medical Association Physician's Current Procedural Terminology CPT
8. American Medical Association's CPT Changes 2003 – An Insider's View
9. HCA Healthcare Laboratory Billing Compliance Plan
10. [REGS.LAB.025](#) (Maintenance of Company Standard Laboratory Chargemaster)