Packaged and Conditionally Packaged Lab Services

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Packaging refers to payment for minor, ancillary services associated with a significant procedure being combined with the primary procedure and paid as a single APC amount.

Under the new OPPS payment policy, a laboratory test will be "packaged" when (1) it is provided on the same date of service as the primary service and (2) it is ordered by the same practitioner who ordered the primary service. In contrast, a laboratory test will not be packaged if it is the only service provided to a Medicare beneficiary on the date of service. Additionally, a laboratory test performed on the same date of service as the primary service will not be packaged if it is ordered for a different purpose than the primary service and is ordered by a different practitioner. Status indicator Q4 will allow the claims processing system to pay for laboratory tests when a "lab only" claim is submitted.

Molina Packaged and Conditionally Packaged Laboratory Services Policy:

Conditionally packaged laboratory service codes (Status indicator Q4) will be denied when billed with any non-lab

According to CMS policy, effective for dates of service on or after January 1, 2014, laboratory services (except for molecular pathology) became packaged services under the Outpatient Prospective Payment System (OPPS). However, packaged laboratory services reported as the only services performed, or reported with clinically unrelated services, are considered separately payable. Services meeting the separately payable criteria are to be reported with Bill Type 0140-014Z (Outpatient hospital-other), or with Bill Type 0120-012Z (Hospital Inpatient Part B).

Additionally, effective January 1, 2016, CMS implemented a conditional package status indicator Q4 (Laboratory services subject to conditional packaging) that identifies laboratory codes when they are the only service rendered in the outpatient hospital (Bill Type 0130-013Z) in order for them to be paid separately under the Clinical Laboratory Fee Schedule (CLFS). The conditional packaging indicator designates that services will be packaged if billed on the same claim as a HCPCS code with an assigned OPPS payable status indicator. Packaged or conditionally packaged laboratory services reported with Bill Type 0120-012Z (Hospital Inpatient Part B) that also have Condition Code W2 (Duplicate of original bill) present will remain packaged and will be denied.

Any packaged or conditionally packaged laboratory services that do not meet the above criteria as separately payable will be denied.

Supplemental Information

Definitions

Term	Definition
Unconditionally packaged services	Services for which separate payment is never made because the payment for the service is always packaged into the payment for other services. Unconditionally packaged services are identified in the OPPS Addendum B with status indictor of N.
Conditional Packaging	Payment concept that indicates an item or service is not separately paid when it is considered integral, supportive, dependent, or adjunctive to an associated primary service. Conditionally packaged items or services are separately payable when provided as a primary service.

References

Government Agencies

CMS

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1678-FC-2018-OPPS-FR-Claims-Accounting.pdf

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3523CP.pdf

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3685CP.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html

Status indicator Q4:

Per CMS:

Expiration of modifier “L1” for unrelated lab tests in the OPPS:

> As a result of the CY 2014 OPPS policy to package laboratory services in the hospital outpatient setting, the “L1” modifier was used on type of bill (TOB) 13x to identify unrelated laboratory tests that were ordered for a different diagnosis and by a different practitioner than the other OPPS services on the claim. In the CY 2016 OPPS final rule, we established status indicator “Q4,” which conditionally packaged clinical diagnostic laboratory services. Status indicator “Q4” designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3”. The “Q4” status indicator was created to identify 13X bill type claims where there are only laboratory HCPCS codes that appear on the clinical laboratory fee schedule (CLFS); automatically change their status indicator to “A”; and pay them separately at the CLFS payment rates. In the CY 2017 OPPS/ASC final rule with comment period, we finalized a policy to eliminate the L1 modifier. Beginning January 1, 2017, we are discontinuing the use of the “L1” modifier to identify unrelated laboratory tests on claims.

Laboratory Services:

- Packaged:

A laboratory test will be considered packaged when:

- It is provided on the same date of service as the primary service and
- It was ordered by the same practitioner who ordered the primary service

- Not Packaged:

  A laboratory test will not be considered packaged when:

  - It is the only service provided to a Medicare beneficiary on the date of service

  OR

  - It is performed on the same date of service as the primary service; however, it is ordered for a different purpose than the primary service; and is ordered by a practitioner who is different from the practitioner who ordered the primary service.

Documentation History

Type	Date	Action
Effective Date	11/20/2020	New Policy
Revised Date	10/19/2022	Links updated, addition of definitions table
Revised Date	08/16/2023	Verified Links- TP
Revised Date	08/16/2023	Updated Template

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***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed*