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 Division of Health Care Financing and Policy (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 Early and Periodic Screening, Diagnostic and Treatment (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 http://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 https://www.medicaid.nv.gov.

- Clinical laboratory services, Current Procedural Terminology (CPT) codes 80047-80081, 80150-80299, 80400-81050, 81513, 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: 81162, 81212, 81214, 81215, 81216 and 81217. All of these codes require prior authorization. Genetic 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 codes 81519 through 81523 (Oncology (breast) mRNA, gene expression profiling). Prior authorization is required.
- CPT codes 36591 and 36592 for collection of blood specimen.

- CPT codes 88373, 88374, 88377 for surgical pathology.
- Healthcare Common Procedure Coding System (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

Drug screenings fall under two categories: Presumptive and Definitive.

- Presumptive Screenings identify the possible use or misuse of a drug or drug class.
    - CPT codes: 80305, 80306 and 80307
- Definitive Screenings identify the specific drug or drug class.
    - HCPCS codes: G0480, G0481, G0482 and G0483

Screenings should be performed when drugs or drug classes are likely to be present based on the recipient's medical history, current clinical presentation or risk potential for abuse and diversion.

Testing for the same drug with a blood and urine specimen simultaneously, screenings for pre-employment/employment purposes, medicolegal/court ordered, participation in school/military and routine drug screenings (unless in conjunction with substance abuse treatment plan) are not covered services. Reimbursement is only allowable for medically necessary screenings.

Screenings must follow structure of screening: presumptive followed by definitive (if warranted) to identify the specific drug or drugs and quantity in the recipient.

Only one presumptive test performed by any of the following methods may be billed per recipient per day and is limited to a maximum of 20 presumptive tests per 12-rolling months before a prior authorization (PA) is required: direct observation, instrument assisted direct observation, and instrument chemistry analyzers. Standing orders for presumptive drug screens may be utilized, but must be individualized for each member, signed and dated by the treating practitioner and updated every 30 days.

Only three definitive drug tests are permitted per recipient per 12 rolling months prior to a PA being required. Standing orders are not permitted for definitive drug screens. Definitive testing is only covered to confirm an unexpected result or identify drugs or metabolites that cannot be detected on a presumptive drug screen.

Per episode of care, regardless of the number of collection/testing items used, the number of procedures and/or the drug classes screened, billing should only reflect one procedure code.

Drug confirmation tests are not eligible to be separately reported under any procedure code, unlisted or otherwise.

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.

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- 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 (PA)

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 the Outpatient Medical/Surgical Services Prior Authorization Request (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.

Billing Instructions

For billing instructions, see the Electronic Verification System (EVS) Chapter 3 Claims on the EVS User Manual webpage and the EDI companion guides on the Electronic Claims/EDI webpage.

When completing the claim, be sure to:

- Enter the laboratory's CLIA or waiver number (as applicable).
- Enter the authorization number obtained by the physician. 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.
- Enter modifier QW when billing for laboratory CLIA waived tests that are granted waived status under CLIA from the Centers for Medicare & Medicaid Services (CMS). The list of the tests granted waived status under CLIA can be found on the following CMS webpage: https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/waivetbl.pdf

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.

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Ordering, Prescribing or Referring (OPR) Provider Requirements

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services (CMS) require all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (§455.410 Enrollment and Screening of Providers). The Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid. Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

For any services or supplies that are ordered, prescribed or referred, the National Provider Identifier (NPI) of the Nevada Medicaid-enrolled Ordering, Prescribing or Referring (OPR) provider must be included on Nevada Medicaid/Nevada Check Up claims or those claims will be denied. To prevent claim denials for this reason, please confirm that the OPR provider is enrolled with Nevada Medicaid; this can be done on the Provider Web Portal by using the Search Providers feature: https://www.medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

Electronic Claims instructions: When reporting the provider who ordered services such as diagnostic and lab, use Loop ID-2310A. For ordered services such as Durable Medical Equipment, use Loop ID-2420E. For detailed information, refer to the 837P FFS Companion Guide located at: https://www.medicaid.nv.gov/providers/edi.aspx

Direct Data Entry/Provider Web Portal instructions: On the Service Detail line enter the OPR provider's NPI in the Referring/Ordering Provider ID field, and select "Yes" or "No" to indicate it if is an Ordering Provider. For further instructions, see the Electronic Verification System (EVS) User Manual Chapter 3 located at: https://www.medicaid.nv.gov/providers/evsusermanual.aspx