blue of california

Payment Policy

Pass-Through Billing for Lab Services	
Original effect date:	Revision date:
03/26/2018	08/03/2018

IMPORTANT INFORMATION

Blue Shield of California payment policy may follow industry standard recommendations from various sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT) and/or other professional organizations and societies for individual provider scope of practice or other coding guidelines. The above referenced payment policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms or their electronic equivalent. This information is intended to serve only as a general reference regarding Blue Shield's payment policy and is not intended to address every facet of a reimbursement situation. Blue Shield of California may use sound discretion in interpreting and applying this policy to health care services provided in a particular case. Furthermore, the policy does not address all payment attributes related to reimbursement for health care services provided to a member. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy such as coding methodology, industry-standard reimbursement logic, regulatory/legislative requirements, benefit design, medical and drug policies. Coverage is subject to the terms, conditions and limitation of an individual member's programs benefits.

Application

Effective March 26, 2018 Blue Shield of California prohibits pass-through billing as outlined in this policy. Any claim submitted by a provider which includes services that were performed by a person or entity other than the billing provider or a direct employee of that provider will not be reimbursed.

Policy

All healthcare care providers must only bill for services that are performed by them or their staff. Pass-through billing is not permitted and may not be billed to the members.

Pass-through billing occurs when a provider bills for a clinical laboratory service, but the service is not performed by the billing provider or individuals under the billing provider's direct employment. Sub-contracted individuals/firms are not under "direct employment."

CLIA Certificate:

For laboratory services, providers will only be reimbursed when they are certified to perform those services through the Federal Clinical Laboratory Improvement Amendments (CLIA). Providers must not bill the members for any laboratory services for which they lack the applicable CLIA certification. CLIA non-compliance consequences are explained under section 42 CFR 493.569.

Modifier 90:

Reference laboratory services that are performed by an outside laboratory or by a party other than the billing provider, must be submitted with Modifier 90. These services will be processed in accords with this policy.

Exceptions:

1) A referring laboratory may bill for clinical laboratory diagnostic tests performed by a reference laboratory if the referring laboratory is wholly owned by the entity performing such tests, the referring laboratory wholly owns the entity performing such tests, or both the referring laboratory and the entity performing such tests are wholly-owned by a third entity; or

2) Hospital should bill for laboratory testing performed by a reference laboratory when they are provided to hospital outpatients when laboratory services are furnished as a

part of outpatient services of a hospital.

A patient is considered hospital outpatient when:
- Patient is present in the hospital when the specimen is collected,
- Other outpatient services are received on the same day the specimen is collected.

The hospital may not charge a marked-up rate, or more than what it has paid the reference lab for performing laboratory testing.

Note: Hospital inpatient claims are usually paid at a case rate, there should not be a separate lab charge from another lab.

Rationale

This policy facilitates Blue Shield of California to reimburse the health care claims for covered services in fair and accurate manner, avoid duplicate payments, overpayments and subsequent recoupments to prevent fraud, waste and abuse, and to ensure accurate member copay, deductible and coinsurance obligations for members in compliance with all state and federal laws, rules, and regulations including Centers for Medicare & Medicaid Services (CMS) instructions.

Reimbursement Guideline

Blue Shield of California will reference national or regional industry standards, such as Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and MUE (Medically Unlikely Edits) rules, and American Medical Association's (AMA) CPT guidelines, as coding standards and as guidance for payment policy. In claims payment scenarios where CMS and/or CPT reference is lacking or insufficient, the Payment Policy Committee (PPC) may develop customized payment policies that are based on other accepted or analogous industry payment standards and or expert input.

Resources
• **American Medical Association https://www.ama-assn.org/** • **Centers for Medicare & Medicaid Services https://www.cms.gov/**

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Payment Policy.

Effective Date	Action	Reason
03/26/2018	New Policy Adoption	Payment Policy Committee
04/13/2018	Revision	Review/Feedback
08/03/2018	Maintenance	Payment Policy Committee

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.