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HEALTH INNOVATION MADE REAL.

Understanding Medicare's Lab Test Billing Rules: Inpatients, Outpatients, and the 14-Day Rule

Since 2007, Medicare has used a quirky set of rules that affect how lab tests are billed when specimens originate from hospital settings. These lab test rules are often called the **14-Day Rule**, but the actual policy is a patchwork of **Date of Service (DOS) rules** that behave differently depending on whether the patient is an inpatient, an outpatient, or not affiliated with a hospital at all.

Here, let's clarify these billing rules by laying them out in **a simple three-column chart** (see page 2):

- **Hospital inpatients**
- **Non-hospital patients** (such as specimens from a physician's office)
- And in the middle—the gray area: **hospital outpatients**, where Medicare policy changes depending on the type of test

What Are DOS Rules?

In most settings outside the hospital, the lab test date is straightforward: the claim form requires a DOS, and this is the **date of specimen collection.** Billing is done directly by the performing lab.

But for **hospital-associated patients**, Medicare uses special logic to **move the DOS**—and then uses the **new DOS to decide whether the test is bundled into a hospital payment or can be billed separately.**

Hold onto this thought: Medicare doesn't start by asking, "Who ordered the test?" or "Where was the test run?" Instead, it manipulates the DOS and then asks: "Was this date a hospital day or not?"

Let's Start With the Two Extremes

We'll begin with the two ends of the spectrum—**hospital inpatients** and **non-hospital patients**—where the rules are easiest. After we study this, we'll move to the **hospital outpatient column** (see page 3), which will be more complicated based on the type of test.

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Hospital Inpatient Sample		Non-Hospital Patient
The DOS is the **date of specimen collection.** Specimen collection is a medical service for the hospital inpatient or outpatient. Since the DOS is **during the inpatient hospital stay**, the lab test is bundled to the Diagostic Related Group (DRG) payment, as if the lab test had really been performed (its DOS) **on that inpatient day** (the date of specimen collection).		The DOS is the **date of specimen collection.** Since lab tests unrelated to hospital inpatient or outpatient stays are always payable as line items, the test is payable as a line item.
14-Day Rule		**14-Day Rule**
If the test is ordered more than 14 days after the date of discharge from the hospital, the DOS is the **date of test performance.** Since this is after the hospital inpatient or outpatient event, the test is not bundled, because it is treated like that of a non-hospital patient (at right).		The 14-day rule makes no difference, since tests unrelated to a hospital inpatient or outpatient stay were already separately payable as line items (as above).

Now for the Middle Column: Hospital Outpatients

We've looked at the two simple cases:

- **Hospital inpatients**, where tests are generally bundled into the DRG payment, and
- **Non-hospital patients**, where the lab simply bills Medicare directly.

In the next table (see page 3), we fill in the **middle column: hospital outpatients.**

This category includes patients seen in a **hospital emergency room, outpatient clinic**, or **hospital-owned surgical center.**

Here's Where Things Get Tricky…

Medicare rules for **hospital outpatients** vary based on the **type of test.**

For **most tests**, billing resembles the inpatient case (the test is bundled into the hospital outpatient encounter), but in 2018, Medicare carved out a special rule for **human molecular pathology tests:**

- The DOS automatically jumps forward to the **date the test is performed**—and this causes the test to be **paid separately and to the performing lab.**

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This 2018 policy change created a narrow but important escape hatch from bundling—but it only applies to human molecular tests and a few other narrowly defined categories (see details at end of document).

Let's look at all three columns together, now including **hospital outpatients.**

Hospital Inpatient Sample	Hospital Outpatient	Non-Hospital Patient
The DOS is the **date of specimen collection.** Specimen collection is a medical service for the hospital inpatient or outpatient. Since the DOS is **during the inpatient hospital stay**, the lab test is bundled to the DRG payment, as if the lab test had really been performed (its DOS) **on that inpatient day** (the date of specimen collection).	For most types of lab tests, the result is the same as for inpatients (at left). Most kinds of tests are bundled to the payment for the outpatient ER visit, clinical visit, or outpatient surgery.	The DOS is the **date of specimen collection.** Since lab tests unrelated to hospital inpatient or outpatient stays are always payable as line items, the test is payable as a line item.
	Hospital Outpatient Molecular Rule (2018) For **human molecular pathology tests**, the DOS **automatically jumps** to the **date of test performance**. The test is paid separately and paid to the lab that performs it.	
14-Day Rule	**14-Day Rule**	**14-Day Rule**
If the test is ordered more than 14 days after the date of discharge from the hospital, then the DOS is the **date of test performance.** Since this is after the hospital inpatient or outpatient event, the test is not bundled because it is treated like that of a non-hospital patient (at right).	The 14-day rule makes no difference to human molecular tests, as they were **already** assigned to the **date of test performance.** **Other** types of tests (eg, clinical chemistry) are unbundled if they are ordered 14 days after the hospital outpatient day.	The 14-day rule makes no difference, since tests unrelated to a hospital inpatient or outpatient stay were already separately payable as line items (as above).

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Where Do These Rules Come From?

Medicare's regulatory framework for these billing policies is located at 42 CFR §414.510, a section of federal regulation that governs the DOS for clinical laboratory tests.

CMS also maintains a webpage explaining these rules, although it focuses primarily on the hospital outpatient setting—the middle column in our charts.

We hope you now understand the most confusing aspect of this framework: CMS uses the DOS as a gatekeeper.

Instead of asking expected questions—like who ordered the test or where it was performed—Medicare first reassigns the DOS based on a set of rules, then asks: "Was the new date a hospital day?" which determines whether the test is bundled into a hospital payment or billable separately.

Outpatient Extra Details

The special escape hatch created by CMS in 2018—the **Molecular DOS Exception**—applies to a defined set of tests performed on hospital outpatient specimens, including:

- Human molecular pathology tests (ie, tests using human DNA or RNA)
- Advanced Diagnostic Laboratory Tests (ADLTs)
- Certain cancer-related multiprotein expression tests
- CPT code 81490 (genomic testing for blood compatibility)

The above tests are assigned status indicator "A" to indicate the hospital outpatient unbundling.

One Last Note

To qualify for your PhD in the 14-Day-Rule, know that genomic tests used in blood banking and transfusion services are always billed to the hospital where the sample originated, regardless of the DOS rule.

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