



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 Clinical Laboratory Improvement Amendments (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> (select "Manuals" from the "Resources" webpage).

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.

The following list of covered services is provided for your convenience. Fee schedules are located on the DHCFP Rate Setting webpage at dhcfp.nv.gov. **Neither of these lists is definitive.** To verify whether a code is covered, and what fee will be paid, please consult "Search Fee Schedule" on the Provider Web Portal at www.medicaid.nv.gov.

- Clinical laboratory services, CPT codes 80047-80081, 80150-80299, 80400-81050, 82009-84403, 84425-84830, 85002-85810, 86000-86078, 86140-86148, 86155-86485, 86490-86510, 86580-86826, 86850-86906, 86920-86985, 87003-87482, 87485-87503, 87510-87625, 87640-87906, 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.
- CPT codes for genetic testing for hereditary breast and/or ovarian cancer mutation: 81211, 81212, 81213, 81214, 81215, 81216 and 81217. All of these codes require prior authorization. Genetic



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counseling must precede genetic testing for hereditary cancer. Please see MSM Chapter 800 for the specific criteria that must be met before the tests can be ordered.

- CPT code 81519 (Oncology (breast) mRNA, gene expression profiling) is payable effective with dates of service on or after January 1, 2015. Prior authorization is required.
- CPT codes 36591 and 36592 for collection of blood specimen.
- CPT codes 88373, 88374, 88377 for surgical pathology.
- HCPCS codes G0306, G0307, G0432, G0433 and G0435 for laboratory services.

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.

Drug Screening and Testing

Presumptive drug class screening is used to identify possible use or non-use of a drug or drug class. A presumptive test may be followed by a definitive test in order to specifically identify drugs or metabolites.

Definitive drug class testing is a qualitative or quantitative test used to identify possible use or non-use of a drug. These tests identify specific drugs and associated metabolites, if performed.

The following drug testing and screening codes for presumptive screening and definitive testing are billable effective with dates of service on or after January 1, 2017:

- For presumptive screening: 80305, 80306 and 80307
- For definitive testing: G0480, G0481, G0482 and G0483

Only one of the three presumptive testing codes may be billed per day and only one of the four definitive G codes may be billed per day. A presumptive test is not required prior to a definitive drug 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 84410, 86079, 86512-86513, 87505-87507, 87631-87633, 87483, 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.



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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 Nevada Medicaid 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 Nevada Medicaid provider website www.medicaid.nv.gov.

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 (26) of a laboratory service. A provider may bill for both services if it is within their scope of practice and they do provide both services. In this case, they would not use a modifier.
- When a provider performs all of the constituent procedures of a covered organ or disease oriented panel, the provider must submit a claim for the panel rather than for each constituent procedure separately. The provider must not define a panel differently than does the CPT, and all of the constituent procedures must be medically necessary or medically indicated. When a provider performs some but not all of the constituent procedures of a panel, the provider must submit a claim for the constituent procedures separately. When a provider performs more procedures than are included in a panel, the provider may submit a claim for the additional procedures separately.