MAGELLAN MEDICAID ADMINISTRATION

Laboratory, Pathology Clinical

Provider Type 43 Billing Guide

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, except CLIA waived tests.

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").

Chapters of interest to laboratories include:

- MSM Chapter 100 contains important information applicable to all provider types.
- MSM Chapter 600 covers physician services.
- MSM Chapter 800 covers laboratory and pathology services.
- MSM Chapter 1500 lists tests covered under the EPSDT program.

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, 86000-86078, 86140-86485, 86490-86826, 86850-86906, 86920-86985, 87001-87905, 88720-88741, 89050-89235 and 89310.
- CPT code 87999 only when used to bill phenotype tropism testing.
- Surgical pathology services, CPT codes 88300-88372, 88381-88388; 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.

Qualitative Drug Screening (see also Web Announcement 347)

Use code G0430 (Drug screen, qualitative; multiple drug classes **other than chromatographic method**, each procedure) for claims with dates of service on or after Jan. 1, 2010. Billing is limited to one time per procedure.

Use code 80100 to bill qualitative drug screening for multiple drug classes **using the chromatographic method**, each procedure.

For recipients eligible for Nevada Medicaid only, use code 80101 to bill for qualitative, **single drug class method** drug screening (e.g., immunoassay, enzyme assay), each drug class. For Medicare/Medicaid dual-eligible recipients, providers must use HCPCS code G0431 to bill this test.

Non-Covered Services

Medicaid does not cover:

- Medically unnecessary services.
- Unlisted codes except for 87999 used only for phenotype tropism testing.
- A tropism test subsequent to a prior mixed or dual tropism test result or performed more than twice in a recipient's lifetime.
- CPT codes 86079, 88380, 89049 and 86910-86911.
- Routine use of genotype and/or phenotype testing when there is no evidence of virologic failure or suboptimal suppression of viral load after initiation of antiretroviral therapy.
- 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 Chapters 600 and 800 for prior authorization requirements.

If prior authorization of a laboratory test is required pursuant to MSM Chapters 600 or 800, submit form FA-6 with appropriate clinical documentation. Call Magellan Medicaid Administration at (800) 525-2395 if you have any questions regarding prior authorization.

Prior authorization must be obtained by the prescribing physician.

The billing laboratory must specify the authorization number on the claim form.

Any service requiring prior authorization that is not prior authorized will be denied for payment.

Prior authorization does not guarantee claim payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Claim Form Instructions

For complete claim form instructions, see the "CMS-1500 Claim Form Instructions" on the Magellan Medicaid Administration 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.