Packaged and conditionally Packaged Laboratory Services

Unconditionally packaged services are 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 is a 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.
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 was ordered by the same practitioner who ordered the primary service. By 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 that is 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 practitioner who is different from the practitioner who ordered the primary service.
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:

Deny conditionally packaged laboratory service codes (Status indicator Q4) when billed with any non-laboratory service and the bill type is 0130-013Z (Hospital outpatient).
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 that meet 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 01/01/2016, CMS has implemented a conditional package status indicator Q4 (Laboratory services subject to conditional packaging) that will identify laboratory codes when they are the only service rendered in the outpatient hospital (Bill Type 0130-013Z) in order to pay them separately under the Clinical Laboratory Fee Schedule (CLFS). The conditional packaging indicator designates services will be packaged if billed on the same claim as a HCPCS code that has 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.

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.

Sources

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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf

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