First Health Services Corporation
A Magellan Health Company

Billing Guidelines for Provider Type 43

Laboratory, Pathology Clinical

Clinical laboratory tests are furnished primarily in three distinct settings: physician office laboratories, hospital-based laboratories, and independent laboratories. Only independent laboratories (hereafter referred to as "laboratories") are a provider type 43.

Clinical laboratories must have current and appropriate CLIA certification for any laboratory test performed.

State Policy

The Medicaid Services Manual (MSM) is on the DHCFP website at http://dhcfp.nv.gov (click "Medicaid Manuals" on the DHCFP Index at left, then select "NV Medicaid Services Manual").

- MSM Chapter 800 covers laboratory and pathology services.
- MSM Chapter 1500 lists tests covered under the EPSDT program.
- MSM Chapter 100 contains important information applicable to all provider types

Managed Care

For recipients enrolled in a Managed Care Organization (MCO), it is the laboratory's responsibility to comply with all MCO service policies.

Covered Services

Medicaid covers laboratory services when they are medically necessary, diagnosis related and prescribed by a physician, physician assistant or nurse practitioner.

As shown on the Provider Type 43 Fee Schedule, the following codes are covered:

- Clinical laboratory services, CPT codes 80047-80299, 80400- 81050, 82000-84830, 85002-85810, 86000-86485, 86490-86985, 87001-87905, 89050-89235, and 89310.
- Surgical pathology services, CPT codes 88300-88386; Cytopathology services, CPT codes 88104-88189; and Cytogenic studies, CPT codes 88230-88291.
- CPT codes 36400-36410, 36420 and 36425.
- CPT code 36415, only if the specimen is collected by a physician's office/clinic and sent to an independent lab for testing.
- CPT code 36416, only when it is not part of or integral to the test procedure (e.g., bleeding or clotting time.)
- CPT code 36600, only for physicians' and/or respiratory therapists' drawing of arterial blood.

Specimen Collection Fee

A specimen collection fee is billable only when the provider drawing the lab is not the same provider or provider affiliate testing the specimen.

A physician's office is reimbursed only one specimen collection fee per encounter regardless of the number of samples drawn or tests performed from a sample.

Non-Covered Services

Medicaid does not cover:

- Medically unnecessary services
- Unlisted codes
- CPT codes 86079 and 88380
- Post mortem examination codes, CPT codes 88000 to 88099
- Reproductive medicine procedures, CPT codes 89250-89356, except for CPT code 89310 (post vasectomy)
- Handling/conveyance fees for specimens, CPT codes 99001- 99002

Prior Authorization Requirements

See MSM Chapter 800 for prior authorization requirements.

Claim Form Instructions

For complete claim form instructions, see the "CMS-1500 Claim Form Instructions" on First Health Services' website (select "Billing Information" from the "Providers" menu).

When completing the claim, be sure to:

- Enter the laboratory's CLIA or waiver number (as applicable) in Field 19.
- Enter the authorization number obtained by the physician in Field 23. This is required only for combined genotype *and* phenotype testing for recipients with chronic HIV prior to the initiation of antiretroviral therapy and for services referred by a physician directly to an out of state laboratory.

If you have billing questions, please contact the Customer Service Center at **(877) 638-3472**.

Special Billing Instructions

Only one provider may be reimbursed for the technical component (TC) or professional component (PC) of a laboratory service.

Do not bill separately for a test that is part of an already-billed panel test.